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Do Midwifery Students Recognize Obstetric Violence? A Descriptive Study Based on Knowledge and Experience

Ebe Adayları Obstetrik Şiddeti Tanıyor mu? Bilgi ve Deneyime Dayalı Tanımlayıcı Bir Çalışma

Yurdagül GÜNAYDIN[1], Esma KIR[2]

ABSTRACT

Recognizing obstetric violence is vital for protecting women's rights and ensuring respectful care; thus, midwifery students must be aware. The purpose of this study was to determine midwifery students' knowledge of, and experience with, obstetric violence during labour. This cross-sectional descriptive study was conducted between April and June 2024. The participants were 258 midwifery students attending a state university who were taking part in clinical practice. Data were collected using both the Descriptive Information Form and Obstetric Violence Diagnosis Form. The mean age of the participants was 21.30±2.21 years. 57% of students participated in birth; 17.4% witnessed violence. The following types of intervention were identified by participants as constituting obstetric violence:not adequately protecting the privacy of the pregnant woman (68.2%); pelvic examinations being conducted without consent (identified by 63.2% of the participants); restrictions of a patient's freedom of movement (57.4%); and patients being forced into the lithotomy position (54.3%). Among the verbal violence expressions against women, the most prominent expressions were "Stop complaining" (64.3%) and "You don't know how to push the baby" (63.6%). Other examples of interventions not approved by the participants include routine episiotomy (48%) and episiotomy and suturing perineal tears without local anaesthesia (56.6%). Overall, 31% of the students stated that obstetric violence was common in health institutions. In preventing obstetric violence, respectful care training for midwifery students, the implementation of national and international guidelines, legal regulations, and a woman-centered childbirth process are of great importance.

Keywords: Midwives, Midwife Candidates, Obstetric Violence

ÖZ

Obstetrik şiddetin tanınması, kadın haklarının korunması ve saygılı bakım için önemlidir; bu yüzden ebe adaylarının bilinçli olması gerekir. Bu çalışmanın amacı, ebelik öğrencilerinin doğum sürecinde meydana gelen obstetrik şiddete ilişkin bilgi düzeylerini ve deneyimlerini belirlemektir. Bu kesitsel tanımlayıcı çalışma, Nisan–Haziran 2024 arasında yapılmıştır. Araştırmanın örneklemini, bir devlet üniversitesinde klinik uygulamaya katılan 258 ebelik öğrencisi oluşturmuştur. Veriler, Tanıtıcı Bilgi Formu ve Obstetrik Şiddet Tanı Formu kullanılarak toplanmıştır. Katılımcıların yaş ortalaması 21,30±2,21 yıldır. Öğrencilerin %57'si doğuma katılmış, %17,4'ü şiddete tanık olmuştur. Katılımcılar tarafından obstetrik şiddet kapsamında değerlendirilen müdahale türleri arasında; hamile kadının mahremiyetinin yeterince korunmaması (%68,2), onam alınmaksızın yapılan pelvik muayeneler (%63,2), hastaların hareket özgürlüğünün kısıtlanması (%57,4) ve litotomi pozisyonuna zorlanmaları (%54,3) yer almıştır. Kadınlara yönelik sözel şiddet ifadeleri arasında; "Şikâyet etmeyi bırak" (%64,3) ve "Bebeği nasıl iteceğini bilmiyorsun (%63,6)" öne çıkmıştır. Katılımcıların onaylamadıkları diğer müdahale örnekleri arasında ise; rutin epizyotomi uygulanması (%48), epizyotomi ve perine yırtıklarının lokal anestezi olmadan dikilmesi (%56,6) yer almıştır. Genel olarak, öğrencilerin %31'i sağlık kurumlarında obstetrik şiddetin yaygın olduğunu bildirdi. Bu çalışma, ebelik öğrencilerinin obstetrik şiddet konusundaki farkındalıklarının artırılması gerektiğini ortaya koymuştur. Obstetrik şiddetin önlenmesinde, ebelik öğrencilerine yönelik saygılı bakım eğitimleri ve ulusal/uluslararası rehberlerin uygulanması, yasal düzenlemeler ve kadın odaklı doğum süreci önem taşımaktadır.

Anahtar Kelimeler: Ebe, Ebe Adayları, Obstetrik Şiddet

Approval was obtained from the Yozgat Bozok University Social and Human Sciences Ethics Commission (Decision No:13/35 and Date 17.04.2024).

[1] Dr. Öğr. Üyesi, Yurdagül GÜNAYDIN, Halk Sağlığı Hemşireliği, Tarsus Üniversitesi, Sağlık Bilimleri Fakültesi, Hemşirelik Bölümü, yurda_gul@windowslive.com, ORCID: 0000-0002-7914-8328.

2 Öğr. Gör. Esma KIR, Ebelik Doktora Öğrencisi, Yozgat Bozok Üniversitesi, Sağlık Bilimleri Fakültesi, Ebelik Bölümü, esma.kir@bozok.edu.tr, ORCID: 0009-0005-0125-2626

İletişim / Corresponding Author: Yurdagül GÜNAYDIN
e-posta/e-mail: yurda_gul@windowslive.com

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INTRODUCTION

The maltreatment of women during childbirth, referred to as Obstetric Violence (OV), is an alarming breach of both human rights and the ethical foundations of healthcare services. OV is understood as stemming from attitudes and practices that are disrespectful, humiliating, and contrary to the human rights of women in healthcare institution (1-4). It includes the violation of women's physical, psychological, and social rights during labour and postnatal care and the disregard of individual autonomy, privacy, and safety. Physical and verbal abuse, humiliation, non-consensual medical interventions, and violations of privacy constitute the main components of OV. In addition, obtaining informal or incomplete consent without providing adequate information, neglecting pain management, preventing access to health services and negligent attitudes of care-providers during the birth process are considered important violations of rights that seriously threaten the health of women and newborns (4-5). Studies demonstrate that the prevalence of OV worldwide varies between 12.6% and 97.4%, in line with the findings of the current study, and reveal how this phenomenon is shaped by a variety of dynamics (6-10).

Women subjected to OV experience negative psychological and social repercussions as well as a deterioration of their general well-being over the long-term. Reactions to obstetric violence may include personality changes and the development of mood and stress-related disorders, such as post-traumatic stress disorder (PTSD) resulting from birth trauma. Additionally, there may be weakening of the maternal-infant emotional bond, disruptions in family dynamics and sexual life, as well as a decreased desire for future childbearing (11-13). In a study conducted on 3.065 women in Brazil, Silveira et al. (2019) reported that women exposed to OV had an above average of developing postnatal depression, and drew attention to the potential long-term effects of OV (14).

Incidents of OV have been known to negatively affect not only the psychological and physiological health of the victims, but also the mental well-being of the healthcare professionals who witness them (15). Studies show that healthcare professionals may experience psychological problems such as emotional burnout, compassion fatigue, and secondary traumatic stress due to witnessing obstetric violence (15). Some choose to undergo elective caesarean section or decide against conceiving altogether in order to avoid being subjected to OV (16). There is also the danger that the prevalence of OV may become normalised for healthcare workers over time (16).

Given the above, it is essential that midwifery students develop an appreciation of the need to support women by eliminating prejudice, antiquated personal beliefs, and negative attitudes regarding the birthing process. Determining the knowledge and experience of midwifery students regarding OV is of critical importance for addressing this problem effectively. The limited number of pertinent studies conducted in our country make the importance and necessity of this research even more evident. This study comprehensively examined the knowledge and experience of midwifery students about OV and revealed their awareness level in this field. Within the scope of the research, answers to the following questions were sought:

What is the knowledge status of midwifery students regarding OV?

What are the experiences of midwifery students with OV?

MATERIALS AND METHODS

Research Methodology

The study was descriptive and cross-sectional.

Place and Time of the Research

The participants in the research were undergraduate students enrolled in the midwifery department of a state university in Central Anatolia. The research took place from April to June 2024.

Population and Samples of the Study

The study population consisted of the 330 undergraduate students enrolled in the midwifery department of a university located in the Central Anatolia Region between April 2024 and June 2024. The study sample consisted of 221 midwifery students, determined using the known population sample size formula with a 99% confidence level and a 5% margin of error. Taking into account possible data loss, estimated at 10%, a total of 258 participants were ultimately included in the study (17). The study employed a convenience sampling method. Students who volunteered to participate, were engaged in clinical practice, and fully completed the research forms were included in the study. Students who did not volunteer to participate or had incomplete data were excluded from the study.

Data Collection Tools

Data were collected using the Introductory Information Form and the Obstetric Violence Diagnosis Form.

Introductory Information Form

This form, prepared by the researchers drawing upon the pertinent literature, had two sections. The first section consisted of questions to elicit the participants' sociodemographic information (age, income status, place of residence, etc.). The second section posed questions designed to obtain information regarding the participants' experience with OV and their knowledge levels concerning such issues as the definition of OV, diagnostic practices, and symptoms (16).

Obstetric Violence Diagnosis Form

This form was prepared by the researchers based on a literature review. It elicited specific information concerning the participants' previous experience in the field, and whether they had conducted their own studies of OV. The form then identified specific interventions which were considered elements of OV. The participants were provided with three options: "yes," "no," and "undecided." A "yes" answer indicated that the participant considered the intervention amounted to OV. A "no" answer indicated that the participant did not consider the intervention to constitute OV. An "undecided" answer was created for participants who felt they did not have enough information or experience to make the decision (16).

Data Collection

The data collection process was conducted in the classroom setting during separate time slots based on students' availability. The purpose of the study was explained to the students, written informed consent was obtained from those who volunteered to participate, and the data collection forms were subsequently distributed. Completing the forms took approximately 10 minutes per student, and all forms were collected directly by the researcher.

Data Evaluation

The statistical evaluation of the obtained data was performed using the SPSS 25.0 package programme in a computer environment. Descriptive statistical measures (mean, standard deviation, percentage, minimum and maximum values) were used.

Ethical Aspects of the Research

Approval was obtained from the Yozgat Bozok University Social and Human Sciences Ethics Commission (Decision No:13/35 and Date 17.04.2024) and written institutional permission was obtained from the institution where the research was conducted. The

purpose of the research was explained to the participants, who were asked to sign an informed consent form attesting to their agreement to participate in the study.

RESULTS

Table 1. Distribution Of Participants According To Their Descriptive Characteristics (n=258)

Characteristics		
Age (Mean ± SD)	21.30 ± 2.21	
Academic level	**n**	**%**
1	60	23.3
2	71	27.5
3	59	22.8
4	68	26.4
Place of residence		
Province	145	56.2
District	80	31.0
Village	33	12.8
Household members		
With their family	224	86.8
With a friend	25	9.7
Alone	9	3.5
Income		
Income less than expenses	66	25.5
Income equal to expense	181	70.2
Income more than expenses	11	4.3
Family type		
Nuclear family	217	84.1
Wider family	37	14.3
Broken family	4	1.6
Mother education status		
Not literate	25	9.7
Primary school	106	41.1
Middle school	57	22.1
High school	50	19.4
University	18	7.0
Postgraduate	2	0.7
Father education status		
Not literate	6	2.3
Primary school	84	32.6
Middle school	49	19.0
High school	79	30.6
University	36	14.0
Postgraduate	4	1.5

n: Number of participant , %: Percentage value

The distribution of the participants according to their descriptive characteristics is provided in Table 1. The mean age of the participants was 21.30 ± 2.21 years; 27.5% were in their second year, 56.2% lived in the province; 86.8% lived with their families; 70.2% had an income equal to their expenses; 84.1% were part of a nuclear family; 41.1% had a primary school graduate mother; and 32.6% had a primary school graduate father.

Table 2. Distribution Of Participants According to Knowledge About or Experience With OV

Characteristics	**n**	**%**
Knowledge of obstetric violence		
Yes	154	59.7
No	104	40.3

Table 2. (Continued)

Having witnessed obstetric violence before		
Yes	45	17.4
No	213	82.6
Source of information about obstetric violence *		
College	68	19.5
The internet and media sources	104	29.9
Hospital-based source	43	12.4
From family and close friends	25	7.2
TV and radio	19	5.5
I have no information	89	25.6
Belief in the prevalence of obstetric violence in healthcare settings		
Yes	80	31.0
No	44	17.1
Partially	134	51.9
Witnessed birth in clinical practice		
Yes	147	57.0
No	111	43.0
Women needed privacy and confidentiality during gynecological examinations, the birth process, and postpartum care. *		
Privacy and confidentiality	235	22.6
Meeting information needs	194	18.7
Cesarean section preference	92	8.8
Episiotomy preference	100	9.6
Deciding on the method of birth	175	16.8
Preference for not being frequently examined	102	9.8
The ability to select healthcare personnel	142	13.7

n: Number of participants, %: Percentage value, * Multiple responses

The distribution of participants according to their knowledge about or experience with OV is set out in Table 2. Fifty-nine point seven percent of the participants stated that they knew about OV; 17.4% stated that they had witnessed instances of OV; 29.9% stated that they learned/heard about OV through the internet and media; 51.9% stated that they thought that OV was partially common in health institutions; 57% stated that they had witnessed birth in clinical practice; and 22.6% stated that women required privacy and confidentiality during gynaecological examinations, during the birth process, and after birth.

Table 3. Participants' İdentification of OV

Characteristics	n	%
Inserting an intravenous channel		
Yes	52	20.2
No	136	52.7
Undecided	70	27.1
Directing the woman's position		
Yes	92	35.7
No	90	34.8
Undecided	76	29.5
Accelerating labour using various interventions		
Yes	110	42.6
No	55	21.3
Undecided	93	36.1

Table 3. (Continued)

Routinely administering enemas		
Yes	100	38.8
No	70	27.1
Undecided	88	34.1
Performing routine genital shaving		
Yes	74	28.7
No	103	39.9
Undecided	81	31.4
Forcing the woman to adopt the lithotomy position		
Yes	140	54.3
No	42	16.2
Undecided	76	29.5
Allowing accompaniment during the second stage		
Yes	64	24.8
No	131	50.8
Undecided	63	24.4
Routinely Performing Amniotomies		
Yes	117	45.4
No	64	24.8
Undecided	77	29.8
Cutting the umbilical cord immediately		
Yes	105	40.7
No	76	29.5
Undecided	77	29.8
Restraining the woman's movements		
Yes	148	57.4
No	53	20.5
Undecided	57	22.1
Performing pelvic examinations without consent		
Yes	163	63.2
No	53	20.5
Undecided	42	16.3
Not providing advice on pain reduction during labour		
Yes	133	51.5
No	68	26.4
Undecided	57	22.1
Encouraging the use of an epidural		
Yes	73	28.3
No	88	34.1
Undecided	97	37.6
Not adequately protecting the privacy of the pregnant woman		
Yes	176	68.2
No	49	19.0
Undecided	33	12.8
Attempting to persuade a woman to have a caesarean section		
Yes	152	58.9
No	54	20.9
Undecided	52	20.2
Not taking into account the woman's opinions and decisions		
Yes	170	65.9
No	53	20.5
Undecided	35	13.6

Table 3. (Continued)

Taking photographs without permission		
Yes	164	63.6
No	56	21.7
Undecided	38	14.7
Performing routine episiotomies		
Yes	126	48.8
No	64	24.8
Undecided	68	26.4
Telling a woman 'you don't know how to push the baby		
Yes	164	63.6
No	53	20.5
Undecided	41	15.9
Performing the crystals manoeuvre		
Yes	118	45.7
No	59	22.9
Undecided	81	31.4
Performing an episiotomy without local anaesthesia		
Yes	146	56.6
No	62	24.0
Undecided	50	19.4
Prohibiting eating and drinking		
Yes	85	32.9
No	80	31.1
Undecided	93	36.0
Not covering/warming the woman during transfer		
Yes	162	62.8
No	57	22.1
Undecided	39	15.1
Telling a woman to "stop complaining", saying "it's not that bad		
Yes	166	64.3
No	52	20.2
Undecided	40	15.5
Telling the woman to refrain from shouting		
Yes	152	58.9
No	58	22.5
Undecided	48	18.6
Performing a caesarean section due to slow dilation		
Yes	97	37.6
No	88	34.1
Undecided	73	28.3
Performing emergency caesarean sections without consent		
Yes	127	49.2
No	67	26.0
Undecided	64	24.8
Refusing to permit the woman to have a companion present during the birth process		
Yes	138	53.5
No	61	23.6
Undecided	59	22.9
Suturing a perineal tear without anaesthesia		
Yes	146	56.6
No	67	26.0
Undecided	45	17.4

Table 3. (Continued)

Separating the mother and newborn		
Yes	137	53.1
No	60	23.3
Undecided	61	23.6
Allowing skin-to-skin contact after the pediatric examination		
Yes	84	32.5
No	116	45.0
Undecided	58	22.5
Giving formula without the mother's consent		
Yes	120	46.5
No	74	28.7
Undecided	64	24.8

n: Number of participants, %: Percentage value

The interventions which have been identified by the participants as constituting OV, along with the percentage of participants who identified them, are listed in Table 3. The interventions include: ordering the pregnant woman to assume a particular position (identified by 35.7% of the participants); accelerating labour using various interventions (42.6%); routinely administering enemas (38.8%); forcing the woman to adopt the lithotomy position (54.3%); routinely performing amniotomies (45.4%); cutting the umbilical cord immediately (40.7%); restraining the woman's movements (57.4%); performing pelvic examinations without consent (63.2%); not providing advice on pain reduction during labour (51.5%); not adequately protecting the privacy of the pregnant woman (68.2%); attempting to persuade a woman to have a caesarean section (58.9%); not taking into account the woman's opinions and decisions (65.9%); taking photographs without permission (63.6%); performing routine episiotomies (48.8%); telling a woman 'you don't know how to push the baby' (63.6%); performing the crystals manoeuvre (45.7%); performing an episiotomy without local anaesthesia (56.6%); not covering/warming the woman during transfer (62.8%); telling a woman to "stop complaining", saying "it's not that bad" (64.3%); telling the woman to refrain from shouting (58.9%); performing a caesarean section due to slow dilation (37.6%); performing emergency caesarean sections without consent (49.2%); refusing to permit the woman to have a companion present during the birth process (53.5%); suturing a perineal tear without anaesthesia (56.6%); separating the mother and newborn (53.1%); and feeding the infant formula without the mother's consent (46.5%).

Also listed in Table 3 are the following interventions, identified by the noted percentage of participants as constituting undecided OV: encouraging the use of an epidural (37.6%); prohibiting eating and drinking (36%).The following interventions were not considered as OV by the participants: inserting an intravenous cannula (52.7%); routine perineal shaving (39.9%); allowing companionship in the second stage of labour (50.8%); allowing skin-to-skin contact after the pediatric examination (45%).

DISCUSSION

OV is a critical problem that endangers the physical, emotional, and psychological well-being of women during the birth process and deeply shakes their trust in health services. This study examined the participants' knowledge of, and experience with, OV in depth, and addressed the prevalence of the perception of OV in health institutions from a comparative perspective using the existing literature. The majority of the participants stated that OV is occurs to some extent common in health institutions and emphasised that women especially need privacy and confidentiality during gynaecological examinations, and during the birth and postnatal periods. Similarly, in a study conducted by Aydın, Kartal, and Bulut

(2023), students (64%) reported that OV was prevalent in health institutions (18). Although these findings reveal that midwifery students are obtaining an increased level of awareness of OV, it can be said that it remains an important problem in the health system.

The findings of this study demonstrate that midwifery students have a growing awareness of OV, and some of them have witnessed interventions amounting to OV. A related study reported similar findings; in that study more than half of the students (50%) had knowledge about OV and one-third (33.3%) had witnessed incidents of OV (18). These findings are consistent with the international literature. Other studies conducted in various geographic locations have also revealed that the level of awareness of the subject is gradually increasing (16,18-20). For example, in a study conducted in Spain, it was determined that midwifery, nursing and medical students had high awareness and perceptions of OV (16). Similarly, in another study conducted with medical students in the UK and India, (26%) and (34%) of the students respectively stated that they had encountered the term OV in the past, and (14%) of the students in the UK and (49%) of the students in India stated that they had witnessed OV in clinical practice (19).

These data reveal that medical students' knowledge of, and experience with, OV differs significantly between countries. A study conducted by Ramos et al. (2022) in Brazil reported that 99.1% of the nursing students who participated in the study stated that they knew about OV (20). This very high level of awareness suggests that health students' knowledge of this subject is increasing, with this awareness becoming more evident among health professionals. In the current study, the evidence of the participants' knowledge of OV is consistent with similar findings in the literature. In addition, that some participants reported having witnessed incidence of OV strengthens the findings, as they are based not only on a theoretical but also on a practical basis.

OV during labour is a multidimensional phenomenon that could include physical, verbal, emotional, and/or psychological abuse of the patient during the labour process that at times results in unnecessary medical interventions. Examples of physical violence of a woman during labour include the refusal to explain or provide pain control methods, placing the woman in uncomfortable positions, applying fundal pressure, and food and beverage restrictions (21-23). In our study, interventions such as pelvic examinations performed without consent, restriction of freedom of movement, forced lithotomy position, and application of fundal pressure, which were acknowledged as occurring by the majority of the participants, constitute important ethical and clinical problems in terms of women's rights. Research results suggest that these practices violate a woman's bodily integrity and autonomy during the birth process. In a study related to the subject published in the national literature, it was reported that practices such as restricting the movements of the pregnant woman, forcing the woman into the lithotomy position, and applying fundal pressure occurred in health institutions (18,24).

These findings coincide with the results of our study and support the conclusions from our research. International studies have argued that forced birth interventions violate patient rights and harm maternal health (15). The World Health Organisation emphasises that unnecessary interventions in the birth process should be reduced and recommends the dissemination of woman-centred care models for giving birth (25). Based on the knowledge and experience of midwifery students, this study revealed that the physical violence to which women are exposed during the birth process remains a serious problem in health services and that students have significant sensitivity to, and knowledge about, this issue. In the literature, it has been remarkably demonstrated that when women are given freedom of movement, especially in the first stage of labour, perceived birth pain decreases, the birth process and duration are shortened, the amount of postpartum

bleeding decreases, and the first contact of the baby with the mother and breastfeeding time are positively affected (26).

Our findings reveal that the participants possessed an acute awareness of verbal violence against women during the birth process. In this context, a significant number of the participants stated that they heard statements such as you don't know how to push the baby and stop complaining, it's not that bad directed at the woman during childbirth. It can be concluded that health professionals sometimes exhibit indifferent or negative attitudes towards women in labour. The findings suggest that this may be a structural problem within the healthcare system. In the literature, there are many studies reporting that women are exposed to verbal violence by healthcare professionals during labour (27-28). This may increase a woman's fear of birth and negatively affect the natural flow of the process. Studies have determined that negative emotional experiences during labour may affect the psychological and physiological status of the woman and prolong the duration of labour (29). Verbal violence may undermine a woman's self-confidence, increase her risk of postnatal depression, and negatively affect her confidence in future health services (14,30). The fact that the participants recognise verbal abuse as a form of violence reveals their positive sensitivity to the issue and concern for the woman's mental and physical health.

Inappropriate medical interventions during the birth process violate the woman's right to exercise control over the birth process and the naturalness of birth itself, and practices such as routine intravenous access, routine administration of enemas, the administration of oxytocin, performing episiotomies, and delivery by caesarean section, all at times administered or performed without consent, stand out (9,31). In this context, it has been reported that delivery by caesarean section without consent is the most common intervention, followed by routine episiotomy and the administration of enemas. Studies on the subject support our research results (18,24). Unnecessary medical interventions may negatively affect the physical and emotional health of women and may traumatise the birth experience (9,31). Therefore, adoption of a rights-based and empathic approach by healthcare professionals that acknowledges the requirement for the consent of the woman is vital for a safe and positive birth process.

Unauthorised interventions by healthcare professionals during the birth process, breach of confidentiality, dishonourable care, isolation, and violation of autonomy are considered behaviours which breach respectful maternal care standards (6). Unapproved care during labour includes medical interventions that do not respect the woman's bodily autonomy and decision-making rights. Practices such as abdominal palpation and vaginal examination performed without the consent of the woman are recognized as unapproved care (23). In our study, approximately two-thirds of the participants mentioned the occurrence of pelvic examinations without consent, and the majority identified episiotomies and perineal repair without anaesthesia as examples of unapproved care. These results strongly suggest that the participants believe that a woman's bodily autonomy and decision-making rights should be unconditionally respected during the birth process. Similarly, studies in the literature have reported that interventions such as unauthorised vaginal examinations and episiotomy without anaesthesia are frequently reported, and these situations lead to serious ethical problems (24).

These findings draw attention to violations of patient rights at the individual level and highlight the necessity to review existing practices in health services. One striking example comes from a study conducted in Mexico that found that intrauterine devices were inserted into women postnatally without their knowledge or consent (32). These findings demonstrate how unapproved care can have negative effects on women's health at the global level.

The participants stated that postnatal interventions may violate the rights of women and newborns and should be evaluated within the scope of OV. In particular, practices such as the separation of the mother and newborn, and giving formula to the baby without the mother's consent, were mentioned by half of the participants. In one study, giving formula to the baby without the mother's consent was reported by 67.5% of the participants (18). In another study, giving formula without permission was reported by approximately two-thirds of the participants (24). The differences in the study findings show that the knowledge and experience of midwifery students may create diversity in the way they perceive and evaluate postnatal care practices. These differences may be shaped by the institutions where the students receive education, their level of clinical experience, and the practice environments they encounter.

CONCLUSION AND RECOMMENDATIONS

This research increases the awareness of midwifery students' knowledge and experience of OV and structural and ethical problems in women's health services. Disrespectful interventions during the birth process can seriously threaten the physical and psychological health of women in both the short and long term. The prevention of OV requires not only an individual effort on the part of students and practitioners, but also fundamental changes in the healthcare system. It is important to improve the training of health professionals and to raise women's awareness of their birth rights. It is also imperative that policies and protocols for preventing OV in health institutions be established and effectively implemented. Strengthening the principles governing the respectful care of women taught to prospective midwives will contribute to the spread of positive birth experiences. Future studies are recommended to use larger samples and qualitative methods. The impact of educational interventions should be examined experimentally.

Conflicts of Interest

The authors have no conflicts of interest to disclose.

Author Contributions

Concept Y.G; Design Y.G., E.K; Data Collection and/or Processing -Y.G., E.K; Analysis and/or Interpretation - Y.G., E.K; Literature Review -Y.G., E.K; Writing - Y.G., E.

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