Original Article

A Qualitative Study of Iranian Women's Experiences with Dimensions of Childbirth Violence in Health System

Abstract

Background: Women who choose natural childbirth feel empowered and in control. Support from midwives can enhance the experience. Women's childbirth experiences affect their care quality, physical/mental health, and future preferences. A study aimed to comprehend women's experiences of childbirth violence within the health system. **Materials and Methods:** The research in Iran focused on creating a questionnaire about childbirth violence by interviewing 26 women who recently gave birth. Participants met specific criteria such as age, delivery experience, and Persian language proficiency. Data from the interviews was analyzed using qualitative content analysis between August and December 2019 in Ilam province, Iran, as part of a broader mixed-method study. **Results:** Dimensions of childbirth Violence in the health system are classified into two main categories based on the mothers' narratives: "The superiority approach of the health system towards the mother" and "deprivation of the mother from desirable health system". These two main categories are described in eight subcategories (physical abuse, psychological abuse, ignoring the human dignity of the mother, refusal of optimal care, poor interaction with mother, lack of resources, lack of skilled care, and weak accountable regulatory policies which included 22 final codes. **Conclusion:** This study serves as a crucial step in recognizing and addressing the multifaceted issue of childbirth violence in Iran, aiming to enhance the quality of care and protect the rights of mothers during one of the most significant experiences of their lives.

Keywords: *Childbirth, maternal care, qualitative research, violence*

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Introduction

Respectful interaction with mothers and their participation in decision-making is very important in shaping positive experiences and women's understanding of maternity care. Respectful care during childbirth is defined as a universal human right that encompasses ethical principles and respect for women's feelings, dignity, choices, and preferences.[1] Women share their reports and knowledge about childbirth trauma and misbehavior with their friends and family privately, while these women's childbirth experiences rarely appear in public discussions. Regardless of whether this is due to shame, perceived stigma, or lack of knowledge about what to expect during childbirth, women often doubt whether these injuries are worthy of a complaint.[2] Abuse during childbirth is not a new phenomenon. Recent evidence from the WHO (2019) showed that more than a third of women have experienced mistreatment in health facilities during childbirth.[3] The prevalence of abusive care during childbirth has been reported from 20% to 99.7% in different parts of the world.[4] Childbirth violence can result in physical harm to women and babies, as well as emotional and psychological trauma to women. It may interfere with bonding, breastfeeding, and newborn adjustment.[5] Also, when women feel that their rights are being violated during health care, their satisfaction and confidence in health facilities and providers are reduced, and this finally leads to adverse health outcomes.[6]

Iran has a favorable situation in terms of reducing maternal mortality and has succeeded in achieving the fifth Millennium Development Goal (MDG5) in the field of improving maternal health.[7] The existing guidelines on respectful maternity care (RMC) lack clear

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strategies and indicators for providing respectful care during normal childbirth. While various studies emphasize the importance of RMC and the need for comprehensive guidelines to promote it[8,9] there is a notable gap in offering specific strategies and indicators within these guidelines.[10] Maternity care in Iran faces challenges leading to poor experiences for women during childbirth rapport.[11] Enhancing respectful communication, involving women in decision-making, ensuring privacy, addressing pain needs, and improving physical environments are crucial for providing respectful maternity care and improving women's childbirth experiences in Iran.[12] Also, a study reported that 75% of women reported perceived disrespectful maternity including not allowing women to choose labor positions and move during labor.[13] The lack of women-centered care and unnecessary medical interventions,[14] not informed decision-making about delivery method,[15] Low freedom of choice and decision-making in access to health services are among the major problems of maternal care in Iranian health settings.[16]

Qualitative studies play a crucial role in understanding maternity violence by delving into women's experiences. These studies reveal various forms of obstetric violence, such as verbal abuse, lack of humanization, and disrespect for women's rights.[17] Qualitative research helps identify individual, provider, hospital, and health system-level factors contributing to mistreatment, guiding interventions to improve the quality of maternity care and reduce disrespectful practices in Iranian healthcare settings. By capturing the nuances and complexities of women's encounters with maternity violence, qualitative studies provide valuable insights for developing interventions to address and prevent obstetric violence effectively.[18] The study aims to investigate women's encounters with childbirth violence in the Iranian health system, exploring both physical and psychological mistreatment. It seeks to understand the various dimensions of this issue and develop a questionnaire to assess and quantify women's experiences with childbirth violence.

Materials and Methods

This study is the first phase (qualitative phase) of a mixed-method study carried out to develop and psychometric of childbirth violence questionnaire.[5] This exploratory qualitative study was conducted from August to December 2019 in Ilam province in western Iran. Ilam is equipped with four maternity hospitals, comprising the public educational hospital of Taleghani (the designated referral maternity hospital in the province), the semi-public hospital of Zagros, and two private hospitals, namely Kowsar and Ghaem. The participants included in the study were selected from individuals who had undergone childbirth in one of the hospitals situated in Ilam. Interviews were conducted in places where the participants were willing. Purposive sampling based on maximum variation in childbirth involves age, parity, type of delivery, place of delivery, educational level, occupational status, and economic status. Inclusion criteria were women of reproductive age (18–49), have previous experience delivery (vaginal delivery or emergency cesarean section) during the last three years in hospitals (public, semipublic, and private), speak in Persian, and were able to talk and provide information. This study used a qualitative approach for data collection using semi-structured in-depth interviews.[19] The interviews were conducted by the first author (M.J), who is a faculty member and a Ph.D in reproductive health with adequate experience in qualitative research.). Women participated with informed consent in all phases of the study. Before starting the interview, we asked the participant's permission to record the interviews. At first, by using a general question such as "Were you annoyed since you were admitted to the hospital, during giving birth until you were discharged from the hospital"? Or "Did certain behaviors of the caregiver make you angry? Women who had a negative view in response to this question were identified and were invited for in-depth interviews. Then, the study participants were asked to express their experiences related to the question.

The childbirth violence theme emerged in the earliest interviews, however, and, it was explored more explicitly and carefully in the next interviews. The next questions were asked based on the participants' responses to the first question. IDIs were recorded and conducted in a private place and convenient time with the consent of the participants. IDIs lasted approximately 30–90 min. The duration of the interview was based on the ability and willingness of the women to continue the interview. At any time and for any reason that women were not willing to continue, the interview ended and if necessary, in subsequent meetings with the consent of the women continued Sampling was terminated after achieving data saturation, which occurred when no new codes emerged during the last two interviews. We performed the analysis process simultaneously with data collection. The qualitative conventional content analysis approach was used, as described by Graneheim and Lundman.[20] After each interview, all audio files and notes of the interviews were handwritten and typed word by word. The typed texts were then read several times to overview their contents until a general impression was received. According to the inductive method, meaning units and the primary codes were obtained from the texts. The primary codes were grouped into sub-categories and categories, according to the comparison of their similarities and differences. Finally, the basic categories formed the main theme.[21] After typing of texts of interviews, MAXQDA v. 18 software was used for better data management.

To ensure the dependability of data, meticulous recording and documentation of all interviews were conducted, with participants' conversations being directly quoted in

the research report. Furthermore, the researcher engaged an external supervisor to scrutinize the research findings. Enhancing the transferability of the study involved providing a comprehensive account of the research process and dissertation writing to facilitate replication by fellow researchers. This endeavor to boost data transferability encompassed a thorough delineation of participant characteristics, sampling methodology, and sampling locations, with samples deliberately chosen to encompass a wide range of ages, educational backgrounds, economic statuses, and delivery settings. The study's confirmability was bolstered by the transparent explication of the research methodology and procedural steps, enabling external experts to replicate and assess the study. Additionally, the scrutiny of interview transcripts and code extraction by an external observer contributed to refining the research findings. The researchers upheld research authenticity through careful selection of participants, sustained engagement throughout the study, and collaborative review of extracted codes and categories with both participants and research team members.[7] To enhance the transferability of the study on childbirth violence and its negative health impacts, researchers incorporated various strategies such as providing a detailed research path, describing participant characteristics, utilizing purposive sampling, conducting member checks, and undergoing external review. The comprehensive account of the research process aided in replicability and context understanding. Participant characteristics were thoroughly documented to reflect diverse experiences. Purposive sampling ensured relevant participant selection. Member checks improved credibility by aligning findings with participants' experiences. External review by a supervisor added trustworthiness. The clarity in research methods supported the confirmability and overall transferability of the study.

Ethical considerations

This study was approved by the Ethics Committee of Tehran University of Medical Science (IR.TUMS.VCR.REC.1398.046). Option participation in the study, confidentiality of information, and audio recording were explained to participants. Informed written consent was obtained from them. The principles of the Helsinki Declaration were followed in this study.

Results

Data were extracted from the analysis of interviews with 26 participants. The average age was 31.7 years. 61.5% of them were the first birth and had given birth vaginally. About half of them were highly educated and had an average economic status. The majority of them (69.2%) had given birth in a public hospital. From the analysis of the text of interviews on the concept of childbirth violence, initial codes were extracted. After merging similar codes, 22 final codes, 8 sub-categories, and 2 main categories including "The superiority approach of health system towards the mother" and "Mother deprivation from the desirable health system" emerged [Table 1]. In the following, these categories are illustrated using women's quotes.

The superiority approach of health system towards the mother

A large part of women's experience of violence during childbirth was related to the superiority approach of the health system towards the mother, which included five sub-categories: physical abuse, psychological abuse, poor interaction with the mother, ignoring the mother's human dignity, and refusal to care.

Physical abuse

The unpleasant experiences of mothers, who complained about it, were frequent vaginal examinations and the imposition of unnecessary painful measures on the mother such as physical pressure on the abdomen, strong stretching of the legs, and unnecessary induction and stimulation of labor in the process of childbirth: *"They put so much vain and terrible pressure on my abdomen. My uterus was even close to tearing. They wanted to give birth to my baby by force" (Participant 3)*

Some mothers had experienced physical abuse in the form of hitting, pushing, and pinching: *"I was forced and beaten, the baby was born, and they hit my feet hard. Pinched me, and said, "You don't cooperate!"* (Participant 11).

Another mother said: *"The doctor had told them to inject me serum induction and stimulate my labour pain. With that ampule, my pain was abnormal, severe and continuous. They shouldn't inject me that ampule, because I had no problem"(Participant 10).*

Psychological abuse

The majority of participants described verbal abuse and use of harsh, inappropriate and humiliating words and yelling at mothers when they are restless and screaming due to severe labor pains as a common inhumane behavior by healthcare providers: *"When I screamed in pain, they yelled at me and said don't raise your voice! Even if you're in pain, you shouldn't scream!" (Participant 19).*

Irrational restrictions on physical activity during childbirth, such as confinement to the delivery bed, supine position, and the prohibition of walking and going to the toilet, were other disturbing experiences of mothers that made them tired and nervous: *"I was tired in bed and I wanted to walk, but they wouldn't let me, they said you shouldn't walk. Just lie down! Don't move. Well, these things bothered me so much! I got bored and nervous, I liked to stand up and bear the pain, but let me they didn't give." (Participant 26)*

Another common experience of the participants in the study was the ignoring of mothers' concerns, pains, and requests by the providers: *"I had the worst birth experience..., I had*

Table 1: Categories and subcategories of the study

Main categories	Subcategories	Codes
The superiority approach of the health system toward the mother	Physical abuse	Unnecessary painful measures on mothers
		The care team's utilization of physical aggression toward the mother to adhere to the care directives.
	Psychological abuse	Verbal violence to the mother by the care team
		Mother's limitation in movement, eating or drinking, etc., during childbirth without a clear explanation
		Ignoring the mother's needs, concerns and requests
		Discrimination in providing care
	Ignoring the human dignity of the mother	Disrespect to the mother's position
		Violation of the mother's privacy
		Ignoring the informed consent of the mother to perform medical procedures
	Refuse of optimal care	Abandoning and leaving the mother alone
		Negligence in taking care of the mother
	Poor interaction with mother	Ineffective and unsympathetic communication with the mother
		Lack of understanding of mother's feelings and wishes
		Mother's lack of rational justification
		Failure to the mother's trust and confidence
Mother deprivation from the desirable health system	lack of resources	Lack of treatment staff
		Unfavorable physical environment
		Lack of medicine or care and welfare facilities
	Lack of skilled care	Lack of timely and correct diagnosis and decision-making
		Different diagnoses of the care team and causing mothers worry and anxiety
		The mothers damage to due to lack of skill in using treatment methods
	Weak accountable regulatory policies	Inappropriate regulatory policies
		Profit-oriented policy in private hospitals

kidney surgery during my pregnancy." When I went to the hospital to give birth, I expected more attention than others because of my illness. I had labor pain for 4 days. But they didn't care about my stress and didn't give me reassurance about my baby's health, which reduced my fear and stress to some extent, it felt like they didn't care at all if my baby died." (Participant 9).

Some mothers expressed painful experiences of discrimination in the provision of care. Some poor mothers stated that maternity care providers provided better care and support to women who were wealthy, urban, or of a higher social class than they were: *"The nomads and those who are at the lower level of the society, they received them less, but those who were in the urban and high class, they received them more. or rich people who spent a lot of money and paid the doctor, thus they were ordered, they used to deliver much more than me. I am poor and have no money, who will put me in a good word? I felt and saw this with my own eyes" (Participant 9)*

The statements of the participants are expressive of creating severe mental concern for the mother: *"They said you have to endure the pain for 3 days. This pain is nothing. When labor pain starts, it will be very intense and terrible! I was under a lot of stress (crying)! I was very disappointed. It preyed on my mind" (Participant 17).*

Ignoring the human dignity of the mother

Respect for the human dignity of mothers plays a pivotal role within healthcare environments, as it directly influences their self-esteem and level of confidence in the medical system. Some mothers considered disrespect for the mother's position as one of their bitter experiences during childbirth: *"When you go to give birth, they treat you the worst, they say you could have not given birth to a child! Are you going to have a baby for us!?" (Participant 2).*

Some instances of the mother's privacy violation have been reported due to lack of care by the health provider, which has led to the feeling of disrespect for the mother's privacy by exposing the mother to the eyes of others: *"I'm a human being after all, I'm ashamed. Several women have been placed next to each other without a curtain between them, and then they say, open your legs, I wasn't comfortable at all. Why should others see me naked or they should know what my condition or problem??" (Participant 9).*

Some mothers complained about not obtaining informed consent before performing examinations and treatment for them: *"They gave me a paper and told me; you have to sign it. I signed it.... I didn't know what it was. They didn't say anything about what it was, they just said that it was for childbirth and you have to sign it. Then they gave me serum injection and connected me to a machinery." (Participant 10).*

Refuse of optimal care

Abandonment and leaving the mother alone and not giving spirit to her during childbirth, has been a very bad experience for them, which has deeply affected the mothers: *"They didn't come to me at night. No matter what I said, they didn't come to check my baby heart. If they came a moment later, the child would suffocate. So, who should be responsible?!" (Participant 2).*

Health provider negligence in maternal care, such as performing or repairing an episiotomy without injecting anesthesia, was one of the other complaints reported by mothers in this study: *"Without anesthesia, he stitched me up.I was screaming in pain and pulling my hair.!" (Participant 9) and another participant stated: "He cut me without making me feel numb." (Participant 17).*

Failure to provide timely maternity care, unnecessarily keeping the mother in the lithotomy position after delivery, and delaying her transfer to the post-partum ward are some of the mother's complains: *"Childbirth should be remembered for the life it brings — not for the violence, fear, or humiliation endured. Every mother deserves respect, compassion, and dignity."*(Participant 12).

Poor interaction with mother

The lack of basic communication skills of the care providers in their relationship with the mother, and failure to understand the mother's feelings and wishes were among the common complaints of mothers in this study: *"They said this is your fourth pregnancy, it's not your first time, why do you spoil yourself so much and scream? You're 43 years old! I want to say they won't understand you at all!" (Participant 14).*

Lack of rational justification of the mother by caregivers or failure to provide information about the progress of labor to the mother and as a result the mother's ignorance of her condition caused her an unpleasant feeling: *"They just did their work and left. They didn't tell me anything! Whatever I asked them, they didn't answer me well! They just said it's too early. It bothered me worse" (Participant 5).*

Mother deprivation from the desirable health system

Depriving mothers of access to the optimal health system can have detrimental effects on both maternal and child health outcomes. A major part of mothers' experiences is related to other factors of the healthcare system, which has made the delivery environment harsh and insulting for mothers. Lack of resources, lack of skilled care, and weak accountable regulatory policies are among these factors.

lack of resources

The shortage of staff has negatively affected the mother's experiences. Long waits to see a doctor, inconsistent care team members, and a lack of experienced care teams are among these: *"I was waiting for the doctor. The doctor didn't come to see me from 10 am to 4 pm. They said that the doctor had another patient. I wish everyone had their own doctor or their midwife was fixed. One came every time. I didn't know who was who" (Participant 24).*

The lack of specialized facilities and the physical constraints were described by the participants as follows: *"We were all next to together, I saw that they took a razor inside the woman's body and her water bag was torn. Even I saw the woman whose baby's head from the birth canal was coming out, and this caused fear and panic in me. I felt that I became demoralized and unable to give birth at that moment. For me, who wanted to give birth vaginally, those scenes were horrible" (Participant 9).*

Among other needs of mothers that have been ignored due to the lack of proper physical space is, the lack of a favorite companion for the mothers during labor pains and delivery:*"I liked that my wife or my mother was with me all the time, but unfortunately it wasn't possible at all, they didn't allow anyone. They said it isn't possible" (Participant 20).*

Another mother described the unfavorable delivery environment:*"Maternity ward was unfavorable and noisy. I felt warm. There were other women in that room and they felt cold. I was very tired, but her child was crying, and another one was sighing and moaning, at 2 am they brought other patients. It was very crowded. "(Participant 24).*

Lack of skilled care

Providers' poor diagnostic and decision-making skills can have significant implications on mothers' care and outcomes. Some mothers complained about providers' poor diagnostic and decision-making skills or unskilled performance of procedures. One participant said: *"After 4 childbirths, I was sutured again. They said that you were torn. This bothered me a lot. Again, when I was discharged, they told me that one of my stitches had been dehiscence and they stitched me up again. I feel that she did not have the necessary experience or she didn't pay much attention" (Participant 1).*

Weak accountable regulatory policies

Weak regulatory policies can lead to unintended consequences like reduced treatment adherence. Some mothers believed that the payment of bribes affects the quality of care provided to them in health centers: *"If someone comes there, gives them a bribe, they will care and respect her. I have experienced this myself. My mother gave money to one of them and she took care of me seriously. But this is wrong and it shouldn't be like this"(Participant 9).*

The profiteering policy in the relationship between the mother and the health providers in the private hospital, is among the complaints of some mothers: *"When I saw old*

towels and things that had a very bad color and surface, I got annoyed and said that this has been used for someone else. Well, they charge a fee, and their things must be disposable" (Participant 1).

Discussion

This study aims to explore women's experiences of different forms of violence during childbirth within the healthcare system

Our study revealed that mothers experienced annoying behaviors from health providers such as physical and psychological abuse. Other studies in different countries of the world have obtained results in line with the results of the current study.[4,11,22,23]

Concerns about mistreatment in Tehran public hospitals during labor and childbirth include physical and verbal abuse, protocol non-compliance, and poor communication.[22] Research in Iran found postpartum women experienced inadequate care, including unauthorized procedures, negligence, and abandonment. Use of pharmacological measures during labor was linked to mistreatment.[11] A recent study aligned with our findings found direct observation of physical and verbal abuse, as well as neglect of women, during clinical care in health facilities across 5 countries.[22]

Research in Iran found postpartum women experienced inadequate care, including unauthorized procedures, negligence, and abandonment. The use of pharmacological measures during labor was linked to mistreatment.[4]

Care providers may mistreat mothers due to a sense of superiority, wanting control, and expecting compliance. Disobedience is seen as the mother's fault, with providers resorting to abusive behavior to enforce compliance.[23]

Participants' experiences show that physical abuse during childbirth, such as unnecessary interventions and the use of force, can contradict women's wishes, leading to demoralization and helplessness among mothers. This behavior not only creates negative childbirth experiences but also goes against WHO guidelines that emphasize empowering women through encouragement, support, and training by healthcare providers.[24] Other studies also support these findings, highlighting the detrimental impact of physical abuse during childbirth. Overall, these experiences underscore the importance of respectful and supportive maternity care to ensure positive outcomes for mothers and babies.[25,26]

Our study showed that poor interaction, ignoring the mother's human dignity and refusal of care that along with the mother's deprivation from the optimal health system causes violation of the mothers during childbirth. A recent study corroborated our findings, revealing that patients frequently encounter confrontational situations when declining recommended treatments. They perceive a power struggle in which healthcare providers exploit their expertise to influence decisions and undermine patient autonomy. Some providers even employ coercive tactics, such as dire warnings, to compel patients to consent to interventions.[27] In confirmation of the results of the current study, another study reported that most mothers feel their dignity is overlooked by caregivers during childbirth, with privacy ignored in delivery and operating rooms. They expressed being treated like educational objects for student exams, causing a sense of neglect.[28]

One of the obvious violations of women's rights during childbirth was the refusal of optimal care for the mothers such as abandoning, delaying care providing, and leaving her alone during the labor pains that the mothers experienced painfully. It seems that the non-adherence of some health providers to ethical and professional principles is one of the causes of refusing services and negligence in care. Also, a study considers the lack of a proper response system, including the lack of planned and systematic care, and the limitations and inappropriate conditions of the system as effective factors in this regard.[29]

The results of our study showed that the mothers commonly complain about the poor interaction of the care providers including failure to greet and welcome on the mother's arrival and not giving reasonable justification to mothers regarding receiving maternity care. Due to these ineffective interactions, they believed that health providers were impatient, non-compassionate, strange, and violent people which often caused a feeling of insecurity, lack of trust and confidence, fear, and extreme anxiety for the mother.

In line with our results, other studies reported that midwives are vital in providing respectful maternity care during childbirth. Their behavior impacts women's childbirth experiences, and negative language and non-individualized care can cause dissatisfaction.[30,31] Research in China shows that midwives with higher empathy levels provide more empathetic care.[32]

A study also refers to poor verbal communication and absence of greeting with the mother as an unpleasant women's experience that negates the social rules and ignores the respect for the social identity of the mother in birth centers.[23] Regarding the annoying communication of the care providers, several factors can be considered. Sometimes, due to the shortage of staff and the multiplicity of assigned duties, the caregivers do not get enough time to communicate, interact, and greet;[33] some do not consider it as malpractice[34] and this may be due to their poor training and lack of understanding of the mothers right.

In contrast to our results, a study in urban Tanzania found that midwives provide both respectful and disrespectful care during childbirth. Midwives offering respectful care focused on women's human rights, building positive relationships through verbal interactions, emotional support, and timely care for safe deliveries. This contrasts with the findings of another study.[29]

In our study, a major part of the mothers' experiences is related to the factors of the health care system, including the lack of resources, unskilled care, and weakness of accountable regulatory policies towards the mother, which in fact raises the mother's deprivation from the optimal health system. Consist with our findings and in several studies, physical limitations of hospitals, shortage of staff and equipment (44), childbirth by inexperienced and unskilled care providers (45), and profit-seeking policies in some health centers (46) have been reported as instances of misbehavior against women during childbirth. Thus, prevention and elimination of childbirth violence should include all layers of health systems. Achieving the highest level of acceptable health standards is the right of every woman,[35] The health system restrictions can be directly experienced as violence and misbehavior by mothers, because, the lack of physical space is associated with the violation of privacy, or the shortage of staff and fatigue of care providers creates a feeling of neglect and concern in the mother. In addition, the unfavorable conditions of the health system cause health providers to misbehave with the mother.

Considering the importance of preventing and eliminating childbirth violence and considering that childbirth violence is a complex and multi-dimensional issue, it is recommended to conduct more studies to identify the solutions and necessary interventions to solve this problem and evaluate the effect of the interventions. It is also suggested that childbirth violence be examined from the perspective of maternity care providers and other stakeholders.

The study on women's experiences with childbirth violence in the health system may have limitations. A small sample size of 26 women interviewed in the past three years, limiting the generalizability to a broader population in Iran. The qualitative nature of the study, relying on personal narratives, could lead to subjective interpretations influenced by emotional state, cultural background, and personal expectations. Participants may have been hesitant to disclose negative experiences due to fear of repercussions, potentially resulting in underreporting. Conducted in a specific region of Iran (Ilam province), variations in healthcare practices and cultural norms may affect women's childbirth experiences.

The study may not fully capture positive experiences or healthcare providers' perspectives, offering an unbalanced view of childbirth in the health system.

One of our study strengths was that the research team tried to improve the richness of the findings and the validity of the study by using purposive sampling, and maximum diversity in the selection of participants who gave birth in different hospitals and had various experiences and viewpoints about childbirth violence.

Conclusion

Our study found that women experience childbirth violence at different levels of the health system, highlighting the need for policymakers and healthcare professionals to address this issue. This information can help improve maternal health care by increasing awareness of childbirth violence, promoting respectful maternity care, and educating women and their families about their rights. Training programs for specialists should emphasize the importance of preventing violations of mothers' rights during childbirth. The public needs to be informed about this serious issue through healthcare centers and media.

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Conflicts of interest

There are no conflicts of interest.

References

1. Birie B, Niguse W. Experience of respectful maternity care during childbirth and associated factors in public hospitals of the South West Region of Ethiopia: An institution-based, cross-sectional study. BMJ Open 2023;13:e066849.
2. Kukura E. Obstetric violence. Geo Law J 2018;106:721-801.
3. Bohren MA, Mehrtash H, Fawole B, Maung TM, Balde MD, Maya E, *et al*. How women are treated during facility-based childbirth in four countries: A cross-sectional study with labour observations and community-based surveys. Lancet 2019;394:1750-63.
4. Tabar JH, Shahoie R, Zaheri F, Mansori K, Nasab LH. Prevalence of disrespect and abuse during childbirth and its related factors in women hospitalized in the postpartum ward. J Family Med Prim Care 2023;12:246-52.
5. Taghizadeh Z, Ebadi A, Jaafarpour M. Childbirth violence-based negative health consequences: A qualitative study in Iranian women. BMC Pregnancy Childbirth 2021;21:1-10.
6. Alghamdi RS, Perra O, Boyle B, Stockdale J. Perceived treatment of respectful maternity care among pregnant women at healthcare facilities in the Kingdom of Saudi Arabia: A cross-sectional study. Midwifery 2023;123:103714.
7. Aghajani F, Maajani K, Nakhostin-Ansari A, Maleki-Hajiagha A, Aghajani R, Tehranian A. Maternal mortality and its determining factors among hospitalised mothers in Tehran, Iran, 2013–2020. J Obstet Gynaecol 2022;42:1905-10.
8. Lusambili AM, Wisofschi S, Wade TJ, Temmerman M, Obure J. A qualitative enquiry of health care workers' narratives on knowledge and sources of information on principles of respectful maternity care (RMC). PLoS Glob Public Health 2023;3:e0000157.
9. Hajizadeh K, Vaezi M, Meedya S, Charandabi SMA, Mirghafourvand M. Designing a respectful maternity care guideline: A multiphase study. Reprod Health 2022;19:81.
10. Vivekanandan K, Sharma U, Sharma B, Subbiah N, Raina D. Respectful maternal care − need for educational interventions among maternal health care providers. ECS Trans 2022;107:5899.

11. Mirzania M, Shakibazadeh E, Bohren MA, Hantoushzadeh S, Babaey F, Khajavi A, *et al*. Mistreatment of women during childbirth and its influencing factors in public maternity hospitals in Tehran, Iran: A multi-stakeholder qualitative study. Reprod Health 2023;20:79.
12. Mirghafourvand M, Meedya S, Mohammadi E, Mohammad-Alizadeh-Charandabi S, Jafarabadi MA, Ghanbari-Homaie S. Iranian women's perception on the determinants of birth experience: A qualitative study. BMC Pregnancy Childbirth 2022;22:751.
13. Hajizadeh K, Vaezi M, Meedya S, Mohammad Alizadeh Charandabi S, Mirghafourvand M. Prevalence and predictors of perceived disrespectful maternity care in postpartum Iranian women: A cross-sectional study. BMC Pregnancy Childbirth 2020;20:463.
14. Ghanbari S, Fardiazar Z, Meedya S, Mohammad-Alizadeh S, Asghari Jafarabadi M, Mohammadi E, *et al*. Predictors of traumatic birth experience among a group of Iranian primipara women: A cross sectional study. BMC Pregnancy Childbirth. 2019;19:182.
15. Cooper M, Briley A, Feeley C, Dillon MF, McNeill ML, Medway MP, *et al*. Changin'it up: Shining the light on what it means to be informed in maternity care. Women Birth 2023;36:S44.
16. Firoozi M, Tara F, Ahanchian MR, Latifnejad Roudsari R. Health care system barriers to vaginal birth after cesarean section: A qualitative study. Iran J Nurs Midwifery Res 2020;25:202-11.
17. Antoniou E. Women's experiences of domestic violence during pregnancy: A qualitative research in Greece. Int J Environ Res Public Health 2020;17:7069.
18. Amel Barez M, Babazadeh R, Latifnejad Roudsari R, Mousavi Bazaz M, Mirzaii Najmabadi K. Women's strategies for managing domestic violence during pregnancy: A qualitative study in Iran. Reprod Health 2022;19:58.
19. Giouleka S, Tsakiridis I, Kostakis N, Boureka E, Mamopoulos A, Kalogiannidis I, *et al*. Postnatal care: A comparative review of guidelines. Obstet Gynecol Surv 2024;79:105-21.
20. Stephens S. Qualitative content analysis: A framework for the substantive review of hospital incident reports. J Healthc Risk Manage 2022;41:17-26.
21. Gurduz A. The concept and problem of code in modern literary studies. Європейські соціо-правові та гуманітарні студії 2024:47-54.
22. Gebeyehu NA, Adella GA, Tegegne KD. Disrespect and abuse of women during childbirth at health facilities in Eastern Africa: Systematic review and meta-analysis. Front Med 2023;10:1117116.
23. Solnes Miltenburg A, van Pelt S, Meguid T, Sundby J. Disrespect and abuse in maternity care: Individual consequences of structural violence. Reprod Health Matters 2018;26:88-106.
24. Organization WH. WHO Recommendations: Intrapartum Care for a Positive Childbirth Experience. World Health Organization; 2018.
25. Amel Barez M, Mirzaii Najmabadi K., Latifnejad Roudsari R. Bazaz MM, Babazadeh R. "Family and society empowerment": a content analysis of the needs of Iranian women who experience domestic violence during pregnancy: A qualitative study. BMC Women's Health 23,2023;370.
26. Gleason EG, López Ríos JM, Molina Berrío DP, Mejía Merino C. Multistakeholder perspectives on the mistreatment of indigenous women during childbirth in Colombia: Drivers and points for intervention. BMC Pregnancy Childbirth 2022;22:197.
27. Niles PM, Stoll K, Wang JJ, Black S, Vedam S. "I fought my entire way": Experiences of declining maternity care services in British Columbia. PLoS One 2021;16:e0252645.
28. Raesi R, Saghari S, Tabatabaee SS, Mirzaei S, Hushmandi K. A survey of women giving birth regarding respect for the human dignity of the mother and the newborn. Open Public Health J 2023;16. doi: 10.2174/18749445-v16-230619-2022-4.
29. Shimoda K, Horiuchi S, Leshabari S, Shimpuku Y. Midwives' respect and disrespect of women during facility-based childbirth in urban Tanzania: A qualitative study. Reprod Health 2018;15:8.
30. Daniel G, Afolaranmi T, Mfuh A, Wina F, Dioso RI. Experiences of midwives in providing respectful maternity care during childbirth in Jos, Nigeria. Malays J Nurs 2023;14:35-45.
31. Borelli S, Walsh D, Spiby H. 'You are only in early labour, you are not in active labour yet': Midwives' language and behaviour and the meaning women make of it. Pract Midwife 2018:25-9.
32. Jin Y, Wu Y, Li J. Midwife empathy and its association with the childbirth experience: A cross-sectional study. BMC Pregnancy Childbirth 2022;22:960.
33. Ishola F, Owolabi O, Filippi V. Disrespect and abuse of women during childbirth in Nigeria: A systematic review. PLoS One 2017;12:e0174084.
34. Martínez-Galiano JM, Rodríguez-Almagro J, Rubio-Álvarez A, Ortiz-Esquinas I, Ballesta-Castillejos A, Hernández-Martínez A. Obstetric violence from a midwife perspective. Int J Environ Res Public Health 2023;20:4930.
35. Organization WH. The Prevention and Elimination of Disrespect and Abuse During Facility-based Childbirth: WHO Statement; 2015.