

Perception Of Medicine And Nursing Students On Interventions That Configure Obstetric Violence

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Abstract:

Background: Violence committed against women during pregnancy, labor and delivery, obstetric violence (OV), has been widely observed in recent years, especially after the adoption of the paradigms of institutionalization and interventions during childbirth. It is known that the professional training of health students is a fundamental part in building the process of eradicating these transgressions. In this context, understanding the perception of students in health courses about OV is essential. Therefore, the present study aims to analyze the perception of Medicine and Nursing students regarding interventions that constitute OV.

Materials and Methods: This is a cross-sectional observational study, where the already validated questionnaire, Perception of Obstetric Violence in Students (PercOV-S) was applied to Medicine and Nursing students who were in the mandatory curricular internship, at the University Hospitals of Federal University of Sergipe, between June and August 2023.

Results: The sample studied presented considerable levels of perception of global OV (4.00 ± 0.38) and non-protocolled-invisible OV (4.24 ± 0.35), however, it demonstrated a moderate level of perception of protocolled-visible OV (3.25 ± 0.63). The perception of OV according to the global PercOV-S and the non-protocolled-invisible PercOV-S was considerable for the general sample, while the perception of protocolled-visible VO was moderate for the general sample. The perception of global protocolled-visible and non-protocolled-invisible VO was lower among Medicine students when compared to Nursing students.

Key Word: Violence; Obstetrics; Students; Medicine; Nursing.

Date of Submission: 25-12-2023

Date of acceptance: 05-01-2024

I. Introduction

In the 1985 United Nations Declaration of Force, it was established that every woman has the right to adequate prenatal care, as well as the right to play a central role in all aspects of that health care, including participation in the planning, implementation and in evaluation¹. Despite this, with the dissemination of the paradigm of institutionalization of births, a process of pathologization of this event, as well as medicalization and sometimes unnecessary interventions were observed. An environment of violations of women's rights was created and physical, mental and emotional harm became common^{2,3}.

The topic of Obstetric Violence (OV) gained attention in the 1980s, through groups of professional activists, defenders of human and reproductive rights who yearned for better birth conditions for pregnant women in Latin America⁴. Venezuela, in addition to adopting and highlighting the term Obstetric Violence, was the precursor in the construction of legislation that classified this type of violence as a crime in 2007. Obstetric violence is understood to be any conduct, action or omission practiced by the team health, directly or indirectly, in public or private spheres⁵.

The organic law on women's rights to a life free from violence characterizes obstetric violence as follows:

Appropriation of the woman's body and reproductive processes by health professionals, which is expressed by dehumanized care, abuse of medicalization and pathologization of natural processes, resulting in loss of autonomy and ability to decide freely about their body and sexuality, negatively affecting your quality of life⁶.

Health students perceive obstetric violence to different degrees. Due to the dissemination and habitual presence of inappropriate practices, the normalization of OV has become part of the training of health professionals, which indicates the need for positive learning, in order to interrupt this embarrassing cycle. It is practically unanimous that one of the main ways to prevent and eradicate OV is education. Preventing such violations of women's rights during pregnancy, childbirth and the postpartum period involves raising awareness, addressing the issue at universities, better training for students in the health area so that they are able to respect women and their individualities in general during their pregnancy⁷.

Given the above, the authors propose to evaluate the perception of Medicine and Nursing students at the Federal University of Sergipe regarding interventions that constitute obstetric violence.

II. Material And Methods

This is a cross-sectional observational study, carried out with Medicine and Nursing students who were in the mandatory curricular internship, at the University Hospitals, of the Federal University of Sergipe, between June and August 2023.

Data collection was carried out through the application of a validated questionnaire about the perception of OV to the selected group. The sample was non-probabilistic for convenience, taking into account the intention of covering all students in the institution's mandatory curricular internship. We included only those who agreed to sign the informed consent form and excluded individuals who completed the questionnaire incompletely.

The *Perception of Obstetric Violence in Students* (PercOV-S) questionnaire is composed of 33 items that measure the perception of OV on a five-level *Likert* scale that ranges from one (totally disregard OV) to five (totally consider OV); higher scores indicate that OV is more perceived.

The PercOV-S is divided into two dimensions: protocolled-visible OV and non-protocolled-invisible OV. The first concerns interventions usually present in health centers that tend to constitute protocols such as directing the woman, providing intravenous access, while the second is related to obstetric interventions that do not tend to be protocolled, such as the Kristeller maneuver. The maximum score per item and dimension, and the overall score, is five points. Higher scores indicate a higher level of OV perception.

The internal consistencies of the general score ($\alpha = 0.897$), as well as the protocolled OV ($\alpha = 0.774$) and the non-protocolled OV ($\alpha = 0.880$), were considered slightly lower than those of the scale validation study (0.936; 0.802; 0.952, respectively), but remained substantial⁷.

The quantitative variables were described as means and standard deviations and were subsequently analyzed using the Student's T or Mann-Whitney U tests, depending on whether or not the assumption of sample normality was met, assessed by the Shapiro-Wilk test. Categorical variables were presented in absolute and relative frequencies. To compare the characteristics of categorical variables between the two courses, the Chi-square or Fisher's Exact tests were used. In all analyses, a significance level of 5% was adopted. Statistical analyzes were processed using the Statistical Package for the Social Sciences (SPSS), version 22.0 (Chicago, IL)⁸.

III. Result

The sample consisted of 141 students with an average age of 25.9 ± 4.4 years, 106 from the Medicine course (75.2%) and 35 from the Nursing course (24.8%).

The sample studied presented considerable levels of perception of global OV (4.00 ± 0.38) and non-protocolled-invisible OV (4.24 ± 0.35), however, it demonstrated a moderate level of perception of protocolled-visible OV (3.25 ± 0.63) – Table 1. The PercOV-S items most perceived as OV by the general sample were: “Saying 'Stop complaining', that's not so bad” (4.91 ± 0.31); “Taking photos without consent” (4.91 ± 0.35); “Episiotomy without anesthesia” (4.89 ± 0.35); “Pelvic examination without consent” (4.83 ± 0.45); and “Not considering the woman’s decision” (4.82 ± 0.41) – all belonging to the domain of non-protocolled-invisible OV. In turn, the scale items least perceived as OV were: “Allow a companion during the second stage of birth” (1.81 ± 1.20); “Allow skin-to-skin contact after the pediatrician examines it” (1.81 ± 1.20); “Central venous access” (1.89 ± 0.98); “Handing baby over to nursing” (2.64 ± 1.10); “Encourage the use of epidurals” (2.94 ± 1.04); and “Position direction” (2.96 ± 1.16) – Table 1.

Table 1 – PercOV-S score for the general sample.

| Variable | General (n=141) |
|------------------------------------|-----------------|
| PercOV-S (global score) | 4,00 ± 0,38 |
| PercOV-S (protocolled-visible OV) | 3,25 ± 0,63 |
| 1. Central venous access | 1,89 ± 0,98 |
| 2. Directing the position | 2,96 ± 1,16 |
| 3. Artificially accelerating labor | 3,68 ± 1,04 |
| 4. Administer routine enema | 4,26 ± 0,88 |

| | |
|--|-------------|
| 6. Routine trichotomy | 4,12 ± 0,96 |
| 15. Reinforcing the position of lithotomy | 3,77 ± 0,99 |
| 16. Allow a companion at the second moment of birth | 1,81 ± 1,20 |
| 28. Immediate section of the umbilical cord | 3,55 ± 1,04 |
| PercOV-S (non-protocoloed-invisible OV) | 4,24 ± 0,35 |
| 5. Routine amniotomy | 4,19 ± 0,84 |
| 1. Patient immobilization | 4,63 ± 0,57 |
| 2. Pelvic examination without consent | 4,83 ± 0,45 |
| 3. Not offering pain control measures | 4,60 ± 0,56 |
| 4. Encourage the use of epidurals | 2,94 ± 1,04 |
| 5. Not preserving privacy | 4,74 ± 0,50 |
| 6. Convincing to give birth by cesarean section to complete the birth quickly and painlessly | 4,71 ± 0,49 |
| 7. Not considering the woman's decision | 4,82 ± 0,41 |
| 8. Taking photos without consent | 4,91 ± 0,35 |
| 17. Perform routine episiotomy | 4,74 ± 0,54 |
| 18. Saying "You don't know how to push" | 4,80 ± 0,48 |
| 19. Kristeller maneuver | 4,69 ± 0,59 |
| 20. Episiotomy without anesthesia | 4,89 ± 0,35 |
| 21. Prohibit eating and drinking | 3,96 ± 0,94 |
| 22. Not offering a warm environment at birth | 4,13 ± 0,76 |
| 23. Saying "Stop complaining", that's not so bad | 4,91 ± 0,31 |
| 24. Do not allow the woman to scream | 4,75 ± 0,51 |
| 25. Indicate cesarean section due to slow dilation | 3,81 ± 0,87 |
| 26. Emergency cesarean section without consent | 3,41 ± 1,24 |
| 27. Do not allow a companion during instrumental births or cesarean sections | 4,27 ± 0,82 |
| 29. Suture laceration without anesthesia | 4,77 ± 0,44 |
| 30. Separate the mother from the newborn | 3,83 ± 1,00 |
| 31. Allow skin-to-skin contact after the pediatrician examines it | 1,81 ± 1,20 |
| 32. Handing baby over to nursing | 2,64 ± 1,10 |
| 33. Give formulas to the baby without the mother's consent | 4,13 ± 1,02 |

Source: data collected by the authors. Self elaboration.

Regarding differences in perceptions of OV between Medicine and Nursing students, it was observed that Medical students had a lower general perception of OV than Nursing students (3.94 vs. 4.16; p=0.003), as well as lower perception of protocoloed-visible OV (3.17 vs. 3.52; p=0.004) and lower perception of non-protocoloed-invisible OV (4.19 vs. 4.36; p=0.016) – Table 2.

When analyzing the differences per item of the protocoloed-visible PercOV-S, it appears that medical students demonstrated a lower perception of OV for "Directing the position", "Artificially accelerating labor", "Reinforcing the position of lithotomy", "Allow a companion at the second moment of birth", while they demonstrated a greater perception of OV with regard to "Administer routine enema" and "Routine trichotomy" (p<0.05) – Table 2. The Medicine and Nursing students exhibited similar perceptions regarding "Central venous access" and "Immediate section of the umbilical cord" (p>0.05) – Table 2.

Regarding the non-protocoloed-invisible PercOV-S items, it can be highlighted that medical students demonstrated lower perception of OV for "Encourage the use of epidural", "Indicate cesarean section due to slow dilation", "Emergency cesarean section without consent", "Do not allow a companion during instrumental births or cesarean sections", "Separate the mother from the newborn", "Allow skin-to-skin contact after the pediatrician examines" and "Give formulas to the baby without the mother's consent" (p< 0.05), as they exhibited greater perception of OV for "Do routine episiotomy" and "Kristeller maneuver" than Nursing students (p<0.05). Students from the two higher education courses did not differ for the other items in this domain of the scale (p>0.05), as observed in Table 2.

Table 2 – Comparison of the PercOV-S Score between Medicine and Nursing students.

| Variable | Medicine (n=106) | Nursing (n=35) | p |
|---|------------------|----------------|--------|
| PercOV-S (global score) | 3,94 ± 0,37 | 4,16 ± 0,37 | 0,003 |
| PercOV-S (protocoloed-visible OV) | 3,17 ± 0,59 | 3,52 ± 0,69 | 0,004 |
| 1. Central venous access | 1,85 ± 0,94 | 2,02 ± 1,07 | 0,431 |
| 2. Directing the position | 2,70 ± 1,11 | 3,74 ± 0,95 | <0,001 |
| 3. Artificially accelerating labor | 3,51 ± 1,01 | 4,20 ± 0,96 | <0,001 |
| 4. Administer routine enema | 4,35 ± 0,81 | 3,94 ± 1,02 | 0,027 |
| 6. Routine trichotomy | 4,25 ± 0,88 | 3,71 ± 1,07 | 0,006 |
| 15. Reinforcing the position of lithotomy | 3,62 ± 1,00 | 4,23 ± 0,81 | 0,001 |
| 16. Allow a companion at the second moment of birth | 1,56 ± 0,98 | 2,57 ± 1,48 | <0,001 |
| 28. Immediate section of the umbilical cord | 3,50 ± 1,03 | 3,71 ± 1,07 | 0,201 |

| PercOV-S (non-protocolled-invisible OV) | | | |
|---|-------------|-------------|--------|
| | 4,19 ± 0,35 | 4,36 ± 0,32 | 0,016 |
| 5. Routine amniotomy | 4,26 ± 0,80 | 3,97 ± 0,92 | 0,089 |
| 7. Patient immobilization | 4,64 ± 0,57 | 4,57 ± 0,56 | 0,398 |
| 8. Pelvic examination without consent | 4,81 ± 0,48 | 4,88 ± 0,32 | 0,489 |
| 9. Not offering pain control measures | 4,61 ± 0,56 | 4,54 ± 0,56 | 0,442 |
| 10. Encourage the use of epidurals | 2,75 ± 1,06 | 3,49 ± 0,78 | <0,001 |
| 11. Not preserving privacy | 4,72 ± 0,53 | 4,83 ± 0,38 | 0,297 |
| 12. Convincing to give birth by cesarean section to complete the birth quickly and painlessly | 4,68 ± 0,51 | 4,80 ± 0,41 | 0,228 |
| 13. Not considering the woman's decision | 4,78 ± 0,44 | 4,91 ± 0,28 | 0,101 |
| 14. Taking photos without consent | 4,92 ± 0,37 | 4,91 ± 0,28 | 0,707 |
| 1. Perform routine episiotomy | 4,83 ± 0,40 | 4,49 ± 0,78 | 0,005 |
| 2. Saying "you don't know how to push" | 4,80 ± 0,51 | 4,80 ± 0,41 | 0,645 |
| 3. Kristeller maneuver | 4,75 ± 0,55 | 4,51 ± 0,66 | 0,021 |
| 4. Episiotomy without anesthesia | 4,91 ± 0,35 | 4,86 ± 0,36 | 0,253 |
| 5. Prohibit eating and drinking | 3,88 ± 0,98 | 4,23 ± 0,77 | 0,072 |
| 6. Not offering a warm environment at birth | 4,12 ± 0,76 | 4,17 ± 0,75 | 0,789 |
| 7. Saying "stop complaining", that's not so bad | 4,90 ± 0,34 | 4,94 ± 0,24 | 0,490 |
| 8. Do not allow the woman to scream | 4,71 ± 0,55 | 4,89 ± 0,32 | 0,090 |
| 9. Indicate cesarean section due to slow dilation | 3,72 ± 0,87 | 4,09 ± 0,82 | 0,029 |
| 10. Emergency cesarean section without consent | 3,24 ± 1,24 | 3,94 ± 1,08 | 0,003 |
| 11. Do not allow a companion during instrumental births or cesarean sections | 4,15 ± 0,86 | 4,63 ± 0,55 | 0,002 |
| 29. Suture laceration without anesthesia | 4,78 ± 0,44 | 4,71 ± 0,46 | 0,358 |
| 30. Separate the mother from the newborn | 3,67 ± 1,01 | 4,31 ± 0,80 | 0,001 |
| 31. Allow skin-to-skin contact after the pediatrician examines it | 1,61 ± 1,04 | 2,40 ± 1,46 | 0,002 |
| 32. Handing baby over to nursing | 2,58 ± 1,07 | 2,80 ± 1,18 | 0,294 |
| 33. Give formulas to the baby without the mother's consent | 4,00 ± 1,08 | 4,54 ± 0,70 | 0,006 |

Source: data collected by the authors. Self elaboration.

IV. Discussion

In the present study, the sample analyzed presented considerable levels of global OV perception (4.00 ± 0.38), a slightly higher index compared to the study by Mena-Tudela and collaborators that evaluated the perception of health students in Spain, and which had an overall mean score of 3.83 (SD ± 0.63; 95% CI = 3.77–3.89)⁹.

In the study by Biurrun-Garrido and collaborators, the same questionnaire was applied, with the same objective, to students who participated in the 1st Congress of Feminist Medicine of the SCMS (State Councils of Medical Students), and the overall average score was 3.83 points (OD = 0.61), observing a moderate perception of OV and slightly lower than that found in this work¹⁰.

We verified that the protocolled-visible OV demonstrated a moderate level of perception. Protocolled-visible OV is considered by the creators of the PercOV-S questionnaire as interventions usually present in the health center even though they are not recommended by scientific evidence and do not represent women-centered care⁷. This finding alerts us to an issue of utmost importance, as the interventions present in the protocols and commonly used create a feeling that these are not violations against women, given their repetition, and still generate the risk of future health professionals health to normalize such transgressions. All of this causes concern, given that the World Health Organization (WHO) has been warning since 2018 about excessive clinical interventions in healthy pregnant women, such as induction of labor and increased use of oxytocin, which negatively impacts care for pregnant women¹¹. We also noticed a tendency among students to normalize behaviors that are OV; and this materializes when we identify a greater degree of perception compared to the non-protocolled-invisible OV in relation to the registered protocolled-visible OV. The average score found by this study for the registered protocolled-visible OV was 3.25; while, for the same classification, work carried out with Spanish students and at the 1st Feminist Medicine Congress of SCMS found 2.83 and 2.79, respectively - which denotes poorly perceived violence.

It is clear that the scenario presented allows the training of professionals who will not understand OV as abusive practices, but as inherent to the labor process. Thus, it is clear that preventing future cases of OV undoubtedly involves raising awareness and sensitizing health professionals in training in order to break with the abusive, violent and embarrassing behaviors that today permeate health institutions and even universities^{7,12}.

The non-protocolled-invisible OV showed considerable levels of perception. According to the study that created the PercOV-S questionnaire, non-protocolled-invisible OV is represented by obstetric interventions that do not tend to be protocolled, such as the Kristeller maneuver. When analyzing the statistical data, we found that the PercOV-S items in which obstetric violence was most identified by students belong to this group of interventions. The present study found an average score of 4.24, which demonstrates a good perception of OV;

while the study carried out in Spain and the work carried out at the 1st Feminist Medicine Congress of SCMS, with the same objective, found scores of 4.15 and 4.16 - respectively, similar to ours. Among the interventions that constitute non-protocolled-invisible OV, “episiotomy without anesthesia”, “pelvic examination without consent” and “not considering the woman's decision” stood out.

The fact that women have their right to make decisions restricted can be explained because, after the institutionalization of births, a model of care was created in which the adoption of institutional protocols, which often disregard the social and cultural context of pregnant women, became rule; in which professionals equipped with technical authority began to establish a power relationship over patients, which resulted in the loss of women's autonomy, which became secondary in importance^{2,3}.

According to Jardim and Modena (2018), witnessing half-naked women in obstetric rooms in the presence of strangers, unaccompanied, with their legs open and raised, with their genitalia exposed, without information about procedures performed during care, undergoing unnecessary cesarean sections, using medications that accelerate labor, episiotomy without consent, exposed to Kristeller maneuvers, are frequent situations. All of this reinforces the need to pay attention to the WHO guidelines that aim to guarantee birth as a positive experience, which defines excessive vaginal touching and by multiple professionals, routine episiotomy, Kristeller maneuver, early amniotomy, use of oxytocin of routine, cesarean section without clinical indication and imposition of the birth position as practices not recommended in care^{2,5}.

The study also found items from the PercOV-S questionnaire in which there was a lower perception of OV by students. Among these, “allowing a companion during the second stage of birth” stands out, which demonstrates a misunderstanding on the part of the students, considering that, since 2005, the presence of a companion chosen by the pregnant woman during labor, delivery and immediate postpartum is a right guaranteed by Federal Law 11,108/2005, and any team member is prohibited from preventing such presence¹³.

It was found that performing “venous access”, “encouraging the use of epidurals” and “directing the position” were not perceived as OV; and this can also be justified by the observation of obstetric interventions routinely carried out in health centers, leading to the impression that providing intravenous access or even anesthetizing the patient are part of the birth protocols. It is worth highlighting, however, that childbirth is a physiological process inherent to the female organism and that unnecessary interventions, as well as the medicalization of this process, corroborate a care model that violates the pregnant woman's rights and negatively impacts her birth experience^{2,3,11}.

When analyzing the perceptions of Medicine and Nursing students, it was found that Medicine students had a lower general perception of OV than Nursing students (3.94 vs. 4.16; $p=0.003$), as well as a lower perception of protocolled-visible VO (3.17 vs. 3.52; $p=0.004$) and lower perception of non-protocolled-invisible OV (4.19 vs. 4.36; $p=0.016$). These findings are similar to those found by Mena-Tudela and collaborators (2020), who observed that Nursing students perception was higher than that of Medicine students in almost all items of the PercOV-S questionnaire. Still according to the authors of the aforementioned work, a possible explanation for the finding is the fact that medical training is more mechanized and focused on interventionist models, including physiological processes such as childbirth; while the Nursing course has training based on salutogenesis. Another explanation that may justify the greater perception on the part of Nursing students is the fact that this profession is mostly made up of women. Biurrun-Garrido and collaborators (2023), concluded in their studies that women presented a greater perception of OV in several items of the PercOV-S questionnaire. Add to this the data shown by Boniol and collaborators (2019) in the study “Gender equity in the health workforce: analysis of 104 countries”, in which 70.3% of health services in the world are made up of women. According to Machado (2017), nursing in Brazil has 85.1% of its total number represented by female workers. This entire context corroborates the inference made. Furthermore, it is worth highlighting that obstetric violence is a violation of women's human rights and that, even if some of them have not suffered from such violence, the fact that they belong to and constitute the gender that suffers from OV allows them a greater empathetic capacity^{9,14,15,16}.

The present study differed, however, from the results found by Biurrun-Garrido and collaborators (2023), who described a similar perception among students of Medicine and Nursing courses for both the global score and dimensions¹⁰.

When analyzing the perception of Medicine and Nursing students regarding the interventions that constitute protocolled-visible OV, we found that Medicine students had a better perception of “Administer routine enema” and “Routine trichotomy”, which presented averages of perception 4.35 and 4.25 respectively, against averages of 3.94 and 3.71 for the respective items in Nursing.

Mena-Tudela and collaborators (2022) found an average of 3.05 for Nursing and 2.68 for Medicine in the item “administering routine enema”; for “routine trichotomy”, the averages were 3.42 for Nursing and 3.02 for Medicine⁹. These results demonstrate a greater perception of Nursing students in these items, which differs from our results.

The present study also concluded that Medicine students have less perception than Nursing students regarding the “Direction of the position”, in which we observed an average score of 2.70 for them, while for Nursing students the score was 3.74. In the study carried out with Spanish students, the perception score was 1.51 and 1.92 for Medicine and Nursing, respectively⁹. Therefore, we have a lower perception of medical students in both works. Furthermore: the perception of Brazilian academics from the two courses analyzed, in these items, was greater. In the work used to validate the PercOV-S questionnaire, however, we observed an inversion in relation to perception, as we found an average score of 2.09 for Nursing students and 2.36 for Medicine students⁷.

Our results on “Artificially accelerating labor” are similar to the results found in the research carried out with Spanish students in which the item in question is more perceived by Nursing students⁹. However, it converges with the results found in the study carried out to validate the PercOV-S, in which medical students had a slightly higher average perception for the item in question⁷.

In relation to non-protocolled-invisible OV, the present study found a lower perception of medical students in relation to the perception of nursing students in the following items: “Encourage the use of epidurals”, “Indicate cesarean section due to slow dilation”, “Emergency cesarean section without consent”, “Do not allow a companion during instrumental birth or cesarean section”, “Separate mother from newborn”, “Allow skin-to-skin contact after the pediatrician examines” and “Give formulas to the baby without consent from the mother.” Comparing the results presented from the aforementioned items to their equivalents in the work carried out by Mena-Tudela and collaborators (2022) with Spanish students, we found variations in the degrees of perception, but in all these items the perception of medical students was also lower in relation to nursing students, which demonstrates similarities in the results of the work⁹.

On the other hand, we observed a greater perception of medical students in the following items: “Performing a routine episiotomy” and “Kristeller maneuver”. These are physical obstetric violence, which are characterized by interventions that result in non-accidental physical damage, discomfort, pain, without scientific support for such interventions. It is extremely important that students are clear about these violations, as the first should not be carried out “routinely”, but when there are precise indications that generate benefits for the woman and the baby; while the second is considered proscribed because it does not demonstrate real benefits, in addition to increasing the risk of complications^{17,18}.

V. Conclusion

The perception of OV according to the global PercOV-S and the non-protocolled-invisible PercOV-S was considerable for the general sample, while the perception of protocolled-visible OV was moderate for the general sample.

The perception of global OV, protocolled-visible and non-protocolled-invisible was lower among Medicine students when compared to Nursing students, mainly due to the lower perception of OV for scale items such as: “Position direction”, “Accelerate artificially labor”, “Reinforcement of the lithotomy position”, “Allow a companion during the second stage of birth”, “Encourage the use of epidural”, “Indicate cesarean section due to slow dilation”, “Emergency cesarean section without consent”, “Do not allow a companion during instrumental births or cesarean sections”, “Separate the mother from the newborn”, “Allow skin-to-skin contact after the pediatrician has examined it” and “Give formulas to the baby without the mother’s consent”.

Furthermore, medical students demonstrated greater perception of OV for the items “Administer routine enema”, “Routine trichotomy”, “Perform routine episiotomy” and “Kristeller maneuver”.

It is worth mentioning that, unfortunately, it was not possible to interview all the students eligible for this research, as many did not respond to the questionnaire. Otherwise, with a larger sample of students, we could have even more significant results.

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