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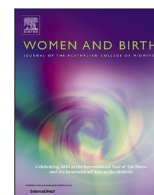

# Experiences with obstetric violence among healthcare professionals and students in Spain: A constructivist grounded theory study

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ABSTRACT

*Background:* Obstetric violence appears to be a worldwide concern and is defined as a type of gender-based violence perpetrated by health professionals. This violence undermines and harms women's autonomy. In Spain, 38.3 % of women have identified themselves as victims of this type of violence.
*Aim:* To explore current information and knowledge about obstetric violence within the Spanish healthcare context, as well as to develop a theoretical model to explain the concept of obstetric violence, based on the experiences of healthcare professionals (midwives, registered nurses, gynaecologists and paediatricians) and nursing students.
*Methods:* A constructivist grounded theory study was conducted at Jaume I University in Spain between May and July 2021, including concurrent data collection and interpretation through constant comparison analysis. An inductive analysis was carried out using the ATLAS.ti 9.0 software to organise and analyse the data.
*Results:* Twenty in-depth interviews were conducted, which revealed that healthcare professionals and students considered obstetric violence a violation of human rights and a serious public health issue. The interviews allowed them to describe certain characteristics and propose preventive strategies. Three main categories were identified from the data analysis: (i) characteristics of obstetric violence in the daily routine, (ii) defining the problem of obstetric violence and (iii) strategies for addressing obstetric violence. Participants identified obstetric violence as structural gender-based violence and emphasised the importance of understanding its characteristics. Our results indicate how participants' experiences influence their process of connecting new information to prior knowledge, and they provide a connection to specific micro- and macro-level strategic plans.
*Discussion:* Despite the lack of consensus, this study resonates with the established principles of women and childbirth care, but also generates a new theoretical model for healthcare students and professionals to identify and manage obstetric violence based on contextual factors. The term 'obstetric violence' offers a distinct contribution to the growing awareness of violence against women, helps to regulate it through national policy and legislation, and involves both structural and interpersonal gender-based abuse, rather than assigning blame only to care providers.
*Conclusions:* Obstetric violence is the most accurate term to describe disrespect and mistreatment as forms of interpersonal and structural violence that contribute to gender and social inequality, and the definition of this term contributes to the ongoing awareness of violence against women, which may help to regulate it through national policy and legislation.

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**Statement of Significance**

**Problem**

A large number of healthcare professionals still do not believe in the existence of obstetric violence, since the structural characteristics of the concept imply that the professional performing it is frequently unaware of it, and that it may even be normalised.

**What is already known**

There is still a global lack of consensus on how violence against women during facility-based childbirth should be defined and measured; however, this type of gender-based violence occurs as a result of structural inequality, discrimination, and patriarchy.

**What this Paper Ads**

Notwithstanding the nuance in terminology, this study generates a new theoretical model for healthcare students and professionals to identify and manage obstetric violence based on contextual factors.

## Introduction

The United Nations Population Fund, a United Nations agency aimed at improving reproductive and maternal health worldwide, recognises that there is still a global lack of consensus on how violence against women during facility-based childbirth is defined and measured [1]. Despite this, some countries have created legislation on this concept and provided a definition, such as Venezuela, which passed the "Organic Law on the Right of Women to a Life Free of Violence" in 2007, and defines obstetric violence as "…*the appropriation of the body and reproductive processes of women by health personnel, which is expressed as dehumanised treatment, an abuse of medication, and to convert the natural processes into pathological ones, bringing with it loss of autonomy and the ability to decide freely about their bodies and sexuality, negatively impacting the quality of life of women*" [2]. Around this concept, the World Health Organisation created a definition of what types of disrespectful and abusive treatments were considered to be profoundly inappropriate and included, for example, humiliation and verbal abuse, coercive or unconsented medical procedures, lack of confidentiality, failure to get fully informed consent or gross violations of privacy [3].

This type of violence appears to manifest itself all over the world, with rates ranging from 18.3 % (Brazil) [4] to 75.1 % (Ethiopia) [5]. In Spain, 38.3 % of women have identified themselves as victims of obstetric violence [6]. Social stratification [7], low socio-economic status [8], age, race, or women's lack of knowledge about their rights [9] have all been identified as causal factors in the literature. One of the hypotheses about its origins lies in gender bias, due to the fact that women's rights to make decisions about their care are often overridden and substituted. Gender-based violence can take different forms and is defined as violence directed against a person because of that person's gender, with women being disproportionately affected by this type of violence [10,11]. According to the United Nations, obstetric violence is defined as a type of gender-based violence and occurs in a context of structural inequality, discrimination and patriarchy. It is also a consequence of insufficient education and training, as well as a lack of respect for women's equal status and human rights [1].

In Spain, the existence of obstetric violence is still not accepted by the majority of the healthcare community and even by society in general, because its structural characteristics mean that the professionals who perform it are frequently unaware of it, and this sort of behaviour has become commonplace [12,13]. Obstetric violence is a taboo and hidden practice in Spanish health care, and the normalisation of this sort of violence can occur among healthcare professionals and health sciences students, such as nursing or medical students [14,15]. A possible perpetuating factor is a lack of proper training for health professionals, rendering them incapable of detecting how violent certain obstetric practices are during pregnancy, childbirth and the puerperium [9,14], which are as common as they are harmful. They may also be unaware of fundamental bioethical issues such as respect for women's autonomy during pregnancy and childbirth, communication skills and emotional management [1,9]. It is also possible that, although health workers may detect events of obstetric violence in their own interventions or in the daily practices of their colleagues, they are unaware of women's legal capacity to defend their rights, are unclear about the reporting procedures, or even fear retaliation from the rest of the colleagues [16]. To progress the study of this phenomenon, researchers must move beyond the current descriptive research on obstetric violence and develop theory that can show the process. Generating theory may promote a better understanding of why obstetric violence occurs and how it is given meaning [17]. Therefore, the purpose of this study was to explore current information and knowledge about obstetric violence within the Spanish healthcare context, as well as to develop a theoretical model to explain the concept of obstetric violence, based on the experiences of healthcare professionals and students, in order to provide a better understanding of the concept of obstetric violence [18], on which no global consensus has yet been reached. Once the concept of obstetric violence is conceptualised and operationalised, it may ease the process of translating it into something that can be measured [19].

## Participants, ethics and methods

### *Design*

A constructivist grounded theory study was conducted from May to July 2021 to explore the experiences of healthcare professionals and students with obstetric violence in Spain and to develop a theory from the data [20]. Particularly, data analysis and representation of our findings followed a modified constructivist grounded theory described by Charmaz [21,22]. This theory provides an in-depth and holistic understanding of experience for the construction of a theory, rather than solely describing what is happening [20]. Therefore, this methodology is appropriate for this study since it allows the researcher to develop a theoretical model to describe the data through an iterative data immersion, analysis, and interpretation process that recognises and considers contextual factors [23].

### *Participants and settings*

Fifteen participants (4 midwives, 6 nursing students, 1 registered nurse, 1 gynaecologist and 3 paediatricians) were recruited through purposive sampling at Jaume I University and were chosen based on their likelihood of providing relevant data in terms of relevance, range of perspectives, and depth [24,25]. Subsequently, five participants (5 midwives) were recruited through theoretical sampling (20 participants in total) [22]. Thus, the selection criteria included nursing students enrolled in Healthcare and Gender who attended the Second International Seminar on Obstetric Violence as part of their practical module, as well as registered professionals who were willing to share their experience and had clinical experience with childbearing women. Table 1 summarises the characteristics of the participants.

### *Data collection*

Twenty in-depth semi-structured interviews were carried out. Researchers developed and agreed on an interview protocol (Supplementary Table S1). All the interviews were conducted at Jaume I University by two nursing researchers with training in qualitative methods research. Each interview was digitally audio recorded and lasted between 40 and 60 min. Data was continuously analysed until data saturation was reached. All transcripts were anonymised and member-checked. Interview statements were translated by a bilingual

researcher to English. Then, another bilingual researcher back-translated them to Spanish and compared them with the original transcripts to maintain their accuracy.

*Data analysis*

Data analysis was conducted using a constant comparative approach and memo writing to continuously monitor emerging themes and identify areas for further exploration [22]. An inductive analysis was carried out using the ATLAS.ti 9.0 software to organise and analyse the data. The categories emerged from the language of the participants as well as data identified by the researcher as relevant to the phenomena of interest. The purpose was to conceptualise the experiences of the participants in order to develop theoretical insights into the concept of obstetric violence. One researcher initially coded transcriptions; other members of the research team reviewed and contributed to this collaborative process. The initial codes and emerging categories were agreed upon by all researchers, and ongoing data collection was discussed. Simultaneous interviewing, initial or open coding and data analysis, revisiting data and re-reading transcripts, with more focused coding directing analysis, were carried out with the aim of generating theory [21]. Using Charmaz's methods [22], this included shifting between healthcare professionals and students' explanations of their experiences, generalisations, and the researchers' interpretative understandings of both theory and practise. In the initial coding stage, core characteristics of the interview data were extracted to generate initial descriptive codes. A second stage included axial coding, in other words, categories were clustered together into topic-oriented categories. Lastly, theoretical coding was used to enable identification of the possible relationships between categories [17] (Fig. 1).

*Ethical considerations*

The study was approved by the Ethics Committee of the Jaume I University (CD/42/2021), which followed all of the criteria of the Declaration of Helsinki and its subsequent revisions. All participants were previously informed about the voluntary nature of their participation and the possibility to withdraw at any moment. Prior to starting, all participants signed a consent form and agreed to audio recording.

*Rigour*

This study was guided following the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines. Following criteria by Lincoln and Guba [26], trustworthiness was verified through credibility, transferability, dependability, and confirmability. To achieve this, a third researcher was consulted to review the codes and analysis, and resolve discrepancies for enhanced credibility. Transferability was achieved through set selection criteria and gathering detailed demographic information. For dependability, the memo writings served as documentation of analysis over time, and sharing these memos with the co-researchers at each phase of analysis served to maintain confirmability.

**Table 1**
Summary of each participant.

| Code | Age | Sex | Working experience (years) | Clinical area (Department) |
|---|---|---|---|---|
| P1 | 43 | Male | 21 | Midwife (Labor & Delivery) |
| P2 | 50 | Female | 30 | Midwife (Labor & Delivery) |
| P3 | 44 | Female | 20 | Midwife (Labor & Delivery) |
| P4 | 47 | Female | 24 | Midwife (Labor & Delivery) |
| P5 | 44 | Female | 25 | Midwife (Labor & Delivery) |
| P6 | 58 | Female | 40 | Midwife (Labor & Delivery) |
| P7 | 51 | Female | 30 | Midwife (Labor & Delivery) |
| P8 | 40 | Female | 12 | Midwife (Labor & Delivery) |
| P9 | 63 | Female | 40 | Midwife (Labor & Delivery) |
| P10 | 22 | Male | – | Nursing student |
| P11 | 31 | Female | – | Nursing student |
| P12 | 27 | Female | – | Nursing student |
| P13 | 22 | Female | – | Nursing student |
| P14 | 24 | Female | – | Nursing student |
| P15 | 22 | Female | – | Nursing student |
| P16 | 46 | Female | 25 | Registered Nurse (Maternity Care Unit) |
| P17 | 42 | Female | 17 | Gynaecologist (Labor & Delivery) |
| P18 | 70 | Male | > 40 | Paediatrician (Primary Care) |
| P19 | 57 | Female | 30 | Paediatrician (Primary Care) |
| P20 | 34 | Male | 10 | Paediatrician (Primary Care) |

## Results

*Participant characteristics*

A total of 20 interviews were conducted, in which 70 % (n = 14) of the interviewees were healthcare professionals (9 midwives, 3 paediatricians, 1 registered nurse, 1 gynaecologist) and 30 % (n = 6) were nursing students. Overall, 80 % of the participants (n = 16) identified as female and 20 % as male (n = 4). The participants' ages ranged from 22 to 70 years old (41.85 ± 14.21). Qualitative analysis revealed three major categories, which are summarised in Table 2.

Our findings, depicted in the form of a conceptual model (Fig. 2), demonstrate that healthcare students and professionals perceived obstetric violence as a facet of systematic gender-based abuse, of which they described certain characteristics, including routine and unnecessary interventions and medicalisation of the mother or infant, verbal abuse, humiliation, lack of resources or inadequate facilities, all factors which inhibit women's autonomy and lead to the normalisation of this type of violence, as well as proposing preventive strategies. This clear and quick approach resulted in micro- and macro-level strategies to promote evidence-based professional decision-making approaches for the detection and prevention of obstetric violence.

*Category 1: Characteristics of obstetric violence in the daily routine*

This category focuses on the perceptions of participants regarding obstetric violence. Our results, in particular, indicate the participants' understanding of the characteristics that comprise obstetric violence based on their experiences, as well as the significant health consequences that this violence could have on women's health.

*Sub-category 1.1: The patriarchal system and systematic gender-based violence*

As examples of obstetric violence, a number of participants experienced verbal and physical abuse against women, such as providing biased information or undergoing non-consented clinical care. Interestingly, many participants identified this sort of care provision as a consequence of a patriarchal society:

> *"I do believe I have been involved in some abusive situations, such as offering biased and subjective information, overlooking the mother's decision, ignoring how they may feel in response to certain comments. For example, I recall a case in which a child was taken away from her mother because she couldn't breathe properly, but no explanation was given!" P9*

> *"We live in a patriarchal and paternalistic system with numerous power- and strength-related relationships, particularly within the healthcare system. For instance, it has long been assumed that the physician is the one with the knowledge, which eventually leads to obstetric violence" P5*

*Sub-category 1.2: The impact of obstetric violence on the physical, mental and sexual health of women*

In this vein, a large number of participants stated that obstetric violence may have a physical, psychological and social impact on women's health. Indeed, the participants pointed out that some women

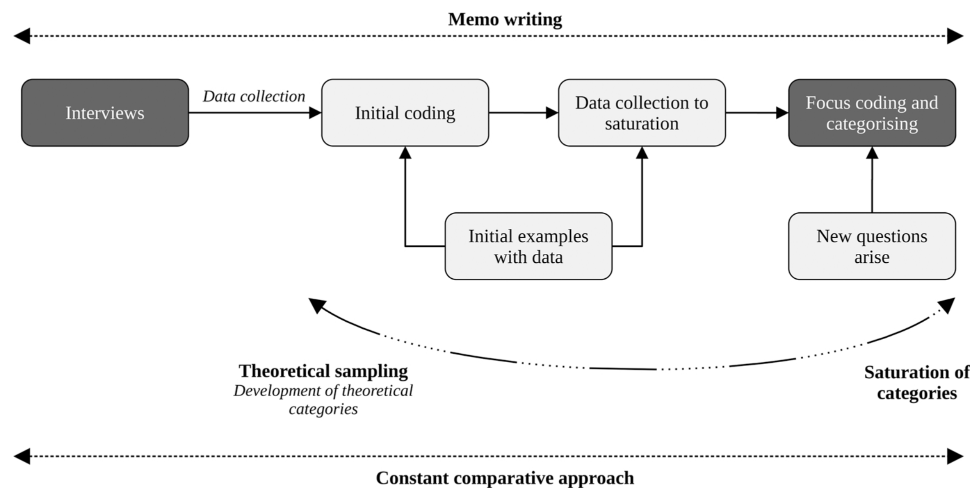


**Fig. 1.** Data analysis process based on Charmaz's methods.

may experience a difficult postpartum period and may even refuse to have another child because of their previous traumatic experiences:

*"I believe it affects all domains, but especially the psychological, emotional, and family situations. How many women tell us, "I expected a normal childbirth, but it turned out to be a caesarean"? This eventually has an impact on the postpartum period. I agree that women must be safeguarded at all levels to guarantee that their rights are not ignored or violated, and that they enjoy a healthy puerperium and start nurturing their infant" P6*

*"For example, the unjustified separation of mother and baby has a significant influence on later mother-child bonding. In fact, how the mother felt during her pregnancy and childbirth has an impact on her overall well-being. I have assisted some mothers who are hesitant to have another child after such a traumatic experience" P17*

*Category 2: Defining the problem of obstetric violence*

This category sheds light on the importance of raising obstetric violence awareness among health professionals and future professionals through training and education, in order to prevent the occurrence of obstetric violence and better detect cases of this abusive behaviour. All participants agreed that the term "obstetric violence" was the most accurate, and no other names or terminology were proposed.

*Sub-category 2.1: Recognising personal previous experiences as obstetric violence*

Many participants highlighted the influence of obstetric violence training on their own knowledge-building process, and how it helped them in developing the ability to recognise and respond to obstetric violence events that occur during clinical practice or placements:

*"At first, the term obstetric violence made me feel uncomfortable, but it also made me aware of the problem. How can healthcare professions, which are based on care, be associated with violence? However, the more I learn, the more I realise that I witnessed violence in pushing for interventions that were not appropriate, such as unnecessary episiotomies or caesarean sections. For example, indicating a caesarean section just because the baby was in a breech position rather than in a cephalic position" P4*

*"It is clear now, at least in my way of thinking, that it is becoming more common to report or describe all obstetric mistreatment as violence. It is recognised not only as physical violence, but also as economic, cultural and gender violence, for which an action mechanism exists. As I said before, as my knowledge and understanding of the concept evolve, I realise that this type of violence occurs at all levels of women's care, not just obstetrics" P12*

*Sub-category 2.2: Defining obstetric violence*

In this sense, the participants' personal experiences with obstetric violence allowed them to generate a possible definition for this sort of violence. These definitions ranged from a lack of respect for women to a broad set of gender-based characteristics of abuse that included physical, psychological, social, economic, and institutional violence, among others:

*"For me, obstetric violence can be defined as any physical, sexual, personal, or institutional abuse perpetrated against women merely because of their gender, with the gynaeco-obstetric care setting being used as a position of power. It includes not only healthcare professionals, but also non-healthcare professions such as clinical assistants, porters, and so on" P15*

*"I admit it is a wide and diverse term. It refers to the medicalisation and instrumentalization of women's reproductive processes, as well as the infantilization and dehumanisation of women by healthcare professionals. On the other hand, I could also include the lack of respect and empathy given when some professionals say "you are overreacting or hysterical, everything is fine!". In summary, I feel it could be anything along those lines" P8*

*"I would say is a set of actions that take place towards a woman during pregnancy, childbirth, postpartum or at any time of her obstetric life that cause her any kind of harm, physical or psychological, or that make her feel invalidated. I believe it is a violation of human rights, even if it may be justified or is said to be justified on a professional level, because that is not always the case" P5*

*Category 3: Strategies for addressing obstetric violence*

This last category highlights the need for a change in strategies to prevent obstetric violence. Healthcare professionals and future professionals emphasised the value of implementing interpersonal and global strategies such as obstetric violence education, professional training courses, legal implications or public awareness.

*Sub-category 3.1: Micro-level strategies*

One of the most frequently mentioned micro-level strategies as a means to prevent obstetric violence by participants was interpersonal-related strategies such as showing empathy for women, receiving ongoing training to stay up-to-date on the different initiatives or changes implemented in this field, and raising awareness among those close to

**Table 2**
Categories, sub-categories and representative quotes.

| Main category | Sub-category | Representative quotes |
|---|---|---|
| Characteristics of obstetric violence in the daily routine | Patriarchal system and systematic gender-based violence | *"I think that obstetric violence has a strong male-chauvinist influence because healthcare professionals tend to take paternalistic attitudes. I have heard some professionals saying "not having become pregnant" when some women complained… That's terrible!"* P10<br>*"Every procedure carried out on the mother must be informed. Currently, it seems that they don't have the right to give an opinion or know what will happen to them. We forget to empathise with her and avoid her uncertainty"* P2 |
| | The impact of obstetric violence on the physical, mental and sexual health of women | *"These situations can make the mother feel like she is underdog… I believe this has an impact on the mother on both a psychological and physical level. There are some women who have severe physical problems, such as anal incontinence, for example"* P16<br>*"Women who experience childbirth as a traumatic experience are especially vulnerable in this situation. Of course, this has also an impact on their reproductive health as well as their intimate relationship."* P4 |
| Naming the problem of obstetric violence | Recognising personal previous experiences as obstetric violence | *"The training is playing an important role in all of this. I believe this is related to society and the fact that they are women. It wouldn't happen if they were men; it would be an isolated case. It is violence against women, against childbearing women"* P11<br>*"For me it wasn't a surprise, when I started to investigate about this matter to find out that violence was perpetrated, mainly in a scenario with many power relationships and infantilisation. It struck a chord with me because, as a woman, you are afraid not only of yourself, but also of the life that lives inside of you"* P13 |
| | Defining obstetric violence | *"I believe it is a lack of respect for women and for the childbearing women's bodies who would be the centre of the obstetric violence"* P7<br>*"Obstetric violence is any action taken against a woman during her pregnancy, childbirth or puerperium that causes physical or psychological harm. Even if it is a justified professional criterion or if they say it is justified, which many it may not be"* P1 |
| Strategies for addressing obstetric violence | Micro-level strategies | *"If someone changes the environment; although it may take time, things will change. That is, go to schools to raise awareness among the younger students and begin to not normalise some things that are currently normalised"* P8<br>*"I think it is necessary to name obstetric violence and to provide training about how it works in the system in which we live. We need to talk about it… Obstetric violence happens on a daily basis, but women are not always aware that it is happening to her."* P14 |
| | Macro-level strategies | *"It is necessary a strategy for a humanised childbirth, with guidelines, policies… Given it the importance that it has. If we must do the skin-to-skin contact, it is not for an opinion, whether mine or yours; it is an evidence-based practice and we must do so. On the other hand, our sisters or managers should re-evaluate what was done. All of this helps"* P3<br>*"Obstetric violence must be monitored in some way by the institutions themselves. I believe that educating future healthcare professionals is very important, as is raising their awareness of the fact that it exists. Moreover, many times I think that healthcare professionals are unaware that what they are doing is wrong. I believe that laws to support it are also needed"* P20 |

them:

> *"Years ago, we thought what we were doing was fine; we didn't realise we were misbehaving, and we barely empathised with the mothers. We couldn't find any other examples, work methods, or models to emulate. This, in my opinion, is critical. Education must take place not just at work, but also at home. People should be aware that things can change" P7*

> *"I consider training to be an essential part. I am not just talking about higher education; I'm also referring to education at primary, middle, and high schools, among other places. The aim shouldn't be to normalise this type of violence; for example, if I am taught at school at a young age that it is not normal for someone to touch my body without my permission, I would then know to speak up and say something. This should also apply to professionals, who require ongoing evidence-based nursing and obstetric violence training more than ever before" P18*

*Sub-category 3.2: Macro-level strategies*

Similarly, actions at the institutional, organisational, and political levels were perceived as amongst the most critical areas highlighted by participants in terms of macro- and multi-level strategies to prevent obstetric violence:

> *"I believe that the change requires a multi-level approach, including involvement from both above and below. When I say "above" I mean the government, politicians, and policymakers but also those in positions of authority such as healthcare managers. And by "below" I refer to people who are standing up for a change, such as cultural and women's organisations, or research institutions in this field" P2*

> *"Specific clinical practice guidelines, which are more precise about what we are doing wrong and how to change it, are required at the workplace. It is necessary to evaluate professional-patient ratios in order to provide humanised care, as well as to insist on the training of healthcare staff. How could we make it visible if we witness violence in the delivery room but are unsure how to report or proceed?" P6*

> *"I feel that some aspects of the health-care system must be changed to prevent obstetric violence. For example, I wish we could get proper feedback on our work through regular meetings, allowing us to evaluate and improve all professional work. I believe it is critical to learn from our actions as well as the actions of our co-workers. Besides, I believe that we must be willing to change some actions that have been in place for decades, such as the O'Sullivan test or the lithotomy position, for other options that the woman can choose" P8*

## Discussion

The aim of this study was to explore current information and knowledge about obstetric violence within the Spanish healthcare context, as well as to develop a theoretical model to explain the concept of obstetric violence, based on the experiences of healthcare professionals and students. obstetric violence information and knowledge within the healthcare context, as well as to develop a theoretical model to explain the concept of obstetric violence based on the experiences of healthcare professionals and students. This theoretical model aims to provide an understanding of the concept of obstetric violence based on data co-constructed with participant interviews, seeking to comprehend meanings about the concept of obstetric violence by the participants.

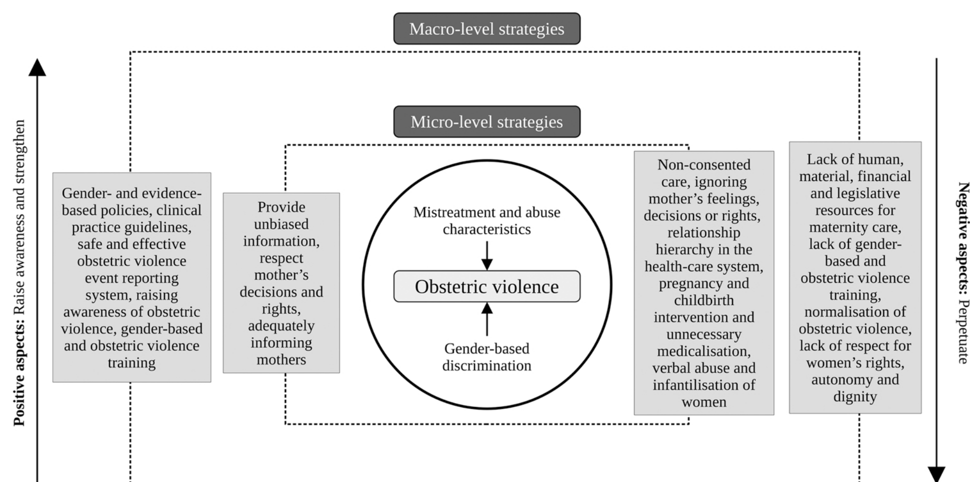


**Fig. 2.** Conceptual model based on experiences with obstetric violence among healthcare students and professionals.

According to the findings, the participants agreed that obstetric violence is a violation of human rights and a serious public health issue. Although previous studies have identified mistreatment against women during facility-based childbirth as a critical issue worldwide [6,27–29], it is interesting to consider these findings in the context of the established midwife-led continuity model [30,31]. This model attempts to explain the benefits of a client-centred pregnancy and childbirth care approach in reducing birth injury, trauma, and caesarean section rates, and whose core principles are: physical, psychological, and social well-being of the mother or birthing parent; autonomy in decision-making for the mother or birthing parent; minimising technological interventions; and identifying and referring women who require obstetrical attention [32]. Therefore, the findings of this study resonate with established principles of women and childbirth care, but also generate a new theoretical model for healthcare students and professionals to identify and manage obstetric violence based on contextual factors.

Based on our findings, participants identified obstetric violence as structural gender-based violence [33] and emphasised the importance of understanding its characteristics in order to control its impact on the health outcomes of women and children. These characteristics have already been documented [27] and classified into seven different categories [34]: physical abuse, non-consented care, non-dignified care, discrimination based on specific patient attributes, abandonment of care, and detention in facilities in some countries. Despite the fact that these characteristics may involve different sorts of disrespect and abuse [35,36], all participants agreed with the importance of identifying these as facets of gender-based discrimination. A possible explanation for these results may be the current intersection of two powerful normative discourses, medical dominance and the patriarchal institution of motherhood [37]. In this context, opting out of the obstetric model is frequently interpreted as a challenge to authority [38] or even so-called maternal-foetal conflict [39,40], compromising women's autonomy and turning the midwife-led model into a paternalistic care approach. This interpersonal inequality between professionals and women, as well as the identified characteristics, has been described as one of the main factors leading to potential health consequences [33,41], and thus further action is required to promote respectful maternal and child-bearing health care and to prevent structural gender inequalities [42]. Other studies have also found obstetric violence to be the result of a patriarchal and hierarchical culture and healthcare system [28,43–45].

Having said that, the findings of this study showed how participants' experiences and perceptions influenced their process of connecting with new information as well as building knowledge based on their decisions to accept certain information regarding obstetric violence [46]. While the term "mistreatment" is widely used around the world [29], the core issue continues to be identifying and conveying the concept of obstetric violence to healthcare professionals [47]. However, based on prior research [41,48] and our participants' responses, defining the term 'obstetric violence' offers a distinct contribution to the ongoing awareness of violence against women, contributes to the creation of national policy and legislation on the concept [49], and involves both structural and interpersonal gender-based abuse, rather than assigning blame only to care providers [33,50]. Notwithstanding the nuance in terminology, obstetric violence could be defined as any gender-based act that compromises the physical, psychological, economic and social well-being of the woman, resulting in a loss of autonomy in decision-making and the ability to make informed and free decisions about their bodies and sexuality [6,27,49].

In addition to establishing a concrete definition of obstetric violence and its characteristics, our findings provide proposals for specific micro- and macro-level action strategies. Micro-level strategies promote changes in obstetric violence training in both undergraduate and postgraduate healthcare professionals in order to provide up-to-date evidence-based practical education [14,47], highlighting the significance of providing women with unbiased and evidence-based information to ensure decision-making autonomy [28,51,52]. Likewise, our participants advocate for additional actions to increase the awareness of the general population using a multi-level approach, engaging health institutions, managers, healthcare professionals, lawmakers, civil society, and other stakeholders at the national and international levels [53]. Macro-level strategies, on the other hand, may contribute to addressing significant structural dimensions that can have an impact at other levels such as legislative, economic, or organisational levels [27,33]. Although these dimensions should not be used to justify obstetric violence, it is necessary to keep in mind that abusive behaviour is not always intentional [53]. Healthcare policymakers, for example, must pay special attention to this, facilitating gender and evidence-based policies and guidelines with the aim of eliminating as well as preventing factors that contribute to obstetric violence such as staffing shortages, inadequate infrastructure, or stressful working environments, while also involving women and their families in decision-making [41,54].

Nonetheless, there are some limitations to consider. To the best of our knowledge, this is the first attempt from a constructivist perspective to identify the concept of obstetric violence and potential preventive strategies. As a result, future research is needed to confirm this definition as well as the model for wider application of the findings. The particular context of this study, on the other hand, may not be generalisable, though the model developed based on our findings should be conceptually useful to the design of similar decision-making care models.

## Conclusions

The theory developed from this study proposes a definition of obstetric violence and offers, for the first time, a structured gender-based framework for controlling its impact on the health outcomes of women. Our findings indicate that obstetric violence is the most accurate term for describing disrespect and mistreatment as forms of interpersonal and structural violence that contribute to gender and social inequality. Defining this term significantly contributes to the ongoing awareness of violence against women, which may help to implement it throughout national policy and legislation. Based on the characteristics identified by our participants, micro- and macro-level strategies have been proposed, including evidence-based and unbiased information, specific training at all levels, gender-based policies and guidelines, as well as other structural changes, but most importantly, involving women and their families in decision-making.

## Ethical statement

Ethical approval was granted by the Ethics Committee of the Jaume I University (CD/42/2021) on 13th May 2021.


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## CRediT authorship contribution statement

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## Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.wombi.2022.07.169.

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