

Experiences and Perceptions of Gynaecological Violence: A Descriptive Exploration of the Phenomenon from Survivors' Standpoints

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ABSTRACT

In the context of increasing movements against gender-based violence, resentment against sexism and disrespect within the medical field has gained attention. Using an exploratory qualitative approach, this study aims to provide a comprehensive description of gynaecological violence (GV) from survivors' perspectives. The convergence of critical thinking, queer theory, and intersectional feminism underscores the importance of understanding diverse and marginalised perspectives as well as individual narratives. Nine participants from Québec (Canada) shared their stories through individual, semi-structured interviews. Phenomenology was used to analyse the deep and nuanced lived experiences, enabling the capture of the essence of GV. The findings first highlight the negative experiences faced by participants, encompassing situations where they felt deprived of choices, unheard, treated insensitively, dehumanised, abandoned, and gaslighted. The results then trace the line between participants' negative experiences and GV, revealing how perceptions of violence are formed. Finally, a phenomenological description of GV is provided, offering insights into how the phenomenon can be personally experienced by individuals. This study bridges a gap in the literature, provides a foundation for future research and advocacy, and presents recommendations. It calls for reevaluating practices in gynaecological health services to ensure they are inclusive and respectful.

Keywords: phenomenology, critical thinking, queer theory, gynaecological violence, intersectional feminism

INTRODUCTION

In recent years, movements against gender-based violence have gained momentum (Russo and Pirlott, 2006), bringing attention to issues of sexism and gender bias within healthcare services (Verdonk *et al.*, 2009). Numerous individuals have disclosed experiences of gynaecological violence (GV), encompassing various harmful acts of neglect, abuse, or misconduct within the context of gynaecological health services (GHS) (Cárdenas-Castro and Salinero-Rates, 2023; Vuille, 2016). These experiences have ignited international discussions and condemnation (Commission sur l'égalité et la non-discrimination [CEND], 2019; Haut Conseil à l'Égalité entre les femmes et les hommes [HCE], 2018; Šimonović, 2019).

Despite the media, activist groups, and the public raising their voices against GV (Vuille, 2016), the subject remains largely understudied, except for its obstetrical dimension (Bohren *et al.*, 2015). The lack of comprehensive research on GV has left a gap in our understanding of the issue, undermining efforts to combat it effectively. This article sets out to lessen this gap by exploring GV from the experiences of those who have faced it, offering an in-depth description of the phenomenon as it is lived.

Prevalence and Manifestations of GV

The concept of GV, while increasingly recognised in political and activist discourse, suffers from a lack of a concise, universally agreed-upon definition. This lack of clarity is evident as the term itself varies. For example, it is sometimes referred to as mistreatment and, at other times, as sexism. Despite this variability, some characteristics of GV are often repeated in its existing definitions. According to these, GV encompasses a broad spectrum of practices, actions, gestures, statements, or behaviours, both committed and omitted, that occur within healthcare (HCE, 2018; Marcilly and Mauri, 2018). It covers the absence of free and informed consent, lack of justification for medical interventions, or interventions going against scientific knowledge and best practices (CEND, 2019;

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Quéré, 2019). GV's perpetrators are healthcare providers across various specialities who may not have violent intentions, and the survivors are the patients (HCE, 2018; Marcilly and Mauri, 2018).

The International Planned Parenthood Federation (2022) provides examples of such violent practices in gynaecology, including psychological and physical violence (e.g., shaming or judgemental remarks), non-consensual acts (e.g., forced vaginal examination), medically unnecessary procedures (e.g., routine episiotomies), and delay or refusal of care (e.g., refusing to help a patient requesting an abortion). The CEND (2019) further expands on this list, adding inappropriate acts, sexist behaviours, disrespectful and abusive treatment, brutality, stigmatisation, marginalisation, pressure to relinquish patients' rights, contempt, and indifference to pain.

To date, only one available study (Cárdenas-Castro and Salinero-Rates, 2023) seems to have directly addressed the subject of GV using that term precisely. This study describes it as the subordination of patients by healthcare providers, leading to a loss of autonomy and decision-making capacity. In that study, GV is characterised by actions such as withholding information, making ironic or impertinent comments, reprimanding, infantilising, performing non-consensual genital examinations, imposing excessive medicalisation, and using deliberately painful procedures. It also encompasses forms of sexual violence, such as a medically unjustified injunction to nudity, inappropriate touching of sexual organs, and sexual assault. However, due to the current lack of studies devoted to defining the concept of GV, their description cannot yet be based on a thoroughly developed, well-established foundation, underscoring the need for more research. Nevertheless, their study has documented the prevalence of GV in Chile's healthcare system. Out of 1,503 women from different areas of Chile, 57.9% experienced GV, with higher rates among marginalised groups: 61.9% for those under 34 years old, 71% for non-heterosexuals, 72% for Indigenous people, and 83.3% for Afro-descendants.

GV, Rooted in Gynaecology's History

GV is said to emerge in a context where sexual-reproductive healthcare is institutionalised and legitimises the power dynamic between providers and patients (CEND, 2019; HCE, 2018). It stems from sexism, racism, classism, and a desire to control, all of which pervade the history of sexual-reproductive medicine (HCE, 2018; Cooper Owens, 2017). Gynaecology's history is indeed unsettling, marked by a legacy of violence. For instance, during the 19th century in North America, doctors were conducting experimental vaginal surgeries forcibly and without anaesthesia on Black enslaved women and impoverished Irish immigrants (Cooper Owens, 2017). The history of violence within the field of gynaecology extended over time, persisting through various manifestations, such as eugenic sterilisations forced upon women from oppressed groups, notably those who were Black, Indigenous, criminalised, poor, or disabled (Bocquillon, 2018).

Today, the echoes of this dark historical background are still felt. For example, in 2014, on Twitter, a French student launched the hashtag #PayeTonUtérus (pay your uterus), prompting over 7,000 people in just 24 hours to publicly disclose their negative experiences with GHS (HCE, 2018). Other hashtags pursuing the same goal subsequently appeared across the globe – #balancetongynéco, #prekinimošutnju, #STOPVGO, #bastatacere, and #MeTooPelvic, to name just a few (HCE, 2018).

The Origins of the Concept of GV and its Relation to Obstetric Violence

GV often falls under the broader concept of 'obstetric and gynaecological violence', which originated in Latin America in the early 2000s (Williams *et al.*, 2018). While obstetrics focuses on perinatal care, closely related to childbirth, gynaecology encompasses feminised sexual-reproductive systems, including body parts such as the vulva, vagina, and uterus (Williams *et al.*, 2018). Obstetric violence (OV) gained prominence through Latin American activist movements, particularly in Brazil (Sadler *et al.*, 2016; Williams *et al.*, 2018). In 2007, Venezuela formally included OV as one of the 19 forms of violence against women punishable by law, framing it as a violation of sexual and reproductive rights (República Bolivariana de Venezuela, 2007). Argentina, Bolivia, Panama, and Mexico have subsequently incorporated it into their legislation against gender violence and inequality (Williams *et al.*, 2018). Recent studies have further enriched our understanding of that phenomenon (Lévesque *et al.*, 2018). A systematic review has even encompassed papers addressing the mistreatment of women during childbirth in 34 countries spanning five continents (Bohren *et al.*, 2015), suggesting a global concern. Meanwhile, GV is still relatively neglected in both academic and legal frameworks.

According to the UN Special Rapporteur Dubravka Šimonović (2019), mistreatment and violence against women in reproductive health services, including gynaecology and obstetrics, are part of a continuum. Building on this, Garcia (2020) expands the concept of OV by including early pregnancy termination procedures and preconception care. Pickles (2024) further notes that definitions of OV can include forced sterilisations or contraception. These insights highlight how pervasive and interconnected various forms of violence in reproductive health services can be. Šimonović (2019) emphasises that such violence is driven by structural inequalities and patriarchal norms. Therefore, GV and OV are likely to overlap, sharing the same root causes (Pickles, 2024; Šimonović, 2019). This idea is further supported by Pickles (2024), who builds on Kelly's (2013)

concept of a continuum of violence against women to show how different forms of violence are interconnected rather than mutually exclusive.

Nonetheless, in this study, emphasising GV is essential to address the epistemic imbalance between GV and OV in the current state of research. While there are similarities between the two, GV also presents distinct characteristics. Encompassing a wider range of interactions and procedures related to sexual and reproductive health, it comprises non-pregnancy-related care, such as cervical screening for cancer, menopause symptoms management, and alleviation of menstrual pain. GV also affects a broader demographic, including younger and older patients and those who may never experience pregnancy or childbirth. Moreover, Pickles (2024) explains that establishing conceptual boundaries is helpful to ensure that interventions are effectively tailored to address integrity violations in specific contexts. Thus, although we acknowledge their potential overlap and the connection through the obstetrics-gynaecology medical speciality, maintaining a conceptual distinction between GV and OV remains opportune.

The Present Study

In this article, we aim to provide a comprehensive and situated description of GV, shedding light on what constitutes this form of violence from the standpoint of individuals who have directly experienced it.

THEORETICAL AND CONCEPTUAL FRAMEWORK

This study adopts a constructivist paradigm with an inductive, qualitative approach inspired by queer theory, intersectional feminism, and critical thinking. We challenge the use of the category 'woman' in GHS by drawing upon various fundamental ideas from queer theory. One of these is Foucault's (1978) views of sexuality as a socially and historically constructed concept influenced by power dynamics. Another one is his critique of the marginalisation and devaluation of groups of people and types of knowledge in establishing what is considered scientific knowledge (Foucault, 1997). These ideas prompted us to reassess the gender-biased biomedical paradigms in GHS. Indeed, if gynaecology is said to be the medical expertise of women's health, then who is included and who is excluded from this category? In some of their most notable work, Butler (1990, 1995) argued that the category 'woman' can be exclusionary and reinforce gender norms, so they advocated for a more inclusive understanding of it. This means not discarding the category but reinterpreting it to accommodate diversity (Baril, 2007, 2009). Oudshoorn (2000) further emphasised that biomedical understandings of the body are socially and linguistically constructed, challenging the notion of objective truths in science. Queer theory allowed this study to acknowledge that those requiring GHS may not identify with the category 'woman' and that not all women require these services. By challenging the traditional binary understanding of gender and sexuality, queer theory exposes the biases and power imbalances within the medical system. It helps to uncover how medical practices marginalise individuals who do not conform to conventional gender norms.

Intersectional feminism, emerging from Black feminism, examines how various oppressions, like racism, sexism, and classism, intersect to form an individual's social position (Gkiouleka *et al.*, 2018; Hill Collins, 2015). Oppressions also include ageism, cissexism, heterosexism, fatphobia (sizeism), sanism, ableism, colonialism, and nationalism and xenophobia (Bilge, 2009; Chbat *et al.*, 2014; Matsuzaka and Koch, 2019; Morrison and Dinkel, 2012; Prohaska and Gailey, 2019). An individual's social position regarding these multiple axes of oppression influences their experiences of the world, including within GHS (Chbat *et al.*, 2014; Quéré, 2019). This study is inspired by this theoretical framework to help contextualise the concept of GV, showcasing its feminist origins and the violent roots of gynaecology. Intersectional feminism reveals that the discrimination and violence faced by patients are not only gendered but also influenced by their socioeconomic status, sexual orientation, and other social positionings. By drawing on intersectional feminism, this study recognises the diverse needs and experiences of all patients.

Critical thinking emphasises the political aspect of research, which affects knowledge production and dissemination (Sensoy and DiAngelo, 2017). It encourages methodological reflexivity, social justice promotion, challenging existing paradigms, and being aware of biases in data interpretation (Sensoy and DiAngelo, 2017). It also involves acknowledging power structures and avoiding exclusions for a comprehensive perspective. The political dimensions of GV are entrenched in historical, ideological, and policy-driven contexts, where identities intersect to shape medical practices and policies. Historically, this is exemplified by experimental genital surgeries performed without consent on enslaved Black women in the nineteenth century (Cooper Owens, 2017). Today, legislation on reproductive rights, funding allocations, and public health initiatives continue to impact how GV is recognised and addressed. Activist movements and political advocacy have been crucial in highlighting GV, pushing for legal reforms and greater accountability (CEND, 2019; HCE, 2018; Šimonović, 2019). By employing queer theory, intersectional feminism, and critical thinking, this study aims to uncover and challenge these political influences and advocate for more inclusive and equitable healthcare practices.

METHODOLOGY

Participants and Recruitment

We used intentional and snowball recruitment. The inclusion criteria were: 18-year-old or older; francophone; report having experienced violence within GHS. Given the variability in the vocabulary surrounding GV, we included in the recruitment posters examples of violence within the context of GHS as cited in the literature: ‘inappropriate behaviours or comments, disrespect, abuse of power, absence of consent, rights denial, unethical practices, discrimination, mistreatment, etc.’ We also provided a few examples of what GHS can encompass: ‘speculum examinations, contraception counselling, perineal rehabilitation, IUD insertion/removal, abortion, STI screening, etc.’

We established an exclusion criterion for those who had experienced violence exclusively related to pregnancy and childbirth. Participants could still recount perinatal experiences if they were relevant to their understanding of GV. However, the criterion ensured we would also analyse experiences beyond perinatal care, complementing previous studies on OV.

To encourage diversity and inclusivity in our recruitment, we solicited 21 organisations in Quebec that work with socially marginalised groups. Twelve were selected because they were members of La collective du 28 mai, a group dedicated to combating GV. They served notably women living with cancer, with disabilities, individuals from the sexual and gender diversity, immigrant women, survivors of sexual violence, and racialised women. The remaining nine organisations were chosen for their work with other marginalised groups, such as individuals experiencing fatphobia, people using drugs, sex workers, polyamorous and non-monogamous individuals, and people with endometriosis. Six of them agreed to collaborate by sharing the calls to participate via their social media (Facebook, Instagram), website, and newsletter: Fédération des Femmes du Québec, Fédération du Québec pour le planning des naissances, Centre des femmes d’ici et d’ailleurs, Réseau des tables régionales de groupes de femmes du Québec, Centre de santé des femmes de Montréal, Endométriose Québec.

Data Collection

Each participant underwent a 90-minute semi-structured interview, delving into themes covering their experiences in GHS, their subjective interpretation of these experiences, and their comprehension of what constitutes GV. To ensure an authentic representation of their self-perception, they were also encouraged to share their pronouns and present their identity without predefined categories, in line with queer theory.

The interview questions were designed by the first author to be open-ended and clear and to promote detailed and spontaneous reflections. As suggested by Baumbusch (2010), emotionally laden questions were placed midway. Following Kallio and colleagues’ recommendations (2016), the interview canvas was revised (by the second author) and tested (with a lab member) to improve question clarity and reduce biases. It featured both primary and probing questions, the latter fostering deepening insights for a more comprehensive approach (Baumbusch, 2010; Kallio *et al.*, 2016). Interviews were conducted in 2021 via Zoom due to COVID-19 restrictions.

Analysis

We opted for phenomenology as the analytical strategy because the study’s aim was to deliver a thorough, contextualised description of GV from the experiencers’ viewpoints. This method excels in revealing detailed, personal perspectives by depicting experiences as they are lived without imposing preexisting theoretical frameworks. It aims to describe the phenomenon in a way that is as close to its essential nature as possible, yet, out of epistemic humility, we acknowledge that our positionality can paradoxically introduce bias and interference in the analysis process. By adopting a phenomenological approach, the study honours the participants’ experiences by inviting their voices to lead the inquiry.

Based on Ransé *et al.*’s (2020) flexible blend of descriptive and hermeneutic phenomenologies procedures, the first author followed these steps, assisted by NVivo: conduct an initial interview; transcribe it; repeatedly read it and listen to the audio recording simultaneously; identify moments of ‘experiencing GV’ and give them titles; *remove, modify, or add titles by asking ‘Does this title illustrate the moment of the explored phenomenon properly?’*; identify exemplars for each of the titled moments; *remove, modify, or add exemplars by asking, ‘Does this exemplar represent the moment of the explored phenomenon?’*; create a lived experience description of the phenomenon; incorporate, where relevant, additional information about the role of phenomenological existentials¹ in participants’ experiences. The second author provided feedback on the italicised steps and contributed to the creation of the phenomenological description by identifying blind spots and unnecessary segments. She also reviewed the presentation of the results in this article multiple times to ensure they were comprehensive, understandable, supported by interview excerpts, consistent with theoretical and analytical approaches, and reasonably concise.

¹ Spatiality (lived space), corporeality (lived body), communality (lived relationships), and temporality (lived time).

Epoche (bracketing), the phenomenological practice of suspending judgment on knowledge of the world (Ndam, 2023; van Manen, 2017), was seen here as a goal inspiring a mindset to be adopted during data collection and analysis (Tufford and Newman, 2012) rather than an absolute state to be achieved, again out of epistemic humility. The authors acknowledge their biases, approaching the study with careful consideration of how they may influence their work, as recommended by Finlay and Gough (2003) and Moustakas (1994).

The description that emerges from this analysis is a co-created anecdote (participants and researchers). This means it does not represent a particular interviewed individual or an exact experience reported. Instead, it is constructed from a balance between evocative interview excerpts, sometimes synthesised and rearranged, combining reported moments and situations (Ranse *et al.*, 2020). The description must still faithfully capture the essence of the lived moments and remain consistent with participants' narratives. It is meant to give a rich, almost palpable sense of what experiencing GV can be like (Ranse *et al.*, 2020).

The interview excerpts provided in the results section were translated by the first author after the analysis, with as much concordance as possible with the original vocabulary and syntax used by the participants. It is, therefore, possible that some sentences or expressions appear grammatically incorrect, unusual, or odd to anglophones. It was nevertheless important to remain as close as possible to the participants' words to ensure coherence with the phenomenological analysis approach and to limit interpretation bias.

We conducted peer debriefings with lab members working on two other GV and OV research projects as well as three external researchers who gave valuable feedback on our research proposal, process, and findings. To promote transparency and replicability, we kept a comprehensive audit trail, including interview transcripts, emails, interview canvas, recruitment posters, collaboration agreements with community organisations, NVivo file, a list of organisations targeted for marginalised representations, initial contact procedures for participants, and pre-interview questions. Our iterative coding process, revisited and refined over 18 months, continued throughout the writing phase for consistency and accuracy. Finally, multiple audits by the second author enabled the review of the study's methodology, data, and findings.

Ethical Considerations

The project obtained approval from UQAM's ethics committee on June 17, 2021, with two annual renewals. We also adapted the guidelines from the Canadian Professional Association for Transgender Health's code of ethics (Bauer *et al.*, 2019) to align with the study's queer framework. An online Qualtrics form was used to obtain information and consent. We provided participants with a list of psychosocial resources but did not offer financial compensation, as the study was unfunded.

RESULTS

The results first introduce participants' profiles and the experiences shared during the interviews. Subsequently, six moments of negative experiences are presented, followed by a delineation of violence within those. Lastly, a phenomenological description of GV is offered.

Participant Profiles

The sample is composed of nine participants. **Table 1** outlines their sociodemographic details, including gender identity, age, relationship and family status, and education. Additionally, it summarises their use of GHS, the axes of oppression they have encountered, and the chronology of their experiences with GV.

Experiences in GHS

The participants interacted with various providers, including internists, gynaecologists, obstetrician-gynaecologists (OB-GYNs), physiotherapists, social workers, nurses, pharmacists, emergency doctors, family doctors, anaesthetists, doulas, and radiologists. Given the complexity of health, gynaecological issues may have implications for other health issues and vice versa. Therefore, it seems consistent to refer to GHS rather than gynaecology when addressing GV.

Experiences within the GHS were portrayed in various ways. Some were described as positive or neutral, with terms like 'good' or 'OK.' Others were seen as negative and described using terms like 'clumsy' and 'uncomfortable.' Within the negative experiences, those considered violent were described using terms like 'extremely mistreating,' 'unacceptable,' and 'nightmarish.' Participants have thus encountered a variety of negative experiences in GHS, but not all were considered violent. The nuance is important if we are to circumscribe what constitutes GV. The fact that participants used various terms to describe their experiences also emphasises the subjectivity behind their shared interpretation of a lived phenomenon. It suggests that the vocabulary used to describe GV can influence whether individuals recognise it as such or not.

Table 1. Participant profiles

Participant	Age	Relationships and family	Education (field) and job field	GHS related to...	Oppressions related to the experiences of GV	GV timeline
Charlie (cis woman)	40s	1 male partner No child	PhD (Spirituality) Spiritual care	Abortion, contraception, endometriosis, menstruation, vaginal mycosis	Ableism, geographical/spatial inequality, sanism, sexism	Started at 16–17-year-old and ongoing
Dany (cis woman)	25	1 male partner No child	BA (Arts and communication) Entrepreneur	Contraception, genital discomfort	Ageism, geographical/spatial inequality, sanism, sexism	Around 20- and 24–25-year-old
Em (cis woman)	27	1 male partner No child	PhD (Social sciences) Researcher	Vestibulitis, vulvodynia	Ableism, ageism, heterosexism, sanism, sexism	Around 21-year-old
Gab (cis woman)	Not disclosed	1 male partner while experiencing GV, now single No child	Not disclosed Immigration and education	Endometriosis, infertility, laparoscopy, ovarian cysts	Ableism, classism, sexism	Around 2016 and 2018
Joe (cis woman)	48	Not disclosed 2 children	MA (not disclosed) Education	Childbirth, contraception, menopause, menstruation, perineal physiotherapy	Classism, geographical/spatial inequality, sanism, sexism, sizeism	Since age 17
Max (cis woman)	34	1 male partner 1 child	Not disclosed Education	Abortion, childbirth, contraception, endometrial biopsy, menstruation, miscarriage, pregnancy	Geographical/spatial inequality, heterosexism, sanism, sexism, sizeism	Since age 18
Pat (cis woman)	40	Not disclosed 2 children	PhD candidate (not disclosed) Public services and communication	Abortion, childbirth, contraception, laparoscopy and laparotomy, mammography, menstruation, miscarriage, perineal physiotherapy, pregnancy, STIs, uterine fibroids	Ageism, geographical/spatial inequality, nationalism/xenophobia, sanism, sexism	From adolescence onwards
Sam (cis woman)	32	1 male partner 1 child	Not disclosed Unemployed (previously self-employed)	Abortion, cervical biopsy, contraception, laparoscopy, menopause, menstruation, miscarriage, oophorectomy, ovarian cysts	Ableism, ageism, classism, sanism, sexism	Over the past 20 years
Vic (non-binary)	28	Not disclosed; not heterosexual No child	Technical diploma (not disclosed) Community worker	Cervical biopsy, STIs, contraception, menstruation, ovarian cysts	Ableism, cissexism, classism, heterosexism, sanism, sexism, sizeism	Since age 22

We divided the negative experiences shared by participants into six phenomenological moments: being deprived of choices, unheard, treated insensitively, dehumanised, abandoned, and challenged in their sense of reality (gaslighted).

Moments of being deprived of choices

Participants shared negative moments that involved having limited choices. They recounted instances where their decision-making autonomy was denied, preventing them from giving or withholding consent due to unclear information and limited options presented. These moments sometimes manifested when they were forced to consult specific providers, follow predetermined treatments, or obstructed from pursuing a chosen care path or treatment. For example, Pat narrated a moment when she was coerced by a provider to take Depo Provera for six

months after she had had an abortion. She said, 'I felt like I was... like a drug addict or something; that there was like a parole officer, and I had to go back.' Lack of choices also encompassed hidden alternatives, deception, and strong pressure towards a professional's favoured approach. Gab said:

When we consult a doctor, they'll often offer us a solution like nothing else was available. That's nonsense because everyone knows there are millions of treatments for all kinds of situations, never just one. When people have a discourse that's very 'That's it, and that's all,' categorical, I think that's manipulation.

The absence of choice in treatment decisions was also illustrated by Em's experience. Confronted with vestibulitis (pain at the entrance of the vagina), she experienced the denial of surgical intervention by her gynaecologist. According to her, the gynaecologist displayed condescension and disdain toward her due to her sexual inexperience, advising her to wait until she found a partner based on the presumption that 'Sometimes, the condition magically disappears with a partner.' She said:

My medical treatment depended on a spouse. I was like, 'Wow! We're back in 1950, this is fantastic.' As a feminist, I have a lot to say on the subject. I was like, 'Wait... I'm being fucked with right now. What's going on? This is a nightmare.'

Em's account underscores the lack of options presented to her and the broader sociocultural implications of such medical practices, which she perceives as regressive and antithetical to feminist principles. Her reflections capture the essence of being trapped in a medical paradigm that can deny individual autonomy.

Moments of being unheard

The participants shared situations in which they perceived that providers did not listen to them, leading them to feel ignored, dismissed, interrupted, or restricted in communication, resulting in a lack of acknowledgement and acceptance. They could not voice concerns, set boundaries, or communicate their needs. Charlie said:

I had a list with five points [to discuss with the doctor]. He said, 'No. When you come here, it's one point.' Imagine! I was starting to be more able to defend myself. I said, 'Sir! I've just come from [city]. These are important things for me. I need prescriptions.' He said, 'Ah... OK.' Geez! What's that? What's the problem? I'm on medication right now; I need a follow-up!

Limited information exchange between them and their providers led to accessing services that were sometimes ill-fitted and unsuitable for their needs. The participants also experienced being unheard when they conveyed information to providers who dismissed their statements as untrustworthy and unreliable. Max said:

He asked me how much I weighed. We're in an emergency room; he could have weighed me. I'm kind of heavy, and I gave him my actual weight (I knew it). He said, 'I'll add a bit to it. All women lower their weight.' I was like, 'Oh yeah, huh? So that's how you start...'

Similarly, the participants felt unheard when providers failed to directly address or engage with them as the primary stakeholders of their health. The latter is shown in another example from Max:

I was like, 'What the hell is the corpus luteum?' And he more or less answered my question. The following week, I asked the same question while lying down, my legs spread. He said, 'Madam, you'll have to ask your husband. Him, he understood.' I went, 'Oh, boy! Really? That's really what you're telling me? If my husband understands, good for him, but I still have questions, so you'll answer them.' I was really angry. I couldn't believe he could say that.

Moments of being treated insensitively

Negative experiences in GHS included moments when providers treated participants rudely, harshly, and insensitively. Max, for example, described an instance of invasive and insensitive behaviour from her doctor, characterised by a dismissive attitude toward her emotional well-being, a coercive approach to the procedure, and a callous disregard for basic principles of patient dignity and privacy:

[The doctor] said, 'OK. Take off your panties; I'm going to do a vaginal exam.' (...) I asked the doctor, 'Do you have a small towel?' Because he'd say, 'Well, take your clothes off, now.' Just like that. In front of him. He wasn't leaving and was chatting with my boyfriend. I said, 'Well, do you have a little something? I'm going to cover up so I can pull down my panties.' (...) He said, 'Oh come on! You're with your husband and me; it's fine!' I said, 'Well, I'd really like a towel.' I kind of insisted. (...) Finally,

he accepted and gave me one, but he kind of threw it at me. Then he said, 'Here, your towel.' And he said, 'Pull down your pants.' But he didn't leave. He just handed me a towel.

The participants endured stony and occasionally brutal behaviours, leaving them with an almost unbearable sense of coldness. This behaviour often disregarded their physical and emotional sensitivities, sometimes even treating their pain and suffering as laughable. As Sam was speaking with her surgeon before an oophorectomy, she told him:

I don't bleed a lot anymore because I've bled so, so much... [Now,] it lasts maybe half a day, two days, but I'm 20 days in excruciating pain, [even though] there's not that much bleeding.' (...) He tells me, 'Don't say it too loud. Some people will envy you; you're lucky.' 'Lucky? Oh, yeah? Sorry, (...) I'm bleeding from my rectum and vagina, so I can't see where my luck is. And it hurts like hell.'

These experiences of pain were not just ignored; they were sometimes intentionally silenced. That means providers recognised the participants' suffering but deliberately chose to prioritise, perpetuate, or even endorse actions causing it. This sent the message that complaints and concerns would not be tolerated and addressed. Charlie said:

The abortion was horrible. I was told to stop screaming so I wouldn't scare the others in the clinic. I had to shut up while it hurt me. Maybe I didn't have enough anaesthesia. That traumatised me. It's like, 'Shut up, woman.' And it was a man who did that, too. Not all men are the same, but... my best friend was there; she was holding my hand; it was rough for her, too, to see that, but *she* didn't tell me to stop.

Alongside this silencing treatment, participants recounted moments where they were insulted and devalued (e.g., for their thoughts, actions, identity, capacities, and looks) or blamed for their problems. Vic said that a provider mocked their attractiveness:

I got comments... terms used to describe me... First, the misgendering, but also... when you want a screening test for STIs, they'll ask: 'Do you want to have the widest screening?' Sometimes, it comes with blood work. But that gynaecologist commented that I probably don't have many partners anyway or that... yup, that it won't be necessary.

Moments of being dehumanised

Instances were reported where participants' human dignity was disregarded. They mentioned not being treated like persons, like whole human beings. Dany, for example, expressed: 'I feel treated... not like a human. I don't feel treated like a person right now.' Using similar words, Pat conveyed: 'I'm not a person anymore. I'm just some kind of thing that you pass through the machine. (...) It's really dehumanising. It's like you're not a person at all.' Denied the possibility of seeing her doctor following surgery that left her in immense pain, Gab said: 'It seemed almost inhuman.'

A few participants explained that their body, or certain body parts, were considered, but not their entire being. Joe articulated that it was as if she was important in the genital area, '[but] that's it; the rest of the body doesn't exist. (...) It's as if they forget that there is a human being in the body.' She felt like 'a belly/vagina/vulva on two legs.' In a similar vein, Max suggested practitioners ought to acknowledge they are interacting with patients, not merely vaginas or uteruses.

For some participants, the experience manifested in being regarded as lesser humans or undeveloped adults. When asked how they felt treated in healthcare services, Vic answered:

Like a human of inferior value... I was going to say like a child, but I'm not sure anyone would mistreat a child so badly...

Sam and Gab also spoke of being infantilised. Sam remarked:

I wasn't treated with respect, and I wasn't treated as if I were a human being in my own right. I felt treated like I belonged to the healthcare system; like it was my parents, and they made the decisions. I was treated very badly.

As for Gab, she repeatedly mentioned that she felt treated as if she were a little girl instead of a fully grown adult. A few participants compared how they were treated to how we treat non-human animals. Joe used the word 'cattle' to convey that perception.

Participants recounted instances in which they experienced being regarded as objects instead of human beings. Joe, Max, and Dany described the sensation of being treated as mere numbers, and Joe specifically mentioned

feeling like ‘a source of cash.’ Pat expressed her sense of being ‘a kind of medical object,’ ‘a kind of object, tossed from one side to the other,’ ‘a problem you need to solve,’ ‘a vessel for babies,’ ‘a woman-object that’s just there to procreate and make babies.’ She said:

In the same way that in the media, women are objectified to the point that you can have a gang rape, and nobody cares... I have the impression that in the medical system, you can have a woman on a table, legs spread, and you insert something inside her without any warning, and it’s completely normal. It’s objectifying, it’s dehumanising, and it’s... completely normalised.

Moments of being abandoned

Participants shared negative situations in which they were left alone in highly vulnerable situations. That included instances such as not knowing where to go or who to speak to and encountering a lack of adapted material or techniques (e.g., day-after pills approved for larger bodies). Many participants had to fight to be prescribed diagnostic tests that would unlock services and treatments. Charlie said:

‘You may have endometriosis or not.’ Then, she basically advised me against laparoscopy. I said, ‘No, no, no! I want to know what’s wrong with me!’ So, with everything I was going through in my body, I had to fight to get... and *that’s* violence: having to fight to get services and know what I have...

Despite having a diagnosis, obtaining further treatment remained a challenge for some. Charlie, after much persistence, managed to persuade her healthcare provider to conduct further tests. However, Em’s efforts to find a remedy for her vestibulitis were met with resistance. Her gynaecologist suggested that her pain might resolve spontaneously, disregarding Em’s explanation of having endured the pain for years.

‘OK. But... if it doesn’t go away, what do I do?’ ‘You may have to go to physiotherapy, see a sex therapist, maybe do couple’s therapy, and only as a last resort, we may have to do surgery.’ I say, ‘Can I have surgery right away if it’ll solve the problem? That would seem to be a better solution.’ She says, ‘No. All the other steps must be tried first to rule out patients who are not good matches and can work with other solutions. We won’t do an operation on you.’ I remembered that my mother had a similar condition and had had surgery. I made the connection: ‘But my mom had it. It’s probably genetic. [Surgery] worked for her. Why not me?’ ‘No. I don’t want to hear about it.’ (...) She refuses to treat me: ‘I can’t do anything for you.’ She doesn’t even give me... a cream, a medication... nothing...

While not demanding instant fixes, the participants expected truthful, unbiased information from their providers. At the very least, they hoped for empathetic and supportive words to uplift them instead of being left in despair or pressured to keep emotions bottled up. Em shared:

She was telling me that I would be in pain forever. (...) I started crying. I was like, ‘I’m always in pain. What am I going to do?’ Then she got very, very cold and said, ‘Stop crying. You’re lucky; you don’t have cancer. I treat people with real problems, more serious than this. It’s going to be OK. Stop crying. You’re not going to die.’ So, I was trying to calm down because I was like, ‘OK. This is it. Am I lucky, after all? No. I’m not lucky in this situation.’ But you just want to get out of there. There’s no solution. (...) She’s the specialist. There’s nothing I can do. I feel stuck.

The participants occasionally had to self-educate about their diagnosis, symptoms, and rights. However, sharing this knowledge with providers often led to contempt and being treated as uninformed, discouraging further knowledge acquisition and hampering empowerment and independence. Pat explained:

I’m a very curious person (...), and I think [reading] has become my go-to when I can’t find answers. (...) I read. I read. I read. But I think that for everything gynaecological, things [I read] were far from reality. (...) And ultimately, I was completely powerless and taken charge of. It was as though even if I had been a specialist in the field, it wouldn’t have mattered. It wasn’t up to me, anyway.

Moments of being gaslighted

Participants described instances where their understanding of reality was doubted, particularly when they chose not to follow their providers’ recommended approach, had differing opinions, encountered providers without solutions, or when their concerns were downplayed as psychological or not significant enough to warrant medical attention. They sometimes faced blame for their problems. Dany said:

He installed the speculum and another instrument to open the cervix, and it hurt so much that I went into vasovagal syncope. I thought I was going to throw up. I’ve never experienced pain as bad as that. I

remember, when I felt the pain, I threw a kick, but it was a reflex; it wasn't intentional. He said, 'Hey! Don't move [or else] of course it'll hurt you!' He blamed it on me.

Participants also felt alienated when their provider's expertise was prioritised over theirs. For example, they were often denied the authority to assess the normality or tolerability of their pain. Gab explained:

The nurse didn't want me to see the doctor. I was telling her: 'Can you at least prescribe me something for the pain? Because right now, I'm in pain, and you've given me something, but it's not working. It really hurts.' And she told me: 'Laparoscopy doesn't hurt, ma'am.'

In addition, the participants faced threats by providers, such as denying assistance or presaging illnesses if they did not follow treatment, inducing fear and vulnerability. Vic explained that when they remained unconvinced by their doctor's cancer and death predictions (unless they complied with treatment), he threatened to close their file and discontinue their follow-up.

The participants described another type of alienating moment: having their health problem psychologised. For example, when Dany expressed her concern about her weight gain after starting the contraceptive pill, she was flagged as having an eating disorder. When she considered genital plastic surgery as a solution to recurrent discomfort triggered by a labia minora hypertrophy (when labia minora are larger or stick out of the labia majora), she was deemed self-destructive and prone to self-mutilation.

Some participants with psychiatric histories (even if long-treated) were discredited as their physical health issues were assumed to be mental. Sam, for example, explained that with providers, she could not speak up for herself – not because she was not able to, but because no matter what she would say, she would be dismissed:

When I [spoke my truth], it was worse every time. I felt like I had no right to do that. Whenever I tried to bring something up, it was like, 'Uuuurgh...?', really badly perceived. They wouldn't call me back. The ER doctors would leave me hanging. It was like, 'Look, she's just crazy. Let her be. She needs attention.'

Even without such a history, Joe's symptoms of severe anaemia due to menstruation were initially ignored, as her providers attributed her condition to a mental health condition (depression) – a diagnosis that did not consider all her complaints.

Delineating Violence Within Negative Experiences Through Subjectivity: Perception of GV

Identifying the previous six phenomenological moments only served as a preliminary step since, as previously stated, participants did not label all their negative experiences as GV. Therefore, we inquired about how they distinguished violent from non-violent negative experiences. According to their answers, limiting the description of GV to a list of actions would be inadequate, as the violent nature of an incident is heavily contextual. For instance, Joe explained that a provider's reaction to their causing unintended pain was pivotal in categorising the act as violent. Acknowledging, empathising, and addressing the error was essential to her:

There can be clumsiness, but if they acknowledge it by themselves or if you tell them and they try to repair the fault, then we're not in violence. But if you tell them about – or you can tell they noticed – your discomfort, and yet they do nothing [about it], in my opinion, we crossed the line of violence.

All participants emphasised the importance of tuning into their feelings and self-confidence during interactions to facilitate the identification of unacceptable experiences and the self-validation of that interpretation. They asked reflexive questions that helped them determine if a situation had been violent: Were there questions of mine left unanswered? Were my choices respected and honoured, or at least were there efforts made to come to a compromise? Were all my rights (human, civilian, institutional) respected? Were my limits trespassed? Was this medical intervention necessary? Did I feel at ease? Did the providers explain what they would do to me before doing it? Did they listen to me? Have I been pressured to consent to something? Max said:

Not having the right to consent to a procedure or not having information, I think that's violence – that treatment, for example, is given to you without you knowing or understanding it. All the statements, comments, or acts that are non-consensual or unnecessary (...), all the judgments you may face (...). Not knowing what's happening to you or not being informed of what's being done to you, in my opinion, that's violence. Techniques or choices that you couldn't make... (...) For example, if a woman doesn't want an epidural, but [the providers] say, 'Ah! well, you know, you don't really have a choice.' Or, 'You have to take it now.' In my opinion, that's violence.

All participants concurred that negative experiences should be deemed violent if perceived as such by the affected individual. They acknowledged that interpretations of violence vary and that while some situations may



Figure 1. GV = Experiencing at least one negative moment + perceiving it as violent (2024)

not subjectively seem violent, they could still objectively be so. However, what ultimately matters most to them is how they feel about the experienced moment, as their subjectivity influences the event's repercussions on their well-being. Vic explained:

The first thing I'd say to a patient is that if they feel uncomfortable, it's because they're experiencing violence and that what's happening is unacceptable. That's a sufficient criterion. (...) It's not normal to be uncomfortable. I mean... uncomfortable, yes, maybe, but I mean... Well, yes, that's it. I stand by my answer because I think failure to do everything possible to ensure we're comfortable is already going too far. (...) As soon as you're not satisfied... that you walk out and you're not well, there, inside, it's because something's wrong.

So, participants described GV as a combination of a negative moment within GHS and a perception of violence associated with that experience. **Figure 1** presents this combination and elements that helped participants acknowledge their perception of violence.

Experiencing GV: A Phenomenological Description

As a reminder, the phenomenological description is a created anecdote that does not represent a specific interviewed individual or an exact reported experience. It is constructed from evocative excerpts from the

interviews, sometimes synthesised and rearranged, combining the experiences of different participants. It aims to bring the experience to life, providing an almost palpable sense of what experiencing GV can be. The goal is not to illustrate the full extent of the phenomenon's manifestations but to provide an overview of the nine participants' experiences with it. This is a preliminary step towards better understanding GV.

The gynaecologist introduces herself with a distanced but professional tone: 'Hello, I'm Dr Johnson, and this is a medical intern, Dr Patel.' The intern says nothing. I wonder why he is here. I feel uncomfortable. My anxiety rises. I worry about being judged. 'What can I do for you, madam...?' 'Alex. My pronouns are they/them,' I say shakily. 'I am here because I am having constant bleeding and intense pain.' She asks me questions and takes notes without looking at me. Then, she instructs me to undress and sit on the examination table. I wish I could refuse the intern's presence.

I am very apprehensive about the examination, as I do not know precisely what they intend to do. I dare not share my concerns because they seem distant and rushed. My body is as tense as a bow. My heartbeat echoes in my chest. My breath fastens. Without warning, the gynaecologist inserts a cold instrument into my vagina, and a sharp pain shoots through me.

'Wait, what are you...?' My voice breaks. She continues her work like nothing has happened. I feel my heart racing, each pulse amplifying my vulnerability. My breath comes in short gasps. 'Excuse me; you could have warned me,' I manage to articulate. 'It's normal; I took a piece of your cervix for the biopsy. It's nothing serious; you'll be fine,' she replies, not even looking at me.

I freeze, trapped in a moment over which I have no control. I feel the heat of anger rising, mixed with fear. The pain intensifies. It does not seem to matter to them. I think they forgot that I am not just a body. I squeeze my hands and eyelids to give myself courage. 'I'd rather be warned,' I murmur. The gynaecologist finally turns to me. 'You don't have to worry so much. Patients are often too anxious.' 'What exactly are you doing to me?' I try to regain control. She sighs. 'It's complicated. You don't need to understand the details.' She turns to the intern, 'Madam here has recurring gynaecological symptoms. I did a biopsy on her, and we'll send that off to the lab.'

I feel invisible. They ignored my pronouns and identity. As I get dressed, blood runs down my leg. I ask for a towel. I feel ashamed, dirty, humiliated. My uterus contracts into painful cramps. Once dressed, I shyly ask, 'Will there be any follow-up or treatment?'

'Your problems probably have more to do with anxiety than any medical condition.' My heart sinks with the frustration of not being heard. 'I think my concerns are valid.' I hope my voice does not betray my vulnerability. I'm nearly in tears. 'I came here because I'm constantly in extreme pain.' The tears finally flow. My voice trembles. 'I'm in pain right now. What am I supposed to do? What are my options?' The gynaecologist disregards my emotions. 'We'll call you if the biopsy results show something. If not, you can always come back if the bleeding continues.'

I was disoriented and emotionally drained after the consultation. I later realised that many questions remained unanswered. My concerns and choices were ignored, and my rights as a patient were overlooked. Unable to express my needs, I doubted the necessity of the medical intervention, given the poor communication. I felt uncomfortable and uninformed. This experience left me with feelings of injustice, disrespect, and the realisation that I had endured gynaecological violence.

DISCUSSION

This study aimed to address GV by investigating patients' experiences. Specifically, it sought to describe it phenomenologically. The results indicate that GV was seen as a negative moment experienced in GHS coupled with a perception of violence linked to that experience.

Six negative moments were identified. These included being unheard and being abandoned, which align with the observations of Marcilly and Mauri (2018) and the HCE (2018), highlighting how GV can involve omission behaviours. Another negative moment was being deprived of choices. This conforms with existing literature (CEND, 2019; Friesen, 2018; Quéré, 2019), emphasising that GV, akin to any form of violence, occurs when people lack free, informed, and continuous consent. The participants also presented gaslighting as a negative moment, which is unsurprising considering that, aligning with Lévesque *et al.*'s (2018) definition, violence involves power abuse and strategies to keep individuals subordinate and compliant. Insensitive treatment and

dehumanisation, the last two negative moments, could fall within a spectrum measuring the extent to which caregivers deny the sentient experiences of patients. Studies (Dawson, 2021; Svenaeus, 2023) suggest that a certain degree of dehumanisation and insensitivity is sometimes necessary to make it bearable for caregivers to administer treatments that inherently cause pain or distress. However, research indicates that dehumanisation disproportionately affects marginalised groups (Dawson, 2021), aligning with intersectional feminist theory and this study's findings. Participants' experiences highlight that an individual's social position on axes of oppression (e.g., being a woman and having a history of psychiatric treatment) makes them experience specific forms of discrimination and prejudice (e.g., questioned lucidity and implied tendency to exaggerate pain).

Few participants discussed experiences of violence other than interpersonal (e.g., institutional, symbolic, systemic). This could be interpreted by the fact that GV awakened anger that tended to be directed toward a present, tangible, and imputable culprit. Participants were aware of external pressures providers face that impact care quality, but they remained more critical of the humans who hurt them than the structures that enabled hurtful actions.

In this study, the delineation of violence within negative experiences through subjectivity revealed a nuanced understanding of GV that aligns with and expands upon existing literature. The idea that violence cannot be confined to a predetermined list of actions resonates with the work of other scholars. For example, Kona (2011) examined violence through a hermeneutical lens, arguing that its understanding requires considering power dynamics, historical contexts, and personal experiences. Violence's recognition is thus subjective, circumstantial, and rooted in broader societal implications. The extension of GV's understanding beyond objectivity echoes a paper from Robbennolt (2009). That article argues that apologies from physicians – an acknowledgement of a fault and expression of regret – can decrease blame and anger while enhancing trust and therapeutic relationships.

The importance of consent and the reliance on internal feelings and self-confidence, as articulated by participants, support feminist perspectives that advocate validating personal experiences as legitimate sources of information (Campbell and Wasco, 2000). It also resonates with the broader discussion on patient autonomy and informed consent (CEND, 2019; Friesen, 2018; Froidevaux-Metterie, 2018; Quéré, 2019). Participants in our study considered that not being informed or feeling pressured into consent is a form of violence, a perspective in line with the challenges to traditional medical paternalism (Talukdar, 2020).

Our study reveals significant overlaps between GV and OV, particularly in the experiences of autonomy deprivation and dehumanisation described by participants. These align with Šimonović's (2019) report on forced medical procedures and lack of informed consent, and Bohren *et al.*'s (2015) global study on mistreatment during childbirth. The structural inequalities and patriarchal norms highlighted by Pickles (2024) and García (2020), including their incorporation of contraception and abortion as part of OV, echo, for example, Pat's forced contraception after her abortion, further underscoring the interconnected nature of GV and OV.

Similarly, Rachele Chadwick (2021) argues that the concept of OV acts as an epistemic intervention, challenging normalised reproductive harms by naming and exposing oppression while rejecting frames that silence and devalue alternative reproductive knowledge and agency. Chadwick emphasises viewing OV as specific violence against reproductive subjects, encompassing various coercions and neglect beyond gendered violence. She highlights the importance of Afro-feminist, decolonial, and queer perspectives in advancing understanding and addressing its broader implications. Her insights illuminate GV by emphasising the need for epistemic interventions that challenge normalised harms in reproductive healthcare. Both OV and GV highlight reproductive oppression, where bodies are controlled, medicalised, and subjected to various forms of violence. Chadwick underscores the need to address intersecting oppressions like racism, cisnormativity, and economic inequalities in GHS. An intersectional and queer approach is indeed essential to recognise the unique experiences of trans men, non-binary individuals, and queer women. Both concepts serve as 'struggle concepts,' rooted in activist resistance and concrete experiences of oppression, advocating for systemic change.

While maintaining distinct definitions seems important, at least for addressing specific contexts, our findings support the relevance of a broader discourse on violence and mistreatment in sexual-reproductive healthcare, emphasising the need for targeted interventions to protect patients in both obstetric and gynaecological settings.

Implications and Recommendations

This study shows the importance of promoting patient-centred care, which involves actively listening to patients, addressing their concerns, and ensuring they feel supported. To prevent GV experiences, it is crucial to implement strategies that enhance patient autonomy and informed decision-making. For instance, Spinnewijn *et al.* (2024) conducted a qualitative study in a Dutch teaching hospital's obstetrics and gynaecology department, interviewing 20 clinicians to explore the adoption of Shared Decision-Making (SDM) using the diffusion of innovations theory. Their findings recommend conducting practice assessments to identify areas needing improvement, fostering open discussions within clinical teams about SDM's utility and challenges, and initiating professional development for reflective practice. Additionally, decision support tools, such as visual aids, was said

to help structuring consultations and clarifying treatment options. Organisational support, including leadership and policy changes, was essential to cultivate a culture that prioritises SDM, supplemented by training programmes to enhance clinicians' awareness and skills in SDM techniques.

Intersectional feminism can promote equity and inclusivity in healthcare by addressing the intersecting oppressions that contribute to gender-based violence. Intersectional advocacy aims to create policies that are inclusive and equitable, ensuring marginalised groups receive adequate protection and resources. For example, integrating policies related to gender-based violence with policies addressing poverty, housing, and healthcare can offer a more holistic support system for survivors (Perez Brower, 2024).

Providing patients with resources and support can help them become better informed about their healthcare rights and the standards of care they should expect (World Health Organisation, 2013). Encouraging patient feedback and offering platforms for sharing their voices can further improve the healthcare system. Adams (2011) conducted a three-year study in the US, UK, and the Netherlands, examining patient narratives on 'share-your-experience' websites to assess their impact on healthcare transparency and quality improvement. Through discourse analysis of 450 patient reviews and interviews with 15 Dutch stakeholders, the study highlights these platforms potential to enhance healthcare transparency and quality despite concerns about representation and bias. Adams recommends improving patient engagement strategies and ensuring healthcare institutions actively respond to feedback, fostering a balanced and credible reflection of patient experiences. This approach could also provide GHS patients with a platform to share their voices.

Trust and transparency, fostered by open communication and a commitment to learning from past shortcomings, are also essential for improving the quality of care. This involves educating healthcare providers to enhance and refine their practices. Towle's study (2022) offers valuable insights into this matter. Her situational analysis of pelvic examination learning materials from five Canadian medical schools revealed that these materials often depicted patients homogeneously and normatively, using outdated and sexualised language and lacking diversity. Clinical authority was frequently emphasised over the patient agency, and many materials did not include modern techniques that enhance patient experiences, such as speculum self-insertion. The study recommends updating these materials to better represent diverse patients, improve patient agency, incorporate contemporary techniques, and focus on patient-centred and culturally competent care to reduce health disparities.

There is a need for further exploration of various aspects of GV, including survivors' needs, strategies, resistance, and resilience; GV's repercussions; perspectives of healthcare providers; effectiveness of prevention and awareness interventions; impacts of inclusive services; efficacy of policies and laws.

Limitations

The study's limitations include using specific examples of violence and GHS in recruitment materials, which likely influenced participants' recognition and description of their experiences. Terms like 'inappropriate behaviours,' 'disrespect,' 'abuse of power,' and 'absence of consent' may have guided participants to frame their responses within these categories, potentially overlooking other forms of violence. To mitigate this bias, we designed broad and open-ended interview questions, such as 'Tell me about your experiences with GHS in general,' and 'From your point of view, what makes a GHS violent?' These measures aimed to capture a wider range of experiences and perspectives.

Despite our emphasis on gender diversity representation, only one participant was not a cisgender woman. Given that trans individuals make up about 0.14% and non-binary individuals about 0.09% of Quebec's population (Institut de la statistique du Québec, 2024), the predominance of cis women may reflect the province's demographics, especially since gynaecology has traditionally been associated with women. However, beyond cissexism, we were able to represent other axes of oppression, such as sanism, ableism, sizeism, and ageism, without prioritising any or attempting to cover all.

The participants, more educated than the average Quebecer, shared traits such as well-articulated political and social ideologies. Their higher education levels might be linked to the lack of financial compensation, as the study was unfunded. The sample also lacks full intersectional representation, particularly in self-reported racialised experiences. This gap likely resulted from recruitment challenges during the COVID-19 crisis, as organisations prioritised immediate community needs like food and shelter over study participation. However, this did not detract from the study's exploratory aims, capturing various intersectional positions and focusing on subjective realities. Future research could further explore intersectionality by case-studying one individual facing multiple social disadvantages.

Collecting information on participants' identities through an open-ended interview question was a deliberate choice to empower their self-expression. This supported our values of subjectivity and agency but made comparing experiences difficult without common parameters. Future studies might benefit from pursuing specific identity categories, like gender or sexual orientation (still without predetermined answer choices), for a more structured yet adaptable intersectional analysis.

Finally, while this study offers valuable insights, the small sample size limits a comprehensive description of GV. Therefore, it should be viewed as a preliminary step towards a more nuanced understanding of the phenomenon, contributing to the ongoing development of its definition.

CONCLUSION

This study adds to the body of knowledge on GV. Its queer approach reminds us of the neglected presence of non-cisgender and non-heterosexual individuals in GHS. Focusing primarily on GV rather than OV, the study offers one of the first detailed, experience-rooted descriptions of this phenomenon from a scientific approach. Describing GV phenomenologically encourages its relatibility. The results offer pointers for intervention and action, providing guidelines for the future.

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