Family Practice, 2024, **41**, 147–154
https://doi.org/10.1093/fampra/cmae016
Advance access publication 22 March 2024
Qualitative Research

Speculum self-insertion: an alternative method for gynaecological examination?

Marie-Morgane Veto[1], Julie Chazalon[1], Corinne Atallah-Seive[1], Rodolphe Charles[1,2], Angélique Savall[1,2,*]

[1]Department of Education and Research in General Practice, Jean Monnet University, Saint-Etienne, France
[2]Inserm CIC-EC 1408, University Hospital, Saint-Etienne, France

[*]Corresponding author: Department of Education and Research in General Practice, Jean Monnet University, Saint-Etienne, France.
Email: a.savall@univ-st-etienne.fr

Background: Speculum examination is an intrusive practice in the clinical care of women. It requires privacy and patients may experience discomfort or anxiety related to the procedure, which can result in delays or avoidance of necessary healthcare. Speculum self-insertion originated in the United States in the 1970s as part of the self-help movement. However, this clinical practice is largely unknown among healthcare providers and has rarely been assessed.

Aim: This study investigates the women's views and healthcare providers' experiences of the self-insertion method.

Method: A qualitative study was conducted between December 2021 and October 2022, including fieldwork combining semi-structured interviews (10 women) and focus groups associated with individual interviews of 13 healthcare providers. The data collected were independently coded by 2 authors and analysed using an inductive approach and grounded theory method.

Results: Speculum self-insertion was described as a way to decrease discomfort and facilitate speculum insertion. Self-insertion was proposed as a means of allowing women to participate in the examination, reducing their vulnerability against power imbalances in the doctor–patient relationship. Both patients and healthcare providers have reported that speculum self-insertion is a method that can contribute to improving trust and communication during the examination.

Conclusion: The practice of speculum self-insertion during the consultation is an alternative to traditional practitioner insertion and may be offered to all women by any practitioner who wishes to use this technique.

Lay summary

The use of a speculum is common in gynaecological consultations and most women are likely to encounter this tool during a medical examination. Several studies have already shown that this examination can cause pain and anxiety. Speculum self-insertion is not widely used and consists of allowing the woman to insert the speculum herself while being assisted by the practitioner. A study was conducted with 10 women and 13 healthcare providers to evaluate this technique and its impact on women's healthcare. This technique reduces the discomfort that can be felt during the examination. The woman will regain control of her body during the examination and this technique will reduce the hierarchical relationship felt by some women. A discussion about the gynaecological examination and women's healthcare is created during the consultation. Even if this technique does not seem to be suitable for all women, routinely offering self-insertion allows the healthcare provider to adapt to each woman and to her choice. The proposal of speculum self-insertion is an alternative technique that can improves women's feelings and their overall health.

Key words: empowerment, gynecological examination, primary healthcare, self-insertion, speculum

Introduction

"If I could do without this examination, it would be nice!" The use of a speculum during a gynaecological examination is an intrusive action, involving intimacy and modesty.[1] Some women may experience anxiety, pain, and discomfort before, during, or after the examination.[2–5] The lack of information about the procedure and the lack of anatomy knowledge may create a barrier to consultation.[6] These difficulties have been identified as a cause of lower participation in cervical cancer screening.[7] Current recommendations attempt to address these gynaecologic examination difficulties by encouraging self-sampling.[8] As of July 2019, cervical cancer screening is performed by testing for the presence of human papillomavirus (HPV) in women over 30 years of age by self-sampling.[7,9] However, speculum examination remains essential for women who present with symptoms such as pain, breakthrough bleeding, or vaginal discharge, as well as for the diagnosis of cervical cancer.[10]

Speculum self-insertion consists of the insertion of the speculum by the patient during a gynaecological examination. The patient can simply push the speculum positioned at the vaginal introitus by the healthcare provider or perform the full insertion. The opening of the speculum can be done by the patient or by the practitioner. Conversely, practitioner insertion, which is widely prevalent in consultations, refers to the practice of speculum insertion solely by the healthcare

Key messages

- Women report that self-insertion facilitates the speculum examination.
- It defined their role as an ally of the healthcare provider by being experts.
- It improves trust and communication between healthcare providers and women.
- It allows a deeper understanding of her body and improve patients' knowledge.
- Healthcare providers confirm self-insertion doesn't increase the time required.
- It could be an alternative and may be offered to all women.

provider. Self-insertion of the speculum is a practice within the field of self-gynaecology, which encompasses various techniques that can be performed by the woman independently or with the aid of the healthcare provider, alone or collectively, to improve her sexual health. A key component of self-gynaecology is self-observation of the cervix, which involves examining the cervix after the speculum has been inserted, either alone or in a group workshop.

The use of speculum self-insertion during the gynaecological examination is not widely understood or utilized and has only recently gained recognition. This practice was inherited from feminist activism in the United States in the 1970s. In 1971, Carol Downer, a lawyer mitigating the right to abortion and women's health, bought a plastic speculum and performed a self-examination in front of other women. She was arrested for illegal medical practice in 1972.[11] The first self-examination workshops and the self-help movement emerged in conjunction with the fight for reproductive rights. This movement is based on the appropriation of gynaecological knowledge. In the 1970s, the practice of self-examination was followed by some feminist groups, such as the Movement for Free Abortion and Contraception (MLAC) and the Our Bodies, Ourselves group.[12]

In France, since 2014, an increasing number of women have reported experiencing gynaecological and obstetrical violence, speaking out on social media using the hashtag "#PayeTonUtérus." Media scandals accusing professionals of physical or psychological violence have multiplied. These testimonials and accusations prompted a report by the Secretary of State into the issue.[13] These events have led to questioning women's healthcare but have also resulted in the emergence or exacerbation of fear of seeking gynaecological consultation.[14] In 2017, a worldwide feminist movement to denounce sexual harassment and violence emerged with the "#MeToo" movement. Women started speaking out about experiences and movements of solidarity between women arose.[15] Consequently, gynaecological self-examination workshops to regain control over one's body are organized again in several world cities, and the speculum self-insertion re-enters the discussions on gynaecological practices.

Through a sociological study, this article aims to assess the women's views and healthcare providers' experiences of the self-insertion method and to consider to what extent this approach could modify the perception of the gynaecological examination from healthcare providers and women's perspectives.

Methods

Study design

A qualitative study was conducted between December 2021 and October 2022, including fieldwork combining individual interviews and focus groups with women and healthcare providers. This study refers to female patients, but the findings may be applicable to others with a cervix. Data were collected by 2 PhD students during their residency in general practice in Saint-Étienne. During their learning of gynaecological practice, there was a societal movement in France, with scandals surrounding medical practices. These societal issues led to the drafting of a charter[16] and, more recently, a notice from the national ethics council about intimate examinations.[17] This societal movement denouncing gynaecological violence has led researchers to take an interest in alternative practices for gynaecological examinations. A bracketing process was carried out by the research team, with preliminary assumptions drafted prior to the fieldwork. In grounded theory, researchers engage in the self-reflective process of "bracketing," whereby they recognize and set aside their prior knowledge and assumptions, with the analytic goal of attending to the participants' accounts with an open mind.[18]

Participants (Fig. 1)

Two recruitment methods were used: (i) information sheets distributed to women in the general practices of 2 towns in the Loire (French District, prefecture Saint-Étienne) and (ii) acquaintances of the interviewers. The healthcare providers were recruited through their peer group. A peer group refers to a group of professionals that includes doctors of the same specialty who meet regularly to make argumentative analyses of their daily practice.

The only exclusion criterion for women participants in the study was being under the age of 18. No other exclusion criteria were applied. A theoretical sampling has been realized. The study employed a comprehensive theoretical sampling approach to maximize diversity. Among women, we sampled for variation in age, socio-professional category, the type of healthcare provider delivering gynaecological care, and the practice of speculum self-insertion. Among healthcare professionals we sampled for variation in age, gender, years of professional experience, medical specialty, and the adoption of speculum self-insertion as a practice.

Data collection

Prior to and during the study, researchers were general practice trainees and they were on their own with patients for 6 months in the Loire (French District, prefecture Saint-Étienne) in a family planning clinic and a general practice. During this period, they used this time of clinic learning to routinely offer self-insertion to women and kept a field notebook. This fieldwork allowed them to observe how the technique was accepted by women and by healthcare providers. It also enabled us to determine the issues linked to self-insertion that were going to be explored in the interviews. Interview

guidelines were developed at the beginning of the study, based on the existing literature and the objectives of the research. These guidelines facilitated the meetings and the collection of women's and healthcare providers' perceptions of gynaecological exams. The interview guides were adapted throughout the research, following an inductive process. The themes covered are presented in Table 1. Individual interviews were conducted by a single interviewer, while both interviewers were present during the focus groups (facilitation and observation). The interviews were conducted in French and recorded with a Dictaphone, transcribed, and blinded to facilitate the analysis.

Analysis

All the data were coded independently on the French written transcripts by the two investigators and analysed using a grounded theory approach. The first step consisted of descriptive coding of data, followed by an inductive thematic coding.

Fieldwork was continued until achieving theoretical saturation of the data (no new emerging data). A triangulation of the data was carried out repeatedly through cross-analysis with an interdisciplinary working group including general practitioners and sociologists. Additional triangulation was done by returning the interviews and results to the participants—women and healthcare providers—which increased the internal validity of the study. Eight women responded that the results sent were consistent with their feelings and statements during the interviews and two did not respond. Seven out of the 13 interviewed healthcare providers agreed with the results and 6 did not respond. Only the verbatims used in the article have been translated into English by the field researchers. The consolidated criteria for reporting qualitative studies (COREQ32, annex 1) were fully respected when the study method was implemented (Supplementary Material).[19,20]

Results

A total of 23 participants were interviewed, consisting of 10 women and 13 healthcare providers. The women ranged in

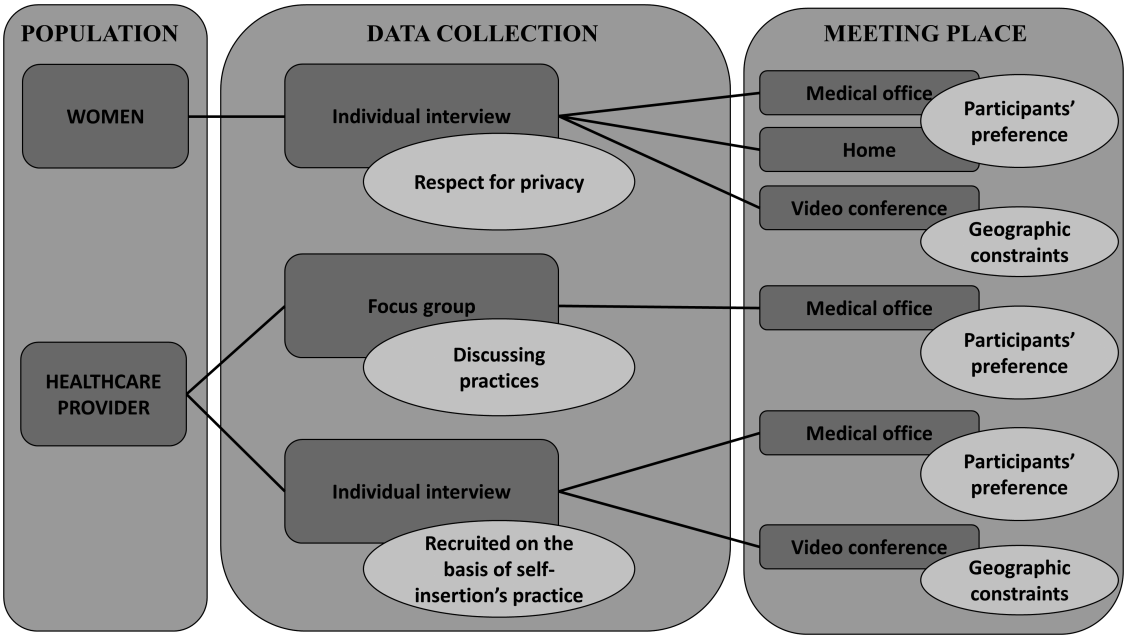

Figure 1. Study population.

Table 1. Interview guides' theme covered.

	First interview guides	Final interview guides
Women	Feelings about their intimacy and relationship with their body Feelings about speculum examination Knowledge about self-help in gynaecology Feasibility in practice to do self-insertion Thoughts about speculum examination's perception with self-insertion	Perception about gynaecological exam and the first speculum examination Feeling about speculum examination Feeling and practice on breast self-examination Knowledge about self-help in gynaecology Thoughts about self-insertion Thoughts about speculum examination's perception with self-insertion
Healthcare providers	Procedure for a speculum examination Thoughts about women's feelings during the exam Feelings during the exam as a healthcare provider Knowledge about self-help in gynaecology Thoughts about self-insertion Feasibility in practice	Procedure for speculum examination Thoughts about women's feelings during the exam Feelings during the exam as a healthcare provider Knowledge about self-help in gynaecology Thoughts about self-insertion Feasibility in practice

age from 22 to 62 and had educational backgrounds ranging from vocational training certificates to master's degrees, with a rather urban lifestyle. The individual interviews lasted between 10 and 50 minutes. All women interviewed had had a previous speculum examination (Table 2). The healthcare providers ranged in age from 31 to 61, with interview times ranging from 22 to 90 minutes (Table 3).

The experience of her body

Self-insertion is a practice in which the woman participates in her examination. She becomes an actor in her health and her role is defined. They declare no longer occupying the position of naked, vulnerable patients on the examination table, waiting for a technical procedure. In this way, she has the opportunity to exist during the examination. Leïla, who practices self-insertion with her midwife, explained: "*the examination is more pleasant because there is also a moment when this insertion time, even if you are half-naked, is a time of less vulnerability because you are not with your feet in the stirrups or just sitting on the table waiting. [...] There is a global approach, at no time did I find myself naked and not knowing what to do with my body.*"

The woman becomes the ally of the healthcare provider. This defined role mitigates the hierarchical relationship felt by the women. Laure recontextualized it in the models of the doctor-patient relationship: "*It's been a long time since we got out of medical paternalism, but it helps to get out of this relationship where you have the doctor who is all-powerful and who is capable of everything and you of nothing.*" Women recognize themselves as experts on their own bodies, but do not want to impose their expertise on healthcare providers. Self-insertion allows them to share their knowledge, as Florence, one of the women interviewed, explained: "*I imagine that professionals are suspicious because you agree to delegate power by doing this, you are sharing your knowledge, which is not at all in the traditional spirit of medicine.*" However, the healthcare provider is not excluded from the examination, Florence specified: "*you have so many different bodies that often the woman will know how to do it much better because she knows herself. [...]. Whereas the doctor keeps a supporting role, which is crucial.*"

By practicing self-insertion, the woman positions herself as an expert in her health. Several patient associations invested in health research enable a partnership between the patient and the healthcare providers. These movements are inspired by self-help groups and reinforce the importance of patient experience in the solutions proposed by the healthcare system.[21] Patient participation ranges from information, where the

Table 2. Women's characteristics.

Name	Age (years)	Gynaecological follow-up (profession)	Profession	Self-insertion's practice
Adèle	28	Gynaecologist and general practitioner	Audiovisual producer	No
Ana	25	Midwife	Real estate agent	No
Camille	22	General practitioner	Restaurant student	No
Céline	62	No follow-up	Retired firefighter	No
Doria	39	General practitioner and gynaecologist	Accountant	No
Florence	28	Midwife and gynaecologist	In charge of coordination	Yes
Laetitia	34	General practitioner	Aesthetician	Yes
Laure	27	Midwife	Physiotherapist	Yes
Leïla	27	Midwife	Midwife then teacher	Yes
Géraldine	22	Gynaecologist	Student in urban planning and development	Yes

Table 3. Healthcare providers' characteristics.

Name	Year of installation	Gender	Age	Medical speciality	Self-insertion's practice
Dr Alice	2011	F	39	General practitioner	No
Dr Karim	1995	M	56	General practitioner	No
Dr Fanny	1995	F	58	General practitioner	No
Dr Jeanne	2001	F	50	General practitioner	No
Dr Josée	2001	F	54	General practitioner	No
Dr Laurette	2005	F	47	General practitioner	Yes
Dr Louise	1996	F	56	General practitioner	No
Dr Marie	1992	F	61	General practitioner	No
Dr Sylvie	1996	F	59	General practitioner	No
Dr Zacharie	2009	M	42	General practitioner	Yes
Dr Viviana	2021	F	31	Gynaecologist	No
Dr Zohra	2012	F	39	General practitioner	Yes
Dr Éric	2017	M	38	Gynaecologist	Yes

patient is recognized as the bearer of knowledge to empowerment. Empowerment is defined here as the highest level of collaboration influencing the care relationship.[22] Since the 1970s, the self-help movement makes experiential knowledge in the field of gynaecology.[23] The practice of self-insertion of the speculum is part of this desire to empower women as patient experts within the care relationship.

This new status acquired by the woman reduces her feeling of vulnerability, and at the time of insertion of the speculum, reduces tension. They report less discomfort and less apprehension about the examination. Géraldine, who suffers from vaginal hypertonia, had undergone several speculum examinations and recalled the discomfort she felt: "*For me, it is a painful moment to go through, because from the passage of the fingers for the vaginal touch to the insertion of the speculum, it is painful, for me it is almost like an instrument of torture*." During her perineal rehabilitation, her physiotherapist suggested that she positions the probes herself and gave her a speculum. She explained what this practice brought her when she placed the speculum herself: "*At least I can go to my own pace. Because when someone else does it, the person doesn't feel what we feel and it's a bit of a rush, whereas if you go slowly and take breaks, it's less difficult to experience*." Leïla explained how she felt about the discomfort of inserting the speculum: "*the fact that I do it myself probably hurts in the same way, but I still have a perception of the pain that comes from me to me and so it is much more attenuated*."

Pain is an entity whose representation is linked to sensory, emotional and behavioural dimensions as well as to characteristics of social and cultural conditions. "Procedural pain" or "induced pain" refers to pain-related to care, certain complementary examinations or technical gestures.[24] When the speculum is inserted by women, the discomfort felt is no longer pain related to care.[25] This perception of pain, not resulting from care, can partly explain the comfort improvement felt by the women. In the study by Wright et al,[26] a questionnaire is used to assess acceptance and satisfaction with self-insertion, ease of the procedure, and anxiety during the examination. The evaluation shows that nearly 91% of the women are satisfied and will prefer to choose this practice for their next examination.[27]

Redefining the Healthcare Providers–Patient Relationship

Florence practiced self-insertion with her midwife. In addition, she needed to go to a gynaecologist for a colposcopy and she had a practitioner exam: "*I recently have an exam with my gynaecologist and it hurt. He asked me 'I'm going to do the pap smear, tell me if I'm hurting you' and it hurt. It didn't last so I didn't have time to tell him but I tell myself he hurt me*." Although the discomfort was related to speculum's practitioner-insertion, as she expressed it, a second factor seemed to come into play: the examination was conducted during a first meeting with this healthcare provider.

The establishment of a trusting relationship and communication between the woman and the practitioner during the examination is essential for the proper conduct of a speculum examination, as demonstrated in numerous studies.[2,4,28] When a trusting relationship has already been established between the woman and the healthcare provider, self-insertion is less significant, as was the case for Doria, who did her gynaecological check-up with her general practitioner: "*I trust her completely, and it always went well, so I don't see any point in doing it myself*."

However, the offering of self-insertion appeared to be a useful tool for fostering a climate of trust. Women who practiced it confirmed that it was a major asset in their relationship with the practitioner. For Florence, "*it played a big role in the relationship I have with my midwife; she lets me do it, she trusts me, she gives me the keys so that I can do it*." Field notes confirmed the importance of constant proposing and how this opens dialogue about the gynaecological examination and women's healthcare. Researchers were often seeing women for the first time and were able to gather testimonies of violence and difficulties about examination. To establish this relationship of trust, communication during speculum examination was crucial. The successful completion of the self-insertion required an explanation of the procedure. Dr Zacharie, who practiced it, explained: "*I always show the patients the speculum before the examination, they touch it, they have it in their hands before they use it themselves or before I use it myself. This approach to the examination opens the discussion about the procedure and their bodies. Women gain additional knowledge*." In the Liston *et al.* study, another aspect of self-insertion is discussed. The practitioner's placement of the speculum is associated with the use of a mirror that allows the woman to observe her body during the examination. The main results show that this reduces anxiety and improves patients' knowledge of the nature and importance of the pelvic examination.[29]

Therefore, self-insertion facilitated inclusive communication with the patient and a deeper understanding of her body, which could enhance trust between the patient and the healthcare provider, as well as the patient's self-confidence. As Adele said: "*I think that if I do it myself I will have a different view of the act itself, it will not really change my perception of the examination, but it will certainly teach me to know myself better.*" This self-confidence allowed them to regain power over their bodies, which illustrates the notion of empowerment mentioned earlier. Empowerment here refers to the women's ability to know, handle, and care for their own bodies. By developing empowerment, women could reclaim their bodies and assert their medical autonomy.[30,31]

Dr Zohra, a general practitioner, who practiced self-insertion, saw it was a way to restore their confidence: "*They regain power over their bodies, even if it is the doctor who is going to do the cervical exam and look at it [...] it's crucial that healthcare providers give power back to the patients because they are not going to take it easily.*" Empowerment and increased self-awareness enable women to achieve better health through increased participation during the consultation and beyond through an active role in the process.[32]

Self-insertion for all?

The practice of speculum self-insertion seemed controversial among healthcare providers. Several drawbacks have been put forward. The lack of knowledge of women about their own bodies was one of them, as Dr Louise and Dr Sylvie said: "*I feel that they would panic if I told them to put the speculum in themselves. Women are not used to examining themselves at all.*" The other barrier mentioned by healthcare providers was the fear of not having enough time to explain self-insertion to women to enable them to do it. According to Dr Alice: "*If they want to put the speculum in before we do a smear, why not, I will not mind, but then I would not have the time to explain to them how to self-examine*." Doctors were not necessarily ready to change their practice, especially

for patients for whom the examination has always gone well. Dr Sylvie said: "*I can't see myself telling girls who have been getting smears for a long time 'now you're going to put your speculum in by yourself', I don't see what good it would do.*"

This reluctance was in line with the mistrust of empowerment in healthcare. Indeed, patient participation is often accepted when the activity of health professionals is not questioned. There are currently only a few experiments on patient empowerment, although involvement and collaboration can be a means of preventing medical errors.[22] Healthcare providers in the field were at least at the beginning suspicious about the technique and didn't see the point, which contrasted with women who were very interested in learning more. However, doctors who were practicing self-insertion expressed ease in carrying out the examination when the patient placed the speculum herself, Dr Zacharie said: "*I find that they are more easily on the cervix; naturally, I would not know how to explain it ergonomically, but I have the impression that they find the cervix more easily than I do.*" Dr. Laurette, who was not familiar with this practice, confirmed her comments. She was astonished when she performed her first self-insertion: "*She inserted the speculum in two steps and started to open it, and I did the smear in three seconds. I am the first one surprised by the adherence.*"

The Wright et al. study[26] confirms these observations. The practitioner can see the cervix without having to manipulate further the speculum for 54% of the women who put their speculum in place, and only one to three manipulations are necessary for 39% of the examinations. In terms of consultation time, the use of self-insertion takes less than 20 minutes in half of the cases, which does not significantly increase the time required for the examination. In our study, some healthcare providers initially reluctant to perform self-insertion during the interview confirmed that they had offered it successfully to their patients since our intervention.

The doctors interviewed noted that this practice could be useful in certain cases, but they did not automatically offer it to all patients, as Dr. Fanny mentioned: "*there are three or four patients to whom I will try to offer it, I think of one who has vaginismus. This technique can help women who have difficulties with gynaecological examination.*" However, women who were victims of gynaecological or sexual violence were not systematically the population to target for self-insertion. Dr. Zacharie, who practiced self-insertion, explained: "*I have patients who describe experiences that, in my opinion, are akin to gynaecological abuse and who nevertheless prefer a* practitioner insertion."

Self-insertion was not for every woman, and there was no strictly defined profile of women who would be interested in this practice. Dr Zacharie began performing the self-insertion on a patient who was having difficulty and with whom he was unable to place the speculum. After the successful insertion with this patient, he began to systematically ask the women to insert the speculum and he testified: "*I realized that there are women who do not want to, who prefer that the doctor insert it [...], that is to say that there are women who, for many reasons that we do not even need to explore, are not comfortable inserting the speculum or looking at themselves in a mirror.*" In addition, some patients preferred to let the doctor do the procedure for various reasons. Adele said, "*If the gynaecologist gave me the speculum and said, 'Would you rather put it in yourself or should I put it in for you,' I would prefer that she does it because it's her job... it makes me feel better to have a health professional do it.*" In the field, most of the women who agreed to self-insertion were young, yet one 82-year-old woman wanted to practice self-insertion and the examination went well, even though she was coming in with metrorrhagia and was anxious. It would be interesting to explore those various reasons to see if some specific criteria would guide patients in their choice to refuse self-insertion. Among these criteria, technicality and professional competence seemed to reassure patients who did not wish to practice it.

Strengths and limitations

The main strength of this qualitative study lies in the data triangulation which was repeatedly achieved through the data collection technique and by the researchers, as well as through cross-analysis with an interdisciplinary working group and the restitution of interviews and results to the participants. In addition, reflexivity was reinforced by on-board field observation when researchers offered self-insertion for the examination and reported how women felt and how healthcare providers reacted in a field notebook. A majority of general practitioners were interviewed; however this qualitative study has no representative intent, and self-insertion seems more suited to primary care practice. Regarding to limitations, the fact that the investigators were inexperienced in social sciences and qualitative research may have had an impact on the report. Moreover, the healthcare provider participants included more general practitioners than gynaecologists.

Conclusion

The gynaecological examination is a delicate examination and a source of anxiety for women, which can cause delays in consulting. Generalizing the offering of speculum self-insertion by the woman during the gynaecological examination is an innovative and interesting option. Indeed, it enabled the woman to be an active participant in her own health, in some cases reduced the discomfort during the examination, and allowed the establishment of a trusting relationship with the practitioner offering it. It was a technique that did not take much time and encouraged communication during the examination. Women gained knowledge about their body and self-confidence. The patients were more involved and therefore, acquired a better state of health (Fig. 2).

However, it should not be a mandatory practice and should only be offered by practitioners if they feel comfortable using this technique. If either the patient or the practitioner feels uncomfortable with self-insertion, it may not be successful and can cause difficulties.

In this study, the women who practiced self-insertion seemed to be younger and followed by midwives or general practitioners. Thus, it would be interesting to investigate the motives of the women willing to adopt this technique. Women followed by a gynaecologist might be looking for expertise and technicality that would make the practice of self-insertion less relevant. Self-insertion was not suitable for all women or all healthcare providers. There is no specific profile to target, so the offer must be adapted to each woman. Self-insertion is an alternative that can be offered in healthcare and may enhance women's trust and confidence in their healthcare provider.

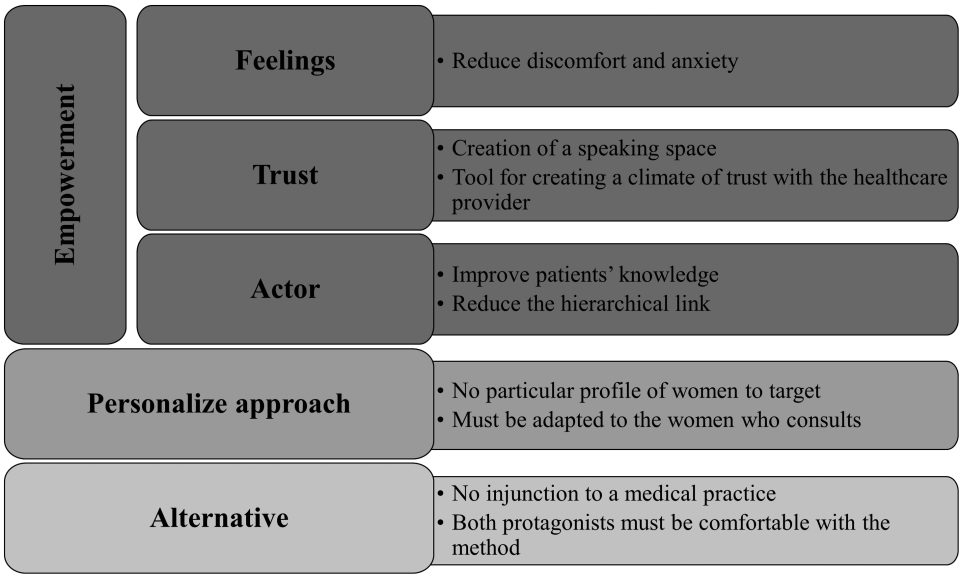

Figure 2. Take home messages.

Supplementary material

Supplementary material is available at *Family Practice* online.

Conflict of interest

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

This research received no specific grant from any funding agency in the public, commercial or not-for-profit sectors.

Ethical approval

Each healthcare provider and woman participant was provided with information and consent form before participation in the research. A simplified declaration of the analysis of the anonymized database of participants in the study was made to the national data protection commission (CNIL) (December 2, 2021). The study was approved by the institutional ethics committee (IRBN1702021/CHUSTE).

Data availability

None.

References

1. Guyard L. Consultation gynécologique et gestion de l'intime. *Champ psychosomatique*. 2002:**27**(3):81–92.
2. Yanikkerem E, Ozdemir M, Bingol H, Tatar A, Karadeniz G. Women's attitudes and expectations regarding gynaecological examination. *Midwifery*. 2009:**25**(5):500–508.
3. Grundström H, Wallin K, Berterö C. « You expose yourself in so many ways »: young women's experiences of pelvic examination. *J Psychosom Obstet Gynaecol*. 2011:**32**(2):59–64.
4. Hilden M, Sidenius K, Langhoff-Roos J, Wijma B, Schei B. Women's experiences of the gynecologic examination: factors associated with discomfort. *Acta Obstet Gynecol Scand*. 2003:**82**(11):1030–1036.
5. Bodden-Heidrich R, Walter S, Teutenberger S, Küppers V, Pelzer V, Rechenberger I, Bender HG. What does a young girl experience in her first gynecological examination? Study on the relationship between anxiety and pain. *J Pediatr Adolesc Gynecol*. 2000:**13**(3):139–142.
6. Larsen SB, Kragstrup J. Expectations and knowledge of pelvic examinations in a random sample of Danish teenagers. *J Psychosom Obstet Gynaecol*. 1995:**16**(2):93–99.
7. Évaluation de la recherche des papillomavirus humains (HPV) en dépistage primaire des lésions précancéreuses et cancéreuses du col de l'utérus et de la place du double immuno-marquage p16/Ki67 [Internet]. [cited 2023 May 24]. 2019. https://www.has-sante.fr
8. IST: la HAS recommande un dépistage systématique de l'infection à Chlamydia trachomatis chez les jeunes femmes [Internet]. [cited 2023 May 24]. 2018. https://www.has-sante.fr
9. Institut National du Cancer. Dépistage du cancer du col de l'utérus - cadre et modalités de recours aux autoprélèvements vaginaux. [cited 2023 May 24]. avr 2022.
10. Evans D, Goldstein S, Loewy A, Altman AD. No. 385-Indications for pelvic examination. *J Obstet Gynaecol Can JOGC*. 2019:**41**(8):1221–1234.
11. Eveleth R. What makes the speculum awful. *The Atlantic [Internet]*. 17 nov. 2014. https://www.theatlantic.com
12. Koechlin A. L'auto-gynécologie: écoféminisme et intersectionnalité. *Trav Genre Sociétés*. 2019:**n° 42**(2):109–126.
13. Actes sexistes durant le suivi gynécologique et obstétrical: reconnaître et mettre fin à des violences longtemps ignorées - Haut Conseil à l'Égalité entre les femmes et les hommes [Internet]. [cited 2023 May 24]. 2018. https://www.haut-conseil-egalite.gouv.fr
14. Schantz C, Rozée V, Molinier P. Introduction. Les violences obstétricales, un nouvel axe de recherche pour les études de genre, un nouveau défi pour le soin et la société. *Cah Genre*. 2021:**71**(2):5–24.
15. Albenga V, Dagorn J. Après #MeToo: Réappropriation de la sororité et résistances pratiques d'étudiantes françaises. *Mouvements*. 2019:**n° 99**(3):75–84.
16. Belaisch Allart J. Charte de la consultation en gynécologie ou en obstétrique. *Gynécologie Obstétrique Fertilité & Sénologie* . avr. 2022:**50**(4):289–290.

17. Avis 142 du CCNE « Consentement et respect de la personne dans la pratique des examens gynécologiques et touchant à l'intimité » - Comité Consultatif National d'Ethique [Internet]. [cited 2023 May 24]. 2023. https://www.ccne-ethique.fr
18. Starks H, Trinidad SB. Choose your method: a comparison of phenomenology, discourse analysis, and grounded theory. *Qual Health Res*. 2007:**17**(10):1372–1380.
19. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *Int J Qual Health Care*. 2007:**19**(6):349–357. https://pubmed.ncbi.nlm.nih.gov/17872937
20. O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. Standards for reporting qualitative research: a synthesis of recommendations. *Acad Med J Assoc Am Med Coll*. 2014:**89**(9):1245–1251.
21. Rabeharisoa V, Callon M. L'engagement des associations de malades dans la recherche. *Revue Internationale des Sciences Sociales*. 2002:**171**(1):65–73.
22. Mougeot F, Robelet M, Rambaud C, Occelli P, Buchet-Poyau K, Touzet S, Michel P. [Emergence of the patient–actor in patient safety in France. A narrative review in social sciences and public health]. *Sante publique (Vandoeuvre-les-Nancy, France)*. 2018:**30**(1):73–81.
23. Ruault L. La circulation transnationale du self-help féministe: acte 2 des luttes pour l'avortement libre? *Crit Int*. 2016:**N° 70**(1):37–54.
24. Peoc'h N, Lopez G, Castes N. Représentations et douleur induite: repère, mémoire, discours... Vers les prémisses d'une compréhension. *Rech Soins Infirm*. 2007:**N° 88**(1):84–93.
25. Wrobel J. *Les douleurs induites*. Rueil-Malmaison: Institut UPSA de la douleur; 2005. 193 p.
26. Wright D, Fenwick J, Stephenson P, Monterosso L. Speculum « self-insertion »: a pilot study. *J Clin Nurs*. 2005:**14**(9):1098–1111.
27. McQueen A. Commentary on Wright D, Fenwick J, Stephenson P & Monterosso L (2005) Speculum « self insertion »: a pilot study. Journal of Clinical Nursing 14, 1098-1111. *J Clin Nurs*. 2006:**15**(6):794–797.
28. Bates CK, Carroll N, Potter J. The challenging pelvic examination. *J Gen Intern Med*. 2011:**26**(6):651–657.
29. Liston J, Liston EH. The mirror pelvic examination: assessment in a clinic setting. *JOGN Nurs J Obst Gynecol Neonatal Nurs*. 1978:**7**(2):47–49.
30. Quéré L. Luttes féministes autour du consentement. Héritages et impensés des mobilisations contemporaines sur la gynécologie. *Nouv Quest Féministes*. 2016:**35**(1):32–47.
31. Fussinger C, Rey S, Vuille M. S 'approprier son corps et sa santé. Entretien avec Rina Nissim. *Nouv Quest Féministes*. 2006;**25**(2):98–116. https://www.cairn.info
32. Wallerstein N. *What is the evidence on effectiveness of empowerment to improve health?* Copenhagen: WHO Regional Office for Europe; 2006 p. **37**.