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A qualitative study of women's experiences with obstetric violence during childbirth in Turkey

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ABSTRACT

Objectives: to examine and explain the feelings, thoughts and experiences of women who reported that they had experienced obstetric violence at any stage of the childbirth process (i.e. pregnancy, delivery and postpartum) in Turkey.
Design: a phenomenological qualitative study using the theoretical thematic analysis approach in data analysis.
Setting: data were collected in individual in-depth interviews via video conferencing between 24 February 2021 and 16 November 2021.
Participants: 27 women who reported that they had experienced obstetric violence during the childbirth process and who met the study inclusion criteria.
Results: participants who reported that they had experienced obstetric violence were categorised into the following themes: (1) types of obstetric violence; (2) failure to meet professional standards of care; (3) reactions; and (4) awareness. Women with different sociodemographic and obstetric characteristics were exposed to diverse types of obstetric violence, causing them to feel stress, anxiety, worry, sadness, helplessness, anger and fear. They had certain expectations of health professionals (e.g. midwives, nurses and physicians), and did not have prior awareness of obstetric violence.
Key conclusions: obstetric violence against women during the childbirth process is a serious problem in the Turkish care system that has a negative effect on women's health.
Implications for practice: awareness of obstetric violence should be increased amongst health professionals and women receiving healthcare services. Further studies should be conducted to determine the prevalence of obstetric violence, and relevant training programmes should be developed to eliminate this type of violence against women in health facilities.

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Introduction

Obstetric violence, another dimension of gender-based violence, is defined as 'the appropriation of the bodies and reproductive processes of women by health personnel, which is expressed as dehumanising treatment, an abuse of medication, and the transformation of 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' (Pérez D'Gregorio, 2010). Obstetric violence is a human rights violation that has a negative effect on women's physical and mental health (Shabot, 2016; Vacaflor, 2016; Kilci et al., 2020).

The World Health Organization has declared that all women have the right to dignified, respectful health care throughout pregnancy and childbirth, as well as freedom from violence and discrimination (WHO, 2014). However, studies have reported that women are exposed to various forms of physical violence during childbirth, such as hitting, pinching, fundal pressure, unnecessary episiotomies, frequent vaginal examinations, forms of verbal violence (e.g. yelling, insults), and ill-treatment/bad behaviour by health professionals (e.g. paying no attention to privacy, disrespecting the self and dignity of women, negligence, discrimination, disregard for healthcare preferences, making medical interventions without adequate information and consent) (Balde et al., 2017; Jardim and Modena, 2018; Aguilar et al., 2020). The prevalence of obstetric violence worldwide ranges from 12.6% to 97.4% (Montesinos-Segura et al., 2018; Bohren et al., 2019; Lansky et al., 2019; Mihret, 2019; Castro and Frías, 2020; Martínez-Galiano et al., 2021). However, in the literature review conducted for this study,

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no reports on women's experiences of obstetric violence, or prevalence, causes and consequences of obstetric violence in Turkey were found.

Maternal–infant health indicators focus on life-saving processes and outcomes such as antenatal care, providing health professionals trained in childbirth, and reduction of maternal morbidity and mortality rates. In Turkey, the number of maternal deaths per 100,000 live births is 13.6, and the number of infant deaths per 1000 live births is 9.1 (TURKSTAT, 2020). In Turkey, 98% of births take place in hospitals (SBSGM, 2020). Both midwives and nurses take an active role in care in the prenatal and postnatal periods. The childbirth process is mainly managed by physicians or midwives (HSGM, 2018a; HSGM, 2018b). However, these indicators are insufficient to explain women's perceptions of care, especially their experiences of issues such as communication, respect and emotional support, and they do not fully reflect the quality of healthcare services (Bohren et al., 2018). Therefore, there is a need for studies on the care experiences of women who are exposed to obstetric violence during pregnancy, childbirth and postpartum.

The aim of this study was to investigate and explain the feelings, thoughts and experiences of women who reported that they had experienced obstetric violence at any stage of the childbirth process in Turkey.

Methods

This qualitative phenomenological study was conducted between 24 February 2021 and 16 November 2021 on the phenomenon of obstetric violence.

Setting, participants and inclusion

The purposive sampling method was used to form the study sample. In this study, women were reached via social media platforms (i.e. Instagram, Facebook). The population included women who were exposed to obstetric violence during the childbirth process in Turkey, and the sample consisted of 27 women from this population. Women who volunteered to participate in the study read the online informed consent form and ticked the option, 'I agree to participate in the study'. Eighty-four women completed the obstetric violence screening form. While filling out the obstetric violence screening form, the women were asked 'Which of the following situations occurred during the childbirth process? (You may mark more than one)', and 49 women who marked at least one type of obstetric violence in response to this question were contacted by telephone. Women were assessed based on inclusion and exclusion criteria. In-depth interviews were scheduled with 27 women who agreed to participate and met the inclusion criteria. The inclusion criteria were: (1) age >18 years; (2) able to communicate in Turkish; (3) had given birth in the last 24 months[1]; (4) reported at least one type of obstetric violence on the obstetric violence screening form; (5) no contraindications for vaginal delivery[2]; and (6) agreed to participate in the study.

[1] Studies have included women with children in different age groups (0–2 years, 0–14 years) (Chattopadhyay et al., 2018; Ravaldi et al., 2018). Therefore, women with babies aged 0–24 months were included in this study.

[2] Contraindications to vaginal delivery: abnormal placental locations and placental anomalies (placenta previa, placenta accreta), malpresentations (face, feet, arm and transverse presentations), multiple pregnancies with breech position (bottom first rather than head first), mono-amniotic twins, history of uterine rupture, and active genital herpes virus infection (Desai and Tsukerman, 2022). Although women may prefer to give birth vaginally in these circumstances, their wishes may not be followed. Women with these conditions were not included in this study because it would not be appropriate to include them under the criteria of obstetric violence (see 'Types of obstetric violence').

Data collection

Data were collected using a participant information form, an obstetric violence screening form, and a semi-structured interview form. The participant information form consisted of 15 questions about women's sociodemographic and obstetric characteristics. The obstetric violence screening form was created by the researchers in line with the relevant literature (Balde et al., 2017; Abuya et al., 2018; Mihret, 2019), and consisted of 18 items to determine the participants' exposure to common types of obstetric violence. The semi-structured interview form consisted of the following questions aimed at learning about the participants' experiences of obstetric violence: (1) How was your childbirth experience? (2) Do you think your childbirth proceeded in the way you preferred? Can you explain? (3) Did you receive any interventions that facilitated your childbirth process? How did you feel in this situation? Can you explain? (4) Did you receive any interventions that obstructed your childbirth process? How did you feel in this situation? Can you explain? (5) What did you experience after giving birth, how did you feel? Can you explain? (6) How did you feel when you first saw your baby? (da-Silva-Carvalho and Santana-Brito, 2017; Bohren et al., 2018). The in-depth interviews with the participants were held via video conferencing (i.e. WhatsApp and voice call) and audio recordings, and lasted around 20–30 min for each participant. The audio recordings were transcribed verbatim. Data collection was terminated when the data from the sample reached saturation and began to repeat itself.

Ethical approval was obtained from a state university in Istanbul (No: 74,555,795–050.01.04). The study was conducted in accordance with the principles of the Declaration of Helsinki, and each woman in the study read the informed consent form and ticked the box stating 'I agree to participate in the study' on the form.

Data analysis

Data were analysed using the theoretical thematic analysis technique, which is widely used in qualitative research, and the analysis was handled in six stages (Braun and Clarke, 2006): (1) After each interview (within 24 h), the audio recordings from the in-depth interviews were listened to carefully and paused before being typed up. Twenty-seven separate Word documents were produced, one for each participant. The printed documents were examined. Each document was reviewed several times, and the initial analytical notes were written alongside the statements. As a result, the goal of familiarity with the data was achieved. (2) The data items in all documents were coded. For example, the expressions of the participants such as '…yelled at me' and '…insulted me' were coded as 'yelling' and 'insulting', and those such as '…pushed me' or '…pressed my stomach by arm' were coded as 'hitting' and 'fundal pressure'. (3) The related codes were brought together to create preliminary themes. For example, codes such as 'hitting' and 'fundal pressure' were thematised as 'physical violence', and those such as 'yelling' and 'scolding' were thematised as 'verbal violence'. (4) Themes covering similar cases were combined. For example, the theme of 'types of obstetric violence' was created by combining the subthemes of 'psychological violence', 'physical violence' and 'verbal violence'. (5) The comprehensibility of the themes that were created was evaluated. A descriptive analysis (code map) was performed using MAXQDA. (6) In the last stage, the researchers interpreted the participants' perceptions on the subject through the themes that were created. The results were reported by evaluating whether the selected vivid and striking quotes met the relevant situation. To protect their privacy and the confidentiality of their identifying information, the participants were given codenames in the form of P1, P2, etc.

Table 1
Sociodemographic and obstetric characteristics of the participants ($n = 27$).

Participant	Age (years)	Residence	Educational level	Employment status	Socio-economic status	Gravidity	Parity	Gestational week+day	Place of delivery
P1	30	Hakkari	Primary school	Unemployed	Income=expenses	8	2	38+2	Public hospital
P2	27	Mardin	High school	Unemployed	Income<expenses	1	1	37+1	Public hospital
P3	27	Rize	University	Unemployed	Income<expenses	2	1	37+6	Public hospital
P4	25	Bitlis	High school	Unemployed	Income<expenses	3	3	39	Public hospital
P5	33	Bitlis	Primary school	Unemployed	Income<expenses	4	3	42	Public hospital
P6	27	Bitlis	University	Employed	Income=expenses	1	1	38+3	Public hospital
P7	29	Istanbul	Secondary school	Unemployed	Income<expenses	2	2	40+2	University hospital
P8	30	Bitlis	University	Employed	Income=expenses	1	1	41+5	Private hospital
P9	35	Istanbul	Graduate school	Employed	Income>expenses	1	1	37+2	Private hospital
P10	27	Kocaeli	Secondary school	Unemployed	Income<expenses	3	3	37	Public hospital
P11	29	Kocaeli	Secondary school	Unemployed	Income<expenses	2	2	40	Private hospital
P12	26	Trabzon	University	Unemployed	Income>expenses	1	1	40	Public hospital
P13	23	Sivas	High school	Unemployed	Income<expenses	1	1	38+5	University hospital
P14	29	Balıkesir	University	Unemployed	Income=expenses	1	1	39+2	Public hospital
P15	30	Bitlis	University	Unemployed	Income=expenses	1	1	39	Private hospital
P16	24	Erzurum	University	Employed	Income>expenses	1	1	39+1	Public hospital
P17	37	Kırklareli	University	Unemployed	Income=expenses	2	2	37	Public hospital
P18	34	Hatay	University	Unemployed	Income=expenses	3	3	38	Public hospital
P19	28	Bitlis	Primary school	Unemployed	Income<expenses	2	2	37	Public hospital
P20	27	Malatya	University	Unemployed	Income>expenses	1	1	39+6	Private hospital
P21	34	Samsun	Graduate school	Unemployed	Income<expenses	1	1	39	Private hospital
P22	21	Çanakkale	Secondary school	Unemployed	Income<expenses	1	1	37+5	Public hospital
P23	32	Bitlis	University	Unemployed	Income<expenses	3	1	40	Public hospital
P24	22	Istanbul	University	Unemployed	Income>expenses	1	1	42	University hospital
P25	34	Istanbul	Graduate school	Employed	Income>expenses	1	1	40	Private hospital
P26	27	Kırklareli	Graduate school	Employed	Income=expenses	1	1	40	Private hospital
P27	30	Kırklareli	Graduate school	Employed	Income=expenses	1	1	39+4	Private hospital

The authors received training in qualitative data analysis. The first author (NA) conducted the analysis. As a consultant, the second author (MMK) gave instructions on how to analyse the data and reviewed each phase of the analysis.

Results

Twenty-seven women from six different geographical regions of Turkey participated in this study. Their mean age was 28.73 (standard deviation 4.05) years (range 21–37 years). amongst the participants, 18 were primiparous, nine were multiparous, 18 had vaginal deliveries, and nine had caesarean section deliveries. All participants had given birth within the last 2 years. P12 tested positive for coronavirus disease 2019 (COVID-19) at childbirth. Table 1 shows the sociodemographic and obstetric characteristics of the participants.

The participants' statements about their experiences of obstetric violence were gathered under four main themes: (1) types of obstetric violence; (2) failure to meet professional standards of care; (3) reactions; and (4) awareness. For 'types of obstetric violence' and 'failure to meet professional standards of care', the participants listed different forms of obstetric violence that they had experienced. 'Reactions' was used to describe the emotions, ideas and acts of women who had reported that they had experienced obstetric violence. For 'awareness', the expectations of the participants who had been exposed to obstetric violence from health professionals during the childbirth process, as well as their lack of prior information, were addressed. The main themes, subthemes, codes and subcodes derived from the collected data are shown in Table 2.

Types of obstetric violence

The participants' reports of the types of obstetric violence that they were exposed to were grouped under three subthemes: psychological violence, physical violence and verbal violence. The most and least frequently mentioned subthemes were psychological violence and verbal violence, respectively.

The participants reported that they were exposed to various types of psychological violence during the childbirth process, such as personnel being rude, disrespectful, threatening, scolding, intolerant, not listening actively, ignoring them, being disinterested, not considering their care preferences, not ensuring their privacy, and making medical examinations in a crowded place:

> …They [health professionals] put huge things inside me. They did it like it was nothing. I mean, like you throw the animal on the ground in Eid-al-Adha [after sacrificing it] and cut it into small pieces carelessly. After all, it is dead, and you can do whatever you want with it. It was something like that. (P22, primipara)

The participants reported being exposed to forms of verbal violence, such as yelling, insults and scolding, especially when they did not comply with the directives of the health professionals:

> …Different people [health professionals] constantly examined me from the bottom [vaginal examination]. One inserted her hand inside me and removed it, covered in blood, another did the same thing. They were constantly sticking their fingers [inside me]. I said I was very uncomfortable. They started insulting me like 'Did you consult us about lying under your husband?', 'You will kill the child!', 'You will leave your child inside!' I was also tired of being exposed to constant electronic foetal monitoring. They yelled and insulted me like 'The baby's heart slowed down, you're a murderous mother!', 'Give birth to the child here, kill him!' (P13, primipara)

The participants reported being exposed to forms of physical violence such as the binding of extremities (hands, arms or feet), exposure to surgical interventions (caesarean section, episiotomy repair) with insufficient analgesia/anaesthesia, use of force, frequent vaginal examinations, unnecessary episiotomy procedures (in their view), pushing and fundal pressure:

> … Then I was already sent to [have] caesarean section. There [in the operating room], the person who gave the injection was

Table 2
Experiences of obstetric violence: main themes, subthemes, codes and subcodes.

Main themes	Subthemes	Codes/subcodes
Types of obstetric violence	Psychological violence	**Being disrespectful** Being rude, disrespectful, threatening, scolding **Poor/inappropriate communication** Being intolerant, not listening actively, ignoring, being uninterested, not considering the care preferences of the patient **Disregarding privacy** Not ensuring privacy, performing medical examinations in a crowded place
	Physical violence	Hitting, binding of extremities such as hands, arms or feet, performing surgical interventions with insufficient anaesthesia, using force, making frequent vaginal examinations, performing an unnecessary episiotomy, pushing, fundal pressure
	Verbal violence	Yelling, insulting, scolding
Failure to meet professional standards of care	Routine practices	Being left without food and water for a long time, not allowing the partner to be present during childbirth, not allowing the relative to enter the ward due to the pandemic, not providing skin-to-skin contact with baby after delivery, not providing skin-to-skin contact with baby after delivery due to the pandemic, making frequent vaginal examinations, forcing the patient to lie on her back, making frequent electronic foetal monitoring examinations, speeding up labour even when not necessary
	Not giving information	Not answering the mother's questions, giving inconsistent information, giving no information about the interventions and procedures
	Failure to provide required care/treatment	Not doing the necessary follow-ups, not providing education on the pregnancy and childbirth process, not relieving pain
	Lack of resources	**Deficiencies related to health professionals** Inadequate health staff, inadequate communication skills of health staff **Institution-related deficiencies** Small labour/delivery room, lack of a labour/delivery room, sharing the same room with others **Health-system-related deficiencies** Insufficient number of health personnel, differences between private and public hospitals in terms of health facilities
	Interventions without consent/permission	Making medical interventions without consent/without giving enough information/by giving misleading information
Reactions	Emotions	Stress, anxiety, worry, sadness, helplessness, worthlessness, regret, anger, fear
	Thoughts	Never thinking of having a vaginal birth again, not thinking about having a child anymore
	Behaviours	Crying, hitting the arm on the side of bed, wanting to end the childbirth process/wishing to get rid of the baby, not wanting to refer to health institutions, refusing to see the baby after delivery, blaming the baby
Awareness	Expectations	Ensuring privacy, supporting the childbirth process, performing no routine practices, giving detailed information about the process and procedures, respecting the childbirth process, having effective/good communication by health professionals
	Lack of information	**Inability to be aware of obstetric violence** Accepting the binding of feet, accepting being forced to lie on her back, accepting fundal pressure, considering the routine practices/violent behaviours for their own benefit **Not knowing one's rights during the childbirth process**

> also a man. He tried to force me to sit down. I wanted to get up when I had pain, but he forced me down on the gurney as if he was trying to strangle me, and then he injected me. (P4, caesarean section)

Failure to meet professional standards of care

The theme of 'failure to meet professional standards of care' was created by combining the subthemes of routine practices, not giving information, failure to provide required care/treatment, lack of resources and interventions without consent/permission. The most and least frequently mentioned subthemes were routine practices and interventions without consent/permission, respectively.

The participants reported being exposed to several routine practices during the childbirth process, including being left without food and water for a long time, their partner not being allowed to attend the childbirth, their relatives not being allowed to enter inpatient wards due to the COVID-19 pandemic, not being allowed skin-to-skin contact with their baby after delivery, not being allowed skin-to-skin contact with their baby after delivery due to the pandemic, exposure to frequent vaginal examinations, being forced to lie on their backs, exposure to frequent electronic foetal monitoring, and the speeding up of labour even when not necessary (via amniotomy, fundal pressure, oxytocin administration, episiotomy, enema) in their opinion:

> There were too many incisions and stitches from down there [perineum]. There were constant excessive interventions from there. They [health professionals] ruptured the [amniotic] sac [amniotomy] and opened my uterus [dilating the vaginal opening by using their fingers] with their hands. I was very uncomfortable. After all, it was like [they were] killing [me]. It was very difficult [for me]. (P5, multipara)

The participants stated that they could not obtain sufficient information during the childbirth process, describing that health personnel did not answer their questions, gave them inconsistent information, and gave them no information about the interventions and procedures to which they were being exposed. The participants also reported that they were given misleading information and subjected to interventions without their permission, and their consent for medical interventions was obtained without providing sufficient information:

> They [health professionals] took me to the operating theatre and obviously deceived me. As I was walking in, I said again

that I did not want spinal anaesthesia, I wanted general anaesthesia. A male caregiver arrived, he was not medical personnel. He sat me down. He put my knees between his knees. He bent my head down. At that time, when they were [deceptively] saying that they were going to examine me [they administered the injection], I felt the injection. I felt pain in my leg. (P19, caesarean section)

Some participants reported that they did not have the necessary follow-ups in the postpartum period (e.g. bleeding control, pad follow-up, blood glucose follow-up for those with diabetes, encouraging/supporting postpartum movements, support in meeting self-care needs), did not receive relevant education (e.g. breastfeeding, milking, baby care), and did not get enough analgesia:

They didn't even come and ask me. [After the birth] Bleeding and pad control was not carried out. I had gestational diabetes. I had already told the nurses before the operation, it was also already written in my file. Despite these [conditions], no blood glucose measurement or follow-up was made. Not for me, not for the baby… (P26, nurse)

Another issue reported by the participants was the lack of resources. The participants reported several deficiencies related to health professionals, including inadequate health staff, inadequate communication skills of health staff, several institution-related deficiencies (e.g. small labour/delivery room, lack of a labour/delivery room, sharing the same room with others) and some health-system-related deficiencies, (e.g. insufficient numbers of health personnel, differences between private and public hospitals in terms of health facilities):

I lay down on my back for almost 2 h. They [health professionals] just left me there and didn't care. Actually, this was a fault of our government because I was the 17th person who gave birth, and there were just two midwives. We didn't have a doctor during the delivery. (P6, primipara)

I didn't have a high income level, but I pushed myself financially to give birth in a private hospital. I wanted to be treated like a human being. (P11, multipara)

The participants stated that they received medical interventions without consent/permission, were not given enough information, or were given misleading information during the delivery process:

They cut me from the bottom [perineum]. They didn't provide information at all, and they didn't ask me either. It's bad to have surgical sutures, so I don't think anyone wants to have such sutures [suture marks]. It also made me feel bad that they did it [applied sutures] without asking me. (P10, multipara)

Reactions

The participants reported feeling stress, anxiety, worry, sadness, helplessness, anger and fear due to the obstetric violence they were exposed to during the childbirth process. They stated that they would never think of giving birth naturally again, and they were no longer considering having another child, even though they had wanted this previously. They stated having regrets about the childbirth process. The participants also said that they experienced negative behaviours such as crying, hitting their arm on the side of the bed, wanting to end the childbirth process/wishing to get rid of the baby, not wanting to present to health institutions, refusing to see their babies after delivery, and blaming their babies:

It was a painful experience to be constantly examined from below [vaginal examination]. She [the midwife] also made the intern [student midwife] do it to teach her. I asked myself: 'Am I a guinea pig?' So, I felt like a guinea pig. (P18, multipara)

I wanted to give birth in the delivery room as soon as possible and get over with it. I had no option, no choice. I don't want to give birth again. They [health professionals] both killed and resuscitated me [figuratively] in the hospital. This was the case there. (P5, multipara)

I didn't even want to look at the baby's face in the first weeks after the birth because of what I experienced in the childbirth process. I was pretty depressed. Whenever I thought of the delivery, I wanted to cry. I didn't want to care for the baby. The delivery was a trauma for me. I don't even want to go to the hospital for any reason. (P13, primipara)

Awareness

The participants reported having certain expectations of health professionals, such as ensuring their privacy during the childbirth process, supporting the labour process, not performing routine practices (including late cord cutting, episiotomy, movement restrictions), giving detailed information about the process and procedures, respecting the childbirth process, and having effective/good communication:

I would prefer having a suture-free delivery. …but at that moment, they [health professionals] had no connection with us, they were only concerned about getting the child out. [At birth] They should have taught me how I should behave. …but when I was taken to the obstetric bed, I had to [quickly] push and give birth, I had no other choice. I would have liked them to give me some time and help. (P5, multipara)

I wish they [health professionals] hadn't examined me from below so much. I wish the doctor had come and informed me about the progress. I also wish that the baby's umbilical cord hadn't been cut right away. My baby had a very bad case of jaundice. (P6, primipara)

The participants did not recognise some of the obstetric violence practices they were exposed to during the childbirth process (e.g. accepting binding of their feet, accepting forced delivery in the supine position, welcoming fundal pressure positively), considering the routine practices/violent treatments to be for their own benefit, and did not know their rights during the childbirth process:

[At birth] They tied and fixed my legs. …but when I thought about it later, it made sense to me because I had severe pain so I might have accidentally hurt the baby. I might have wanted to get up, lift my legs, get down… I wouldn't have known what to do. I was screaming and crying. (P20, primipara)

The code map in Fig. 1 shows the themes that were frequently used together.

Discussion

The results of this study show that the participants were exposed to various forms of obstetric violence, including psychological, physical and verbal violence. Psychological violence was predominant. Likewise, Beck (2018) reported that women were most exposed to neglect and the abandonment of care, which are amongst the most common elements of psychological violence. Abuya et al. (2018) stated that women were mostly exposed to lack of privacy, which is an element of psychological violence. Contrary to these results, Martínez-Galiano et al. (2021) reported a higher prevalence of physical and verbal violence than psychological violence during childbirth. Studies have shown that women are exposed to various forms of physical violence during the childbirth

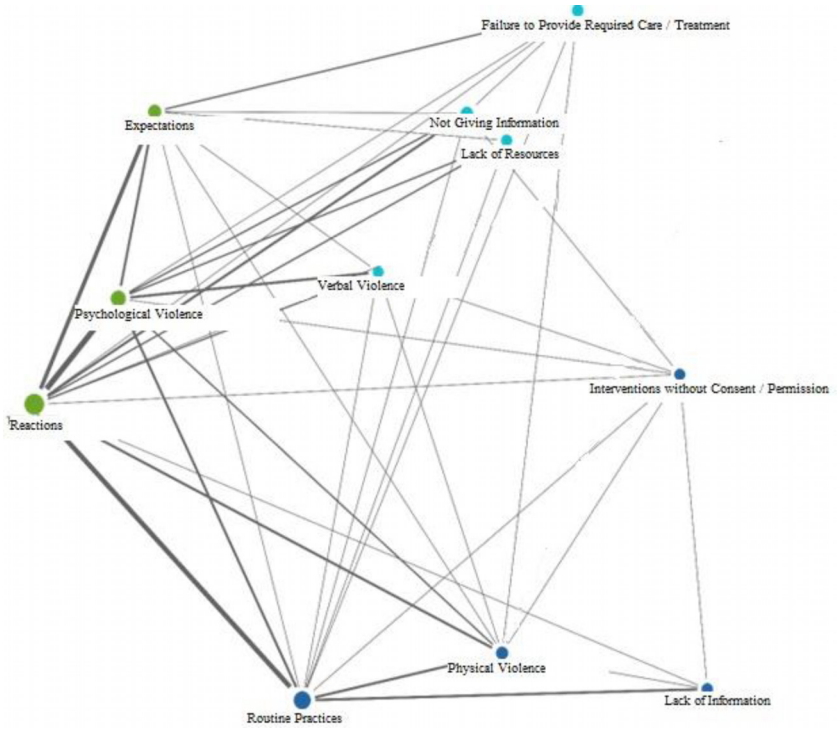

Fig. 1. Themes that were commonly used together: code map. Thick lines indicate the themes and subthemes that were frequently used together, and thin lines indictate the themes and subthemes that were relatively infrequently used together.

process, such as hitting, beating, slapping, kicking, pinching, using force, physical restraint, surgical intervention (caesarean section, episiotomy, abortion) without analgesia/anaesthesia, frequent vaginal examinations, unnecessary episiotomies and fundal pressure (Beck, 2018; Brandão et al., 2018; Kruk et al., 2018; Castro and Savage, 2019; Sharma et al., 2019; van der Pijl et al., 2020; Martínez-Galiano et al., 2021). Studies have also revealed that women are exposed to forms of verbal violence such as insults, yelling, threatening and scolding during the childbirth process (Abuya et al., 2018; Bohren et al., 2019; Martínez-Galiano et al., 2021; Sharma et al., 2019; Vedam et al., 2019). Unlike these studies, the participants in the present study did not report discrimination, an element of psychological violence, or forms of physical violence such as hitting, beating, slapping, kicking or pinching.

This study found that the participants were exposed to forms of obstetric violence such as psychological, physical and verbal violence, as well as several situations that resulted or may have resulted in physical or mental harm (i.e. administration of routine labour practices, not providing information, lack of necessary care/treatment, lack of resources, and medical interventions without consent/permission). Likewise, researchers have reported that women are exposed to several ill-advised routine labour practices, such as being left without food and water for a long time, their partners not being allowed to attend the labour and birth, not allowing skin-to-skin contact with the baby after birth, making frequent vaginal examinations, forcing the woman to lie on her back, applying fundal pressure, and speeding up labour even when not necessary (Souza et al., 2017; Brandão et al., 2018; Bohren et al., 2019; Flores et al., 2019; Sharma et al., 2019; Meijer et al., 2020; Martínez-Galiano et al., 2021). Some researchers have also shown that women are not adequately informed about care and treatment practices during the childbirth process (Souza et al., 2017; Brandão et al., 2018; Meijer et al., 2020). Researchers have argued that women are exposed to negative situations, such as being left alone, delayed care, or being ignored when in need (Brandão et al., 2018; Hameed and Avan, 2018; Montesinos-Segura et al., 2018; Bohren et al., 2019; Maldie et al., 2021; van der Pijl et al., 2020). In this study, the participants complained of frequent vaginal examinations performed by different people, which is one of the routine practices. Similarly, Martínez-Galiano et al. (2021), in a study of 899 women in Spain, reported that 22.2% of women were exposed to frequent vaginal examinations performed by different people. It has also been reported in the literature that women perceive vaginal examinations to be extremely uncomfortable or painful (Souza et al., 2017; Aktas and Aydin, 2019; Bohren et al., 2019). Similarly, as stated in this study (see 'Results' section, P11 statement), one participant stated in a study conducted by Morales et al. (2018) that 'You have to pay to be treated nicely – in a nice way'. Sharma et al. (2019) reported that public hospitals are crowded, presenting a challenging work environment for health professionals in maternal health services – usually without basic facilities and incentives – which is not conducive to evidence-based maternal care practices. Finally, it has been observed that women are commonly exposed to medical practices without their consent/permission during the childbirth process (Abuya et al., 2018; Lansky et al., 2019; Mihret, 2019). Unlike these studies, in the present study, the participants reported that their relatives were not allowed in the room during labour due to the ongoing COVID-19 pandemic, they received inconsistent information from health professionals, and they did not have some of the necessary follow-ups during and after childbirth (e.g. bleeding control, pad control, blood glucose follow-up for those with diabetes). These deficiencies related to health professionals, health institutions or the health system are important factors in the context of obstetric violence. Excessive workload, especially due to high patient density and staff shortages, may cause women to be exposed to routine ill-advised interventions, not to receive necessary care services or to receive them inadequately, and to have medical interventions without being informed and giving permission.

The results of this study demonstrate that the participants had negative emotions and short-term or long-term physical/mental problems due to the obstetric violence they were exposed to during the childbirth process. It has been found that women have short-term problems (e.g. changes in mood and thoughts) or long-term problems (e.g. post-traumatic stress disorder, postpartum depression) due to the obstetric violence that they are exposed to at any stage of the childbirth process (Souza et al., 2017; Morales et al., 2018; Annborn and Finnbogadóttir, 2022; Martinez-Vázquez et al., 2022). Chadwick et al. (2014) stated that women feel abandoned, forgotten, anxious, lonely and invisible, and they sometimes cry when they are neglected during childbirth. van der Pijl et al. (2020) argued that women have difficulty sleeping and nightmares due to obstetric violence, causing them to be afraid of getting pregnant and giving birth again, and they feel sad when they remember these bad experiences. The results of this study were similar to those in the literature.

Although an increase in women's awareness of their autonomy and desires has been reported (van der Pijl et al., 2020), the majority of women do not know their rights during the childbirth process, and they do not realise that their autonomy has been violated. In this study, the participants reported having certain expectations of health professionals about the childbirth process. Additionally, this study revealed that some of the participants did not recognise obstetric violence and were not aware of this type of violence. Likewise, Meyer et al. (2022) reported that almost all women expected health professionals to treat them with respect and empathy, provide more support, help them and spare more time. Annborn and Finnbogadóttir (2022) stated that women want to be informed about decisions and measures regarding the childbirth process. On the other hand, Dwekat et al. (2021) found that health professionals stated that most women were unaware of their rights, such as their right to receive respectful care during childbirth. Balde et al. (2017) found that women considered slapping, pinching, rude behaviours, yelling or insults by healthcare professionals acceptable when they failed to cooperate with them. In this regard, women's lack of knowledge about the childbirth process and the progress of this process causes them to accept the inappropriate practices and behaviours of healthcare professionals without questioning them.

Limitations

The results of this study are limited to the participants in the sample in Turkey. As the participants were reached online, only those who had an internet connection and used Instagram or Facebook were recruited to the study. Additionally, as the study was conducted during the COVID-19 pandemic, in-depth interviews with the participants could not be held face to face.

Conclusion

The results of this study show that women with different sociodemographic and obstetric characteristics experienced obstetric violence, another dimension of violence against women, during the childbirth process; they had short- or long-term physical and mental problems due to obstetric violence; and they expected health professionals to eliminate obstetric violence in the childbirth process. This study also found that women were unaware of the obstetric violence they were subjected to during the childbirth process, violating their right to receive quality care.

There is a need for more studies to examine women's experiences of obstetric violence, and reveal the factors associated with obstetric violence and its prevalence and consequences. Therefore, it is recommended that further studies should be undertaken to determine the perceptions and attitudes of health professionals and women towards obstetric violence, plan training programmes to increase their awareness of obstetric violence, and plan in-service training programmes to address obstetric violence and improve the communication skills of health professionals.

Author contributions

The first author (NA) designed this study on the basis of her Master's thesis, conducted in-depth interviews, analysed the data, and wrote the article. As a consultant, the second author (MMK) reviewed each phase of the study. She suggested changes and regulations. She gave instructions on how to analyse the data. Finally, she edited and revised the article. Both authors read and approved the final version of the manuscript.

Declaration of Competing Interests

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

CRediT authorship contribution statement

Nihal Avcı: Conceptualization, Methodology, Data curation, Formal analysis, Writing – review & editing. **Meltem Mecdi Kaydırak:** Conceptualization, Methodology, Supervision, Writing – review & editing.

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Ethical approval

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