TITLE

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

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 [*Hidden for blinding purposes*] 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.

KEYWORDS

Grounded theory; Health workforce; Nursing; Obstetric violence; Students

INTRODUCTION

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.

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

51 This type of violence appears to manifest itself all over the world, with rates ranging from 18.3% (Brazil)
52 [4] to 75.1% (Ethiopia) [5]. In Spain, 38.3% of women have identified themselves as victims of obstetric
53 violence [6]. Social stratification [7], low socio-economic status [8], age, race, or women's lack of knowledge
54 about their rights [9] have all been identified as causal factors in the literature. One of the hypotheses about
55 its origins lies in gender bias, due to the fact that women's rights to make decisions about their care are
56 often overridden and substituted. Gender-based violence can take different forms and is defined as

57 violence directed against a person because of that person's gender, with women being disproportionately
58 affected by this type of violence [10,11]. According to the United Nations, obstetric violence is defined as
59 a type of gender-based violence and occurs in a context of structural inequality, discrimination and
60 patriarchy. It is also a consequence of insufficient education and training, as well as a lack of respect for
61 women's equal status and human rights [1].

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

82 global consensus has yet been reached. Once the concept of obstetric violence is conceptualised and
83 operationalised, it may ease the process of translating it into something that can be measured [19].

84 PARTICIPANTS, ETHICS AND METHODS

85 *Design*

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

94 *Participants and settings*

95 Fifteen participants (4 midwives, 6 nursing students, 1 registered nurse, 1 gynaecologist and 3
96 paediatricians) were recruited through purposive sampling at [*Hidden for blinding purposes*] and were
97 chosen based on their likelihood of providing relevant data in terms of relevance, range of perspectives,
98 and depth [24,25]. Subsequently, five participants (5 midwives) were recruited through theoretical sampling
99 (20 participants in total) [22]. Thus, the selection criteria included nursing students enrolled in [*Hidden for*
100 *blinding purposes*] who attended [*Hidden for blinding purposes*] as part of their practical module, as
101 well as registered professionals who were willing to share their experience and had clinical experience
102 with childbearing women. Table 1 summarises the characteristics of the participants.

103 *[INSERT TABLE 1 ABOUT HERE]*

104 *Data collection*

105 Twenty in-depth semi-structured interviews were carried out. Researchers developed and agreed on an
106 interview protocol (Supplementary Table S1). All the interviews were conducted at [*Hidden for blinding*
107 *purposes*] by two nursing researchers with training in qualitative methods research. Each interview was
108 digitally audio recorded and lasted between 40 to 60 minutes. Data was continuously analysed until data
109 saturation was reached. All transcripts were anonymised and member-checked. Interview statements
110 were translated by a bilingual researcher to English. Then, another bilingual researcher back-translated
111 them to Spanish and compared them with the original transcripts to maintain their accuracy.

112 *Data analysis*

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

130 *[INSERT FIGURE 1 ABOUT HERE]*

131 *Ethical considerations*

132 The study was approved by the Ethics Committee of [*Hidden for blinding purposes*], which followed
133 all of the criteria of the Declaration of Helsinki and its subsequent revisions. All participants were
134 previously informed about the voluntary nature of their participation and the possibility to withdraw at
135 any moment. Prior to starting, all participants signed a consent form and agreed to audio recording.

136 *Rigour*

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

144 **RESULTS**

145 *Participant characteristics*

146 A total of 20 interviews were conducted, in which 70% (n=14) of the interviewees were healthcare
147 professionals (9 midwives, 3 paediatricians, 1 registered nurse, 1 gynaecologist) and 30% (n=6) were
148 nursing students. The data was collected from May to July 2021. Overall, 80% of the participants (n=16)
149 identified as female and 20% as male (n=4). The participants' ages ranged from 22 to 70 years old
150 (41.85±14.21). Qualitative analysis revealed three major categories, which are summarised in Table 2.

151 *[INSERT TABLE 2 ABOUT HERE]*

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

160 *[INSERT FIGURE 2 ABOUT HERE]*

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

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

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

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

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

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

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

181 In this vein, a large number of participants stated that obstetric violence may have a physical,
182 psychological and social impact on women's health. Indeed, the participants pointed out that some
183 women may experience a difficult postpartum period and may even refuse to have another child because
184 of their previous traumatic experiences:

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

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

194 *Category 2: Defining the problem of obstetric violence*

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

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

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

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

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

215 *Sub-category 2.2: Defining obstetric violence*

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

220 *"For me, obstetric violence can be defined as any physical, sexual, personal, or*
221 *institutional abuse perpetrated against women merely because of their gender, with the*
222 *gynaeco-obstetric care setting being used as a position of power. It includes not only*

223 *healthcare professionals, but also non-healthcare professions such as clinical assistants,*

224 *porters, and so on"* P15

225 *"I admit it is a wide and diverse term. It refers to the medicalisation and*

226 *instrumentalization of women's reproductive processes, as well as the infantilization and*

227 *dehumanisation of women by healthcare professionals. On the other hand, I could also*

228 *include the lack of respect and empathy given when some professionals say "you are*

229 *overreacting or hysterical, everything is fine!". In summary, I feel it could be anything*

230 *along those lines"* P8

231 *"I would say is a set of actions that take place towards a woman during pregnancy,*

232 *childbirth, postpartum or at any time of her obstetric life that cause her any kind of harm,*

233 *physical or psychological, or that make her feel invalidated. I believe it is a violation of*

234 *human rights, even if it may be justified or is said to be justified on a professional level,*

235 *because that is not always the case"* P5

236 *Category 3: Strategies for addressing obstetric violence*

237 This last category highlights the need for a change in strategies to prevent obstetric violence. Healthcare

238 professionals and future professionals emphasised the value of implementing interpersonal and global

239 strategies such as obstetric violence education, professional training courses, legal implications or public

240 awareness.

241 *Sub-category 3.1: Micro-level strategies*

242 One of the most frequently mentioned micro-level strategies as a means to prevent obstetric violence by

243 participants was interpersonal-related strategies such as showing empathy for women, receiving ongoing

244 training to stay up-to-date on the different initiatives or changes implemented in this field, and raising

245 awareness among those close to them:

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

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

258 *Sub-category 3.2: Macro-level strategies*

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

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

267 *"Specific clinical practice guidelines, which are more precise about what we are doing*
268 *wrong and how to change it, are required at the workplace. It is necessary to evaluate*
269 *professional-patient ratios in order to provide humanised care, as well as to insist on the*

270 *training of healthcare staff. How could we make it visible if we witness violence in the*
271 *delivery room but are unsure how to report or proceed?"* P6

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

278 **DISCUSSION**

279 The aim of this study was to explore current information and knowledge about obstetric violence within
280 the Spanish healthcare context, as well as to develop a theoretical model to explain the concept of
281 obstetric violence, based on the experiences of healthcare professionals and students. obstetric violence
282 information and knowledge within the healthcare context, as well as to develop a theoretical model to
283 explain the concept of obstetric violence based on the experiences of healthcare professionals and
284 students. This theoretical model aims to provide an understanding of the concept of obstetric violence
285 based on data co-constructed with participant interviews, seeking to comprehend meanings about the
286 concept of obstetric violence by the participants. According to the findings, the participants agreed that
287 obstetric violence is a violation of human rights and a serious public health issue. Although previous
288 studies have identified mistreatment against women during facility-based childbirth as a critical issue
289 worldwide [6,27–29], it is interesting to consider these findings in the context of the established midwife-led
290 continuity model [30,31]. This model attempts to explain the benefits of a client-centred pregnancy and
291 childbirth care approach in reducing birth injury, trauma, and caesarean section rates, and whose core
292 principles are: physical, psychological, and social well-being of the mother or birthing parent; autonomy
293 in decision-making for the mother or birthing parent; minimising technological interventions; and
294 identifying and referring women who require obstetrical attention [32]. Therefore, the findings of this study

295 resonate with established principles of women and childbirth care, but also generate a new theoretical
296 model for healthcare students and professionals to identify and manage obstetric violence based on
297 contextual factors.

298 Based on our findings, participants identified obstetric violence as structural gender-based violence [33]
299 and emphasised the importance of understanding its characteristics in order to control its impact on the
300 health outcomes of women and children. These characteristics have already been documented [27] and
301 classified into seven different categories [34]: physical abuse, non-consented care, non-dignified care,
302 discrimination based on specific patient attributes, abandonment of care, and detention in facilities in
303 some countries. Despite the fact that these characteristics may involve different sorts of disrespect and
304 abuse [35,36], all participants agreed with the importance of identifying these as facets of gender-based
305 discrimination. A possible explanation for these results may be the current intersection of two powerful
306 normative discourses, medical dominance and the patriarchal institution of motherhood [37]. In this
307 context, opting out of the obstetric model is frequently interpreted as a challenge to authority [38] or even
308 so-called maternal-foetal conflict [39,40], compromising women's autonomy and turning the midwife-led
309 model into a paternalistic care approach. This interpersonal inequality between professionals and
310 women, as well as the identified characteristics, has been described as one of the main factors leading
311 to potential health consequences [33,41], and thus further action is required to promote respectful maternal
312 and childbearing health care and to prevent structural gender inequalities [42]. Other studies have also
313 found obstetric violence to be the result of a patriarchal and hierarchical culture and healthcare system
314 [28,43–45].

315 Having said that, the findings of this study showed how participants' experiences and perceptions
316 influenced their process of connecting with new information as well as building knowledge based on
317 their decisions to accept certain information regarding obstetric violence [46]. While the term
318 "mistreatment" is widely used around the world [29], the core issue continues to be identifying and
319 conveying the concept of obstetric violence to healthcare professionals [47]. However, based on prior
320 research [41,48] and our participants' responses, defining the term 'obstetric violence' offers a distinct

321 contribution to the ongoing awareness of violence against women, contributes to the creation of national
322 policy and legislation on the concept [49], and involves both structural and interpersonal gender-based
323 abuse, rather than assigning blame only to care providers [33,50]. Notwithstanding the nuance in
324 terminology, obstetric violence could be defined as any gender-based act that compromises the physical,
325 psychological, economic and social well-being of the woman, resulting in a loss of autonomy in
326 decision-making and the ability to make informed and free decisions about their bodies and sexuality
327 [6,27,49].

328 In addition to establishing a concrete definition of obstetric violence and its characteristics, our findings
329 provide proposals for specific micro- and macro-level action strategies. Micro-level strategies promote
330 changes in obstetric violence training in both undergraduate and postgraduate healthcare professionals
331 in order to provide up-to-date evidence-based practical education [14,47], highlighting the significance of
332 providing women with unbiased and evidence-based information to ensure decision-making autonomy
333 [28,51,52]. Likewise, our participants advocate for additional actions to increase the awareness of the general
334 population using a multi-level approach, engaging health institutions, managers, healthcare
335 professionals, lawmakers, civil society, and other stakeholders at the national and international levels [53].
336 Macro-level strategies, on the other hand, may contribute to addressing significant structural dimensions
337 that can have an impact at other levels such as legislative, economic, or organisational levels [27,33].
338 Although these dimensions should not be used to justify obstetric violence, it is necessary to keep in
339 mind that abusive behaviour is not always intentional [53]. Healthcare policymakers, for example, must
340 pay special attention to this, facilitating gender-based evidence-based policies and guidelines with the
341 aim of eliminating and preventing factors that contribute to obstetric violence such as staffing shortages,
342 inadequate infrastructure, or stressful working environments, while also involving women and their
343 families in decision-making [41,54].

344 Nonetheless, there are some limitations to consider. To the best of our knowledge, this is the first attempt
345 from a constructivist perspective to identify the concept of obstetric violence and potential preventive
346 strategies. As a result, future research is needed to confirm this definition as well as the model for wider

347 application of the findings. The particular context of this study, on the other hand, may not be
348 generalisable, though the model developed based on our findings should be conceptually useful to the
349 design of similar decision-making delivery care models.

350 **CONCLUSIONS**

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

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