UNFPA

CENTRUL Parteneriat pentru Dezvoltare

# Respectful Maternity Care

## Women's Experiences and Outlooks in Eastern Europe and Central Asia

Photo: UNFPA Republic of Moldova/Ion Ples

# About UNFPA

**UNFPA, the United Nations Population Fund, is the sexual and reproductive health agency of the UN.**

It works to uphold the rights and choices of women, girls and young people across more than 150 countries. UNFPA aims to ensure that every pregnancy is wanted, every childbirth is safe, and every young person can fulfil their potential.

Find out more at eeca.unfpa.org.

**UNFPA in Eastern Europe and Central Asia**
**United Nations Population Fund**
Istanbul, Türkiye
eecaro@unfpa.org

# Contents

# Executive summary

Respectful maternity care is now globally recognized as a fundamental human right and a key component of quality reproductive health care. It means ensuring that women are treated with dignity, empathy and respect throughout pregnancy, childbirth and the post-partum period. According to the World Health Organization, many women still experience disrespect and mistreatment during childbirth in health-care facilities. Such mistreatment includes forced medical procedures, non-consensual interventions, privacy or confidentiality breaches, verbal and physical abuse, neglect and discrimination based on socioeconomic status, ethnicity or gender identity.

The analysis conducted in this study reveals that 67 per cent of surveyed women across the studied countries (n = 2,616)[1] faced at least one form of obstetric mistreatment during labour, including unjustified obstetric procedures without consent, abuse (verbal, physical, sexual), poor interaction with health-care staff, low-quality care and discrimination. Younger women (18–24 years old) are more vulnerable to such treatment compared with women aged 35–46 (78 per cent versus 63.5 per cent reporting mistreatment during childbirth, respectively). Economic vulnerability is another risk factor of obstetric mistreatment, as unemployment is associated with higher rates of reported cases of mistreatment. Single or separated women, who may be deprived of a companion's support, are also likely to face mistreatment. Educational levels and the type of maternity facility also influence the likelihood of mistreatment during childbirth.

Nearly half of the respondents experienced unjustified obstetric procedures without consent or poor interaction with medical staff during childbirth. Specifically, 48.1 per cent of women reported undergoing an obstetric procedure without consent (Kristeller manoeuvre, episiotomy, use of oxytocin, Caesarean section), while 47.4 per cent reported poor interaction with health-care staff, citing a lack of information about procedures, pressure to accept certain interventions or refusal to allow a support person to be present during labour.

Around 24 per cent of women reported verbal abuse during childbirth, including threats, humiliation, and harsh or demeaning language from medical staff. This mistreatment ranged from threats of being denied care to blame for their baby's condition, often leaving women feeling powerless and distressed. Such abuse reflects broader systemic issues in maternal health care, including power imbalances, a lack of accountability and insufficient training in respectful care.

About 1 in 10 women faced physical or sexual abuse. For example, 12 per cent of the surveyed women reported being physically restrained during labour, such as being tied to the bed or subjected to aggressive physical contact under the pretext of facilitating delivery. On the

1. Since data were collected through an online platform, the sample is not fully representative for the overall population of women with young children in the 17 countries studied; it includes the views only of the women who took part in the survey.

other hand, 10.4 per cent of women experienced different forms of sexual abuse, ranging from inappropriate touch to more severe forms of assault (disrespectful manipulation of the genitals).

A quarter of the women surveyed reported receiving low-quality care during childbirth, highlighting serious shortcomings in the standards of maternity services. Reported issues included violations of physical privacy, such as being exposed unnecessarily during examinations or procedures, and interactions with staff perceived as lacking sufficient qualifications or expertise.

Despite its widespread nature, obstetric mistreatment is significantly underreported, with only 2 per cent of surveyed women coming forward, revealing a critical gap between lived experiences and institutional accountability. This low reporting rate can be attributed to several factors, including a lack of institutional trust, fear of retaliation and the normalization of abusive practices within certain health-care systems. Young women, women from rural areas and those with low educational levels are less likely to report mistreatment. Of those who choose to report mistreatment, only a few turned to formal authorities. In 10 per cent of cases, women who reported such mistreatment faced retaliation, exposing a grim reality, where reporting abuse can lead to further harm without any resolution or responsibility taken by the perpetrators.

More than half of the women surveyed (53.7 per cent) are unaware of the term “obstetric violence”, indicating a widespread lack of awareness. This phenomenon is especially prevalent among women from rural areas and those with lower education levels. Women aged 35–46 represent a significant share (38.8 per cent) of those unfamiliar with the term. In addition, 60.8 per cent of women with lower educational attainment do not recognize or understand the concept. Among respondents from Central Asian countries, such as Kazakhstan, Kyrgyzstan and Uzbekistan, around two thirds of women are unaware of obstetric violence due, in part, to cultural and social norms. Conversely, awareness is higher in Eastern European countries, where advocacy initiatives regarding women’s rights during childbirth have contributed to increased visibility of the issue.

A majority of the women surveyed reported satisfaction with the care and attitude of medical staff during childbirth, while 21.4 per cent of respondents expressed dissatisfaction with their childbirth experience, and 8 per cent were completely dissatisfied. Young mothers aged 18–29 reported the highest dissatisfaction rate, at 34.8 per cent, while dissatisfaction declined with age, reaching 14.5 per cent among women aged 35–46. Education also played a significant role, with 25.0 per cent of women with lower education levels reporting dissatisfaction, compared with 19.6 per cent of highly educated women. Satisfaction levels were notably higher among women who gave birth in private facilities (70.4 per cent) compared with those who delivered in public hospitals (49.5 per cent). Additionally, the survey revealed that mothers of four or more children were generally more satisfied (69.8 per cent) than first-time mothers (47.0 per cent), suggesting that experience and adaptation improve perceptions.

From a regional perspective, the highest dissatisfaction rates were recorded among respondents from the Western Balkans (Albania, Serbia and Kosovo*), while women from Central Asian countries exhibited lower levels of dissatisfaction. These differences are influenced by the health-care infrastructure, cultural norms and expectations about respectful care. Overall, unequal access to quality maternal care, especially between the public and private sectors, as well as among age and education groups, highlights systemic gaps that affect women’s childbirth experiences.

---

* Hereafter referred to in the context of United Nations Security Council Resolution 1244 (1999).

# Acknowledgements

The research for this report was made possible through collaboration with the amma app (amma.family), a key UNFPA partner and digital pregnancy tracker that served as the primary platform for data collection. We gratefully acknowledge amma's instrumental support in facilitating the gathering of information to advance healthier lives for women.

Special thanks go to Dr. Tamar Khomasuridze and Dr. Teymur Seyidov from the UNFPA Regional Office for Eastern Europe and Central Asia and to the SRH programme coordinators from the region's UNFPA country offices for their technical support, quality assurance, peer review and coordination at different levels and stages of the production, as well as to Alina Andronache, Alexandra Ermolenco, Natalia Covrig and Veaceslav Batrinescu from the Center Partnership for Development (Republic of Moldova) who authored the report.

# Abbreviations and acronyms

| | |
|---|---|
| CEDAW | Convention on the Elimination of All Forms of Discrimination against Women |
| EBCOG | European Board and College of Obstetrics and Gynaecology |
| FIGO | International Federation of Gynaecology and Obstetrics |
| MMHS | Maternal mental health services |
| PACE | Parliamentary Assembly of the Council of Europe |
| SDGs | Sustainable Development Goals |
| WHO | World Health Organization |

# Introduction

At the international level, a paradigm shift is unfolding in maternity care, moving away from a focus solely on survival and mortality reduction towards ensuring a positive, woman-centred experience during pregnancy and childbirth.[2] The World Health Organization (WHO)[3] and UNFPA, the United Nations sexual and reproductive health agency, anchored in the 1994 International Conference on Population and Development Programme of Action,[4] emphasize that quality maternal care must be not only medically effective but also respectful of and centred on the patient's needs, paying due attention to the lived experiences of women within the health-care system. In other words, besides preventing complications and maternal deaths, health systems must guarantee adequate communication, empathy and the active involvement of women in birth-related decisions, as well as a safe and supportive environment for both mother and newborn. This patient-centred approach – promoted by WHO's holistic, human rights–based model and reinforced by UNFPA's mandate to advocate for reproductive rights – recognizes that a positive birth experience furthers the physical, mental and emotional well-being of women. Additionally, enhancing women's birth experiences fosters trust in the health-care system and encourages continued use of services, yielding long-term benefits for individuals and communities.

Quality maternal care and the safeguarding of women's reproductive rights are essential components of public health and the global development agenda. UNFPA, as the leading UN agency dedicated to sexual and reproductive health, plays a major role in advancing these objectives through its commitment to ensuring universal access to maternal health-care services and upholding the rights and dignity of women. UNFPA's stated mission – "to deliver a world where every pregnancy is wanted, every childbirth is safe and every young person's potential is fulfilled" – reflects this vision, reinforcing the importance of high-quality maternal care and respect for women's rights in all regions of the world.

UNFPA's Regional Office for Eastern Europe and Central Asia serves as the main catalyst for initiatives aimed at improving maternal and obstetric health in the region. In a combined effort with the relevant ministries, WHO and civil society organizations, the Regional Office has implemented programmes to strengthen maternal health-care services – from training personnel and expanding access to emergency obstetric care, to promoting woman-centred maternity care

2. Diana Bowser and Kathleen Hill, "Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth: Report of a Landscape Analysis" (USAID-TRAction Project, 2020). Available at https://content.sph.harvard.edu/wwwhsph/sites/2413/2014/05/Exploring-Evidence-RMC_Bowser_rep_2010.pdf (accessed on 7 September 2025).
3. World Health Organization (WHO), *WHO Recommendations: Intrapartum Care for a Positive Childbirth Experience* (Geneva, 2018). Available at https://www.who.int/publications/i/item/9789241550215 (accessed on 28 September 2025).
4. UNFPA, *International Conference on Population and Development Programme of Action* (Cairo, 1994).

Photo: UNFPA Türkiye/Yasin Güngör

(also known as respectful maternity care). At the same time, research has been undertaken to better understand women's birth experiences, recognizing that obstetric mistreatment (i.e., abusive or disrespectful practices during childbirth) constitutes a serious violation of women's fundamental rights to quality health care. In Türkiye,[5] for instance, UNFPA carried out a nationwide qualitative study in which post-partum women and maternity-care staff were interviewed to document their experiences during labour.

The Center Partnership for Development is a non-governmental organization with extensive experience in social research and survey development, particularly on issues related to gender equality and women's rights. Founded in 1998, the Center has established itself as a leading centre of expertise in promoting evidence-based public policies, with a strong reputation for rigorous data collection and analysis of social issues. In 2023, the Center[6] carried out the first comprehensive national study on obstetric and gynaecological mistreatment in the Republic of Moldova. The survey systematically collected women's accounts regarding how they were treated during childbirth and while receiving gynaecological care, highlighting both good practices and shortcomings or abuses within the medical system.

Based on the above-mentioned premises, the UNFPA Regional Office for Eastern Europe and Central Asia, in cooperation with the Center Partnership for Development, launched an innovative methodology, reaching women through the amma app, a digital pregnancy tracker, to implement a regional survey on women's experiences in obstetric and gynaecological care. Fielded in 2023 across 16 countries and territories in Eastern Europe and Central Asia – Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Georgia, Kazakhstan, Kyrgyzstan, North Macedonia, the Republic of Moldova, Serbia, Tajikistan, Turkmenistan, Ukraine, Uzbekistan and Kosovo – and completed online by 2,616 respondents, the study systematically examines women's experiences during pregnancy and childbirth. Its areas of inquiry include access to quality medical care, patients' perceptions of the treatment received and the attitudes of medical staff. The main objective of the research was to provide the data required to improve maternal and gynaecological health services in the region. The findings will help shape evidence-based public policies and foster a more equitable and respectful health-care framework for all women in the region. The study is part of a series of regional and international efforts aimed at ensuring that every woman benefits from a safe and dignified experience throughout pregnancy and childbirth, free from any abuse or negligence within the medical system.

---

5. UNFPA Türkiye Country Office, *Respectful Maternity Care in Türkiye: Qualitative Study on Women's and Providers' Experiences* (Ankara, 2023).
6. Alina Andronache and others, *Fără voce. Fără lege. Fără dreptate: Studiu privind violența obstetrică și ginecologică în Republica Moldova* (Chișinău, Centrul Parteneriat pentru Dezvoltare, 2023). Available at https://progen.md/wp-content/uploads/2023/06/Raport-VOG-RO-ENG.pdf (accessed on 26 October 2025).

# Methodology

Between December 2024 and February 2025, statistical data were collected through the Microsoft Forms online interview platform, capturing the perceptions of women who had given birth regarding their childbirth experience. The research was primarily shared through the amma app (amma.family), a key UNFPA partner and digital pregnancy tracker, which served as the main conduit for data collection. The survey was available in 10 languages: Albanian, Armenian, Bosnian, English, Georgian, Macedonian, Romanian, Russian, Serbian and Ukrainian. The survey was conducted across the following 16 countries and territories: Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Georgia, Kazakhstan, Kyrgyzstan, North Macedonia, Republic of Moldova, Serbia, Tajikistan, Turkmenistan, Ukraine, Uzbekistan and Kosovo.

The survey targeted women aged 18 to 46 who had at least one child under the age of 6. Following the survey process, a total of 5,319 questionnaires were completed, only 2,616 of which met the eligibility criteria for inclusion in the present study. Questionnaires were deemed ineligible if they were completed by respondents residing outside the 16 countries and territories participating in the study or by respondents who did not have children under the age of 6 – a key research sampling criterion.

**Table 1**. Composition of the study sample

| | | N, % | Unweighted count |
|---|---|---|---|
| Total | | 100% | 2,616 |
| Age | 18–24 years old | 26.6% | 402 |
| | 25–34 years old | 31.0% | 1,441 |
| | 35–46 years old | 42.4% | 773 |
| Education | Incomplete secondary education or less | 4.6% | 95 |
| | Completed secondary education / high school | 17.6% | 366 |
| | Technical/vocational school | 17.6% | 433 |
| | University degree | 60.3% | 1,722 |
| Marital status | Single | 2.6% | 62 |
| | Married | 84.6% | 2,254 |
| | Live with a partner | 10.3% | 233 |
| | Widowed/separated/divorced | 2.5% | 67 |

| | | | |
|---|---|---|---|
| Number of children | 1 | 46.4% | 1,298 |
| | 2 | 27.7% | 753 |
| | 3 | 15.2% | 348 |
| | 4 or more | 10.7% | 202 |
| Employment status | Full-time/part-time employee | 34.8% | 987 |
| | Unemployed | 10.0% | 202 |
| | Homemaker | | |
| | 17.4% | 394 | |
| | On maternity leave | 37.8% | 1,033 |
| Country/territory | Albania | 9.5% | 211 |
| | Armenia | 2.4% | 68 |
| | Azerbaijan | 0.4% | 11 |
| | Belarus | 5.0% | 142 |
| | Bosnia and Herzegovina | 0.1% | 2 |
| | Georgia | 1.0% | 25 |
| | Kazakhstan | 35.7% | 922 |
| | Kyrgyzstan | 5.5% | 146 |
| | North Macedonia | 1.5% | 53 |
| | Republic of Moldova | 12.6% | 315 |
| | Serbia | 9.9% | 255 |
| | Tajikistan | 0.9% | 22 |
| | Turkmenistan | 0.4% | 11 |
| | Ukraine | 4.6% | 126 |
| | Uzbekistan | 7.1% | 186 |
| | Kosovo | 3.5% | 121 |
| Residence | Urban | 60.1% | 2,137 |
| | Rural | 39.9% | 479 |

Source: Unless otherwise indicated, the source of all figures and tables in this report is the study conducted by the UNFPA Regional Office for Eastern Europe and Central Asia and the Center Partnership for Development.

## Cluster approach

To provide a more comprehensive analysis, the data were examined through the lens of the cluster approach, which is a statistical method used to group individuals or items into clusters based on similar characteristics or behaviours. This approach makes it possible to detect patterns or trends within the data by classifying respondents into distinct groups that share common features.

Thus, two clusters were developed: (i) based on the respondents' level of satisfaction with their childbirth experience, and (ii) based on the forms of obstetric mistreatment, as described below.

### Cluster A: The degree of respondents' satisfaction with their childbirth experience

Respondents were asked to reflect on their satisfaction with the services and behaviours of the staff involved in the childbirth process. They were asked to rate various aspects on a scale from 1 to 5, where 1 meant "not at all satisfied" and 5 meant "very satisfied" (Table 2).

**Table 2**. Degree of satisfaction with childbirth experience

| Thinking about the maternity staff at your last birth (when you were in the maternity ward), how pleased were you with the following? | Please answer the question using a scale from 1 to 5, where 1 means you were not at all satisfied and 5 means you were very satisfied | | | | |
|---|---|---|---|---|---|
| The friendly and respectful attitude of the staff | 1 | 2 | 3 | 4 | 5 |
| The availability of the staff and the attention and flexibility with which they treated you | 1 | 2 | 3 | 4 | 5 |
| The staff's dedication to helping you | 1 | 2 | 3 | 4 | 5 |
| The capacity (abilities, qualifications, etc.) of the medical staff to deliver quality services | 1 | 2 | 3 | 4 | 5 |
| The staff's communication skills | 1 | 2 | 3 | 4 | 5 |
| The attitude of the doctor who delivered your child | 1 | 2 | 3 | 4 | 5 |
| The attitude of the nurse or midwife | 1 | 2 | 3 | 4 | 5 |
| The attitude of the cleaning staff | 1 | 2 | 3 | 4 | 5 |
| The quality of the services provided | 1 | 2 | 3 | 4 | 5 |

By applying the arithmetic mean, respondents were grouped into three distinct clusters based on their satisfaction with their childbirth experience: (i) not at all satisfied – women who, for the most part, expressed dissatisfaction with the services and behaviours of the medical staff, with their response scores ranging up to 2.0 points; (ii) unsatisfied – women who rated more than half of the situations involving their childbirth experience as unsatisfactory, with their response scores ranging between 2.1 and 3.0 points; (iii) satisfied – women who rated more than half of the situations involving their childbirth experience as satisfactory, with their response scores ranging between 3.1 and 4.0 points; and (iv) very satisfied – women who, for the most part, expressed high levels of satisfaction with the services and behaviours of the medical staff, with their response scores ranging between 4.1 and 5.0 points.

**Figure 1.** Clusters based on the level of satisfaction with the childbirth experience


### Cluster B: Prevalence of obstetric mistreatment encountered by respondents

Participants were asked several questions concerning the behaviour of the medical staff they encountered and instances of mistreatment that took place during the childbirth process. One of the key questions asked was whether participants had ever encountered any of a list of situations during gynaecological checkups, pregnancy or childbirth. Based on their responses, respondents were categorized according to the specific forms of mistreatment they experienced during childbirth.

Although the types and manifestations of obstetric mistreatment are not universally defined, this study will assess their incidence across several dimensions, including (i) physical abuse, (ii) verbal abuse, (iii) sexual abuse, (iv) stigma and discrimination, (v) level of professional standards of care, (vi) quality of doctor–patient interaction, and (vii) health-care system conditions and constraints.

**Table 3.** Prevalence of obstetric mistreatment encountered by respondents

| Have you ever experienced any of the following situations during gynaecological checkups, pregnancy or childbirth? | Cluster distribution |
|---|---|
| Physical force was used against you during childbirth (e.g., hitting, aggressive physical contact). | **Physical abuse (12.0%)** |
| The medical staff physically restrained you during childbirth (e.g., you were tied to the bed). | |
| The medical staff used harsh or rude language when interacting with you (e.g., yelling, scolding). | **Verbal abuse (24.0%)** |
| You were threatened in some way during childbirth (e.g., that you would not be cared for by medical staff, that you would be separated from your baby, that pain would be induced). | |
| The medical staff mocked or humiliated you (e.g., laughing at you, joking about your pain). | |
| The medical staff blamed you for your newborn's poor health. | |

| | |
|---|---|
| The gynaecologist performed a digital vaginal examination without wearing gloves. | **Sexual abuse** (10.4%) |
| The medical staff manipulated your genitals in a disrespectful manner. | |
| The medical staff touched your body in an inappropriate way during a gynaecological examination. | |
| You were discriminated against because of certain personal attributes (e.g., ethnicity, age, religion, nationality, socioeconomic status). | **Stigma and discrimination** (8.8%) |
| An episiotomy (surgical incision of the perineum and posterior wall of the vagina) was performed without asking for your consent or without a sufficient and clear explanation of the procedure. | **Obstetric procedures without consent** (48.1%) |
| A Caesarean section was performed without asking for your consent or without a sufficient and clear explanation of the procedure. | |
| The medical staff induced labour without asking for your consent or without providing a sufficient and clear explanation of the procedure. | |
| The Kristeller manoeuvre was applied (in the process of giving birth, the medical staff pressed on your belly to make the baby come out faster). | |
| Some examinations and procedures were carried out even if you were against them. | |
| The medical staff ignored you, refused your requests for help or did not respond to your requests within a reasonable time period. | |
| During childbirth, information, explanations and reasons regarding what procedures might be performed on you were provided in an inadequate manner, leaving you insufficiently informed. | **Poor interaction with health-care staff** (47.4%) |
| Your accompanying person (e.g., spouse, friend, family member, etc.) was not allowed to attend the childbirth. | |
| You were not allowed to give birth in your preferred position because the medical staff insisted on a different position. | |
| The medical staff pressured you to accept interventions you did not want. | |
| Some of the medical staff who treated you were not sufficiently qualified. | **Low-quality care** (25.1%) |
| Your physical privacy was violated (e.g., your body was not covered, you were not given a blanket, or there were strangers in the delivery room or during the gynaecological examination without your consent). | |
| You did not feel free or safe to express your views and concerns throughout childbirth. | |

## Binary linear regression

As part of the research, binary linear regression analysis was applied to examine the relationship between the independent variables (satisfaction with childbirth experience and prevalence of obstetric mistreatment) and the dependent variables (demographic data, which were recoded into binary variables). This method was selected for its capacity to estimate the linear effect of specific factors on observable outcomes.

## Survey limitations

- Given that data collection was conducted through an online platform, the sample is not fully representative of the overall population of reproductive-age women with childbirth experience over the past five years in the 16 countries and territories studied.
- Representativeness limitations may influence the estimated regression coefficients, affecting the robustness of the results. Therefore, the findings of the regression analysis should be interpreted as indicative rather than conclusive, to catalyse comprehensive research at the country or territory level.
- Because of the format (online survey), some respondents may have found certain questions open to interpretation or unclear, which could have led to less certain or imprecise responses.
- The number of respondents from seven countries (Armenia, Azerbaijan, Bosnia and Herzegovina, Georgia, North Macedonia, Tajikistan and Turkmenistan) fell below the minimum required threshold for representative weighting. As a result, these respondents were categorized into the “Other” group.

Photo: UNFPA Armenia/ Jody Hilton

# Maternity care: A human rights issue

The right to reproductive health refers to the ability of every person to attain complete physical, mental and social well-being in all aspects of the reproductive system and its functions. This right implies access to health services that enable a satisfying and safe sex life; the ability to decide freely if, when and how often to have children; and access to safe maternal care. The right to reproductive health is internationally recognized as an integral part of the fundamental right to health.[7] A turning point in the affirmation of this right was the International Conference on Population and Development in 1994, where 179 governments agreed that reproductive health and rights are human rights and emphasized the need for universal access to reproductive health services (family planning, antenatal and delivery care, prevention and treatment of sexually transmitted diseases, etc.).

WHO explicitly states that "every woman has the right to the highest attainable standard of health, which includes the right to dignified and respectful care",[8] drawing attention to the fact that "many women experience disrespectful and abusive treatment during childbirth in health facilities. Such treatment not only violates women's right to respectful care, but can also threaten their rights to life, health, bodily integrity and freedom from discrimination."[9]

Since the International Conference on Population and Development, a global consensus has formed that reproductive rights are part of fundamental human rights, essential for women's empowerment and the development of society. At the international level, the right to reproductive health is supported by numerous documents and initiatives. Among these are the UN Sustainable Development Goals (SDGs), in particular SDG 3 (health and well-being), which includes the target of reducing maternal mortality and promoting universal access to reproductive health services, and SDG 5 (gender equality), which emphasizes reproductive health and rights as crucial for women's empowerment.

Recently, UNFPA has drawn attention to the concept of "reproductive violence", defining it as any form of abuse, coercion, discrimination or exploitation that compromises a person's reproductive autonomy and highlighting the need for structured approaches to identifying and preventing this type of violence.[10]

---

7. UNFPA, *International Conference on Population and Development Programme of Action*.
8. WHO, "The prevention and elimination of disrespect and abuse during facility-based childbirth", WHO statement, 2015. Available at https://www.who.int/publications/i/item/WHO-RHR-14.23 (accessed on 28 September 2025).
9. Ibid.
10. UNFPA, "Ending gender-based violence in a world of 8 billion: How a new term, reproductive violence, helps confront an old problem", 15 November 2022. Available at https://www.unfpa.org/news/ending-gender-based-violence-world-8-billion-how-new-term-reproductive-violence-helps-confront (accessed on 28 September 2025).

Moreover, the recognition of obstetric violence as a violation of women's fundamental human rights has been further strengthened by a report by the UN Special Rapporteur on violence against women, who highlights that abusive treatment during childbirth reflects systemic issues, including gender discrimination, power imbalances and entrenched medical hierarchies.[11]

Major human rights treaties (e.g., the Convention on the Elimination of All Forms of Discrimination against Women [CEDAW]; the International Covenant on Civil and Political Rights; and the International Covenant on Economic, Social and Cultural Rights) and milestone frameworks such as the 1995 Beijing Platform for Action, which build on the 1994 International Conference on Population and Development, further cement women's rights to make autonomous decisions about their reproductive health, to the fullest extent permitted by national legislation and international human rights law, free from discrimination, coercion or violence.

WHO and UNFPA actively promote these rights, emphasizing that reproductive health is not only the absence of disease but also the right of women to receive information, make informed choices and receive quality reproductive services. In addition, severe violations of reproductive health and autonomy – such as forced sterilizations, forced abortion or the prohibition of safe abortion – are recognized as serious human rights violations.

The UN Committee on the Elimination of Discrimination against Women, in its General Recommendation No. 35 (2017),[12] explicitly states that violations of women's sexual and reproductive rights (e.g., forced sterilization or forced pregnancy, denial of access to safe abortion or post-abortion treatment, abuse of women seeking reproductive health services) constitute forms of gender-based violence and may amount to torture or inhuman and degrading treatment. Specifically, Article 12 of CEDAW[13] requires that governments eliminate discrimination against women in the field of health care, including family planning and all aspects of pregnancy, childbirth and the post-partum period. Thus, the right to reproductive health is firmly anchored in international human rights law, and States have the responsibility to respect, protect and enforce it through appropriate public policies.

## Respectful maternity care

Respectful maternity care means treating women with dignity and empathy and without abuse during pregnancy, childbirth and the post-partum period. The principles of woman-centred care (also called "humanized birth" or "respectful maternity care") include respecting the dignity and privacy of the patient, ensuring informed consent to interventions, involving the woman in decisions regarding her own childbirth, and providing ongoing physical and emotional support.

WHO defines respectful maternity care as care that "maintains dignity, privacy and confidentiality, ensures a woman's freedom from abuse or harmful treatment, and enables her to make informed choices and have a trusted companion with her during labour and birth".[14] Such practices create an environment that not only ensures medical safety but also enables women to feel comfortable, respected and in control.

---

11. A/74/137.
12. CEDAW/C/GC/35.
13. United Nations, Treaty Series, vol. 1249, No. 20378.
14. WHO, *WHO Recommendations: Intrapartum Care for a Positive Childbirth Experience*.

Adopting a woman-centred, human rights–based philosophy of care paves the way for care choices that many women desire – for example, the right to have a birth companion, freedom of movement in labour and choice of birthing position, and clear communication with health-care providers. These options, endorsed by international guidelines and supported by clinical evidence, have been shown to enhance the birth experience.

Over the past decade, WHO has developed important frameworks and guidelines to improve the quality of maternal health care, emphasizing both clinical excellence and the health-care experience. In 2016, WHO released comprehensive standards for improving the quality of maternal and newborn care in health facilities. This quality-of-care framework[15] defines eight quality domains, including not only timely and effective clinical practices but also the experience of care. For the first time, WHO explicitly set a standard that women in childbirth must be treated with respect and dignity, with no tolerance for disrespect, abuse, neglect or discrimination.

Standard 5 of this framework is Respect and Preservation of Dignity,[16] which requires privacy, confidentiality and freedom from mistreatment for women and newborns. In practical terms, this standard means that treatment within maternity wards must comply with policies and training, ensuring that no woman is shouted at, coerced, physically or verbally abused, or subjected to any procedure without informed consent.

The WHO framework urges health systems worldwide to measure and account for respectful care as an integral part of quality (alongside clinical safety). This marks a shift from viewing mistreatment as merely anecdotal to recognizing it as a systemic quality problem that can be measured and resolved.

In 2018, WHO published *Intrapartum Care for a Positive Childbirth Experience*,[17] comprehensive guidelines that introduced a new model of woman-centred care, highlighting that a positive childbirth experience

Photo: UNFPA Republic of Moldova/Ion Pleș

15. WHO, *Standards for Improving Quality of Maternal and Newborn Care in Health Facilities* (Geneva, 2016).
16. Sarah Hodin, "Improving quality of care for mothers and newborns in health facilities: New standards and measures from the World Health Organization (WHO)", Harvard T. H. Chan School of Public Health, 2 September 2016. Available at https://hsph.harvard.edu/maternal-health-task-force/news/improving-quality-of-care-for-mothers-and-newborns-in-health-facilities-new-standards-and-measures-from-the-world-health-organization-who/ (accessed on 28 September 2025).
17. WHO, *WHO Recommendations: Intrapartum Care for a Positive Childbirth Experience*.

involves more than delivering a healthy baby; it also involves fulfilling women's personal and emotional needs through a holistic, human rights–based approach.

The guidelines reinforce the notion that women's freedom of choice, continuous support (such as the involvement of a childbirth companion of the woman's choice), effective communication, pain relief, and respectful, non-abusive interactions are all evidence-based components of quality care. The guidelines also urge providers to abandon outdated, over-medicalized or punitive practices, and instead to focus on individualized care that respects each woman's dignity and preferences. By promoting this vision globally, WHO made clear that "care that is respectful and preserves dignity"[18] is not optional; it is a prerequisite for high-quality maternity services.

In 2014, WHO released a statement on the prevention and elimination of disrespect and abuse during facility-based childbirth. Together with the 2016 standards and the guidance described above, this statement provides a robust framework that many countries are now using to reform maternity care practices, train health workers in respectful care, and implement zero-tolerance policies for disrespect and abuse during childbirth.

Organizations of health professionals have also taken strong positions against obstetric and gynaecological violence, issuing guidelines to promote respectful care. The International Federation of Gynaecology and Obstetrics (FIGO), which represents obstetrics and gynaecology practitioners worldwide, has explicitly stated that respectful care must be a central element of obstetric practice.[19]

In 2021, FIGO released the Charter on Respectful Maternity Care and recommendations urging providers to "treat every woman and newborn with compassion, respect and dignity without physical, verbal or emotional abuse", and to provide culturally sensitive care that respects women's values and autonomy. FIGO calls for zero tolerance for practices such as shouting at or coercing women and emphasizes that no woman or baby should be subjected to unnecessary or harmful procedures. It also highlights women's rights to informed consent, freedom of choice (including the presence of a companion) and to be free from discrimination in maternity care. In FIGO's view, obstetricians must practise in partnership with women (the Mother–Baby–Family model) and ensure a supportive, individualized, evidence-based approach rather than a paternalistic one. FIGO has committed to working with its member associations to promote training on respectful care, incorporate human rights into curricula and hold practitioners accountable for upholding patients' rights.

The International Confederation of Midwives (ICM) likewise strongly advocates respectful maternity care and has formally recognized the term "obstetric violence". ICM's 2024 position statement on obstetric violence, mistreatment and violence against women in reproductive health services classifies these abuses as gender-based violence and calls for embedding human rights principles (dignity, equality and consent) in all maternity care.[20] ICM decided to adopt the terminology used by human rights bodies and women's movements – specifically using "obstetric violence" to designate

---

18. WHO, *Goal 3: Promote respectful care for safe childbirth* (Geneva, 2014). Available at https://cdn.who.int/media/docs/default-source/mca-documents/nbh/enc-course/revised-resources/supplemental-materials/communication-and-respectful-care/respec-1.pdf (accessed on 26 October 2025).
19. International Federation of Gynecology and Obstetrics (FIGO), "Health system strengthening and respectful care", September 2021. Available at https://www.figo.org/sites/default/files/2021-09/FIGO_Statement_Health_Systems_Strengthening_Respectful_Care_0.pdf (accessed on 28 September 2025).
20. International Confederation of Midwives (ICM), "Obstetric violence and mistreatment and violence against women in reproductive health services", 22 November 2024. Available at https://internationalmidwives.org/resources/obstetric-violence-and-mistreatment-and-violence-against-women-in-reproductive-health-services/ (accessed on 28 September 2025).

violence during childbirth – to concentrate on women's experiences and make clear that these abuses are not only clinical issues but also human rights violations. The midwives' philosophy of care emphasizes holistic support and the inherent dignity of women; ICM calls for embedding human rights principles (dignity, equality, non-discrimination and consent) into all maternity care practices. Midwives, who are often witnesses or perpetrators of obstetric interventions, are encouraged by ICM to critically examine power dynamics and champion a model of care that eliminates coercion and prioritizes women's autonomy. By speaking openly about obstetric violence, ICM joins FIGO in breaking the silence within the medical community and pushing for cultural change in maternity wards.

In Europe, the European Board and College of Obstetrics and Gynaecology (EBCOG) – representing obstetrics and gynaecology societies from 37 countries – has also acknowledged obstetric and gynaecological violence as a reality that must be confronted. EBCOG's position statement for World Patient Safety Day 2021[21] stressed that gender-based violence and disrespectful care affect maternity outcomes and women's birth experiences. EBCOG noted that compassionate, safe and respectful childbirth is an essential part of patient safety and quality, echoing the WHO slogan to "act now for safe and respectful childbirth".[22]

EBCOG has urged health-care providers and policymakers to treat obstetric violence as a legitimate patient safety issue. Additionally, EBCOG has helped develop European standards for maternity care and training curricula that include respecting informed consent and improving provider communication skills.[23] A joint statement issued in 2024 by EBCOG and other European professional bodies directly addressed terminology, cautioning that dismissing patients' reports of obstetric violence or downplaying the term is detrimental; instead, the statement emphasized that the focus should be on eliminating substandard and disrespectful care rather than debating semantics.[24] Overall, the message from professional groups – obstetricians and midwives alike – is clear: the principle of "first, do no harm" in maternity care means not only avoiding clinical errors but also eradicating any form of abuse, coercion or disrespect towards women.

Current guidelines and public policies emphasize humanizing childbirth and reducing unnecessary medical interventions. WHO expressly recommends educating health professionals to avoid over-medicalized childbirth and to provide evidence-based care tailored to each woman's needs – for example, promoting non-invasive comfort and pain-relief techniques, respecting a woman's choice of birthing position or the presence of a support person, and limiting procedures such as routine episiotomies or forceful manoeuvres (e.g., fundal pressure), which can be traumatizing. Several countries have integrated these principles into their clinical guidelines and patient rights. In Portugal, for example, the law on the rights of health service users explicitly sets out women's

---

21. European Board and College of Obstetrics and Gynaecology (EBCOG), "Position statement to mark 'World Patient Safety Day – Safe Maternal and Newborn Care' on 17th September 2021". Available at https://ebcog.eu/wp-content/uploads/2021/11/EBCOG_World-Patient-Safety-Day.pdf (accessed on 28 September 2025).
22. Ibid.
23. EBCOG and UNFPA Regional Office for Eastern Europe and Central Asia, *European Standards of Care for Women's Health in Europe: Obstetric and Neonatal Services* (2016). Available at https://eeca.unfpa.org/en/publications/EuropeanSRHStandardsRU (accessed on 28 September 2025).
24. Diogo Ayres-de-Campos and others, "European Association of Perinatal Medicine (EAPM), European Board and College of Obstetricians and Gynaecologists (EBCOG), European Midwives Association (EMA), "Joint position statement: Substandard and disrespectful care in labour – because words matter", *European Journal of Obstetrics & Gynecology and Reproductive Biology*, vol. 296 (2024). Available at https://ebcog.eu/wp-content/uploads/2024/03/Joint-position-statement-Substandard-and-disrespectful-care-in-labour---because-words-matter.pdf (accessed on 4 November 2025).

rights during pregnancy and childbirth: the right to privacy, decent and respectful treatment (without coercion, violence or discrimination, along with the right to a humanized birth), the right to a companion, the right to receive informed consent for interventions, the right to the best quality of care, the right to breastfeed and receive pain relief, and the right to access to abuse reporting mechanisms. These standards exemplify how respectful approaches to maternity care are translated into practice: through clinical protocols that prioritize patient dignity and through the Pregnant Women's Bill of Rights displayed in hospitals.

International organizations have also developed practical tools to support the implementation of patient-centred maternity care. For example, the Quality of Care—Equity, Dignity[25] initiative coordinated by WHO and other global partners helps countries to assess women's experiences in maternity hospitals and introduce changes to eliminate disrespectful treatment. It also encourages the diversification of models of care: the creation of midwife-led birthing centres integrated into the hospital system for low-risk pregnant women offers an alternative focused on personalized support; the presence of midwives and staff providing doula-type emotional support has proven beneficial in many health systems. Such measures increase women's autonomy and reduce the depersonalization of care, helping to prevent the occurrence of abuse or neglect in maternity hospitals.

## Recognition and definition of obstetric and gynaecological violence

The term "obstetric violence" has emerged to describe forms of abusive, coercive or disrespectful treatment that women may be subjected to during childbirth or when receiving other reproductive health services. There is not yet a universally accepted definition, but the concept covers a wide range of harmful practices and inappropriate behaviours in obstetric and gynaecological settings. In practical terms, obstetric and gynaecological violence can be understood as any abuse, disrespect or mistreatment of women by health-care personnel during gynaecological consultations, pregnancy, childbirth or post-partum care that violates their dignity, autonomy and physical integrity.[26] This form of gender-based violence has long been hidden or normalized under the guise of standard medical practice, even though it can be deeply traumatic for women.

The term initially gained attention in Latin America in the 1990s, amid movements aimed at humanizing childbirth. For example, Venezuela pioneered the legal recognition of obstetric violence, defined in 2007 as "the appropriation of a woman's body and reproductive processes by medical personnel, manifested through dehumanising treatments, medicalisation abuse and pathologisation of natural processes, leading to the loss of autonomy and ability to freely decide regarding one's own body and sexuality".[27]

---

25. WHO, UNICEF and UNFPA, *Quality, equity, dignity: The network to improve quality of care for maternal, newborn and child health* (Geneva, WHO, 2018). Available at https://iris.who.int/server/api/core/bitstreams/7cae620b-4f94-4c38-aca0-4ee22670855e/content (accessed on 28 September 2025).
26. Silvia Brunello and others, "Obstetric and Gynaecological Violence in the EU: Prevalence, Legal Frameworks and Educational Guidelines for Prevention and Elimination", European Parliament, Policy Department for Citizens' Rights and Constitutional Affairs, Directorate-General for Internal Policies, PE 761.478, April 2024. Available at https://www.europarl.europa.eu/RegData/etudes/STUD/2024/761478/IPOL_STU(2024)761478_EN.pdf (accessed on 28 September 2025).
27. Bolivarian Republic of Venezuela, Organic Law on Women's Right to a Life Free of Violence, *Official Gazette*, No. 38.668 (23 April 2007), Article 15. Available at https://www.acnur.org/fileadmin/Documentos/BDL/2008/6604.pdf (accessed on 26 October 2025).

Photo: UNFPA Armenia/Jody Hilton

Argentina explicitly defines "obstetric violence as the violence exerted on women's bodies and reproductive processes by medical personnel, manifested through desensitising treatments, abuse of medicalisation, and transformation of natural processes into pathologies".[28] Essentially, obstetric violence undermines a woman's right to consent and participate in decisions regarding her childbirth, reducing her to an object of medical intervention.

Obstetric and gynaecological violence takes many forms, from overt physical violence to routine practices that violate patients' rights. Documented examples[29] include physical abuse (kicking, slapping or applying force to women during labour, and painful procedures performed without anaesthesia, such as episiotomies or the Kristeller manoeuvre, applied without medical necessity and consent), verbal abuse and humiliation (yelling, insults and insulting comments by medical staff on a woman's reactions to pain or her body), and forced or non-consensual medical interventions – such as performing vaginal examinations or manoeuvres (membrane ruptures, the administration of oxytocin to induce labour, or the performance of a Caesarean section or episiotomy) without the patient's informed consent. A serious form of gynaecological violence is forced sterilization or procedures carried out against a woman's will, such as forced abortions or the insertion of contraceptives without consent. Such practices have been historically reported in various countries (including forced sterilizations of Roma women in Eastern Europe in the past[30]) and are explicitly condemned by human rights bodies.

Other manifestations of such violence include[31] neglect and abandonment during childbirth (leaving the woman to struggle alone in labour, ignoring requests for help or medical warning signs), refusal of or delay in providing care (e.g., unjustified refusal to administer painkillers or anaesthesia upon request, refusing to assist in a safe delivery or abortion for unjustified reasons) and discrimination against or treating patients differently on the basis of race, ethnicity, socioeconomic status or other characteristics.

Even seemingly minor behaviours, such as calling women by derogatory names, ridiculing their emotions, or ignoring their questions and concerns, fall under the scope of disrespectful treatment. Obstetric violence can occur not only in the delivery room but also in routine prenatal

---

28. Argentina, Comprehensive Law to Prevent, Punish, and Eradicate Violence against Women in the Areas in Which They Develop Their Interpersonal Relationships, Law No. 26.485, *Official Gazette* (14 April 2009), Article 6(e). Available at https://www.argentina.gob.ar/sites/default/files/ley_26485_violencia_familiar.pdf?utm_source=chatgpt.com (accessed 28 September 2025).
29. Meghan A. Bohren and others, "The mistreatment of women during childbirth in health facilities globally: A mixed-methods systematic review", *PLOS Medicine*, 30 July 2015. Available at https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001847 (accessed on 28 September 2025).
30. European Roma Rights Centre, *Coercive and Criminal: Forced Sterilisation of Romani Women in Europe* (Budapest, 2016); see also *V.C. v Slovakia*, European Court of Human Rights, Application no 18968/07, Judgment of 8 November 2011.
31. Brunello and others, "Obstetric and Gynaecological Violence in the EU".

or gynaecological consultations, when the doctor fails to explain procedures or ask for consent or makes sexist comments. A lack of confidentiality (e.g., intimate examinations in the presence of others without consent) is another form of frequently cited abuse.

International organizations and human rights experts have begun to recognize obstetric violence as a systemic women's rights issue. In 2019, the United Nations put a global spotlight on obstetric violence through a dedicated report by the UN Special Rapporteur on violence against women, its causes and consequences. In her report to the UN General Assembly, Special Rapporteur Dubravka Simonović presented a "human rights-based approach to mistreatment and violence against women in reproductive health services, with a focus on childbirth and obstetric violence".[32] This was the first time a UN report compiled comprehensive evidence of the various abuses women suffer during childbirth worldwide and explicitly framed them as violations of women's fundamental rights. The Special Rapporteur noted a pervasive "lack of respect for women's equal status and human rights" in maternal health settings, manifesting in numerous types of misconduct by health providers.

The report defined obstetric violence as "violence experienced by women during facility-based childbirth", and catalogues examples from all regions, including physical abuse (such as slapping or restraining women during labour, sometimes even shackling women in custody during labour), verbal abuse and humiliation (yelling, scolding or mocking women in labour), non-consensual medical procedures (like performing episiotomies, Caesarean sections or sterilizations without the woman's consent), denial of pain relief, the performance of procedures such as a symphysiotomy (surgically widening the pelvis) that may amount to torture when medically unwarranted, neglect (leaving women unattended in childbirth or in unhygienic conditions), and detention of women and their newborns in hospitals for failure to pay fees.

The report emphasized that these practices are not isolated incidents but reflect systemic problems – including gender discrimination, power imbalances and entrenched medical hierarchies – that lead to violations of the rights to health, privacy, autonomy and freedom from cruel treatment.

Crucially, the Special Rapporteur's report called on States to take specific actions to combat obstetric violence. It urged governments to collect data on maternal health-care abuses (since a lack of data often leaves the problem invisible) and to establish accountability and complaint mechanisms so that women can safely report mistreatment and seek redress. It further recommended integrating human rights and WHO guidelines into all maternity care protocols – for example, ensuring the presence of birth companions, obtaining informed consent for every procedure, and banning practices that have no scientific basis or violate women's dignity. The report also encouraged training health workers in respectful care and communication and sensitizing them to the rights of vulnerable groups (adolescents, minorities, women with disabilities, etc., who often suffer compounded discrimination in childbirth).

While the Special Rapporteur did not create new legal obligations, she synthesized existing standards and best practices, thereby providing governments with a clear roadmap on how to fulfil their human rights duties in maternity settings. The 2019 report has since been used as an advocacy tool worldwide; it has granted the UN the authority to tackle obstetric violence and

32. A/74/137.

reinforce the fact that treating women with dignity is not optional but rather a legal imperative derived from established rights (such as the right to health, life, equality and freedom from torture). By characterizing obstetric violence as a part of the continuum of gender-based violence, the UN sent a strong message that these issues belong on national and international agendas for ending violence against women.

In Europe, the Council of Europe has formally recognized obstetric violence at the regional level. The Parliamentary Assembly of the Council of Europe (PACE) took a landmark stance by adopting Resolution 2306 (2019), titled "Obstetrical and Gynaecological Violence".[33] Adopted on 3 October 2019, this resolution is one of the first official documents in Europe to explicitly name and condemn obstetric and gynaecological violence as a violation of women's rights.

PACE noted that an estimated one in three women in Europe experience gender-based violence in their lifetime, and that "no area is spared by this scourge",[34] including supposedly safe medical care environments. PACE recognized obstetric and gynaecological violence as a form of violence that had "long been hidden and is still too often ignored".[35] It acknowledged that behind the closed doors of delivery rooms or gynaecological exams, women may be subjected to practices that are violent or perceived as such. The resolution offers concrete examples – such as invasive procedures without consent (e.g., episiotomies or vaginal exams performed without permission), fundal pressure during delivery, painful interventions without anaesthesia, as well as sexist or belittling remarks by medical personnel – all of which had been reported by women in Member States. PACE affirmed that such behaviours are unacceptable and undermine women's human rights. The Parliamentary Assembly also called on national parliaments to break taboos by debating this issue and reviewing domestic laws to determine whether they adequately protect patients' rights in childbirth. Overall, Resolution 2306 (2019) sends a powerful message: it officially calls obstetric and gynaecological violence a form of gender-based violence and lays out a roadmap for European governments to tackle it.

Following the adoption of this resolution, several European countries, including France, Spain and others, initiated dialogues or studies on obstetric violence, and some have since implemented measures such as charters of maternity patients' rights. The Council of Europe's leadership has thus been instrumental in moving the issue from the whispered experiences of women onto policymakers' agenda as a matter of public policy and human rights accountability.

The momentum at the European level continued with the European Parliament's resolution of 24 June 2021 on Sexual and Reproductive Health and Rights in the EU,[36] a wide-ranging resolution addressing many aspects of sexual and reproductive health and rights within Europe, and explicitly covering concerns about obstetric violence and respectful maternity care. The European Parliament called on all EU Member States to ensure access to high-quality, evidence-based and respectful maternity care for everyone. It stressed that maternity, antenatal, childbirth and postnatal care must be provided without discrimination and in line with current WHO standards, which implies

---

33. Parliamentary Assembly of the Council of Europe, Resolution 2306 (2019), "Obstetrical and Gynaecological Violence", 3 October 2019. Available at https://assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-EN.asp?fileid=28236 (accessed on 28 September 2025).
34. Ibid.
35. Ibid.
36. European Union, "European Parliament resolution of 24 June 2021 on the situation of sexual and reproductive health and rights in the EU, in the frame of women's health (2020/2215(INI))", *Official Journal of the European Union*, C 81/43, 18 February 2022. Available at https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A52021IP0314 (accessed on 28 September 2025).

incorporating respectful care and eliminating abuse. The resolution urged reforms of any laws or practices that exclude or disadvantage certain groups in accessing maternity care (for example, removing barriers for migrants or minorities) so that equity is achieved in maternal health services.

Significantly, the Council of Europe's Parliamentary Assembly, in its 2019 Resolution 2306 on obstetrical and gynaecological violence, urges member states to collect data on obstetric violence, to ask national medical associations to discuss the issue and provide recommendations, to conduct awareness campaigns on patients' rights and on preventing sexism and violence, and to ensure that care respects human rights and dignity.

However, it is important to acknowledge that the expression "obstetric violence" remains contested. Some UN agencies and their country offices use other terms – such as "mistreatment during childbirth" or "disrespect and abuse" – and some health-care professionals argue that "violence" implies intentional wrongdoing and does not capture the complexity of systemic issues.

The European Parliament's 2021 resolution amounts to an unambiguous denunciation of obstetric violence as incompatible with EU values. The Parliament recognized that such abuses violate women's human rights and may constitute gender-based violence and, therefore, require a firm response. It is noteworthy that the resolution places gynaecological and obstetric violence in the context of violations of women's sexual and reproductive health and rights alongside other issues such as restricted abortion, forced sterilization and maternal mortality disparities. This comprehensive approach signals that, from the EU's perspective, obstetric violence is part of the sexual and reproductive health and rights agenda and the fight for gender equality.

Furthermore, the resolution called on the European Commission to develop common EU standards in maternity care and facilitate the sharing of best practices among countries. It also urged Member States to ensure that health-care providers are trained in women's human rights and in obtaining free and informed consent and informed choice in maternity care. In other words, the EU is advocating not just passive condemnation of mistreatment but proactive measures such as education and system reforms to embed respect for autonomy in clinical practice.

The European Parliament's stance reflects mounting evidence and advocacy at the EU level that many women, especially those from vulnerable communities, experience disrespect or neglect during childbirth – and that this needs to change.

Although the resolution is not legally binding, it carries political weight. Since its adoption, there have been increased discussions in EU Member States of topics such as obstetric violence, rising Caesarean rates, lack of informed consent, and racialized discrimination of women and related vulnerability to maltreatment in maternal care. The resolution reinforces the notion that women's bodies and choices in childbirth deserve the same respect and freedom from violence as in any other context, and it aligns EU policy with global human rights recommendations.

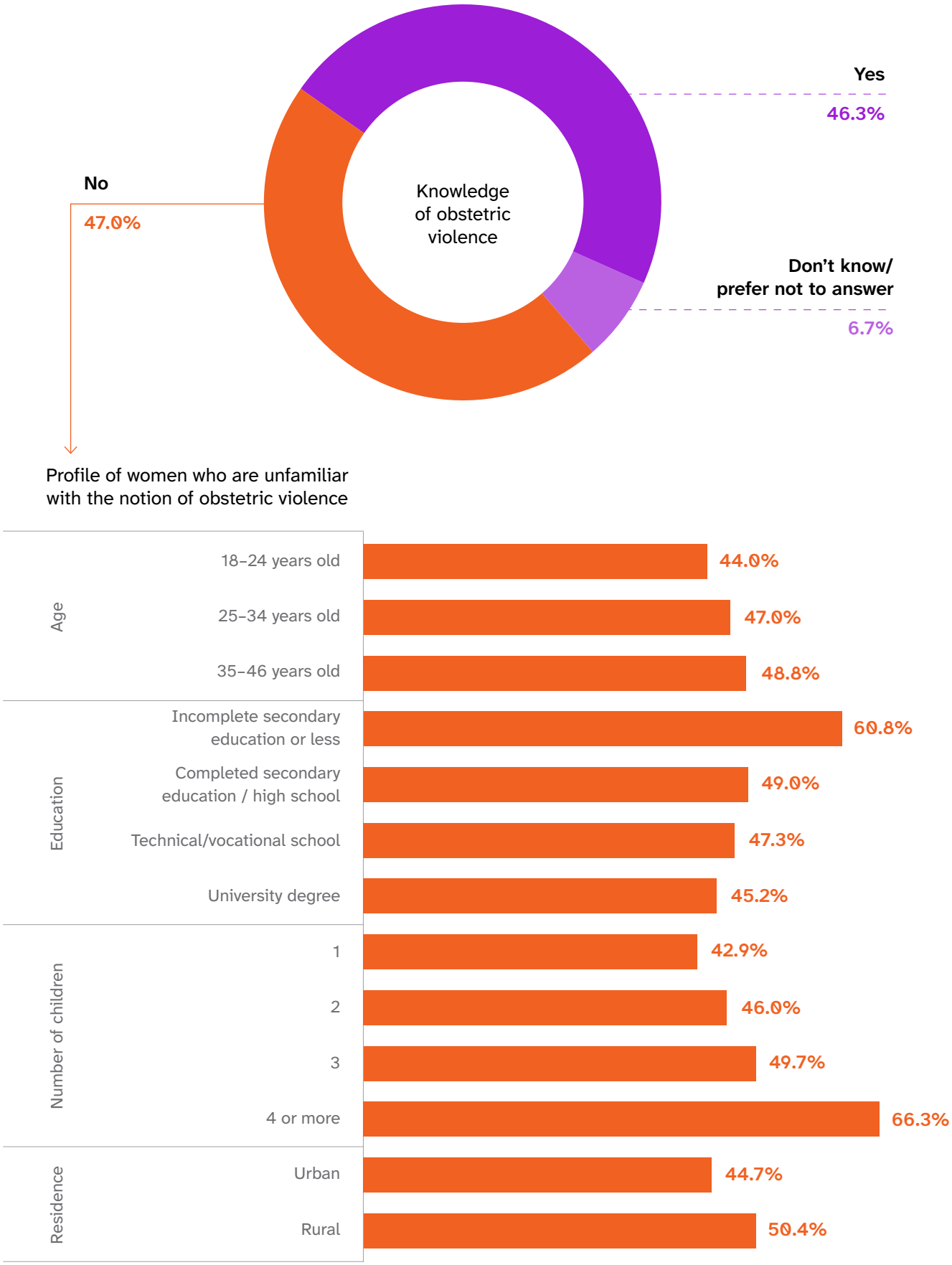
# Perceptions regarding obstetric care

The study revealed that a significant portion of women remain unaware of the concept of obstetric violence, with more than half of the respondents (53.7 per cent) admitting that they had either never heard of or did not know the meaning of the term “obstetric violence”. This finding is indeed concerning, as it reveals a gap in awareness regarding the formal concept of obstetric violence, defined as mistreatment or abuse during childbirth, often by health-care professionals. While many women may still have a general sense that they deserve respectful and dignified treatment, not knowing the term or its implications may limit their ability to recognize, articulate or report experiences of mistreatment as violations of their rights.

Women from rural areas and those with lower levels of education tend to have less awareness and understanding of obstetric violence. When examining the data from a demographic perspective, it is clear that certain groups of women are more likely to be unaware of the term “obstetric violence”. Specifically, women aged 35–46 represent a significant portion (38.8 per cent) of those who have not encountered or do not recognize the term. Additionally, women with lower levels of education, accounting for 60.8 per cent of the respondents, are also less likely to be familiar with the term. The reason why women in these categories are less familiar with the term may be because they have had less exposure to discussions about women’s rights and health-care standards, particularly in the childbirth context. This finding suggests that education plays a crucial role in raising awareness and understanding of such issues, highlighting the need for better educational outreach and support for women across various levels of society.

Photo: UNFPA Kosovo/Arben Llapashtica

**Figure 2.** Knowledge of obstetric violence and the profile of women who are unfamiliar with it, 2025



In the countries of Central Asia, obstetric violence is discussed less frequently than in the European countries analysed. From a regional perspective, it has been noted that the highest proportion of women who were interviewed and who had not heard of or did not know about obstetric violence came from Kazakhstan, Kyrgyzstan and Uzbekistan. In these countries, approximately two thirds of women are unaware of the term.

This situation can be partially explained by cultural and social differences in these regions, where traditional norms surrounding women's roles and childbirth may make women less open to discussions about obstetric abuse. On the other hand, the situation is very different in Eastern European countries, with awareness and knowledge of obstetric violence appearing to be higher among respondents from countries such as the Republic of Moldova and Serbia. In some cases, such as the Republic of Moldova, aspirations for EU integration may have played a role in encouraging the alignment of national legal frameworks with EU standards on patient rights and respectful maternity care. Serbia – where EU integration remains an important political objective – has historically placed strong emphasis on maternal and reproductive health. However, the persistence of outdated practices and policy frameworks within many maternity hospitals signals a clear need for modernization and renewed investment in this area.

Efforts to address obstetric violence in the Republic of Moldova have gained visibility through national research and public campaigns. A groundbreaking 2023 study on obstetric and gynaecological violence, conducted by the Center Partnership for Development,[37] revealed the extent of the problem and highlighted the need for an institutional response. Also in 2023, the National Programme for Preventing and Combating Violence against Women and Domestic Violence (2023–2027) was approved, reinforcing the Republic of Moldova's commitment to this issue. As part of the Programme's action plan, the Ministry of Health has committed to conducting repeated surveys on obstetric violence and developing programmes aimed at improving the quality of maternal health care, with a special focus on respectful care as a key component of quality services, including the improvement of the capacity of medical staff in respectful maternity care.[38] In parallel, UNFPA Moldova has launched awareness campaigns and training initiatives,[39] while medical institutions, such as the State University of Medicine and Pharmacy, have also hosted educational events on respectful maternity care.

On the other hand, increased public awareness in Serbia has been driven by both advocacy and disturbing testimonies from women, which became public through social media following the publication of a report by three female legal experts. The report they published in 2022, based on testimonies from nearly 200 women, identified 16 types of obstetric violence, from verbal abuse

37. Alina Andronache and others, *Fără voce. Fără lege. Fără dreptate: Studiu privind violența obstetrică și ginecologică în Republica Moldova*.

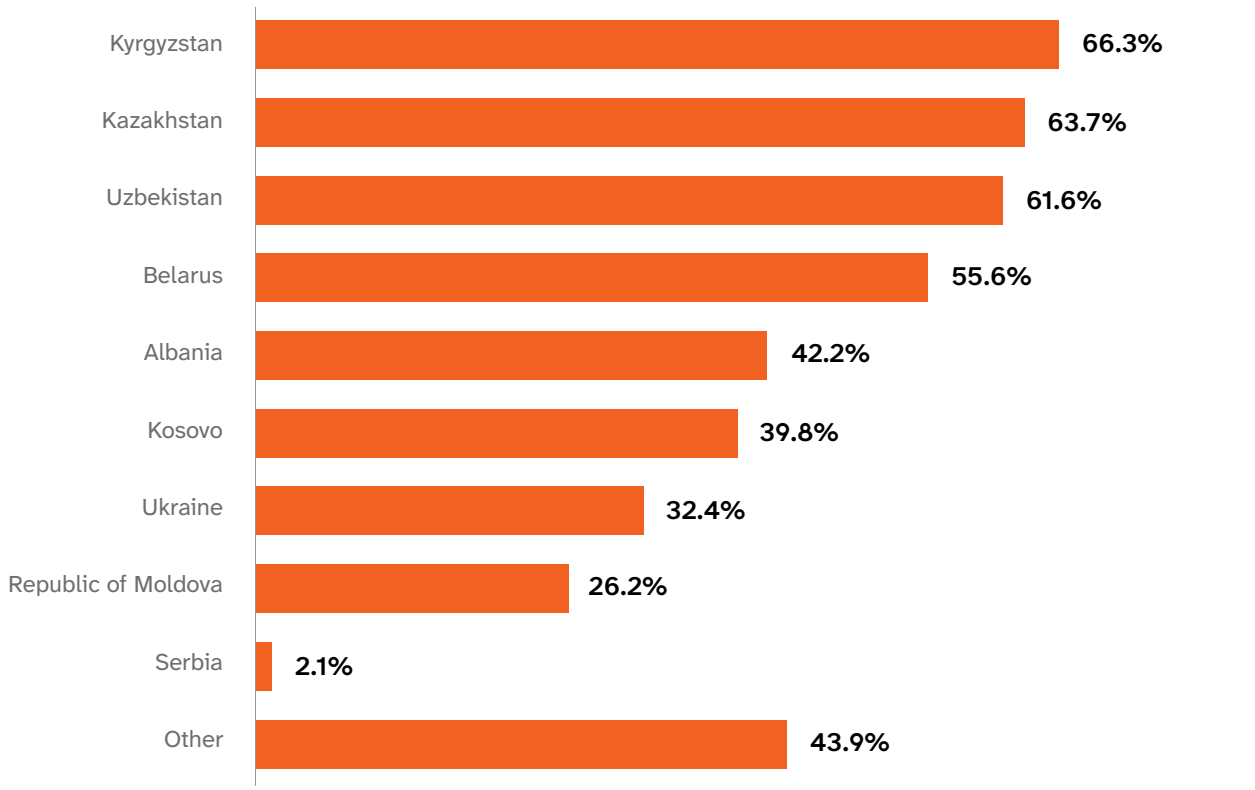
38. Republic of Moldova, Government Decision on the Approval of the National Programme on the Prevention and Combating of Violence against Women and Domestic Violence for the years 2023–2027, Decision No. 332 (31 May 2023), *Official Gazette,* No. 240–245 (14 July 2023). Available at https://www.legis.md/cautare/getResults?doc_id=140367&lang=ro (accessed on 28 September 2025).

39. UNFPA Moldova, in collaboration with the Ministry of Health and the State University of Medicine and Pharmacy, organized a training-of-trainers workshop on human rights–based intrapartum care for a positive birth experience on 18–19 April 2024 for 30 specialists in obstetrics and gynaecology. The workshop, which covered fundamental human rights and positive birth experience, psychological needs and respectful maternity care, and the WHO Labour Care Guide, was preceded by group discussions on applying WHO recommendations within the national context as well as a presentation of European guidelines related to positive birth experiences.

to physical interventions without consent.[40] A public outcry following recent incidents[41] has led to calls for institutional reforms, such as allowing birth companions and improving communication in maternity wards.

Additionally, UNFPA Serbia conducted a study in 2023 on women's experiences in maternity hospitals during and after the COVID-19 pandemic. The findings, which became available in 2024, were shared with the Ministry of Health and relevant professional bodies. In response, the Ministry, working closely with the Republic Expert Committee for Gynaecology and Obstetrics (its official advisory body), promptly established a working group to develop new clinical guidelines. These include (i) antenatal care, in cooperation with UNICEF, and (ii) physiological vaginal childbirth, in cooperation with UNFPA. The new guidelines place strong emphasis on respectful care, effective communication, informed consent and other key principles of quality maternal health care. The guidelines underwent a public consultation process and were also presented and discussed at the 68th Gynaecology and Obstetrics Week, the largest and most significant annual gathering of gynaecologists and obstetricians in Serbia, held on 29–30 May 2025. Following official endorsement by the Ministry of Health, the guidelines will be promoted and accompanied by training sessions at all maternity hospitals across the country.

**Figure 3**. Percentage of women who are unfamiliar with obstetric violence, 2025




40. Marina Mijatović, Jelena Stanković and Ivana Soković-Krsmanović, "Waiting for justice: A system that has failed women", 2022. Available at https://www.cins.rs/stories/waiting-for-justice-a-system-that-has-failed-women/ (accessed on 28 September 2025).
41. Sandra Petrušić, "Combating obstetric violence with a fresh coat of paint: How to restore medical ethics?", Nedeljne Informativne Novine, 1 February 2024. Available at https://www.nin.rs/english/news/44848/combating-obstetric-violence-with-a-fresh-coat-of-paint-how-to-restore-medical-ethics?utm_source=chatgpt.com (accessed on 28 September 2025).

# Perspectives on the quality of obstetric care services

The data indicate that more than half of the surveyed women were satisfied with both the attitude of the medical staff and the services they received during childbirth. This finding suggests that the overall experience during labour and delivery met the expectations of a significant proportion of the patients. Additionally, the findings reveal that the highest level of appreciation from respondents was directed towards the doctor who performed the delivery and the midwife who provided support throughout the process. In fact, over 70 per cent of the women surveyed gave an affirmative response when asked about the performance of these key medical professionals, highlighting their critical role in ensuring a positive birthing experience. This percentage was calculated based on the average weighting of respondents who rated the medical team's attitude with a score of 4 or 5 points, specifically referring to the attitude of the doctor who performed the delivery, the nurse or midwife, and even the cleaning staff. This finding suggests that, while many women were satisfied with the care they received, there were still areas for improvement, particularly in terms of staff responsiveness and personalized care.

**Figure 4.** Level of satisfaction regarding the behaviour and capacities of maternity staff, %, 2025

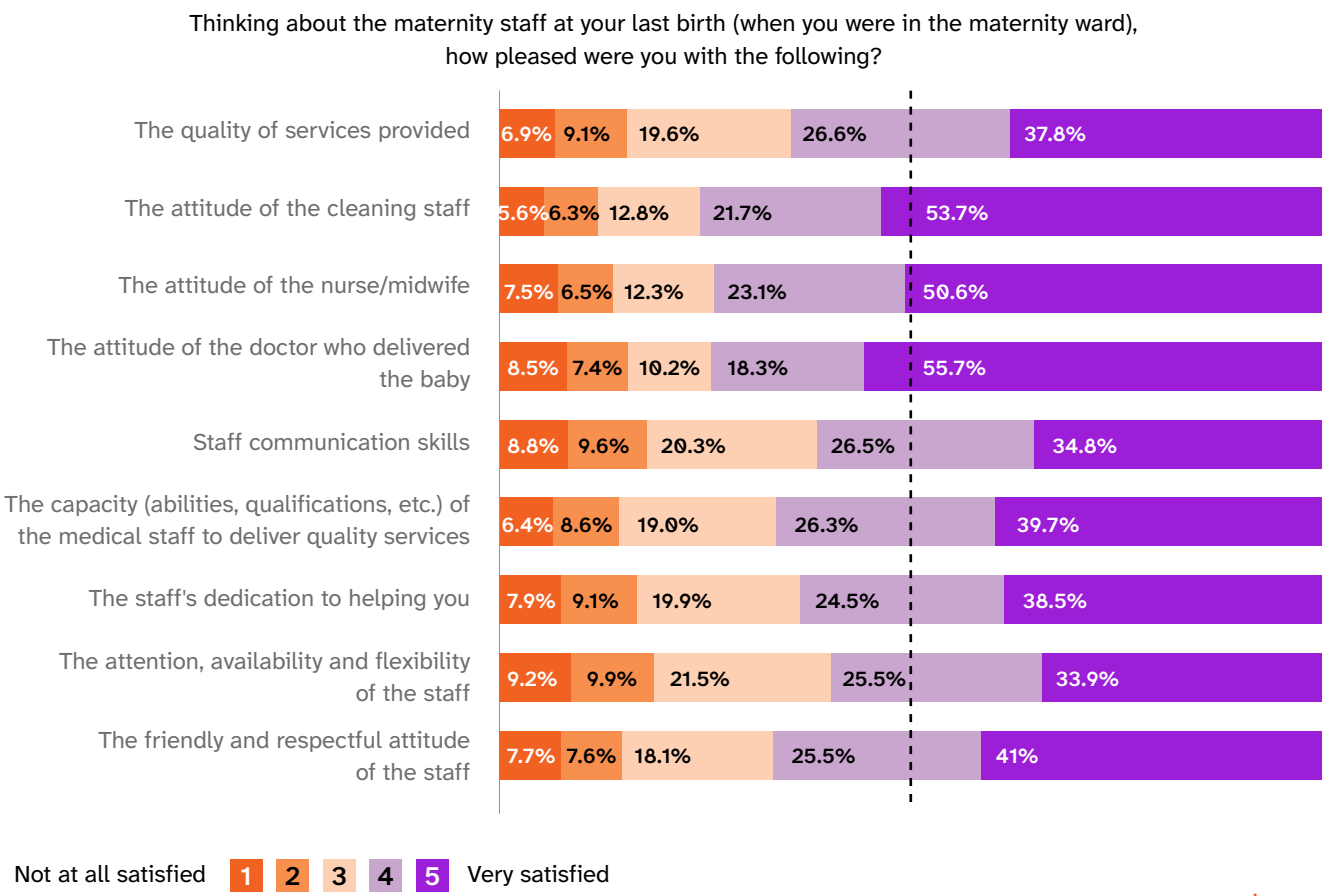



Photo: UNFPA Tajikistan/Farhodjon Nabiyulloev

On the contrary, one in five women who had experienced childbirth expressed dissatisfaction with the services they received during labour and delivery. These findings highlight that, while many women have positive experiences, a significant portion still feel that the care they received did not meet their expectations.

An analysis of the responses based on overall satisfaction shows that 21.4 per cent of the women surveyed were dissatisfied with their childbirth experience in some way, and 8 per cent were completely dissatisfied with the care and support provided during the birth process.

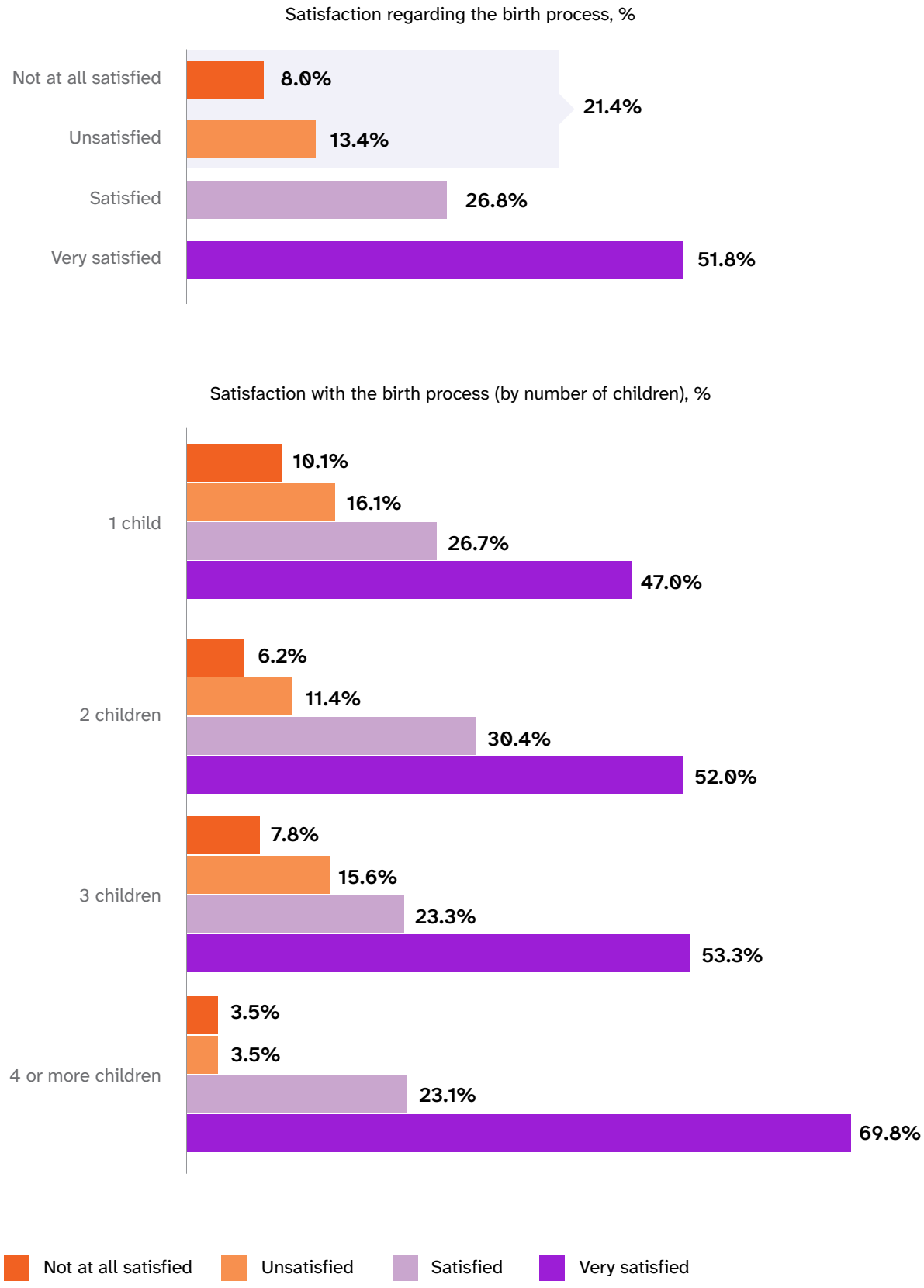
The data also provide grounds for deducing that the quality of the childbirth experience may play a significant role in women's decisions about having more children. Figure 5 illustrates that mothers of four or more children show a much higher level of satisfaction with their childbirth and motherhood experiences, at 69.8 per cent, compared with mothers of only one child, where satisfaction levels are notably lower, at 47.0 per cent. This finding suggests that women who have experienced multiple births may develop a greater sense of fulfilment and comfort with the process over time, perhaps due to improved health-care experiences or personal adaptation to childbirth challenges.

Furthermore, the data suggest a clear correlation between the number of children a woman has had and her satisfaction with the services received during childbirth ($p < 0.001$, CI [95%] B = 0.169 [0.123 and 0.216]). The number of births was positively correlated with the level of satisfaction with the care received. This correlation underscores the importance of ensuring decent conditions and high-quality services during childbirth, as these factors have a significant impact on women's overall experience.[42] Negative birth experiences not only affect the immediate well-being of mothers but can also have far-reaching consequences for their future decisions regarding family planning. The more women experience dissatisfaction with their childbirth experiences, the less likely they may be to view future childbirth positively or to choose to give birth again.[43] While individual decisions are driven by diverse factors, consistent negative experiences within maternal health-care systems could contribute, over time, to broader societal trends in declining birth rates. That is why it is essential to recognize the high stakes of ensuring positive childbirth experiences, as they not only impact individual women but can also play a pivotal role in shaping the future of a nation's population and economy.

---

42. WHO, "Individualized, supportive care key to positive childbirth experience, says WHO", 15 February 2018, https://www.who.int/news/item/15-02-2018-individualized-supportive-care-key-to-positive-childbirth-experience-says-who (accessed on 28 September 2025).
43. Johanna Maria Joensuu and others, "Effect of the maternal childbirth experience on a subsequent birth: A retrospective 7-year cohort study of primiparas in Finland", *BMJ Open*, vol. 13 (2023). Available at https://bmjopen.bmj.com/content/13/3/e069918 (accessed on 28 September 2025); Shefaly Shorey, Yen Yen Yang and Emily Ang, "The impact of negative childbirth experience on future reproductive decisions: A quantitative systematic review", vol. 74, No. 6 (2018). Available at https://pubmed.ncbi.nlm.nih.gov/29394456/ (accessed on 28 September 2025).

**Figure 5**. Satisfaction with the birth process, %, 2025



A significant number of young mothers are not satisfied with their birth experiences. Specifically, one in three young mothers report dissatisfaction with the care they received during childbirth. According to the survey, 34.8 per cent of mothers aged 18–29 expressed dissatisfaction with both the birth experience itself and the attitude of the medical staff during childbirth. This finding highlights a notable gap in satisfaction for younger mothers ($p < 0.001$, CI [95%] B = -0.125 [-0.153 and -0.097]). Among mothers aged 25–34, the level of dissatisfaction decreases to 20.9 per cent. For mothers aged 35–46, the dissatisfaction level decreases further to 14.5 per cent, suggesting that, as women grow older, their experiences with childbirth and medical staff may improve ($p < 0.001$, CI [95%] B = 0.080 [0.055 and 0.105]) or that they may have more informed expectations.

The disparity in satisfaction can be explained, at least in part, by the type of health-care system accessed. Women with higher socioeconomic status are more likely to be able to afford paid services or to give birth in private health-care facilities, which typically offer better infrastructure, more favourable staff-to-patient ratios and higher levels of personalized care ($p < 0.001$, CI [95%] B = 0.110 [0.067, 0.153]).

Additionally, educational attainment is often associated with improved socioeconomic conditions, and as such women with higher education levels are more likely to access these enhanced services. Clear trends emerge when comparing women with different education levels. Around 25 per cent of women with a lower level of education indicated that they were not satisfied with the care they received ($p < 0.001$, CI [95%] B = -0.072 [-0.102 and -0.042]), in contrast to 19.6 per cent of women with advanced education ($p = 0.001$, CI [95%] B = 0.043 [0.018, 0.069]). On the other hand, women with lower levels of education may not have the same level of knowledge of their rights or the ability to identify mistreatment.[44] As a result, they are less likely to stand up for their rights or confront poor treatment during labour. This disparity highlights the importance of ensuring that all women, regardless of their education level, have access to the information and resources required to defend their rights during childbirth.

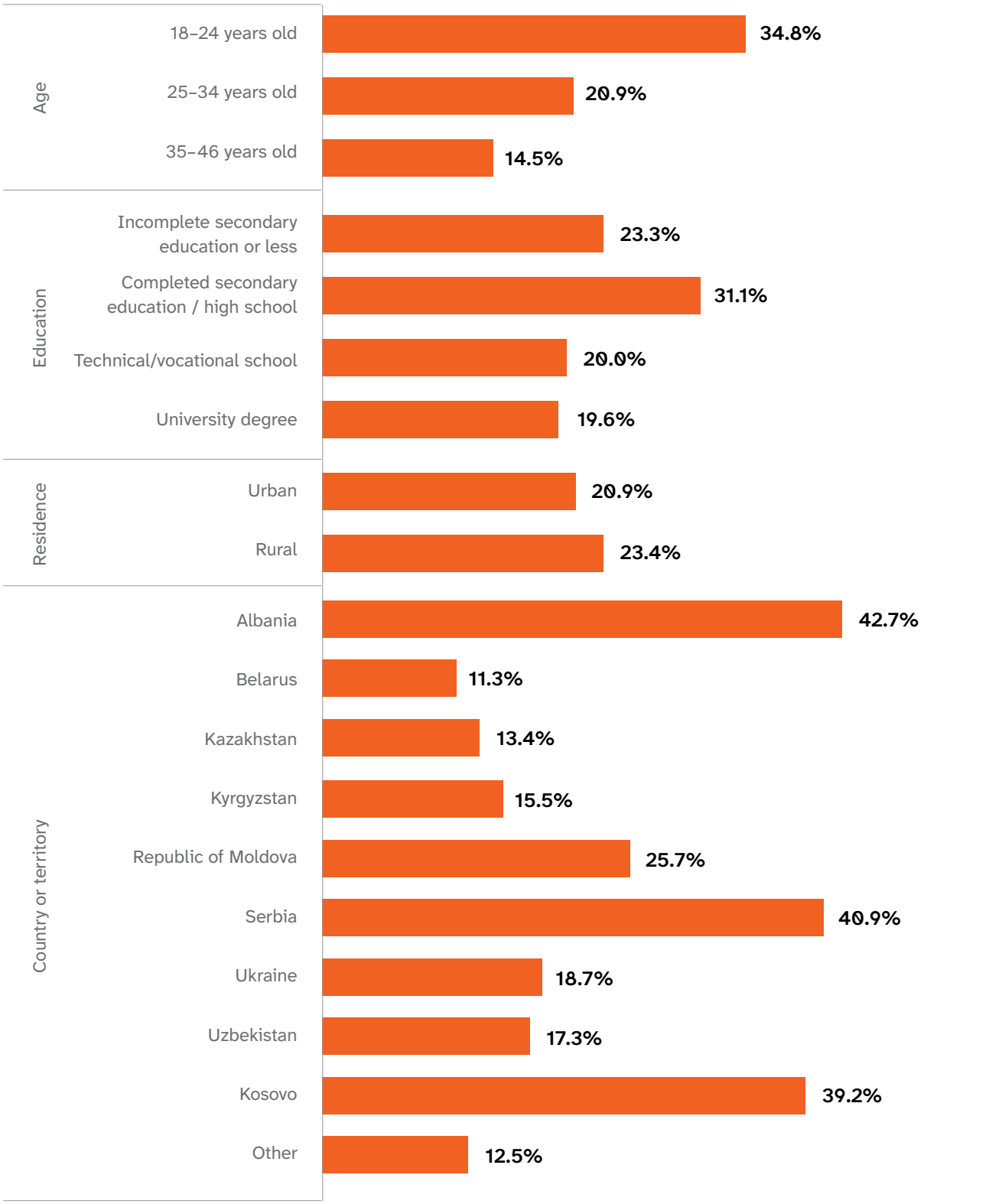
Female respondents from the Western Balkans reported the highest levels of dissatisfaction with their birth experience, highlighting a relationship between the region from which respondents come and the birth experience ($p < 0.001$, CI [95%] B = -0.413 [-0.571 and -0.256]). Specifically, surveyed women from Albania (42.7 per cent), Serbia (40.9 per cent) and Kosovo (39.2 per cent) recorded the highest percentages of dissatisfied respondents among all the surveyed countries. In contrast, the share of dissatisfied interviewed women in Central Asian countries is approximately 15 per cent. While this gap may partially reflect differences in the health infrastructure,[45] it is also important to consider cultural and societal factors that influence how women perceive and report their experiences. As noted earlier, moving from East to West is often associated with a greater awareness of obstetric violence and stronger expectations for respectful care. These evolving perceptions may contribute to higher reported dissatisfaction among respondents from the Western Balkans, where fertility rates are also declining. This finding suggests a potential link between perceived quality of care and broader demographic trends, highlighting the importance of improving maternal care standards to support both women's well-being and long-term population sustainability.

---

44. Meghan A. Bohren and others, "The mistreatment of women during childbirth in health facilities globally".

45. Vesna Bjegovic-Mikanovic and others, eds., *Serbia: Health System Review 2019, Health Systems in Transition*, vol. 21, No. 3 (WHO, 2019). Available at https://eurohealthobservatory.who.int/publications/i/serbia-health-system-review-2019 (accessed on 28 September 2025).

**Figure 6.** Percentage of women unsatisfied with the birth experience (Not at all satisfied + Unsatisfied), %, 2025

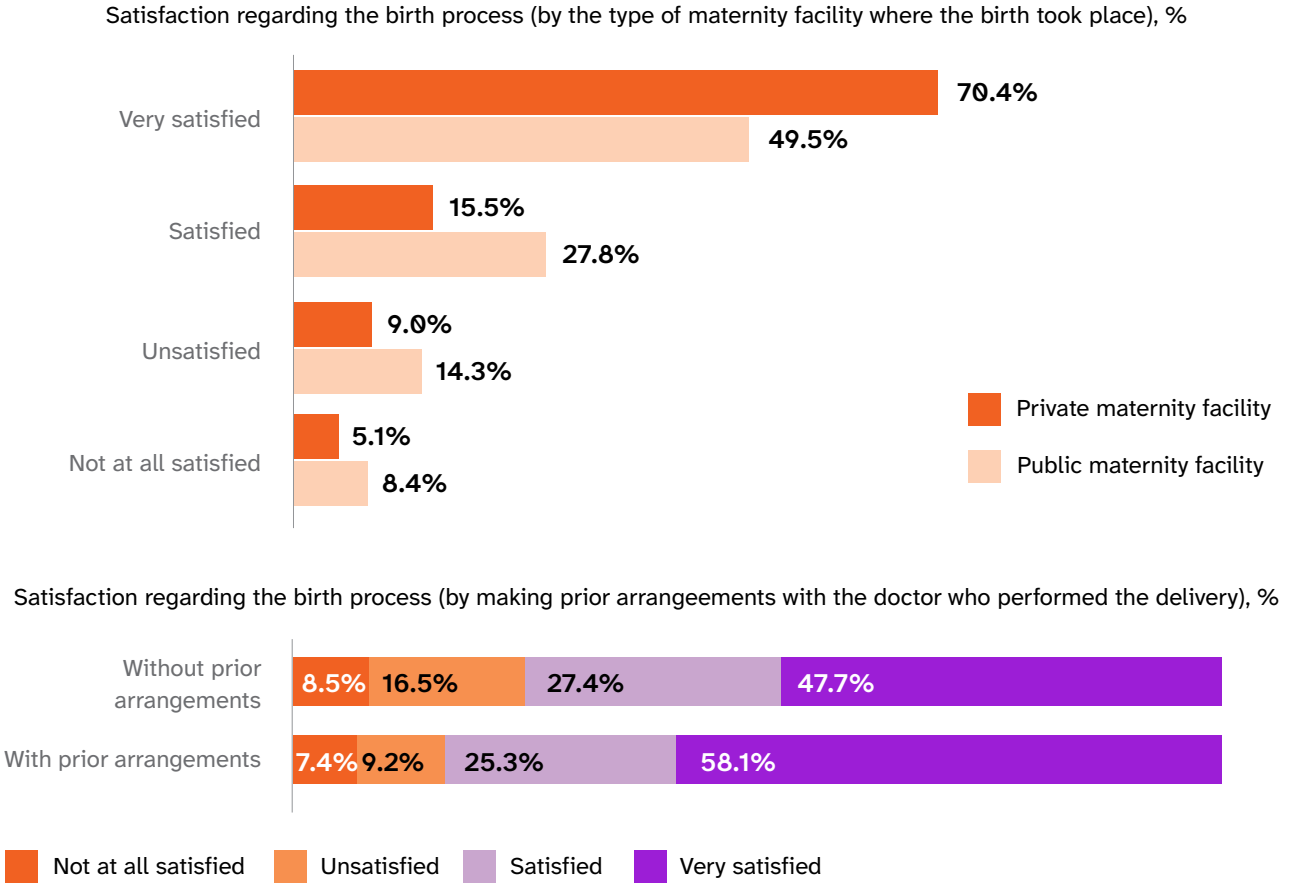


Women who gave birth in private maternity hospitals, especially those who had the opportunity to make prior arrangements with their doctor, generally reported having a much better experience during childbirth. The ability to plan ahead and establish a relationship with the medical professional who would be performing the delivery often provided women with a sense of security and confidence. For this reason, 58.1 per cent of women who made prior arrangements with their doctors reported being very satisfied with their experience, compared with 47.7 per cent of those who did not make such arrangements ($p < 0.001$, CI [95%] B = 0.148 [0.090 and 0.205]).

However, such prior arrangements may also raise questions about equal access to quality care. In some cases, these agreements might involve additional expenses or expectations that go beyond standard medical services, which may not be financially accessible to all women. The extra costs involved create disparities in the childbirth experience, as those who are able to cover the extra costs may benefit from more attentive or personalized care, while others may not have the same opportunities.

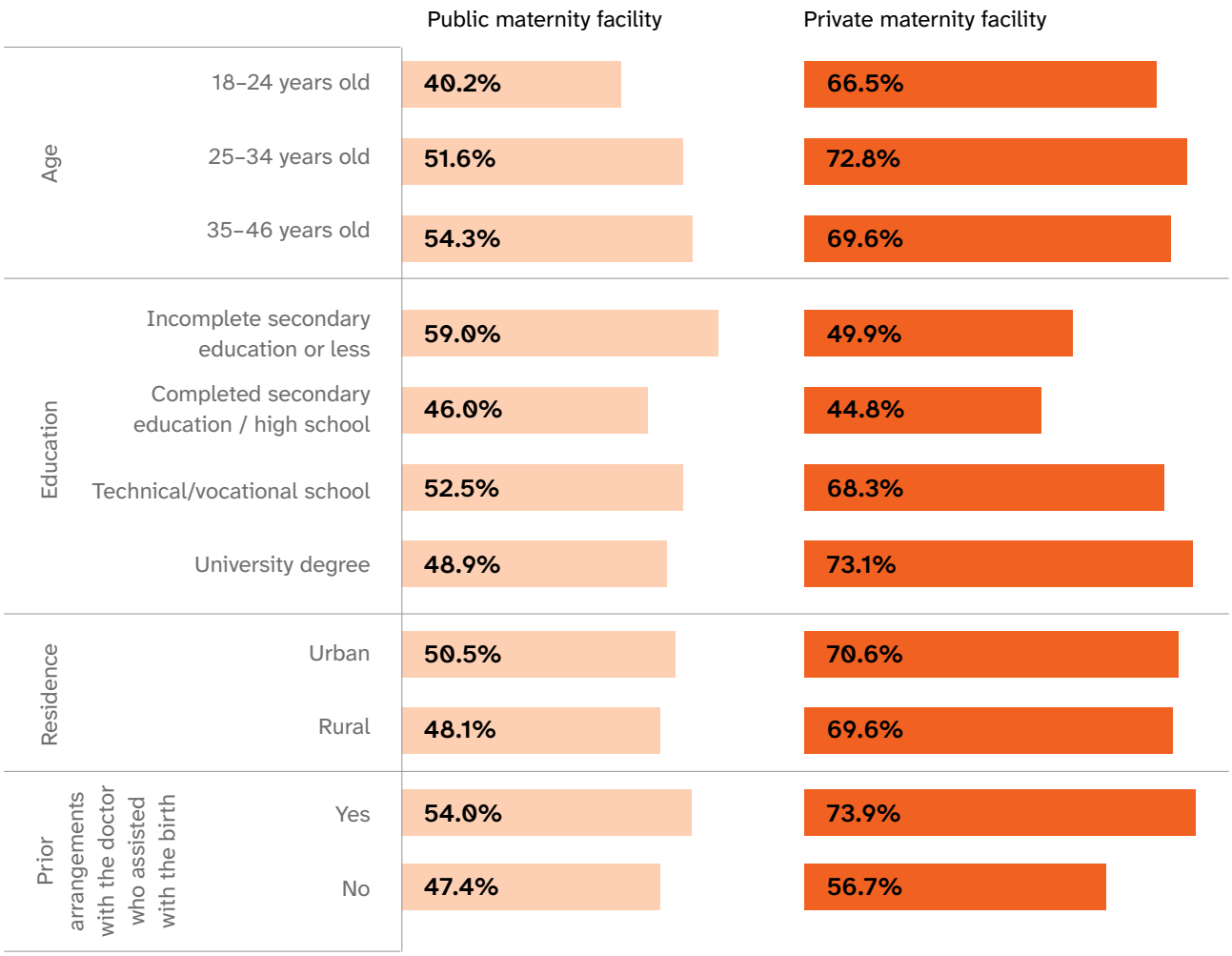
Also, there is a significant difference in satisfaction between women who gave birth in private clinics, with 70.4 per cent saying that they were very satisfied ($p < 0.001$, CI [95%] B = 0.110 [0.067 and 0.153)]), and those who gave birth in public hospitals, with 49.5 per cent saying that they were very satisfied ($p < 0.001$, CI [95%] B = -0.110 [-0.153 and -0.067]). This gap can be explained by the better conditions offered by private clinics, including modern infrastructure, a more favourable staff-to-patient ratio and a higher level of personalized attention. In contrast, public hospitals often have overstretched facilities, older equipment and overcrowded conditions, which negatively affect the patient experience.

**Figure 7.** Satisfaction regarding the birth process, by type of maternity facility and by making prior arrangements with the doctor, %, 2025



Satisfaction with the childbirth experience is much greater among women with higher education and among those residing in urban areas. When analysing the demographic profile of women who reported being very satisfied with their childbirth experience, several patterns emerge. In addition to the higher satisfaction rates among those who gave birth in private facilities, there are notable differences by age. Women aged 25 or above tend to report greater satisfaction than younger women, which may be attributed to the fact that older women are more likely to experience subsequent births and have a better understanding of the process. From an educational perspective, women with higher education who gave birth in a private hospital report particularly high satisfaction levels (73.1 per cent). On the other hand, satisfaction among highly educated women who gave birth in public hospitals is lower than among women with lower levels of education. This finding can be explained by the fact that women with higher education are more likely to have access to higher-quality conditions and services that not all public hospitals are able to provide due to limited funding and resources.

**Figure 8**. Profile of women with the highest satisfaction regarding their childbirth experience, by type of maternity facility, %



# Prevalence of and risk factors for mistreatment in obstetric care

Despite significant advancements in maternal care, reproductive health inequality remains unresolved in many countries. The analysis reveals that 67.0 per cent of surveyed women across the studied countries and territories (n = 2,616) experienced at least one form of obstetric mistreatment[46] during labour and childbirth. The study assessed mistreatment through two lenses: the perceived experience (the share of women who believed that they experienced obstetric mistreatment without prior explanation of what it constitutes) and the actual prevalence (the share of those who acknowledged having experienced mistreatment after being informed of its various forms).

Photo: UNFPA Kazakhstan

The results show a significant gap: only 20.2 per cent initially reported possible mistreatment, whereas 67.0 per cent acknowledged mistreatment following explanations of the forms mistreatment can take. This gap reconfirms the critical issue of low awareness and understanding of obstetric mistreatment. The forms of mistreatment that women endure during childbirth range from subtle disrespect and discrimination to unjustified procedures without their consent and outright abuse (verbal, physical, sexual). The childbirth experience already makes many women susceptible to physical and emotional vulnerability. As such, the lack of respect for their autonomy and mistreatment exacerbates the trauma: they are exposed to a higher risk of mental health problems, such as anxiety, stress and symptoms of post-partum depression or post-traumatic stress disorder.[47]

---

46. "Obstetric mistreatment" is an umbrella term used by WHO to refer to any disrespectful, abusive or neglectful treatment that women experience at the hands of health providers or systems while giving birth. Such mistreatment can manifest in various forms, including physical violence or rough handling, non-consensual medical interventions, verbal abuse such as shouting or humiliation, ignoring women's calls for help or leaving them unattended, breaches of privacy or confidentiality, and discrimination or stigma in care.

47. María de la Calle, Silvia M. Arribas and Eva Garrosa, "Factors associated with obstetric violence implicated in the development of postpartum depression and post-traumatic stress disorder: A systematic review", *Nursing Reports*, vol. 13, No. 4 (2023). Available at https://doi.org/10.3390/nursrep13040130 (accessed on 28 September 2025); Ijlas El Founti Khsim and others, "Risk factors for post-traumatic stress disorder after childbirth: A systematic review", *Diagnostics*, vol. 12, No. 11 (2022). Available at https://www.mdpi.com/2075-4418/12/11/2598 (accessed on 28 September 2025).

**Figure 9.** Percentage of surveyed women experiencing mistreatment in obstetric care, by clusters, %


A detailed analysis shows that nearly half of the surveyed women experienced obstetric procedures without consent or poor interaction with the medical staff during childbirth. The most common form of mistreatment was invasive procedures without consent. Overall, 48.1 per cent of women reported that they experienced at least one unjustified obstetric procedure (Kristeller manoeuvre,[48] episiotomy,[49] use of oxytocin,[50] Caesarean section[51]) without clear communication or the patient's consent, raising critical questions about respect for women's autonomy in the birthing process. On the other hand, 47.4 per cent of women reported poor interaction with the health-care staff, citing a lack of information about procedures, pressure to accept certain interventions or refusal to allow a support person to be present during labour. The absence of companions during antenatal visits, labour and post-partum care can be partially attributed to COVID-19-related restrictions after 2020, when face-to-face interactions were prohibited.[52] Studies show that women who did not have labour companions were more likely to report mistreatment, such as non-consensual procedures or inadequate treatment.[53]

A quarter of women reported receiving low-quality care during childbirth, including violations of their physical privacy, such as being exposed unnecessarily during examinations or procedures, and interactions with staff perceived as lacking sufficient qualifications or expertise. These experiences compromise the quality of medical care and contribute to feelings of insecurity and mistrust in the health-care system.[54]

48. The Kristeller manoeuvre, defined by WHO as the "application of manual fundal pressure to facilitate childbirth during the second stage of labour", is classified as "not recommended". See Recommendation 40 in WHO, *WHO Recommendations: Intrapartum Care for a Positive Childbirth Experience*.
49. An episiotomy is a surgical incision made in the perineum (the area between the vagina and the anus) during childbirth to widen the vaginal opening.
50. Oxytocin is a hormone used to stimulate contractions of the uterus during labour.
51. A Caesarean section is a surgical procedure to deliver a baby through an incision in the mother's abdomen and uterus.
52. Sarah Meaney, "The impact of COVID-19 on pregnant women's experiences and perceptions of antenatal maternity care", *Women and Birth*, vol. 35, No. 3 (2022). Available at https://www.sciencedirect.com/science/article/pii/S1871519221000792?via%3Dihub (accessed on 28 September 2025).
53. Özlem Aşci and Meltem Demirgoz Bal, "The prevalence of obstetric violence experienced by women during childbirth care and its associated factors in Türkiye: A cross-sectional study", *Midwifery*, vol. 124 (2023). Available at https://doi.org/10.1016/j.midw.2023.103766 (accessed on 28 September 2025).
54. Haylane Nunes da Conceição and others, "Disrespect and abuse during childbirth and postpartum depression: A scoping review", *Cadernos de Saúde Pública*, vol. 39, No. 5 (2023). Available at https://www.scielo.br/j/csp/a/vQtcLgTDqdB7sN8mKxTc5ZS/?lang=en (accessed on 28 September 2025).

**Figure 10.** Percentage of surveyed women experiencing mistreatment in obstetric care, by clusters and specific forms


Photo: UNFPA Republic of Moldova

About 24 per cent of women reported experiencing verbal abuse during childbirth, which included a range of threats, humiliation and harsh language from medical staff. Some women respondents were threatened with being denied care, such as being told they would be kept separated from their newborns or even threatened with the intentional infliction of pain to control their behaviour (6.0 per cent). Others were unjustly blamed for their newborn's health problems (7.9 per cent), further compounding the emotional toll of the birth experience. In some cases, medical staff made fun of women, joked about their pain or made cruel comments, belittling them and making them feel powerless (12.9 per cent). The use of harsh, rude language, including yelling or scolding (19.6 per cent), added to the sense of fear and distress. Verbal abuse during childbirth, while largely undocumented, appears to be a common issue globally,[55] reflecting broader systemic problems in maternal health care, including power imbalances, a lack of accountability and insufficient training in respectful care practices.

Around 1 in 10 women faced physical or sexual abuse during labour or gynaecological examinations. Specifically, 12.0 per cent of women who took part in the survey reported being physically restrained during labour, such as being tied to the bed, or subjected to aggressive physical contact under the pretext of facilitating delivery. Such actions constitute clear violations of medical ethics and human rights, stripping women of their autonomy at a moment of extreme vulnerability.[56] On the other hand, 10.4 per cent of women experienced different forms of sexual abuse, ranging from inappropriate touch to more severe forms of assault (disrespectful manipulation of the genitals). Insufficient training, insufficient competencies on the part of the health workforce in providing women-centred care[57] and a lack of institutional commitment[58] perpetuate such abuses.

---

55. Bohren and others, "The mistreatment of women during childbirth in health facilities globally: A mixed-methods systematic review".
56. Meghan A. Bohren and others, "How women are treated during facility-based childbirth: A cross-sectional study with labour observations and community-based surveys", *The Lancet*, vol. 395 (2019). Available at https://www.thelancet.com/action/showPdf?pii=S0140-6736%2819%2931992-0 (accessed on 28 September 2025).
57. Merette Khalil, Kashi Barbara Carasso and Tamar Kabakian-Khasholian, "Exposing obstetric violence in the Eastern Mediterranean region: A review of women's narratives of disrespect and abuse in childbirth", *Frontiers in Global Women's Health*, vol. 3 (2022). Available at https://pmc.ncbi.nlm.nih.gov/articles/PMC9082810/ (accessed on 28 September 2025).
58. Danúbia Mariane Barbosa Jardim and Celina Maria Modena, "Obstetric violence in the daily routine of care and its characteristics", *Revista Latino-Americana de Enfermagem*, vol. 26 (2018). Available at https://www.redalyc.org/jatsRepo/2814/281458425084/281458425084.pdf (accessed on 28 September 2025).

**Figure 11.** Percentage of surveyed women experiencing mistreatment in obstetric care, by clusters and specific forms

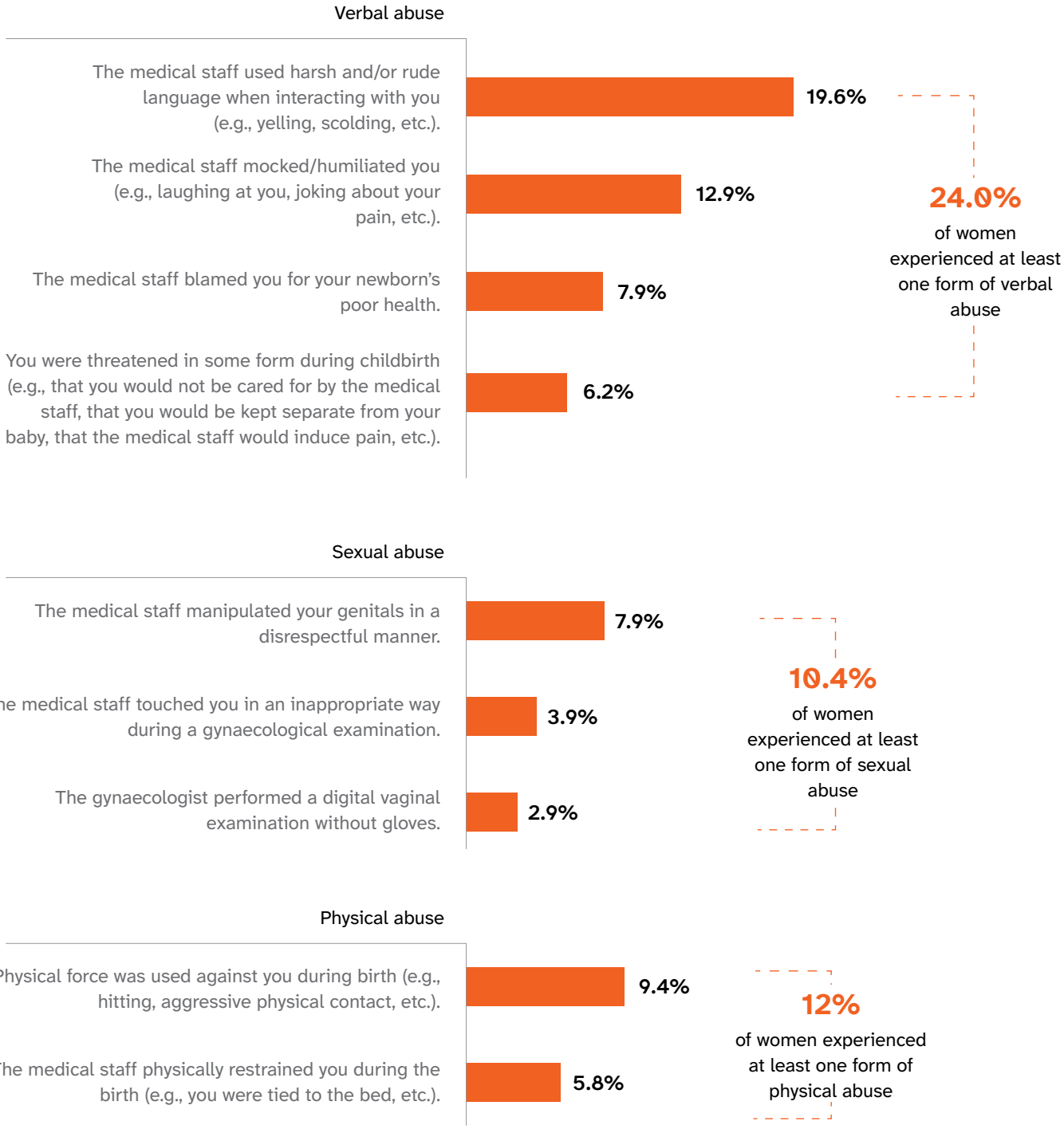
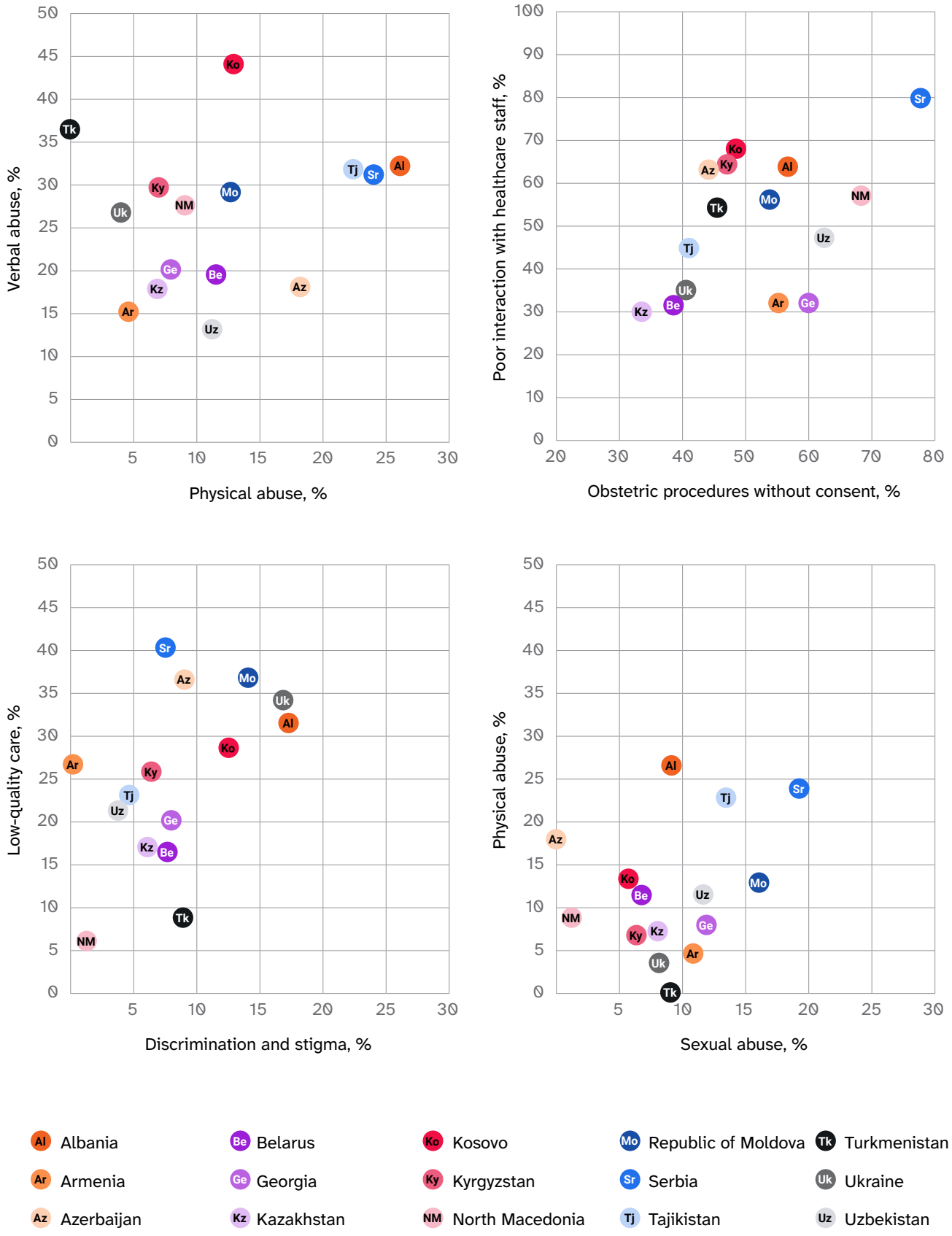


Photo: UNFPA Uzbekistan

The data reveal substantial variations in the prevalence of obstetric mistreatment across different countries and territories. In Albania, the Republic of Moldova, Serbia, Tajikistan and Kosovo, surveyed women were more likely to report significant forms of mistreatment, including discrimination, abuse (verbal,[59] physical,[60] sexual[61]), as well as deficiencies in the health-care system (unjustified obstetric procedures without consent,[62] poor interaction with health-care staff,[63] low-quality care[64]). In Albania, 32.0 per cent of women respondents reported verbal abuse, and 26.0 per cent reported physical abuse during childbirth, while in Tajikistan 31.8 per cent of women faced verbal abuse, and 22.7 per cent endured physical abuse, highlighting the widespread issue of mistreatment in maternity care across both countries. In North Macedonia, 58.0 per cent of respondents reported undergoing procedures without their consent, while in Ukraine 34.0 per cent of women were given low-quality care, such as having their physical privacy violated or receiving inadequate care due to poorly qualified staff. In Serbia, 19.0 per cent of women reported sexual abuse, followed by the Republic of Moldova, where 16.2% of women reported similar experiences. These disparities highlight that obstetric mistreatment is a pervasive challenge, but its prevalence varies based on local health-care systems, cultural norms and social factors.

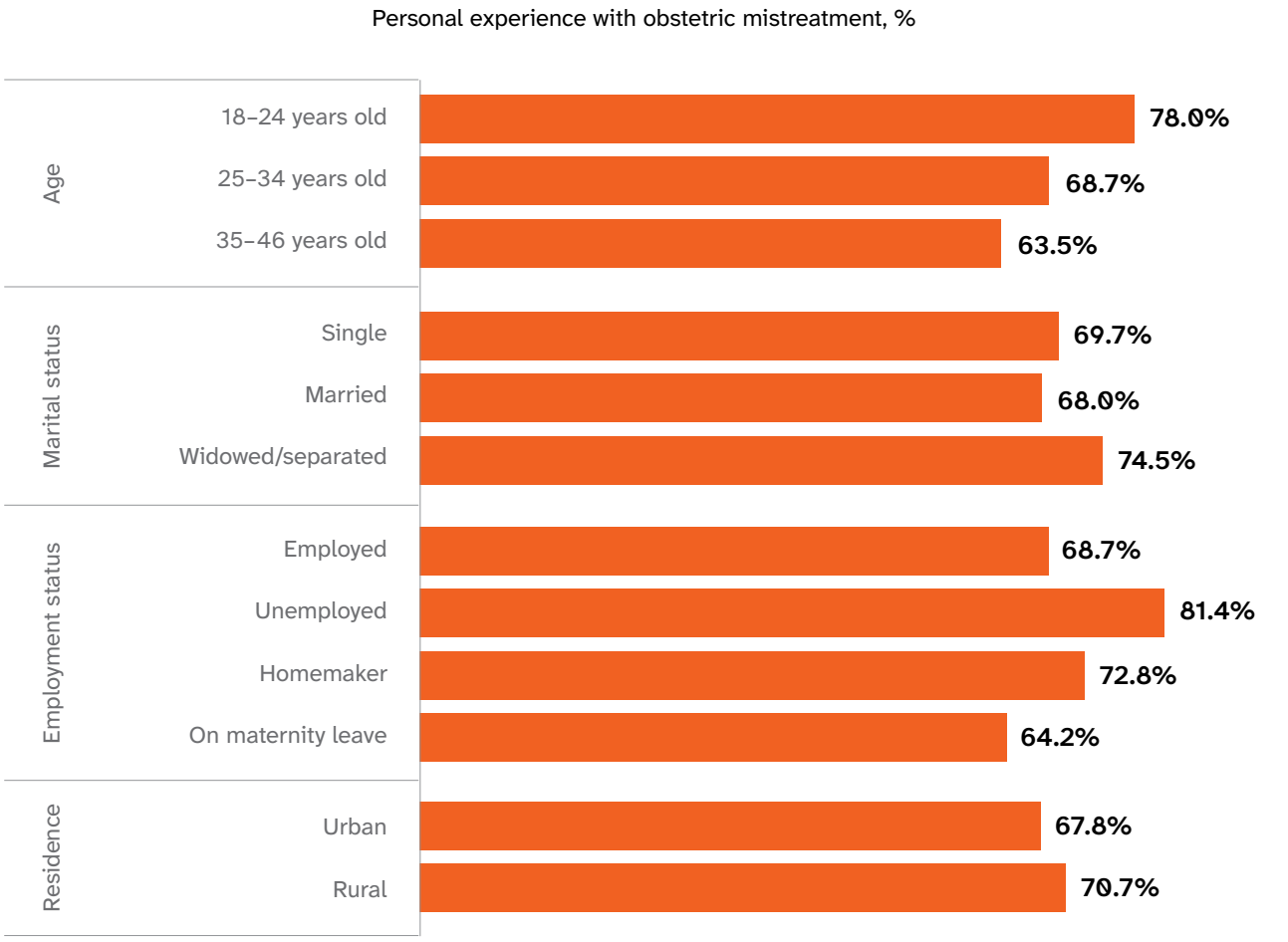
59. Verbal abuse includes harsh or rude language, shouting, insults, scolding, mocking, judgmental comments and threats. It can also involve blaming the woman for current or potential future outcomes or threatening to withhold or use unnecessary treatments.
60. Physical abuse refers to the use of physical force or restraint by medical staff, including tying a woman to the bed, hitting or making aggressive physical contact.
61. Within this analysis, sexual abuse refers to inappropriate or non-medically justified touching of intimate body parts, disrespectful or forceful manipulation of the genitals or performing vaginal examinations without gloves.
62. For the purposes of this report, performing medical procedures without informed consent refers to procedures such as the Kristeller manoeuvre, an episiotomy, the administration of oxytocin or a Caesarean section, as well as ignoring or delaying responses to a woman's requests for help during childbirth.
63. For the purposes of this report, poor interaction with health-care staff refers to a breakdown in respectful communication and support during maternity care, including inadequate or unclear information about medical procedures, coercion into unwanted interventions and the exclusion of the woman's chosen support person during childbirth.
64. For the purposes of this report, low-quality care refers to situations where medical staff lack sufficient qualifications, where the woman's physical privacy is not respected – such as exposure without consent or the presence of unauthorized individuals – and where women do not feel safe or free to express their concerns or preferences.

**Figure 12.** Mapping of countries by clusters of obstetric mistreatment (the data are representative only for the surveyed women)



Certain women are more likely to experience abusive behaviours. Young women, particularly those aged 18 to 24, face a higher risk of mistreatment ($p < 0.001$, CI [95%], B = 0.092 [0.054 and 0.129]), with 78.0 per cent reporting abusive behaviour during childbirth, compared with 63.5 per cent of women aged 35–46. This finding suggests that younger women (18–24 years old), who may be less experienced or lack the confidence to assert their rights, are more vulnerable to such treatment.[65] Additionally, single or separated women are also at greater risk of mistreatment ($p = 0.252$, CI [95%], B = 0.045 [-0.032 and 0.121]), particularly in the absence of a support companion, which is often associated with a higher likelihood of non-consensual procedures and inadequate care.[66] Economic vulnerability is another risk factor of obstetric mistreatment,[67] as unemployment is associated with higher rates of reported mistreatment ($p < 0.001$, CI [95%], B = 0.100 [0.045 and 0.156]). While the mistreatment rate is slightly higher among women from rural areas, the difference is not significant compared with those from urban areas.

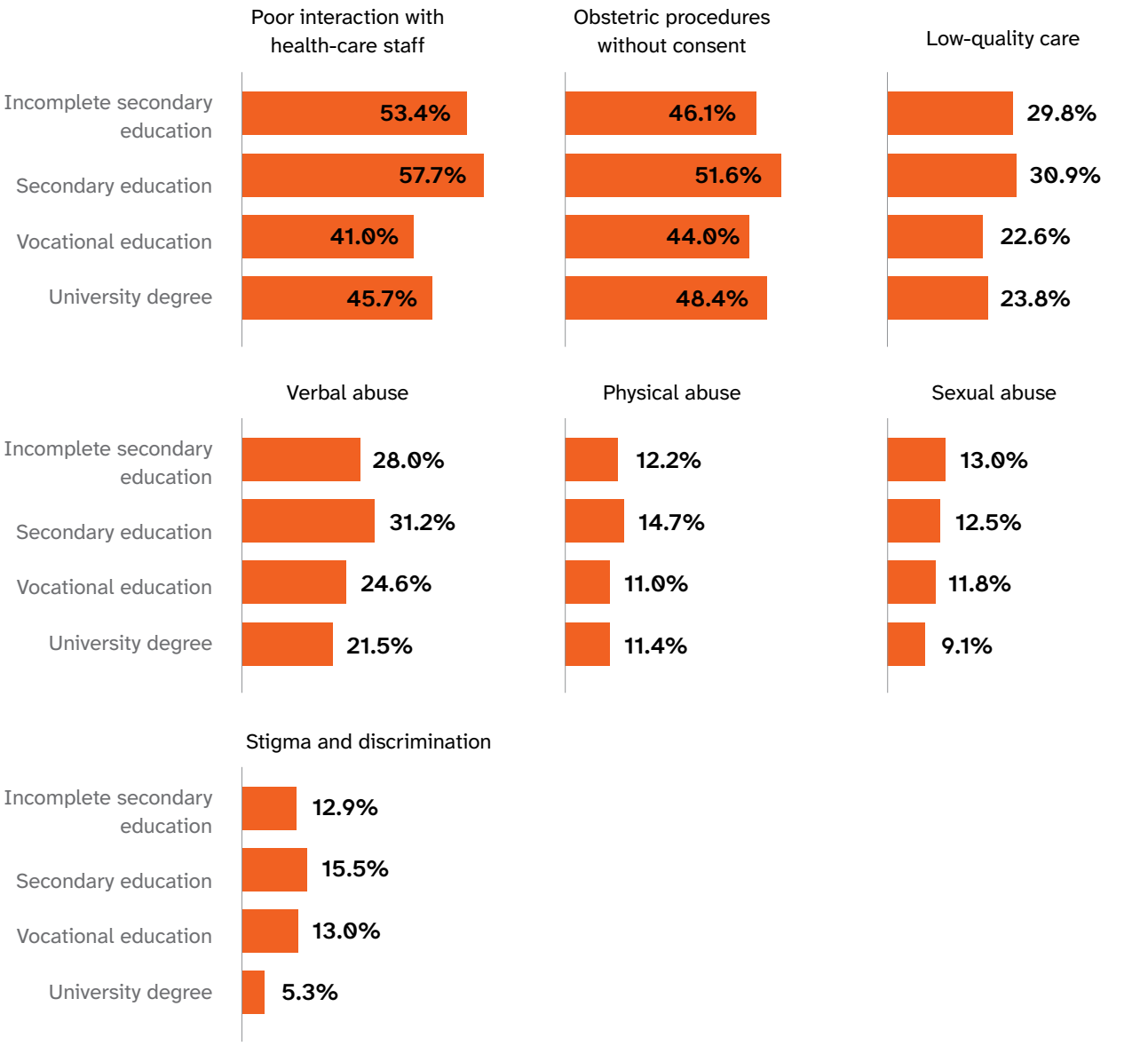
**Figure 13.** Profile of surveyed women who experienced at least one form of obstetric mistreatment within health-care facilities




65. Dinusha Perera and others, "Obstetric violence is prevalent in routine maternity care: A cross-sectional study of obstetric violence and its associated factors", *International Journal of Environmental Research and Public Health*, vol. 19, No. 16 (2022). Available at https://www.mdpi.com/1660-4601/19/16/9997 (accessed on 28 September 2025).
66. Aşci and Bal, "The prevalence of obstetric violence experienced by women during childbirth care and its associated factors in Türkiye".
67. Ibid.

Women's level of education may influence their risk of experiencing mistreatment during childbirth, with those with lower levels of education being more vulnerable. Women with secondary education or less were more likely to experience poor interaction with medical staff ($p < 0.001$, CI [95%], B = 0.120 [0.074 and 0.166]) and undergo obstetric procedures without consent ($p < 0.001$, CI [95%], B = 0.089 [0.044 and 0.135]) compared with those with higher education. Around 13.0 per cent of women with secondary education reported experiencing stigma and discrimination (B = 0.080), compared with 5.3 per cent of women with higher education. Similarly, verbal abuse was more prevalent among those with secondary education (31.2 per cent; B = 0.069) than those with higher education (21.5 per cent). These disparities may reflect biased behaviours and a lack of respect from health-care professionals towards women with lower educational attainment.[68]

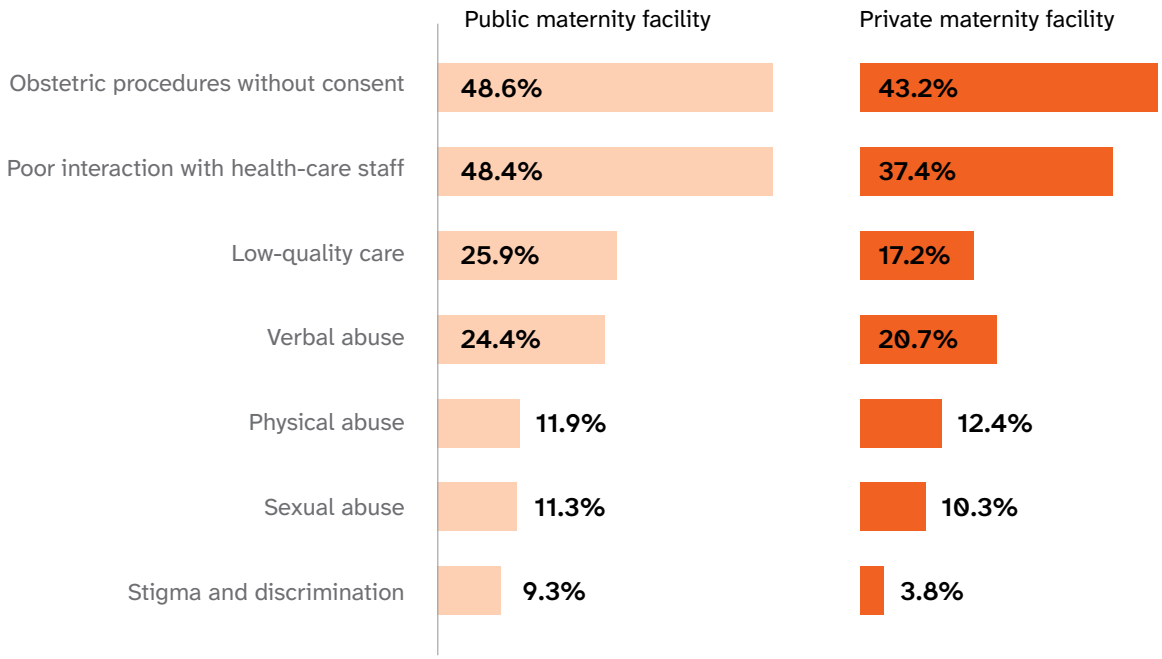
**Figure 14.** Percentage of surveyed women who experienced obstetric mistreatment, by clusters and education level




68. Cristiano Scandurra, "Obstetric violence in a group of Italian women: Socio-demographic predictors and effects on mental health", *Culture, Health and Sexuality*, vol. 24 (2022). Available at https://www.tandfonline.com/doi/full/10.1080/13691058.2021.1970812?scroll=top&needAccess=true (accessed on 28 September 2025).

The type of maternity facility also impacts the likelihood of mistreatment. Women who gave birth in public facilities were more vulnerable to various forms of mistreatment. For example, women in public facilities reported higher rates of poor interaction with medical staff (48.4 per cent), including a lack of clear information on procedures, pressure to accept certain interventions and denial of a support companion during labour ($p < 0.001$, CI [95%], B = 0.129 [0.063 and 0.195]). In comparison, the mistreatment rate was lower in private facilities, at 37.4 per cent, again demonstrating the disparity in the quality of interpersonal care and respect for patient rights across health-care settings. Women in public facilities were more likely to report low-quality care ($p < 0.001$, CI [95%], B = 0.121 [0.060 and 0.183]), including violations of physical privacy and inadequately trained staff, as well as intensified feelings of insecurity and mistrust.[69]

**Figure 15.** Percentage of surveyed women experiencing obstetric violence, by type of maternity facility

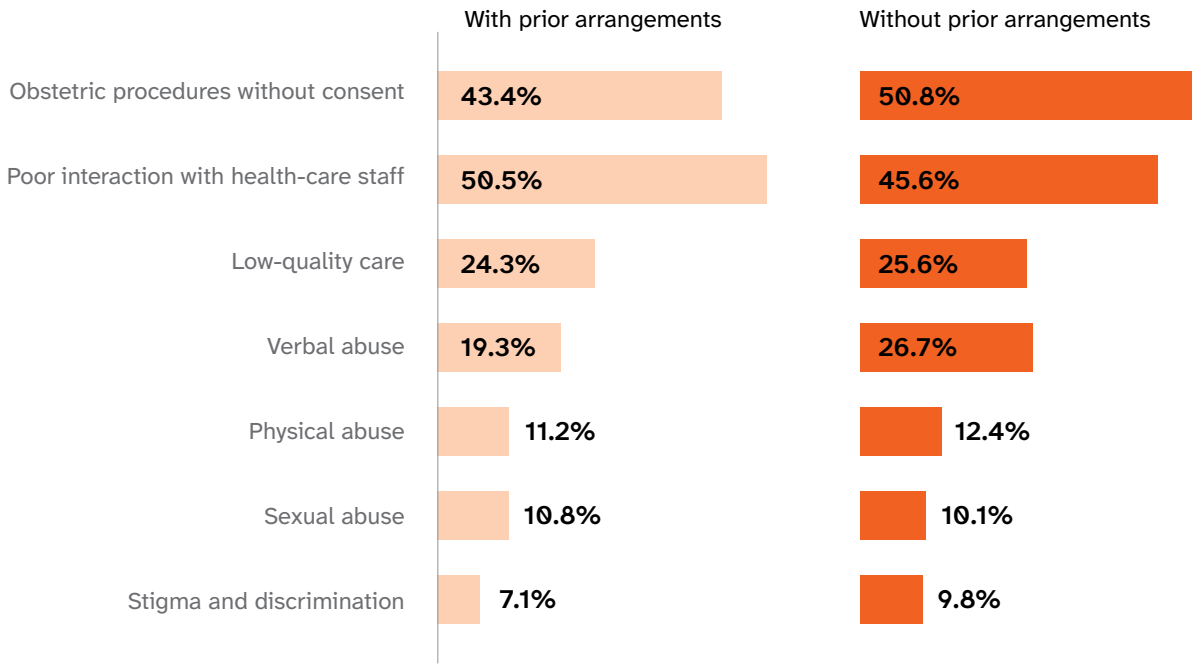



Prior arrangements with a doctor, often contingent on financial means, can influence the risk of experiencing abuse during labour. Women who secured prearranged delivery agreements addressing their preferences and expectations, typically by paying additional fees, were less likely to experience mistreatment during childbirth: 43.4 per cent of respondents underwent invasive procedures without consent, compared with 50.8 per cent of those without prior agreements. Similarly, 19.3 per cent of women with prior arrangements experienced verbal abuse, versus 26.7 per cent of those without prearranged care. These differences are statistically significant. Regression analysis shows that the absence of prearranged care is associated with increased risk of non-consensual procedures ($p = 0.013$, CI [95%], B = -0.050 [-0.089 to -0.010]) and verbal abuse ($p = 0.000$, CI [95%], B = -0.078 [-0.114 to -0.043]). These findings suggest that women who

69. Juan Miguel Martínez-Galiano and others, "The magnitude of the problem of obstetric violence and its associated factors: A cross-sectional study", *Women and Birth*, vol. 34, No. 5 (2021). Available at https://www.sciencedirect.com/science/article/abs/pii/S1871519220303590?via%3Dihub (accessed on 28 September 2025).

cannot afford prior arrangements or private care are more likely to face mistreatment, especially in public facilities, where such cases have been shown to be more prevalent overall.[70]

**Figure 16.** Percentage of surveyed women experiencing obstetric violence, by presence of prior arrangements with the doctor




A lower economic status is closely correlated with a higher risk of obstetric mistreatment, highlighting the significant socioeconomic disparities in maternal care. Available evidence has shown that women with higher income tend to have better access to private health-care providers and facilities that emphasize patient-centred, high-quality care, where their rights are prioritized and respected.[71] This financial advantage not only enables them to seek out private arrangements, such as paying for separate consultations or specialized care with doctors, but it also enhances their ability to navigate the health-care system with greater ease. In contrast, those without such means are more likely to rely on public maternity services, which often deliver lower-quality, less person-centred care.[72]

Obstetric mistreatment is often perpetuated by certain beliefs about maternity care. A significant proportion of women (58.4 per cent) strongly agree that they have to accept any intervention, even if potentially harmful to them, viewing it as an expected part of childbirth. Additionally, 19.6 per cent strongly believe that it is acceptable for doctors to make decisions without the mother's

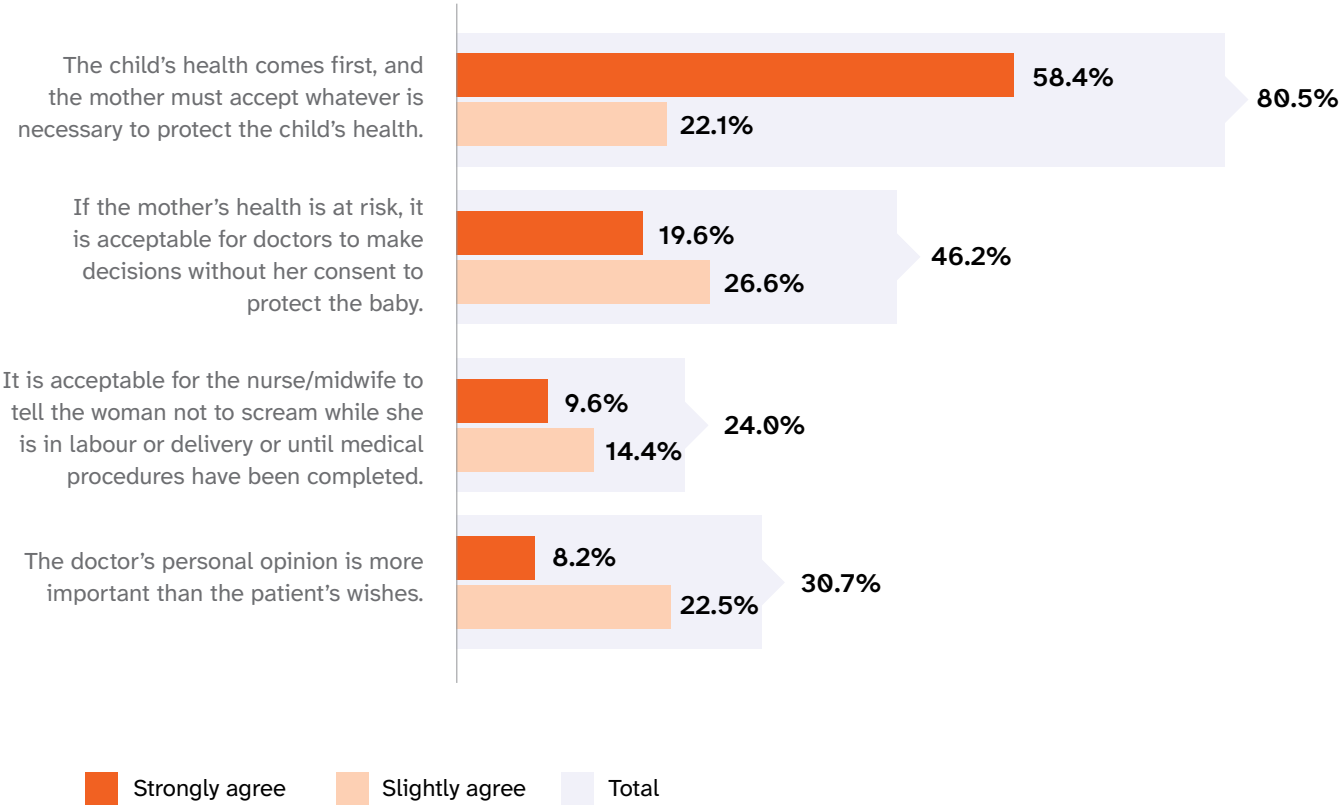
70. Centers for Disease Control and Prevention, "One in 5 women reported mistreatment while receiving maternity care", 22 August 2023. Available at https://www.cdc.gov/media/releases/2023/s0822-vs-maternity-mistreatment.html (accessed on 28 September 2025).

71. Sevil Hakimi and others, "Global prevalence and risk factors of obstetric violence: A systematic review and meta-analysis", *International Journal of Gynaecology & Obstetrics*, vol. 169 (2025). Available at https://obgyn.onlinelibrary.wiley.com/doi/epdf/10.1002/ijgo.16145 (accessed on 28 September 2025).

72. Anne-Sophie Jung, "Private sector quality interventions to improve maternal and newborn health in low- and middle-income countries: A scoping review", *Frontiers in Public Health*, vol. 13 (2025). Available at https://www.frontiersin.org/journals/public-health/articles/10.3389/fpubh.2025.1332612/full (accessed on 28 September 2025).

consent to protect the baby. These beliefs reflect societal norms and pressures that often consider the mother's well-being and autonomy to be secondary to the infant's safety. While ensuring the newborn's health is undoubtedly essential, and many women naturally prioritize their child's safety, this concern should not come at the expense of the mother's own rights, health and informed decision-making. Women may feel compelled to accept procedures they may otherwise question or refuse and often hold back from voicing concerns or asking questions,[73] which can increase their vulnerability to mistreatment and coercion during labour. This finding underscores the importance of promoting a balanced approach to maternal and newborn health – one that recognizes that protecting the infant and respecting the mother's autonomy are not mutually exclusive, and that both must be central to quality, respectful maternity care.

**Figure 17**. Percentage of surveyed women who share certain beliefs about maternity care




73. Yousra A. Mohamoud and others, "Vital signs: Maternity care experiences — United States, April 2023", *Morbidity and Mortality Weekly Report*, vol. 72, No. 35 (2023). Available at https://www.cdc.gov/mmwr/volumes/72/wr/mm7235e1.htm?s_cid=mm7235e1_w (accessed on 28 September 2025).

# Reporting on disrespectful and abusive maternity care

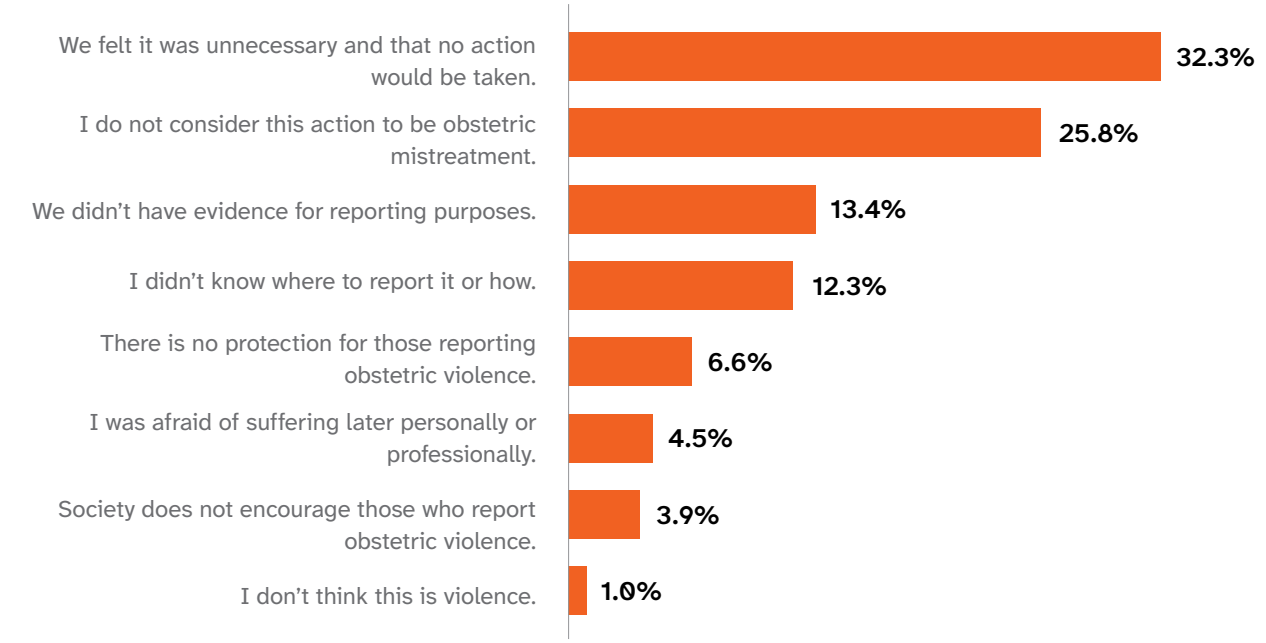
Despite the high prevalence of obstetric mistreatment (67.0 per cent), only 2.0 per cent of surveyed women reported it, revealing a critical gap between lived experiences and institutional accountability. Reporting on obstetric abuse is crucial for raising awareness of the mistreatment many women experience during childbirth and for addressing systemic issues in maternal health care. The cultural context and societal pressure play a significant role in reporting obstetric mistreatment. In some countries, the normalization of certain harmful practices, such as coerced procedures or disrespectful care, makes it difficult for women to even recognize when they are being mistreated or encourages them to accept these practices in silence.[74]

The high rates of underreported obstetric mistreatment reflect deep-seated fears and systemic health-care challenges. Around 30.0 per cent of surveyed women believe reporting is unnecessary, being convinced that no action would be taken and their concerns would be dismissed. Formal complaints are frequently classified as irrelevant or justifiable by oversight bodies, thus eroding trust in accountability mechanisms.[75] Moreover, 6.6 per cent of women pointed to the lack of protection for those submitting complaints, expressing fear of retaliation, either personally or professionally. This finding underscores a broader lack of trust in the system, as individuals are unlikely to come forward when they believe doing so may put them at risk.[76] This fear was often associated with women's belief that they lacked sufficient evidence to support their claims (13.4 per cent), further discouraging formal complaints. Around 26 per cent of women did not identify their experiences as mistreatment, likely due to limited awareness of what constitutes obstetric violence or the normalization of harmful practices within the medical system.[77] Another 12.3 per cent of women stated that they did not know where or how to report mistreatment, pointing to a critical gap in the availability and accessibility of information regarding complaint mechanisms. These reasons highlight a troubling cycle of silence, where fear, the lack of support, the lack of trust in the system and the perception that reporting will not make a difference discourage women from standing up against mistreatment during childbirth, ultimately perpetuating the culture of obstetric violence.

---

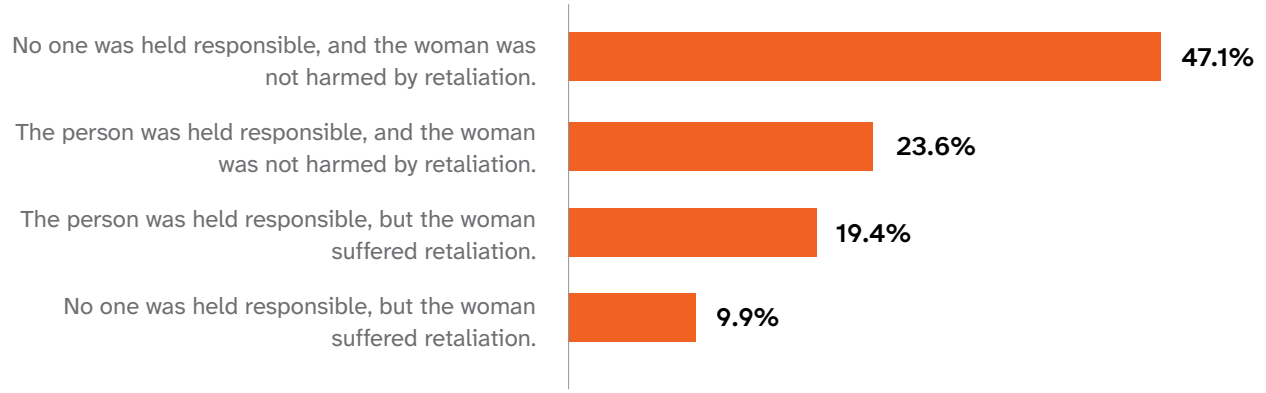
74. Myra L. Betron and others, "Expanding the agenda for addressing mistreatment in maternity care: A mapping review and gender analysis", vol. 15 (2018). Available at https://link.springer.com/article/10.1186/s12978-018-0584-6?utm_source=chatgpt.com (accessed on 28 September 2025).
75. Virginie Rozée and others, "Case Studies on Obstetric Violence: Experience, Analysis and Response", European Commission, 2023. Available at https://www.saage-network.eu/sites/default/files/media/publication/obstetric-violence_CASE-STUDIES_DEF.pdf (accessed on 28 September 2025).
76. Brunello and others, "Obstetric and Gynaecological Violence in the EU".
77. Betron and others, "Expanding the agenda for addressing the mistreatment in maternity care".

**Figure 18.** Reasons for not reporting mistreatment during obstetric care



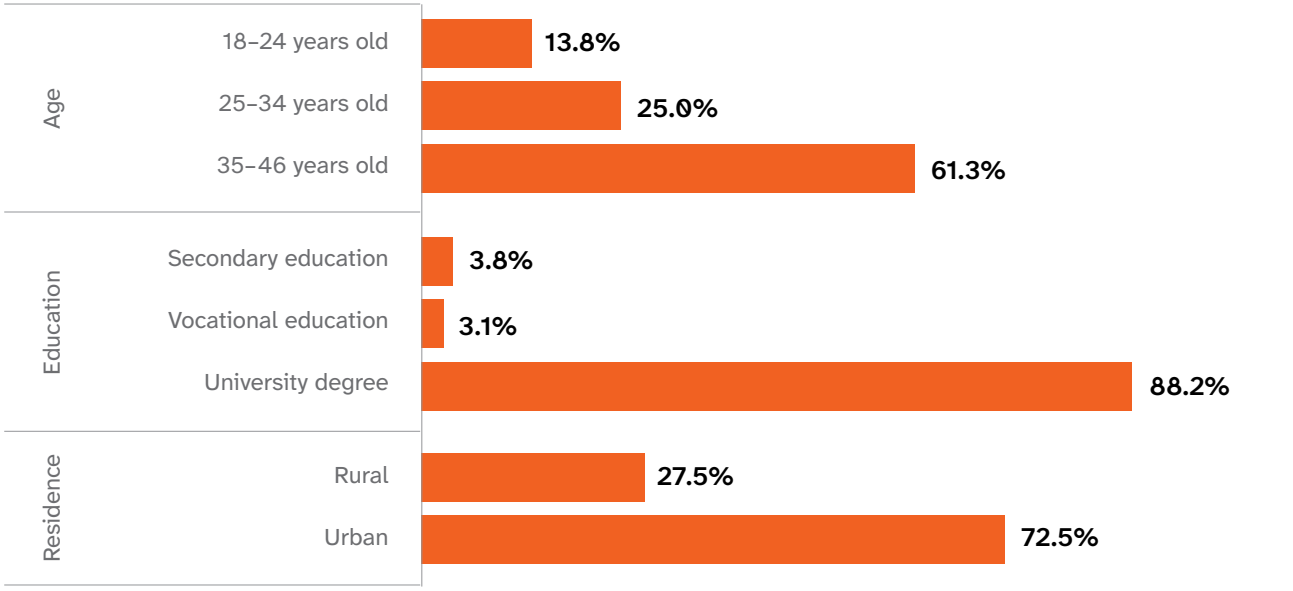

Many of those who chose to report obstetric abuse faced challenges and consequences that undermined the effectiveness of the reporting process. In 47.7 per cent of reported cases, women stated that no one was held responsible for the mistreatment they experienced, and they did not face any retaliation. This finding suggests that, although they were not subjected to further harm, their complaints were ultimately ineffective in ensuring accountability. In 19.4 per cent of cases, women saw the person responsible for the mistreatment held accountable, but they still suffered retaliation, indicating that even when there was a form of justice, there were negative personal or professional consequences for the women involved. In 9.9 per cent of cases, women reported that no one was held accountable, but they did face retaliation, highlighting a troubling reality where reporting abuse can lead to further harm without any resolution or responsibility taken by the perpetrators. These consequences reveal a complex and often discouraging reality for women who attempt to address obstetric violence.

**Figure 19.** Consequences for women who reported mistreatment during obstetric care



The reporting of obstetric mistreatment varies across age groups, education levels and geographic locations, pointing to disparities in both women's awareness of their rights and their ability or willingness to speak out. Women aged 35–46 were more likely to report the mistreatment they experienced (p = 0.006, CI [95%], B = 0.018 [0.005–0.031]), accounting for 61.3 per cent of reports. In contrast, only 13.8 per cent of reports came from women aged 18–24, with a negative association between younger age and reporting. Education also plays a critical role: higher education was positively associated with reporting behaviour (p = 0.000, CI [95%], B = 0.024 [0.011 and 0.036]). Women with only secondary or vocational education had lower reporting rates (below 4.0 per cent), with a low education level showing a negative relationship with reporting (p = 0.021, CI [95%], B = -0.020 [-0.036 and -0.003]). Furthermore, mistreatment reports were considerably more prevalent in urban areas, indicating better information accessibility, support systems and mechanisms for raising concerns. These findings highlight the need for more targeted awareness efforts, particularly among younger, less educated and rural populations, to ensure that all women are informed of their rights and feel supported to report mistreatment.

**Figure 20**. Profile of women who reported mistreatment during obstetric care

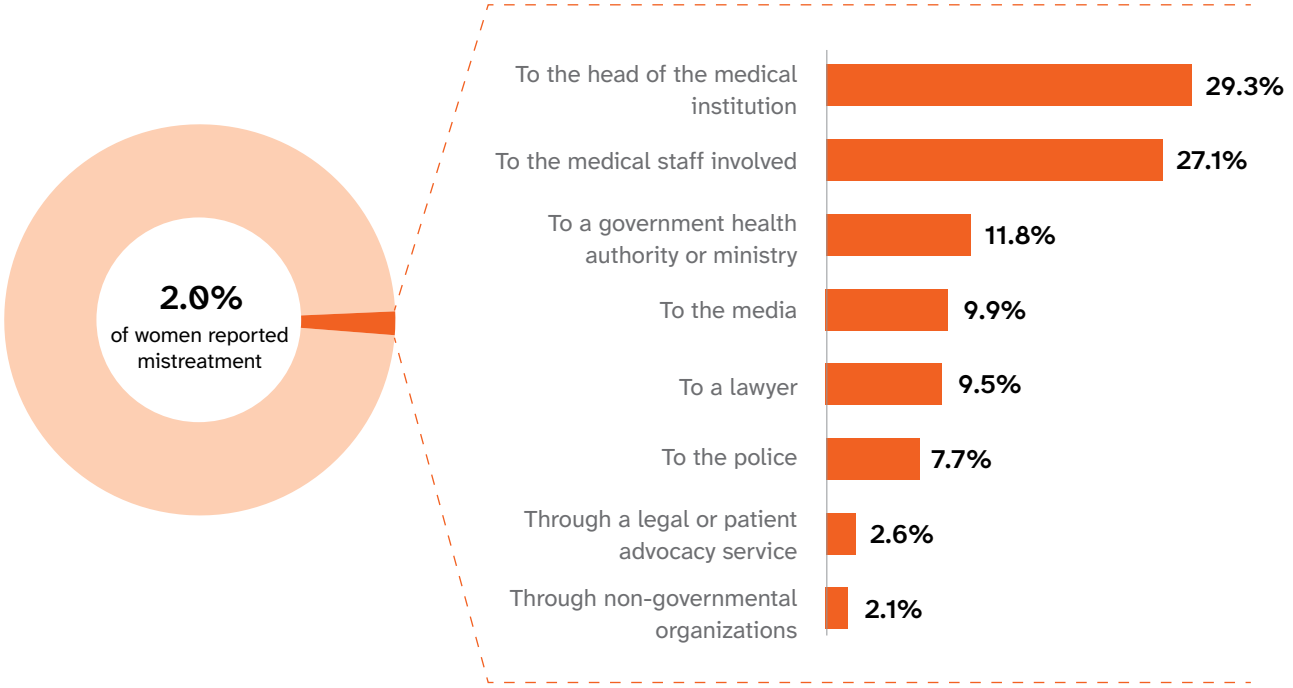



Only a small proportion of surveyed women who reported obstetric mistreatment turned to formal authorities. The most common route was reporting to the head of the medical institution where the mistreatment took place (29.3 per cent), followed closely by addressing the issue directly with the medical staff involved (27.1 per cent). In contrast, only 11.8 per cent of women reported their experiences to a government health authority or ministry, and only 7.7 per cent sought police assistance, a figure that aligns with findings from international studies indicating a general reluctance to involve law enforcement in medical mistreatment cases.[78] The overall distribution

78. Michelle Sadler and others, "Moving beyond disrespect and abuse: Addressing the structural dimensions of obstetric violence", *Reproductive Health Matters*, vol. 24, No. 47 (2016). Available at https://doi.org/10.1016/j.rhm.2016.04.002 (accessed on 28 September 2025).

of reporting channels highlights key structural and perceptual barriers: a lack of trust in the responsiveness of these systems, fear of retaliation, scepticism concerning the effectiveness of complaint resolution mechanisms, and a poor understanding of where and how to report mistreatment (see Figure 18). Strengthening transparent, well-publicized reporting structures within both health institutions and public oversight bodies is essential to closing this accountability gap.

**Figure 21.** Channels chosen to report mistreatment during obstetric care



# Recommendations

Effectively addressing obstetric and gynaecological violence requires a phased, evidence-based approach that is tailored to each national context. Accordingly, before the implementation of the actions outlined in the recommendations below, every State should conduct a thorough analysis of the existing research findings, supplement them with local research and qualitative data, and carry out a comprehensive national assessment. Such an assessment is indispensable for establishing the scope and distinctive features of the problem and for taking remedial action – whether legislative amendments, institutional reforms, changes in standards and guidelines for services, or public-awareness campaigns – based on solid evidence.

In parallel, governments are urged to establish a robust monitoring and data-collection framework with clearly defined indicators on the protection of women's rights in the provision of sexual and reproductive health services. Relevant indicators may include women's reported birth experiences, the number and nature of obstetric-violence incidents, and effective access to complaint and redress mechanisms. Continuous monitoring of these indicators will enable continuous monitoring of progress, foster accountability in health care, and ensure that women's dignity and rights are upheld in practice.

At the same time, international and regional bodies – such as the UNFPA Regional Office for Eastern Europe and Central Asia, WHO's Europe office and other development partners – can support national efforts by facilitating the exchange of good practices, developing common standards, providing technical assistance and undertaking coordinated advocacy. This external support is particularly valuable for low- and middle-income countries that may face resource constraints and implementation challenges. Through concerted domestic and international efforts, and based on systematically collected data, States will be able to adopt sustainable and effective solutions for eradicating obstetric and gynaecological violence.

Against this backdrop, the recommendations in this chapter are organized around four essential dimensions of action, designed to ensure a comprehensive and effective response to the issue: (1) women as service beneficiaries; (2) the health system as health-care provider; (3) public policies and legislation as structural support; and (4) society as a space for awareness and engagement. Each dimension is introduced, along with a description of its significance, followed by technical, actionable recommendations. These recommendations align with human rights frameworks and international standards (WHO, FIGO, CEDAW, etc.) and draw on examples from various countries to inform effective strategies and institutional reforms.

# 1. Women as service beneficiaries

Ensuring that women are informed, empowered, and supported is fundamental to preventing obstetric and gynaecological violence. Many abusive practices persist due to the power imbalance between patients and providers and the fact that women often lack information about their rights and options.

### 1.1 Ensure universal access to comprehensive prenatal education and empowerment courses for all expectant mothers, making participation highly encouraged but never a precondition for receiving clinical care.[79]

Courses must be free or fully subsidized and delivered through multiple channels – on site at primary-care facilities, mobile outreach, community centres and interactive online modules – so that the cost, distance, work schedules or childcare needs do not exclude low-income, rural or single mothers. The curriculum should cover pregnancy and newborn physiology along with women's rights in maternity care, informed consent and evidence-based, respectful obstetric practices. Emphasizing positive, science-backed knowledge (e.g., labour hormones such as oxytocin and endorphins) facilitates the shift from fear to confidence.

**International standards**

The WHO framework for a positive childbirth experience calls for effective communication and education throughout maternity care,[80] and FIGO's statement "Childbirth: A Bill of Rights" underscores informed preparation for birth as a right.

**Examples**

**France:**[81] The national health insurance system fully covers prenatal education and birth preparation courses. Expectant mothers can receive 7–8 sessions of childbirth preparation, reimbursed at 100 per cent by Assurance Maladie, France's national health insurance service. This policy, grounded in the Social Security Code, ensures that women have access to free antenatal courses as part of standard maternity care. In addition, one session is devoted to women's legal rights in childbirth – covering informed consent, refusal of procedures and redress mechanisms – and entails participants receiving the contact details of the hospital's User Commission and national ombuds platform, Health Info Rights (Santé Info Droits), for reporting mistreatment.

79. The institutional structures responsible for maternal and reproductive care vary considerably from one country or territory to another: some have specialized ministries and agencies, while others operate through decentralized networks or public–private partnerships. For this reason, the recommendations provided in this document are not aimed at specific institutions. Instead, the authors have limited themselves to providing directions for action that each country or territory can adapt to its own institutional arrangements.
80. Cochrane, "Cochrane Evidence used in new WHO guideline on intrapartum care for a positive birth experience", 15 February 2018. Available at https://www.cochrane.org/about-us/news/cochrane-evidence-used-new-who-guideline-intrapartum-care-positive-birth-experience (accessed on 28 September 2025).
81. République française, "Femme enceinte : prise en charge à 100 % (Assurance maladie)", 24 June 2025. Available at https://www.service-public.fr/particuliers/vosdroits/F164 (accessed on 28 September 2025).

**Sweden:**[82] Prenatal education is provided as part of Sweden's public maternal health services. Midwife-led antenatal courses are traditionally offered at no cost to expectant parents, focusing on health promotion and birth preparation. Sweden has a long-standing policy of including antenatal education as an essential component of maternity care. Free antenatal courses delivered through county maternal-health centres cover patient rights under the 2014 Patient Act, explain complaint pathways (Patient Council and the National Board of Health and Welfare) and encourage women to voice concerns about disrespectful care.

**Brazil:**[83] Since 2011, the federal Stork Network (Rede Cegonha) has required public primary-care units to run group prenatal education sessions covering physiology, birth rights and post-partum self-care. Evaluations in São Paulo and Bahia demonstrate enhanced knowledge of informed-consent rights and a measurable decline in the number of unnecessary intrapartum interventions among participants. Each group session also reviews women's legal entitlements under Law No. 11 108/2005 (companionship in labour) and the Ministry of Health's Appropriate Childbirth Charter; the facilitator distributes a pregnancy handbook (Caderneta da Gestante), which lists the toll-free hotline number and the ombudsman of Brazil's public health system (Sistema Único de Saúde) as formal channels for reporting mistreatment.

**Philippines:**[84] Under the Department of Health's Basic Emergency Obstetric and Neonatal Care Strategy, rural health centres conduct free, community-based parenting courses that combine antenatal education with rights-based counselling; uptake exceeds 70 per cent in several low-income provinces and is associated with higher facility birth rates and improved patient–provider communication scores. Modules include a rights segment based on the Magna Carta of Women and Responsible Parenthood and the Reproductive Health Act, and midwives explain how to lodge complaints with the local Barangay Health Board, Department of Health Centre for Health Development or via a national hotline in cases of disrespectful care.

### 1.2 Provide accessible therapy and psychological support for women who experience obstetric or gynaecological trauma.

Health systems should ensure that counselling services (individual or group) are available for mothers (and their families) who have endured obstetric or gynaecological violence, both in the immediate aftermath of an incident and in the longer term. Such care is crucial, as the harm of obstetric violence extends beyond physical injury to deeply psychological damage: survivors

82. 1177.se, "Föräldraförberedande information i Örebro län", 20 January 2025. Available at https://www.1177.se/Orebrolan/barn--gravid/graviditet/foraldraforberedande-information-i-orebro-lan/ (accessed on 28 September 2025).
83. Ministério da Saúde, "Conheça a Rede Cegonha", January 2013. Available at https://bvsms.saude.gov.br/bvs/folder/rede_cegonha.pdf (accessed on 28 September 2025).
84. Department of Health, Center for Health Development, Cordillera Administrative Region, *Health Program Briefer 2020* (2020). Available at https://caro.doh.gov.ph/wp-content/uploads/2021/11/Program-Briefer_2020_UPDATED_FINAL.pdf?appgw_azwaf_jsc=cHpfIC8TRPY5nUZxLsi836PlK5DRGHsGcu5q_y76lzY (accessed on 30 September 2025).

often suffer trauma, post-partum depression or anxiety that can undermine their well-being and discourage them from seeking future care. Offering professional psychological support aids in the healing process and validates women's experiences.

**International standards**

According to WHO, respectful maternity care includes emotional support and the right to dignity and confidentiality, which extends to providing support following traumatic experiences. CEDAW's[85] framework on violence against women also implies that States should provide appropriate services, including rehabilitation, to victims of gender-based violence.

**Examples**

**United Kingdom:**[86] The National Health Service (NHS) has established perinatal mental health as a strategic priority. Under the NHS Long Term Plan, specialized maternal mental health services (MMHS) were launched to offer psychological therapy for women affected by birth trauma, pregnancy loss and other perinatal mental-health issues.

The roll-out timeline was as follows: 26 early-implementer MMHS teams were launched in 2020–2021; by 2021, the network had expanded to 32 teams; by April 2023, every integrated care system in England had at least one operational team; and by March 2024, the service comprised 40 MMHS hubs nationwide. In the fiscal year 2023–2024, these hubs treated over 57,000 women, providing trauma-informed counselling, targeted cognitive-behavioural therapy, bereavement support and interventions for severe tokophobia. This comprehensive coverage demonstrates a firm policy commitment to ensure that every woman is able to access the mental-health support they need after difficult births or losses.

**Spain:**[87] Spain has begun integrating perinatal mental health into national strategies. The National Mental Health Strategy 2022–2026 explicitly identifies perinatal mental health as a focus area. It calls for specialized programmes and training to support women's mental health during pregnancy and post-partum. In practice, Spanish regional health systems also offer post-partum counselling and screening. For example, the 2018 Spanish national plan on violence against women in reproductive health included measures aimed at improving maternal psychological care. Ongoing efforts (including an upcoming 2025–2027 action plan) are aimed at strengthening trauma counselling for birth-related experiences as part of comprehensive maternal care.

85. Northeastern University School of Law, Center for Global Law and Justice, "Spanish courts' handling of obstetric violence violated CEDAW, committee finds", 11 March 2020. Available at https://ijrcenter.org/2020/03/11/spanish-courts-handling-of-obstetric-violence-violated-cedaw-committee-finds/ (accessed on 30 September 2025).
86. NHS England, "New maternal mental health services supporting hundreds of expectant, new, or bereaved mothers to get mental health support". Available at https://www.england.nhs.uk/mental-health/case-studies/perinatal-mental-health-case-studies/new-maternal-mental-health-services-supporting-hundreds-of-expectant-new-or-bereaved-mothers-to-get-mental-health-support/ (accessed on 30 September 2025).
87. Senado, XV Legislatura, Registro General, Entrado 36.501, "Respuesta del Gobierno", 24 February 2025. Available at https://www.senado.es/web/expedientdocblobservlet?legis=15&id=220837 (accessed on 30 September 2025).

### 1.3 Encourage and formalize the presence of a partner or chosen support person during childbirth.

Health-care providers and facilities should actively promote policies allowing a birth companion (such as the baby's father, the woman's partner, or another family member or support person) to accompany the woman during labour and delivery. While many countries have established legal frameworks for this practice, some hospitals still discourage or limit the presence of support persons, which can leave women isolated. Studies have demonstrated that the continuous presence of a support person throughout childbirth has significant benefits: it leads to lower rates of obstetric violence, a more supportive birth environment and improved outcomes for both the mother and the baby. Partner attendance at childbirth is linked to increased involvement in postnatal care.

**International standards**

Recommendation 3.1 of WHO's *Intrapartum Care for a Positive Childbirth Experience* states that "every woman should be offered the option to have a companion of her choice present during labour and childbirth",[88] citing strong evidence for reduced Caesarean rates, shorter labour and improved satisfaction.

Step 2 of the International Childbirth Initiative calls on facilities to "ensure continuous emotional and physical support from a chosen companion, doula or family member"[89] as a core right and a quality-of-care indicator.

**CEDAW communication *S.F.M. v Spain* (2020).[90]** In its decision on communication No. 138/2018, adopted in 2020, the CEDAW Committee found that a woman was subjected in a public hospital to numerous vaginal examinations, administration of oxytocin, an instrumental delivery and an episiotomy without informed consent; she was immediately separated from her newborn, her partner was not allowed to accompany her, and her placenta was manually removed. The Committee determined that such treatment – undertaken without informed consent, shaped by gender stereotypes and contrary to the woman's wishes – constituted obstetric violence and discrimination. It ordered compensation and recommended systemic measures, including ensuring informed consent at every stage of childbirth, training health and justice personnel, conducting research into obstetric violence and guaranteeing the right to have a chosen companion present.

88. WHO, *WHO Recommendations: Intrapartum Care for a Positive Childbirth Experience*.

89. International Childbirth Initiative, *12 steps to safe and respectful motherbaby-family maternity care* (2018). Available at https://internationalmidwives.org/resources/12-steps-to-safe-and-respectful-motherbaby-family-maternity-care/ (accessed on 30 September 2025).

90. CEDAW/C/75/D/138/2018.

**Examples**

In many high-income countries, partner presence is now a standard practice. In Canada[91] and the United States,[92] for instance, delivery rooms and birth centres routinely accommodate birthing partners or doulas, fostering a supportive culture. In Hungary,[93] a concerted campaign in the 2010s led to almost all maternity wards allowing fathers in delivery rooms, which resulted in increased patient satisfaction.

## 2. The health system as provider of care

Professional behaviour, training and accountability within health care are central to addressing obstetric and gynaecological violence. Most mistreatment occurs in clinical settings perpetrated (actively or passively) by medical staff who may be influenced by stress, cultural norms, inadequate training in patient-centred care or a lack of oversight. Reforming the medical system requires instilling a culture of respect for patient rights and zero tolerance for abuse within all levels of health-care delivery.

### 2.1 Ministries of health and professional regulatory bodies should strengthen the training of health-care personnel on respectful maternity care and patient rights.

Continuous professional development programmes should be established to train obstetricians, gynaecologists, midwives, nurses and ancillary staff in providing evidence-based, human rights–centred care. Training must go beyond clinical skills, incorporating modules on medical ethics, effective communication, empathy and the prevention of obstetric violence. To embed these competencies, programmes should employ interactive pedagogies – for example, scenario-based simulations, role-play with standardized patients, team debriefings and video-assisted reflection – which have proven more effective than lecture-only formats in shifting attitudes and behaviour. Enforcing such mandatory training (e.g. as a licensing requirement or a recurring in-service module) ensures that providers understand the boundary between accepted practice and abuse. This training is essential, as many may not recognize behaviour such as scolding a woman in labour, ignoring her pain or performing procedures without explanation as rights violations; experiential learning can correct these misconceptions and reinforce professional duties.

91. Public Health Agency of Canada, *What Mothers Say: The Canadian Maternity Experiences Survey* (Ottawa, 2009). Available at https://www.canada.ca/content/dam/phac-aspc/migration/phac-aspc/rhs-ssg/pdf/survey-eng.pdf (accessed on 30 September 2025).
92. American College of Obstetricians and Gynaecologists, "Labour & Delivery". Available at https://www.acog.org/womens-health/pregnancy/labor-and-delivery (accessed on 30 September 2025).
93. Réka Kinga Papp, "Decriminalizing childbirth", *Eurozine*, 28 June 2017. Available at https://www.eurozine.com/decriminalising-childbirth-power-dynamics-in-hungarian-birthing-care/ (accessed on 30 September 2025).

| International standards |
| --- |
| WHO[94] and partners have identified provider training as a component of strategies to reduce obstetric mistreatment, noting that interventions should target attitudes and norms, not just knowledge. FIGO's ethical framework[95] calls for multidisciplinary education to ensure optimal, respectful care for women and babies and explicitly states that health practitioners must identify and eliminate disrespect and abuse. |
| **Examples** |
| In **Belgium**,[96] the 2022–2024 action plan to combat obstetric violence incorporates specific training for health professionals to develop expertise in recognizing and responding to obstetric violence. In response to the action plan, workshops have been developed for maternity staff on topics such as informed consent and cultural sensitivity. |
| Similarly, in **India**[97] the Labour Room Quality Improvement Initiative (LaQshya), launched by the government and WHO, provides training and mentoring for laboratory ward teams on respectful maternity care, resulting in measurable reductions in abuse reports in pilot hospitals. |
| In **Estonia**,[98] the Sexual Health Association organized a series of national training courses in 2019 titled Obstetric Violence and Human Rights–Based Approaches in Reproductive Health. These courses, which were attended by medical personnel from maternity wards, were aimed at promoting best practices and facilitating the identification of abusive behaviours. |

### 2.2 Implement standards and support mechanisms, a positive work environment and mandatory patient-feedback practices for maternity-care teams.

Hospitals and clinics should introduce measures that support health-care workers in providing compassionate, patient-centred care. Such measures should include establishing mentoring programmes for newly qualified doctors and midwives to learn from senior staff who model respectful practice, as well as offering psychological support or counselling services for providers who face stressful and emotionally challenging situations. The need for such measures is underscored by the evidence that some instances of obstetric violence originate in provider burnout, high stress or the normalization of abuse as a coping mechanism in demanding work environments. By safeguarding staff well-being and professionalism, health institutions can prevent frustration from translating into patient mistreatment.

94. WHO, "Improving the experience of pregnant and birthing women", 12 October 2023. Available at https://www.who.int/news/item/12-10-2023-improving-the-experience-of-pregnant-and-birthing-women (accessed on 27 October 2025).
95. FIGO, "Ethical Framework for Respectful Maternity Care during Pregnancy and Childbirth", September 2021. Available at https://www.figo.org/sites/default/files/2021-09/FIGO_Statement_Ethical-Framework-Respectful-Maternity-Care-During-Pregnancy-Childbirth_0.pdf (accessed on 30 September 2025).
96. Brunello and others, "Obstetric and Gynaecological Violence in the EU", pp. 9–11.
97. Ministry of Health and Family Welfare, Government of India, "Labour room quality improvement initiative (LaQshya)", 2024. Available at https://nhm.gov.in/index1.php?lang=1&level=3&lid=690&sublinkid=1307 (accessed on 30 September 2025).
98. International Planned Parenthood Federation, Estonian Sexual Health Association. Available at https://www.ippf.org/about-us/member-associations/estonia (accessed 30 September 2025).

**2.3 Collect feedback from women in a mandatory, systematic fashion – for example, by carrying out brief exit interviews before discharge or anonymous digital surveys 4–6 weeks post-partum or by integrating patient-reported-experience measures into electronic medical records.**

Implementing a requirement for such instruments and discussing the aggregated results at regular quality-improvement meetings closes the learning loop, highlighting good practice, detecting early signs of disrespectful behaviour and supplying concrete data for staff appraisal and continuing-education plans. Such feedback mechanisms are recommended in WHO quality-of-care standards, which state that women's experience of care should be routinely measured and acted upon to drive systemic improvement.

**International perspective**

The importance of caring for caregivers is increasingly recognized in global health; charters on respectful maternity care often cite staff well-being as a pre-condition for respectful patient care.

Although WHO has no stand-alone guideline on mentoring, Standard 8 of the WHO *Standards for Improving Quality of Maternal and Newborn Care in Health Facilities* explicitly calls for "competent, motivated personnel" and for facility environments that enable staff to perform optimally and ethically.[99]

The standard lists a set of management practices that hospitals can institutionalize: (i) adequate staffing and fair rostering – evidence-based nurse- or midwife-to-patient ratios; rota systems that prevent excessive consecutive night shifts; (ii) protected reflection time – scheduled debriefings, or so-called Schwartz rounds, at least monthly, where multidisciplinary teams discuss the emotional aspects of difficult cases; (iii) psychological-safety mechanisms – anonymous incident-report portals and "freedom to speak up" guardians (modelled on the NHS) that allow staff to raise concerns without retaliation; (iv) on-site wellness infrastructure – quiet rooms for rest and lactation, easy access to counselling and occupational-health services that include burnout screening; (iv) supportive supervision and continuing education – regular bedside coaching, peer mentoring and facilitated access to e-learning on respectful care and human rights principles; and (v) recognition systems – non-monetary awards or progression points linked to demonstrated respectful-care behaviour, reinforcing positive norms.

**Examples**

Some high-performing maternity units in the United States have adopted Schwartz rounds to foster empathy and reduce stress, thereby indirectly improving patient interactions. In Sweden, where adherence to ethical standards in obstetric care is mandated by law, hospitals have reported using peer support groups for midwives and doctors to reflect on difficult cases; these measures, combined with strict oversight (including the possibility of licence revocation for repeated violations), have created a culture where seeking help is encouraged and unethical behaviour is not tolerated.

99. WHO, *Standards for Improving Quality of Maternal and Newborn Care in Health Facilities*. See Standard 8, "Human resources are sufficient, competent and motivated".

### 2.4 Enforce a zero-tolerance policy for obstetric and gynaecological violence within all health-care facilities.

Medical institutions must adopt clear internal policies declaring that any form of abuse, disrespect or violence towards patients is unacceptable. Such policies should be accompanied by well-defined protocols for reporting misconduct, protecting whistleblowers and patients who complain, and taking disciplinary action against staff found guilty of mistreatment. Formalizing these policies and protocols as standard practices is essential for transforming the professional culture: when health-care workers know that their workplace is committed to protecting patients' rights and penalizing abusive behaviour, they are more likely to adhere to respectful practices.

**International standards**

Human rights principles and professional ethics codes (e.g., the FIGO guidelines) support zero tolerance for gender-based violence in health care. In its communication *S.F.M. v. Spain* (2020), the CEDAW Committee recognized that mistreatment during childbirth – including refusal to allow a companion – constitutes discrimination and gender-based violence, and it recommended that States ensure informed consent, provide training to medical and judicial personnel, and establish effective mechanisms for reporting and remedy. Guidance on preventing gender-based violence likewise emphasizes the need for pre-service and in-service training of health workers on gender norms and patient rights and for laws and procedures that prohibit violence in health-care settings and ensure accessible complaint channels.

**Examples**

**Italy**[100] provides a leading example: its 2017 legislation on patient safety (Law No. 24/2017) and subsequent Code of Obstetric Practice (2018) require that health-care providers obtain informed consent for all procedures and explicitly grant women the right to file complaints against medical staff for obstetric violence. Operating under this framework, Italian hospitals have enforced new internal rules ensuring that any reported verbal or physical abuse of a patient triggers an immediate review and, if substantiated, results in sanctions (ranging from mandatory retraining to dismissal or legal action). In France, professional colleges in obstetrics have endorsed charters of maternity care that outline respectful care standards and pledge to sanction members who violate them, in line with the national plan to improve childbirth experiences.

100. Italy, Provisions Concerning the Safety of Care and of the Person Receiving Care, as Well as the Professional Liability of Health-Care Professionals, Law No. 24 (8 March 2017), *Official Gazette*, No. 64 (17 March 2017); Federazione nazionale degli Ordini della Professione di Ostetrica, *Codice di pratica ostetrica: Linee guida per la tutela della donna e del neonato* (2018).

**2.5 Adopt an interdisciplinary, patient-centred approach in maternity care. Health facilities should foster collaborative care models in which obstetricians, midwives, nurses, anaesthesiologists, neonatologists and other professionals work as a single, integrated team with women's well-being and preferences at the centre.**

Regular case reviews and joint ward meetings can be used to discuss how to improve birth and post-partum care in a way that respects the patient's perspective. An interdisciplinary approach – unlike a siloed, multidisciplinary one – promotes shared decision-making and real-time dialogue: for example, a midwife or nurse can amplify a woman's concerns if a physician is focused on protocol, and, conversely, the physician can support concerns raised by the midwife or nurse, ensuring that the woman's voice is heard. By flattening hierarchical structures, the model provides for checks and balances that reduce the risk of abusive or disrespectful behaviour and improve overall clinical outcomes.

**International standards**

FIGO and the International Confederation of Midwives, through the International Childbirth Initiative, promote teamwork and shared decision-making, noting that collaborative practice leads to better outcomes and reduces the risk of abuse or neglect. WHO's intrapartum care guidelines likewise emphasize respectful, person-centred care, which often requires a coordinated team effort.

**Examples**

In the **Netherlands**,[101] an integrated maternity-care system pairs obstetricians and midwives for most deliveries; this cooperation is credited with high maternal satisfaction and lower intervention rates – especially Caesarean sections (around 15 per cent versus an OECD average of 28 per cent[102]), episiotomies and instrumental vaginal births – compared with countries using more physician-centred models.

## 3. Public policies and legislation as structural support

Strong public policies and legal frameworks form the structural backbone for sustained change to prevent obstetric and gynaecological violence. Without laws, regulations, and official guidelines that define and prohibit such violence, efforts remain piecemeal and lack authority. Clear legal recognition of obstetric and gynaecological violence as a violation of women's rights establishes accountability at the national level and empowers both patients and providers to adhere to higher standards. This dimension addresses the role of the state and health authorities in creating an enabling environment through legislation, policies and monitoring mechanisms that support prevention, enforcement and redress.

101. Netherlands Perinatal Registry, *Perinatal Care in the Netherlands 2022*. See Tables 3.2 and 4.1.

102. Organisation for Economic Co-operation and Development, *Health at a Glance 2023: OECD Indicators* (Paris, OECD Publishing, 2023). Available at https://www.oecd.org/en/publications/2023/11/health-at-a-glance-2023_e04f8239.html (accessed 30 September 2025). See Indicator 7.3.

### 3.1 National legislatures and health ministries should enact comprehensive legal provisions to prevent and address obstetric and gynaecological violence.

This legal framework – whether through a dedicated law or an amendment to existing statutes on health care, patient rights and gender-based violence – should clearly define acts constituting obstetric and gynaecological violence, such as non-consensual medical procedures, verbal harassment by medical staff, discrimination in care or unnecessary use of force in childbirth, and establish penalties or consequences for violations.

| **International standards** |
| --- |
| States are committed under human rights treaties such as CEDAW to eradicating discriminatory practices and protecting women from gender-based violence, including in maternity settings. In 2019, the UN Special Rapporteur on violence against women likewise identified obstetric violence as a human rights issue and called on governments to outlaw such practices. |
| **Examples** |
| Several countries have already adopted legislative provisions. **Venezuela** became the first country to formally address obstetric violence within its legal framework, specifically through its 2007 Organic Law on the Right of Women to a Life Free of Violence. This law prohibits actions that interfere with the natural course of childbirth unless medically justified and that disrespect women's autonomy during care. Argentina followed with a landmark law in 2009 that defines the rights of the mother and newborn and explicitly qualifies obstetric violence as a violation, with provisions for penalizing health professionals. |
| **Mexico** has also made strides, with several states (e.g., Nuevo León, Veracruz) taking steps to ensure that women are protected from obstetric violence through updated legislation on violence against women, prohibiting practices such as forced sterilization and unwarranted denial of care. |
| While European countries have delayed their legislative response, the process is still moving forward: in 2021, for instance, **Spain's** national legislation on violence against women was amended to encompass obstetric violence, addressing practices such as forced pregnancy, denial of lawful abortion and non-consensual medical interventions as forms of violence. |

### 3.2 Integrate obstetric violence prevention into national health policies, guidelines and protocols.

Beyond laws, ministries of health and other relevant authorities should embed the prevention and response to obstetric and gynaecological violence into official health strategies and clinical guidelines. This means that any national strategy on maternal and child health, patient safety or gender-based violence should explicitly include objectives and actions to prevent, detect, address and remediate mistreatment in obstetric or gynaecological care. Clinical protocols (for

prenatal care, labour and delivery management, post-partum care, gynaecological exams, etc.) should be reviewed and revised to ensure that they align with the principles of respectful care and explicitly discourage practices deemed violent or disrespectful.

**International standards**

WHO's guidance on quality of maternal and newborn care includes maintaining dignity, communication and respect as core elements of care, recommending that health systems adopt policies that guarantee those rights. Furthermore, FIGO and the International Confederation of Midwives, in a joint effort with other international organizations, launched the International Childbirth Initiative, which calls on governments, midwives' professional associations, obstetric societies and other stakeholders to implement systemic quality-of-care improvement initiatives and abuse protocols. Aligning national health policies with such frameworks and engaging both medical and midwifery professional bodies in the implementation process adheres to global best practices.

**Examples**

**France** incorporated respectful maternity care into its national strategy via a dedicated action plan in 2018.[103] The government launched the National Action Plan for Better Birth Experiences in response to publicized cases of obstetric violence. The plan introduced measures to improve women's experiences in maternity units – from better communication and pain management to the prevention of obstetric violence. It provides for staff training, improved patient feedback mechanisms and public reporting on the quality of maternity care. The plan is part of France's broader strategy on women's rights in health care, aligning with its gender-equality policies.

While **Italy** does not have a single stand-alone obstetric violence action plan, it has integrated respectful maternity care into multiple national policy instruments. Italy's National Health Plan[104] and its adherence to WHO guidelines have emphasized the humanization of birth since the late 2000s. The Italian health-care system is now legally required to guarantee informed consent and respectful care in childbirth, following a resolution passed as a result of debates on obstetric violence in 2017–2018. Consequently, the elements of a strategy emerged: the Ministry of Health supported the drafting of the 2018 Obstetric Practice Code and encouraged Italy's regions to implement surveillance of birth experiences. Additionally, Italy's current National Plan on Violence against Women (which traditionally covered domestic violence) now acknowledges obstetric violence as a form of gender-based violence to be addressed.

103. Ministère des Solidarités et de la Santé, "Plan d'action national 'Pour des naissances respectées' 2018-2020", 2018.
104. Senato della Repubblica, Mozione 1-00551 "Tutela della partoriente e contrasto alla violenza ostetrica", approved on 13 December 2017.

**Spain**[105] has explicitly integrated respectful maternity care into its national strategies in recent years. In 2018, the Spanish government approved the National Action Plan for the Prevention of Obstetric Violence in line with its broader gender-based violence framework. This plan (under the Ministry of Equality and the Ministry of Health) provided a roadmap for upholding women's autonomy in childbirth, training health personnel and reviewing clinical protocols to eliminate unnecessary or harmful practices. Moreover, Spain's landmark Organic Law 1/2004 on Violence against Women was amended in 2021 to tackle obstetric violence, linking it to Spain's strategy on gender-based violence. The current Strategic Plan for Sexual and Reproductive Health also promotes a respectful and dignified childbirth environment.

### 3.3 Establish effective complaint and accountability mechanisms for victims of obstetric or gynaecological violence.

A crucial policy measure in this respect is the implementation and enhancement of women's reporting protections, which involves several components: setting up confidential and accessible complaint platforms (e.g., a dedicated hotline, an online portal or a patient ombudsman in hospitals) and guaranteeing a safe and unbiased complaint investigation process. In addition, clear pathways for disciplinary and legal action are needed to ensure accountability for proven cases of misconduct (such as professional sanctions or legal action under new laws).

**International standards**

In the case of *S.F.M. v. Spain* (CEDAW Communication No. 138/2018,[106] decision adopted 28 February 2020), the CEDAW Committee determined that Spain violated the Convention by subjecting a woman to obstetric violence during childbirth. In its remedies section, the Committee called on the State party to ensure "information at each stage of childbirth and establish a requirement for their free, prior and informed consent to be obtained for any invasive treatment performed during childbirth" and to "ensure access to effective remedies in cases in which women's reproductive health rights have been violated, including in cases of obstetric violence, and provide training to judicial and law-enforcement personnel". The decision thus requires States to adopt measures such as mandatory training for health-care and judicial professionals, public guidelines on informed consent and effective legal procedures for obstetric-violence cases.

105. Spain, Law 17/2020 Amending Law 5/2008 on Women's Right to Eradicate Gender-Based Violence (22 December 2020), *Official Gazette*, No. 11 (13 January 2021). Available at https://www.boe.es/diario_boe/txt.php?id=BOE-A-2021-464 (accessed on 30 September 2025).

106. CEDAW/C/75/D/138/2018.

| Examples |
| --- |
| In **Portugal**,[107] legislation provides for several complaint channels: (a) the Health Regulation Authority, where patients can report severe incidents; (b) the mandatory online complaints book in public institutions; and (c) the relevant professional council, which can receive direct complaints. However, a European Parliament study revealed that, until recently, obstetric and gynaecological violence had not even been listed as a distinct category in certain online complaint forms (e.g., in Denmark), hindering quantification. As a solution, dedicated mechanisms have been implemented in some countries. |
| In **Italy**,[108] in 2022, senators and deputies proposed the establishment of a National Birth Observatory to anonymously collect women's reports and monitor indicators such as the rate of interventions that bypass consent protocols. |
| Meanwhile, in **Belgium's** 2020–2024 plan,[109] partner non-governmental organizations (NGOs) play a central role: they are allocated funds to run awareness campaigns and can also provide a safe and accessible feedback channel for patients who may be hesitant to complain directly. |

### 3.4 Implement a system for routine monitoring, data collection and research on obstetric and gynaecological violence.

Public authorities should establish a framework to analyse the current study's findings, supplement them with qualitative research and then continuously measure the prevalence of obstetric and gynaecological violence and evaluate the effectiveness of interventions. This framework could include the addition of specific indicators to health information systems and surveys – for example, incorporating questions about respectful care and any abusive experiences in postnatal patient satisfaction surveys or demographic and health surveys. Regular research studies or audits should also secure funding – for instance, periodic surveys of women's birth experiences, studies on the impact of new policies (such as birth companion programmes or provider training) and facility compliance reviews. Findings must be integrated into the national action cycle – policy revision, budgeting and institutional reform – to ensure that subsequent actions are evidence-based.

| Examples |
| --- |
| Several countries have established systematic monitoring.[110] For example, **Croatia** included questions about obstetric violence in a national survey on account of widespread public reports, yielding data that spurred policy debate. |

107. Republic of Portugal, Law No. 15/2014 Establishing the Health Regulation Authority (ERS) Patient-Complaint Drocedure; Decree-Law No. 74/2017 on the Mandatory Electronic "Complaints Book".
108. House of Representatives, Bill C. 3474 (2022), Establishment of a National Birth Observatory.
109. International Planned Parenthood Federation Europe, "Gynaecological and obstetric violence", Policy Paper, July 2022. Available at https://europe.ippf.org/sites/europe/files/2022-11/Gynaecological%20and%20Obstetric%20Violence_IPPF%20EN%20Policy%20Paper.pdf (accessed on 4 November 2025).
110. Brunello and others, "Obstetric and Gynaecological Violence in the EU".

| |
|---|
| In **Brazil**, a multidisciplinary team formed from the Ministry of Health, public-health institutes and university researchers carried out the “Birth in Brazil” study, a nationwide survey of childbirth interventions and women’s experiences, uncovering high rates of unnecessary interventions and prompting updated guidelines. |
| **Spain** has incorporated obstetric-violence metrics into national surveys in recent years; in 2020, the Government’s Macro-Survey on Violence against Women for the first time included questions on childbirth, revealing that an estimated 1 in 10 women reported experiences of obstetric violence. |
| Outside Europe and Latin America, research conducted in **Tanzania** – the STaha (Respect) Project – demonstrated that a facility-level package of staff training, patient feedback and public charters reduced reported disrespect and abuse by two thirds within one year. These examples present compelling evidence that effective monitoring can be led by academic institutions, ministries of health or practice-based implementation teams, provided that data collection adheres to strict standards. |

## 4. Society as a platform for awareness and engagement

Obstetric and gynaecological violence is deeply rooted in societal attitudes towards women, pregnancy and health care. Therefore, meaningful change requires engaging broader society – not just those directly giving or receiving care. This approach emphasizes the crucial roles of community awareness, public discourse and civic engagement in preventing violence and supporting victims. When society at large moves beyond accepting certain behaviours as normal and instead regards them as violations of human rights, societal pressure can drive shifts in institutional and professional practices.

### 4.1 Launch public awareness and education campaigns on respectful maternal care and obstetric and gynaecological violence.

Government agencies (such as ministries of health, ministries of education and gender-equality bodies), in partnership with NGOs and the media, should run nationwide campaigns to inform the public about women’s rights in reproductive health care and the unacceptability of obstetric violence. Such campaigns could use radio, television, social media and community events to reach a broad audience, including people who may not be currently involved in childbirth. Whenever possible, they should feature credible advocates – reputable obstetricians, midwives, neonatologists or other high-profile public-health figures – who can lend professional authority, model positive attitudes and mitigate scepticism within the medical community. Key messages should include defining obstetric and gynaecological violence (with examples to make it identifiable), detailing why it constitutes a fundamental rights violation and how families and communities can support women in asserting their rights (for instance, encouraging a pregnant woman to ask questions and helping her seek a second opinion in cases of perceived infringement).

| International standards |
| --- |
| The need for public education is echoed in broader violence prevention strategies. For example, Council of Europe Resolution 2306/2019 on obstetric and gynaecological violence notes that "awareness-raising activities for the general public are essential to end obstetrical and gynaecological violence" and calls on member States to conduct information and awareness campaigns on patients' rights and on preventing sexism and violence against women, including gynaecological and obstetric violence, particularly during pregnancy, delivery and the post-partum period. Additionally, UN experts have highlighted that disseminating information widely is critical to spurring change across many countries. |
| **Examples** |
| **Belgium's** action plan on violence against women includes conducting awareness campaigns about obstetric violence, which involve disseminating information and holding talks at community centres and on maternity wards. In Argentina, the government's Respectful Birth campaign uses social media graphics and videos to educate the public about the fact that the routine use of certain interventions (such as episiotomies) or the denial of companionship can constitute obstetric violence and to encourage women to know their birthing rights. These campaigns have led to greater public discourse and contributed to more women demanding birth plans and respectful care |
| In the **Republic of Moldova**, during the 2024 16 Days of Activism campaign, the Center Partnership for Development and the news portal Agora launched a social media campaign called Care Heals What Fear Destroys. Using the pink rose emblem of the global Roses Revolution, the campaign reached around 450,000 online users in two weeks, generating more than 2,500 shares and 60 press stories. |
| In **Italy**, in 2016, the online movement #Bastatacere (Enough with the Silence) sourced hundreds of Facebook testimonials from new mothers about the abuse they experienced in maternity wards – ranging from verbal insults to forced medical interventions. The movement sparked public outrage and prompted members of parliament to propose specific legislative initiatives in response. |
| In **Croatia**, the 2014 campaign #PrekinimoŠutnju (Break the Silence) uncovered traumatizing obstetric practices. As a result, the issue was debated in the Sabor (parliament), and the Ministry of Health launched a pilot reform plan for maternity care. |
| In **Finland**, the 2019 #metooinbirth initiative provided a platform for many women to share their painful hospital experiences, highlighting the long-term impact of obstetric abuse; some reported a loss of trust in medical professionals and persistent trauma. |

### 4.2 Integrate education on gender equality, human rights and respectful health care into school curricula, youth programmes and pre-conception counselling.

To achieve lasting change, learning should begin early and continue throughout life. Educational content on respectful treatment in health services (including maternity care) should be embedded in secondary-school curricula and extracurricular youth initiatives and incorporated into pre-conception counselling sessions in line with WHO guidelines. Training prospective parents, health-care users, and providers about consent, bodily autonomy and patient–provider communication fosters a culture of respect and helps dismantle gender-unequal norms that legitimize abuse.

**International standards**

Comprehensive sexuality education – with specific components on gender equality, prevention of gender-based violence, human rights and respectful health care – should be integrated into school curricula, youth programmes and pre-conception counselling. While specific international standards on school curricula for obstetric violence are lacking, this recommendation aligns with broader goals of comprehensive sexuality education and human rights education promoted by UNESCO and other UN agencies, which include teaching about consent and gender equality. It also resonates with the Istanbul Convention's call for education to change attitudes about gender-based violence.

**Examples**

In **Sweden**[111] and **Norway**,[112] school programmes on sexual and reproductive health include discussions on childbirth and parenthood, including the importance of shared decision-making between a woman and her health-care providers. These discussions normalize the idea that a woman in childbirth has rights and should be treated as an active decision maker. In **France**,[113] some high schools incorporated topics on sexism in medicine into civics classes following national debates on obstetric violence, helping students understand that abuse can occur even in hospitals and must be challenged.

Outside formal schooling, countries such as the **Philippines**[114] offer community-based courses for parents, where expecting couples (even teenagers) receive training on pregnancy, including respectful care, effectively raising awareness in communities about maternal-care best practices.

111. UNESCO, "Sweden: Comprehensive Sexuality Education". Available at https://education-profiles.org/europe-and-northern-america/sweden/~comprehensive-sexuality-education?utm_source=chatgpt.com (accessed on 30 September 2025).
112. UNESCO, *The Journey towards Comprehensive Sexuality Education: Global Status Report* (Paris, 2021). Available at https://unesdoc.unesco.org/ark:/48223/pf0000379607 (accessed on 26 October 2025).
113. Seine-Saint-Denis Department, "Jeunes contre le sexisme et le Brevet de lutte contre les comportements sexistes et violents", 2023. Available at https://seinesaintdenis.fr/solidarite/ovf/article/jeunes-contre-le-sexisme-et-le-brevet-de-lutte-contre-les-comportements (accessed 30 September 2025).
114. Department of Health, *Basic Emergency Obstetric Care: A Trainer's Guide* (2004). Available at https://www.jica.go.jp/Resource/project/philippines/0600894/04/pdf/bemoc_guide.pdf (accessed on 30 September 2025).

In **Poland**, the Rodzić po Ludzku Foundation developed a national network of so-called guardians of respectful birth, 35 trained local women's rights advocates who encourage women to complete questionnaires on their birth experiences and who partner with local communities and hospitals to ensure that any identified issues are included in the public agenda. The guardians visit maternity wards to present patients' perspectives to medical staff and, thanks to their knowledge of local conditions, are able to act effectively to foster change, leading to lasting improvements in the quality of care.

In **Belgium**,[115] women's and midwives' organizations partnered in the development of a francophone anti-violence plan. They not only called for the inclusion of obstetric violence on the political agenda but are now also implementing government-funded projects (e.g., the creation of an educational video game for medical students on gynaecological violence and awareness campaigns targeting young women).

### 4.3 Support and partner with civil society organizations, women's rights and feminist groups, patient advocacy coalitions and survivor-led initiatives to combat obstetric violence.

Governments and health institutions should actively collaborate with human rights NGOs and feminist organizations – often the pioneers of legal and social change for women's autonomy – as well as maternal health NGOs, patient advocacy groups and survivor networks. These actors drive public awareness and, through their direct work with women and families, bring first-hand accounts of patient experiences and rights-based perspectives to the attention of policymakers. Support can include providing funding or venues for their activities, involving them in policymaking processes (such as committees drafting guidelines or monitoring implementation) and amplifying their campaigns.

**International standards**

The importance of civil society engagement is highlighted in various human rights mechanisms: the CEDAW Committee, for instance, often consults NGOs and encourages joint efforts with States to promote women's rights. FIGO and other professional bodies also encourage collaboration with women's groups as part of the International Childbirth Initiative.

**Examples**

In **Spain**, the Roses Revolution began as a grass-roots movement, where women who suffered obstetric violence laid roses at hospital doors and shared letters describing their experiences every year on 25 November (International Day for the Elimination of Violence against Women). This movement, led by activists and supported by associations of new mothers, generated widespread attention to obstetric violence in Spain and internationally. Validating its impact, several local governments across Spain initiated partnerships with these activists to implement training and awareness programmes.

115. Brunello and others, "Obstetric and Gynaecological Violence in the EU".

| |
|---|
| In the **United States**, organizations such as Improving Birth and the National Birth Equity Collaborative, which include women who have experienced traumatic births, have been instrumental in pushing hospitals to adopt respectful care practices; they often collaborate with hospital boards to incorporate patient feedback into quality improvement efforts. |

### 4.4 Promote open dialogue and media coverage to destigmatize experiences of obstetric and gynaecological violence.

This recommendation calls for leveraging media – from news outlets to social media platforms – to shed light on obstetric violence in a responsible, informative way. Health authorities and advocates can facilitate this effort by providing data, anonymized case studies and expert spokespeople to discuss the issue. Encouraging women who are willing to share their birth stories (with respect for their privacy and consent) in the media can also humanize the problem and break the culture of silence.

| Examples |
|---|
| In **Croatia**, in 2018, a wave of women's testimonies about abusive gynaecological procedures (sparked by a parliamentary speech recounting one woman's ordeal) flooded social media and the press, precipitating what was termed the #BreakTheSilence campaign. The intense media coverage forced the Croatian health minister to acknowledge the issue and resulted in the launching of a new phone line for complaints. |
| In **Brazil**, *telenovelas* (popular television soap operas) have begun to include storylines about respectful versus disrespectful maternity care, thereby raising awareness among broad audiences in an accessible way. |
| In the **United Kingdom**, investigative reports by the BBC and *The Guardian* on maternity scandals (though not framed as obstetric violence) have exposed patterns of substandard, disrespectful care and spurred inquiries and new guidelines for hospital care. |

# About UNFPA in Eastern Europe and Central Asia

In an era of unprecedented demographic change, UNFPA, the United Nations Population Fund, is helping shape a future where people and countries can thrive.

We champion demographic resilience, empowering countries to transform complex population shifts – from shrinking and ageing populations in Eastern Europe to expanding youth populations and growing workforces in Central Asia – into powerful opportunities for prosperity.

At the heart of our mission is the empowerment of women and young people – a key strategy for building a strong human capital base that can withstand and adapt to demographic change. By dismantling discrimination, challenging harmful norms, and removing systemic barriers, we help forge inclusive societies where everyone can reach their full potential.

Our work ensures that individuals, especially women and young people, have access to the information and services they need for a healthy life, free from violence. We help guarantee that everyone, throughout their life course and even in humanitarian crises, is empowered to make decisions about their bodies, health, and future. And we support countries in creating conditions so people can fully realize their family aspirations and have the number of children they desire.

Through policy expertise and strategic partnerships, UNFPA enables governments and communities to mitigate the potential risks of demographic change and harness its opportunities. We strengthen national capacities to understand and manage population dynamics with comprehensive, people-centered, and evidence-based strategies, building a sustainable, equitable, and prosperous future for all.

# About the Center Partnership for Development

Established in 1998, the Center Partnership for Development is a public institution dedicated to fostering inclusive dialogue on gender issues, women's status, and equal opportunities for women and men. As a non-governmental organization, the Center advocates building a community with equal perspectives and opportunities for its members, a society in which women and men are citizens with full rights who are able to find shared solutions to problems, benefit equally from new opportunities, and engage fully in political, economic and social activities. The Centre aims to ensure equal opportunities for and equal representation of men and women, including those who are marginalized, across all areas of life, by developing gender-sensitive public policies and empowering women via advocacy, research, training and capacity-building. Ensuring that no one is left behind and inclusion are key principles integrated within the Center's activities.

**Purpose.** To develop and strengthen resources and mechanisms for the equitable empowerment of women and men, fostering gender equality in the Republic of Moldova through a coherent and policy-driven approach.

**Mission.** To promote the values of gender equality as a fundamental element of an open and inclusive society, working towards a meaningful gender partnership.

**Vision.** A community where women and men have equal opportunities and prospects – a society in which all individuals are full citizens, capable of addressing challenges together, benefiting equally from emerging opportunities and actively engaging in their communities.

**Address**

Centrul Parteneriat pentru Dezvoltare / Center Partnership for Development
Str. Tighina 23/1, Chisinau, MD-2012, Republic of Moldova
Tel.: +(373 22) 23-70-89
www.progen.md
e-mail: cpd@progen.md

**UNFPA in Eastern Europe and Central Asia**
**United Nations Population Fund**
Istanbul, Türkiye
eecaro@unfpa.org

Find out more at eeca.unfpa.org