

# Evaluating the Effectiveness of an Obstetric Violence Awareness Education for Midwifery Students: A Quasi-Experimental Pilot Study

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## What is currently known about this topic?

- Midwifery students have limited awareness of obstetric violence.
- Obstetric violence is often unrecognized in routine maternity care.
- Training on obstetric violence is rarely included in midwifery curricula.

## What the paper adds to the existing knowledge?

- The training improved students' ability to identify obstetric violence.
- Students began questioning normalized harmful birth practices after training.
- Awareness increased in areas like consent, mistreatment, and unnecessary care.

## How the information in your manuscript can be applied to practice?

- Training content can be embedded into midwifery and nursing education.
- Education fosters respectful, rights-based, and woman-centered care.
- Early awareness may help reduce mistreatment in clinical maternity settings.

## ABSTRACT

**Objective:** Obstetric violence is a prevalent yet often overlooked problem in maternity care.

This study aimed to examine the effectiveness of an awareness-based education program in improving midwifery students' perceptions of childbirth violence.

**Methods:** This quasi-experimental study employed a pilot single-group pre-test–posttest design. Forty-two final-year midwifery students from a university in Türkiye participated. Data were collected between May 22, 2025 and May 23, 2025, and data were analyzed using IBM SPSS Statistics 23.0. Students completed the obstetric violence awareness scale (OVAS) before and after a structured training session incorporating case-based scenarios, role-play, ethical discussions, and group reflections.

**Results:** Posttraining, students demonstrated significant improvements in recognizing intrapartum mistreatment, non-evidence-based practices, lack of consent, and restricted accompaniment rights ( $P < .005$ ). Increased awareness of postpartum mistreatment indicated that students began to question previously normalized practices. The total score increase was not statistically significant.


**Conclusion:** The education program enhanced students' ability to identify and critically reflect on obstetric violence. Incorporating such training into midwifery curricula could promote respectful, rights-based, and woman-centered maternity care. The findings indicate that the training achieved its intended goal of increasing students' awareness and critical understanding of obstetric violence.

**Keywords:** Midwifery students, obstetric violence, respectful maternity care

## Introduction

Negative attitudes and behaviors, whether physical, emotional, verbal, or structural, experienced by women during pregnancy, childbirth, and the postpartum period are defined in the literature as obstetric violence<sup>1</sup>. Obstetric violence encompasses a range of actions such as disregarding a woman's privacy, performing medical interventions without informed consent, conducting unnecessary or excessive procedures, using derogatory language, engaging in discrimination, and neglecting care.<sup>2,3</sup> Such practices represent not only violations of individual rights but also manifestations of structural inequalities embedded within the healthcare system.

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Obstetric violence is a significant public health issue that has been increasingly documented in perinatal care settings worldwide.<sup>4</sup> Studies conducted across different countries report prevalence rates ranging from 15% to 97%.<sup>5-9</sup> Although research in this area is limited in Türkiye, existing studies indicate alarming rates. For instance, Aşçı and Bal (2023) reported a prevalence of 76.4%, while Okyay et al (2022) found that women experienced multiple forms of violence during childbirth.<sup>10,11</sup>

The consequences of obstetric violence extend beyond the birth process, negatively impacting postpartum psychological well-being, mother–infant bonding, trust in health services, and the likelihood of re-utilizing these services.<sup>3,12</sup> Situations in which women’s voices are unheard, their autonomy is violated, and their needs are disregarded are particularly common in medicalized birth settings. A qualitative study by Sánchez et al (2023) highlighted that women are often pushed into passive roles during childbirth and their participation in decision-making is limited.<sup>13</sup>

Awareness among healthcare professionals is essential in combating obstetric violence. Accordingly, it is crucial for future professionals in childbirth services—such as midwifery and nursing students—to be able to recognize obstetric violence and implement preventive measures. However, literature findings reveal a substantial lack of awareness in this field. Dağlar and Acar (2024) reported that midwifery and nursing students could not adequately define obstetric violence and failed to perceive certain routine practices as harmful. Similarly, Aydın Kartal and Bulut (2023) found that midwifery students had insufficient knowledge on the topic and that it was not adequately covered in their curricula.<sup>12,14</sup>

Therefore, fostering a woman-centered, respectful, and compassionate approach to care requires the systematic inclusion of these concepts early in professional education. This study aims to evaluate the effectiveness of obstetric violence awareness training for midwifery students and to contribute to the development of human rights-based practices in maternity care.

Research Hypotheses:

H1: Students’ awareness scores regarding the intrapartum mistreatment subdimension will significantly change after the training.

H2: Students’ scores for the non-evidence-based routine practices subdimension will significantly change after the training.

H3: Students’ scores for the postpartum mistreatment subdimension will significantly change after the training.

H4: Students’ scores for the informed consent and companionship subdimension will significantly change after the training.

H5: Students’ scores for the unnecessary interventions subdimension will significantly change after the training.

H6: The total score of students’ obstetric violence awareness will significantly change after the training.

## Methods

### Type of Research

This study employed a single-group, pretest–posttest quasi-experimental pilot design.

### Research Location and Time

The research was conducted in a classroom setting at a foundation university on May 22, 2025–May 23, 2025.

### Population and Sample

The study population consisted of 48 fourth-year students enrolled in the Midwifery Department of a foundation university during the 2024–2025 academic year. The curriculum contained no course addressing obstetric violence. No sample selection was undertaken; instead, the aim was to reach the entire population.

Of these, 42 midwifery students who regularly attended classes during the study period and volunteered to participate were included. Four students were excluded due to absence or withdrawal from the study.

Fourth-year students were selected as the study sample because this group was deemed most appropriate for assessing awareness levels regarding obstetric violence. The primary rationale was that these students had completed theoretical and practical courses on women’s health, childbirth, and maternity services, and had gained direct observation and clinical experience. At this stage of training, students also have greater awareness of obstetric practices due to their active participation in the birth process.

As this study was designed as a pilot to assess the feasibility and preliminary effectiveness of the educational intervention, no formal sample size calculation was performed. Instead, the study aimed to include the entire accessible population of senior midwifery students at the institution ( $n = 48$ ). Of these, 42 students who met the inclusion criteria and volunteered to participate were included in the analysis. Although the sample size is relatively small, it is considered acceptable for a pilot study aiming to generate preliminary data.

The criteria for inclusion in the study were: being a midwifery student, not having previously taken an obstetric violence course/training, and volunteering to participate in the study. Students enrolled in dual-degree programs were excluded.

### Data Collection Tools

Data were collected using an information form and the Perception of Obstetric Violence Perception Scale for Students (OVPSS), which were prepared by researchers in line with the literature.

### Information Form

The information form contains a total of 4 questions regarding the students’ age, whether they have received education on obstetric violence, whether they have experienced obstetric violence, and whether they have heard of the concept of obstetric violence before. The questions in the form were developed by researchers in line with the relevant literature.<sup>15,16</sup>

### Obstetric Violence Perception Scale for Students

The original scale was developed by Mena-Tudela and colleagues (2020), and the Turkish adaptation was carried out by Gönenç and colleagues.<sup>6,17</sup> With 27 items and a 5-factor structure, it is considered a valid and reliable tool for assessing perceptions of obstetric violence. The OVPSS consists of 5 sub-dimensions, each evaluating a specific aspect of obstetric care practices: (1) non-evidence-based routine practices, which refer to interventions or procedures performed during pregnancy, childbirth, or postpartum without clinical justification or scientific evidence; (2) intrapartum mistreatment, encompassing verbal, physical, or emotional abuse, neglect, or disrespect experienced by women during labor; (3) postpartum mistreatment, which includes inappropriate, neglectful, or disrespectful practices towards women and newborns in the postnatal period; (4) informed consent and companionship, assessing the degree to which women are provided with adequate information to make informed decisions and are allowed to have a companion of choice during childbirth; and (5) unnecessary interventions,

referring to medical or surgical procedures performed without clear medical indication that may interfere with the physiological process of birth. The Cronbach's alpha reliability coefficients of the scale were found to be 0.93, and those of its subscales ranged from 0.69 to 0.90. There are no reverse-coded items. The minimum score that can be obtained from the OVPSS is 27, and the maximum score is 135. An increase in the total score obtained from the scale indicates an increase in the perception and awareness of obstetric violence. The Cronbach's alpha internal consistency coefficient of the OVPSS used in this study was found to be 0.90, indicating that the scale is highly reliable.

### Data Collection

**First session:** Participants who agreed to participate in the study were informed about the subject and purpose of the study, and their informed consent was obtained. The personal information form and the OVPSS were administered to the students by the researchers. The questions used in the study were distributed to the students in sealed envelopes and then collected. It took 10 minutes to complete the forms.

**Second session:** The second session was conducted 1 week after the first session. In this session, the researchers prepared educational content (definition of obstetric violence, influencing factors, characteristics, etc.) in accordance with adult education principles, using methods such as presentations, brochures, discussions, question-and-answer sessions, and role-playing, and presented it to the students in a classroom setting. The session lasted approximately 60 minutes.

In the second session, the training program included case-based scenarios and role-playing activities to facilitate experiential learning. For example, 1 scenario involved a situation where an episiotomy was performed without informed consent, prompting group discussion and analysis. Role-playing exercises were used to simulate patient-midwife interactions in order to develop empathy and improve communication skills. Ethical discussions focused on power dynamics, autonomy, and informed consent during childbirth. To increase the repeatability and transparency of the intervention, an example of the training content is provided in Table 1, and examples of cases and role-playing are provided in Table 2.

**Third session:** The third session took place 1 week after the second session. In this session, the educational content and students' knowledge related to the education were reviewed, and questions were answered. Subsequently, the OVPSS was repeated, forms were distributed in sealed envelopes and later collected, and the research was concluded. This session also lasted approximately 60 minutes.

### Ethical Aspects of the Study

Ethical approval for this study was obtained from the Istinye University Ethics Committee (Date: January 23, 2025; No.: 24-337). Participants were informed of the purpose of the study and were told that they were free to participate in the study on a voluntary basis, that they could withdraw at any time, and that their responses would remain confidential.

### Statistical Analysis

Data were analyzed using IBM SPSS Statistics 23.0 (IBM SPSS Corp.; Armonk, NY, USA). The Shapiro–Wilk test assessed normality of scale scores. Descriptive statistics included frequencies, percentages, means, and standard deviations. As the data were non-normally distributed, the Wilcoxon signed-rank test was used to compare pre- and posttest scores for the total scale and subdimensions.

### Results

This section presents the statistical findings obtained from statistical analysis conducted to test the hypotheses of the study. The mean age of the participants was 23.35 years (SD=2.34; range=21-34 years). Most participants (90.5%) reported having previously heard of the term obstetric violence, and 81.0% stated that they had witnessed such a situation (Table 3). The mean scores and statistical comparisons related to the subdimensions of the OVAS before and after training are presented in Table 4.

For the subdimension of non-evidence-based routine practices, the mean score decreased from 19.00 (SD=4.50) pre-training to 17.40 (SD=4.20) posttraining, a statistically significant change ( $Z=-2.259$ ,  $P=.024$ ). In the intrapartum mistreatment subdimension, the pretest mean was 24.10 (SD=5.30), and the posttest mean was 21.80 (SD=5.10); this decrease was found to be statistically significant ( $Z=-3.781$ ,  $P<.001$ ). Regarding the postpartum mistreatment subdimension, the pretest score was 16.00 (SD=3.58), and the posttest score increased to 17.31 (SD=4.52), showing a statistically significant change ( $Z=-2.943$ ,  $P=.038$ ). In the subdimension of informed consent and companionship, the pretest mean was 9.20 (SD=1.80), and the posttest mean was 8.60 (SD=1.70); this difference was statistically significant based on the Wilcoxon signed-rank test ( $Z=-2.120$ ,  $P=.034$ ). Finally, in the subdimension of unnecessary interventions, the mean score decreased from 10.10 (SD=2.00) to 9.20 (SD=2.10) after the training, and this change was statistically significant ( $Z=-3.215$ ,  $P=.002$ ).

**Table 1. Educational Content of the Obstetric Violence Awareness Training**

<b>1. Introduction to Obstetric Violence</b>	<ul style="list-style-type: none"> <li>• Definition and scope</li> <li>• World Health Organization (WHO) and national definitions</li> <li>• Data on obstetric violence in the world and in Türkiye</li> </ul>
<b>2. Types and Manifestations of Obstetric Violence</b>	<ul style="list-style-type: none"> <li>• Physical violence (e.g. unnecessary episiotomy, forced intervention)</li> <li>• Verbal and psychological violence (e.g. insults, scolding, threats)</li> <li>• Sexual violence (e.g. disrespect for privacy, examination without consent)</li> <li>• Structural and institutional violence (e.g. excessive medical intervention, inadequate care)</li> </ul>
<b>3. Respectful Maternity Care</b>	<ul style="list-style-type: none"> <li>• Birth in the context of women's rights</li> <li>• Components of respectful birth care</li> <li>• Ethical principles (autonomy, non-maleficence, beneficence, justice)</li> </ul>
<b>4. Non-Evidence-Based Routine Practices in Maternity Care</b>	<ul style="list-style-type: none"> <li>• Unnecessary medical interventions</li> <li>• Comparisons with WHO recommendations</li> <li>• Clinical examples and potential harms</li> </ul>
<b>5. Informed Consent and Communication Skills</b>	<ul style="list-style-type: none"> <li>• Informed consent process</li> <li>• Effective communication techniques</li> <li>• Respecting the woman's preferences</li> </ul>
<b>6. Recognition and Prevention Strategies</b>	<ul style="list-style-type: none"> <li>• Recognizing obstetric violence</li> <li>• Preventive approach and professional responsibility</li> <li>• Examples in clinical practice</li> </ul>
<b>7. Case Scenarios</b>	<ul style="list-style-type: none"> <li>• Case examples (episiotomy, ban on companions, examination without consent, etc.)</li> <li>• Role-play activities</li> </ul>

**Table 2.** Sample Educational Content Used in the Training Program

<b>1. Case Scenario: “Episiotomy Without Consent”</b> <b>Scenario:</b> A 25-year-old primiparous woman is in the second stage of labor. The attending midwife performs an episiotomy without informing or obtaining consent from the patient, considering it a routine practice. <b>Discussion Questions:</b> <ul style="list-style-type: none"> <li>• Which ethical principles are violated in this case?</li> <li>• How should the midwife have acted differently?</li> <li>• Is this an example of obstetric violence? Why or why not?</li> </ul>
<b>2. Role-Play Activity: “Breaking the Silence”</b> <b>Objective:</b> To practice communication skills in a scenario where a woman expresses discomfort and emotional distress due to non-consented procedures during childbirth. <b>Roles:</b> <b>Midwife</b> <b>Women</b> <b>Observer</b> <b>Focus Points:</b> Active listening, explaining procedures, seeking consent.

**Table 3.** Sociodemographic Characteristics of the Participants (n = 42)

Variable	Mean ± SD	Min-Max
Age	23.35 ± 2.338	21-34
	n	%
<b>Previously heard the term “obstetric violence”</b>	38	90.5
Not heard	4	9.5
<b>Witnessed obstetric violence</b>	34	81.0
Not witnessed	8	19.0

When the total scores of the OVAS were examined, the mean score before the training was 94.83 (SD = 16.71), while the posttraining mean was 100.36 (SD = 20.81). According to the Wilcoxon signed-rank test, the increase in the total score was not statistically significant ( $Z = -1.894$ ,  $P = .065$ ). Although the total score change was not significant, statistically significant differences were observed in most subdimensions following the intervention.

## Discussion

This study aimed to evaluate the effectiveness of obstetric violence awareness training for midwifery students. The findings showed significant differences in several sub-dimensions—such as intrapartum maltreatment, non-evidence-based routine practices, accompaniment, and consent—between pre- and post-training measurements. While the total score on the scale did not show a statistically significant increase, notable improvements in specific sub-dimensions suggest that the training partially enhanced students' ability to recognize and critically question women-centered and human-rights-based care.

Based on the study findings, several of the proposed hypotheses were supported. Significant changes were observed in the subdimensions of intrapartum mistreatment, non-evidence-based routine practices, postpartum mistreatment, informed consent and companionship, and unnecessary interventions, indicating that  $H1$ ,  $H2$ ,  $H3$ ,  $H4$ , and  $H5$  were supported. These findings suggest that the training effectively

enhanced students' awareness in specific domains of obstetric violence. In contrast, although the total scale score increased after the intervention, this change did not reach statistical significance; therefore,  $H6$  was not supported.

The absence of a statistically significant change in the total score may be explained by several factors, including the relatively small sample size, the short duration or one-off nature of the training, the possibility that some participants already had high baseline awareness, and the short time interval between the pre- and post-test measurements. Moreover, changes in awareness levels may require a longer follow-up period before they translate into behavioral change.

Previous studies indicate that healthcare professional candidates often lack sufficient knowledge about obstetric violence and may struggle to identify its manifestations.<sup>18,19</sup> In line with this, the findings suggest that educational interventions can play an important role in increasing awareness in targeted areas, even if overall perception scores do not change significantly. Similar results have been reported in the literature, where focused training sessions yielded subdomain-specific gains without uniformly affecting total scores.<sup>20-24</sup>

The outcomes obtained through the educational intervention highlight the importance of addressing obstetric violence in midwifery education through a holistic framework. Rather than focusing solely on knowledge transfer, such programs should incorporate content related to emotional labor, empathy, ethical reasoning, and the analysis of power dynamics. These components contribute positively to students' clinical decision-making processes. Similar findings are supported by existing literature. Mena-Tudela et al (2020)<sup>6</sup> reported that students who received education on respectful care and obstetric violence were more capable of identifying structural inequalities in healthcare and became more sensitive to inappropriate interventions. Likewise, Alghamdi et al (2023)<sup>25</sup> found that students exposed to obstetric violence and respectful care training began to critically question commonly normalized and routine clinical practices, which aligns with the findings of this study.

**Table 4.** Comparison of Pretest and Posttest Scores of Obstetric Violence Awareness Subdimensions Among Students (n = 42)

Subdimension	Test	Pretest Mean ± SD	Posttest Mean ± SD	Z	P
Intrapartum mistreatment	Wilcoxon	24.10 ± 5.30	21.80 ± 5.10	-3.781	<b>.000*</b>
Non-evidence-based practices	Wilcoxon	19.00 ± 4.50	17.40 ± 4.20	-2.259	<b>.024*</b>
Postpartum mistreatment	Wilcoxon	16.00 ± 3.58	17.31 ± 4.52	-2.943	<b>.038*</b>
Informed consent and companionship	Wilcoxon	9.20 ± 1.80	8.60 ± 1.70	-2.120	<b>.034*</b>
Unnecessary interventions	Wilcoxon	10.10 ± 2.00	9.20 ± 2.10	-3.215	<b>.002*</b>
Scale total score	Wilcoxon	94.83 ± 16.71	100.36 ± 20.81	-1.732	.064

$P < .05$  was considered statistically significant. Values marked with \* and shown in bold indicate statistical significance ( $p < 0.05$ ).

The increase in scores for the postpartum mistreatment subdimension may appear negative at first glance; however, this pattern likely reflects an improved ability to recognize previously overlooked or normalized practices as mistreatment. As seen in Sadler et al (2016)<sup>19</sup>, awareness-based education led women to reclassify previously accepted practices—such as privacy violations and inadequate support as forms of violence. Similarly, Bohren et al (2015)<sup>3</sup> emphasized that many types of mistreatment in maternity care remain invisible until explicitly addressed in training. The findings of this study indicate that students began to critically reassess the postpartum period as part of the continuum of respectful care, disrupting the “normalization of deviance” described by Goffman.<sup>19</sup> In clinical maternity care, certain forms of postpartum mistreatment such as neglect, lack of communication, or limited emotional support may become so routine that they are no longer recognized as problematic. The observed increase in students’ awareness of postpartum mistreatment after the training indicates a disruption of this normalization process and a reevaluation of what constitutes respectful and ethical care.

The post intervention increase in awareness scores regarding unnecessary interventions suggests that students developed a greater tendency to question non-medically indicated practices during childbirth. As highlighted in the literature, unnecessary procedures that disrupt the physiological course of birth may compromise women’s autonomy and contribute to traumatic birth experiences.<sup>26</sup>

Increases in awareness scores regarding unnecessary interventions indicate that students developed a stronger tendency to question non-medically indicated practices, such as routine episiotomy, amniotomy, positional restrictions, and continuous electronic fetal monitoring without indication.<sup>6,19</sup> Although these gains were observed at the subdimension level rather than in the total score, they reflect a deeper critical perspective toward structural norms in childbirth care. This underscores the importance of addressing such topics within an ethical, evidence-based, and rights-focused educational framework.

Understanding obstetric violence requires looking beyond individual actions to examine institutional culture, care models, and entrenched norms. Educational content should therefore go beyond knowledge transfer to include emotional labor, empathy, ethical reasoning, and recognition of subtle forms of mistreatment. This study supports the integration of such comprehensive and participatory content into midwifery curricula to enhance students’ professional reflexivity and ethical decision-making skills.

From a practical perspective, obstetric violence awareness can be incorporated into undergraduate curricula through dedicated modules within women’s health or ethics courses, supplemented by case-based learning, role-play, and reflective discussion sessions. Embedding these topics early in training could help shape students’ professional values before they enter clinical practice. Future research should employ control groups or longitudinal designs to determine not only short-term effects but also the retention of knowledge and changes in clinical behavior over time.

### Strengths and Limitations

This study also has several notable strengths. It provides preliminary evidence on the feasibility and effectiveness of an awareness-based obstetric violence education program using a structured and interactive training format. The use of a validated measurement tool and scenario-based teaching further supports the reliability of the findings.

These findings should be interpreted in light of the study’s limitations. First, the absence of a control group limits the ability to draw causal conclusions about the effectiveness of the intervention. Second,

although the study aimed to include the entire population of final-year midwifery students, no formal sample size calculation was conducted due to its pilot nature. Third, the sample was relatively small and drawn from a single institution, restricting the generalizability of the findings to other settings or cultural contexts. Additionally, nonparametric tests were used due to the small sample size and non-normal data distribution, which may have influenced the statistical power.

Future research should address these limitations by employing randomized controlled designs, increasing sample diversity, and incorporating longitudinal follow-up to assess not only short-term knowledge gains but also retention of awareness and behavioral changes in clinical practice.

This study demonstrated that awareness-based obstetric violence education led to a positive shift in midwifery students’ perceptions. Students improved their ability to recognize power dynamics, unnecessary interventions, and unethical practices, thereby contributing to a more women-centered and rights-based approach to care. Based on these findings, obstetric violence should be systematically incorporated into midwifery curricula. Programs should be designed to enhance ethical reasoning, emotional awareness, and critical thinking alongside theoretical knowledge. Experiential learning—through role-play, case analysis, and simulation—may be particularly effective. To maximize effectiveness, training should be followed by long-term outcome monitoring, reflective evaluation, and supervised clinical practice. These measures support a comprehensive approach to midwifery education aimed at fostering respectful and non-violent maternity care.

**Data Availability Statement:** The data that support the findings of this study are available on request from the corresponding author.

**Ethics Committee Approval:** Ethics committee approval was received for this study from the ethics committee of Istinye University Ethics Committee (Date: January 23, 2025; No.: 24-337).

**Informed Consent:** Written informed consent was obtained from participants who participated in this study.

**Peer-review:** Externally peer-reviewed.

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