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No woman receiving care at any Obstetrics and Gynaecology (Ob-Gyn) Institution should ever be regarded merely as a case or a diagnosis. She is, first and foremost, a human being - entitled to compassionate, respectful, and dignified medical treatment, free from all forms of abuse, coercion, and degrading treatment.

TREATMENT OF WOMEN IN OBSTETRICS AND GYNAECOLOGY INSTITUTIONS

Belgrade, August 2022

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1. Introduction

In recent years, women worldwide have publicly reported experiencing obstetric violence in obstetric and gynaecological institutions (Ob-Gyn). Numerous studies conducted by international organisations have confirmed that women have been subjected to abuse and inhuman and degrading treatment across various aspects of medical care provided in the context of the protection of their reproductive health. Verbal abuse may be regarded as the initial manifestation of obstetric violence, whereas physical violence resulting in fatal outcomes may represent its most extreme consequence.

Obstetric violence became a subject of public attention in the Republic of Serbia at the beginning of 2022, when two women, Milica Filipović from the City of Šabac and Maja Simić Simeunović from the City of Belgrade, publicly disclosed their respective experiences. Milica Filipović was subjected to obstetric violence during a medically induced termination of pregnancy performed at the largest maternity facility in Serbia, the Obstetrics and Gynaecology Clinic “Narodni Front”. In the case of Maja Simić Simeunović, whose labour also took place at the Obstetrics and Gynaecology Clinic “Narodni Front”, the child died, and the mother sustained serious health consequences, including four uterine ruptures, as a result of obstetric violence. Through their public statements, these women brought the issue of obstetric violence into the public sphere and encouraged other women who had experienced similar treatment to report inhuman or degrading conduct in obstetric and gynaecological institutions.

With the aim of providing a platform for the disclosure of experiences related to obstetric violence, Milica Filipović established a Facebook group entitled “Stop Violence in Maternity Wards!” (**“Stop nasilju u porodilištima!”**), which has since grown to approximately five thousand members.¹

Obstetric violence constitutes a violation of legal norms governing human rights and patients’ rights within the healthcare system. It is essential to ensure that all women have access to effective legal protection in circumstances where their rights have been or may be violated. The testimonies publicly disclosed by women within the Facebook group “Stop Violence in Maternity Wards!” confirmed that obstetric violence exhibited the characteristics of a systemic violation of women’s rights in the context of the protection of their reproductive health.

¹ <https://www.facebook.com/groups/469792581448784>

In order to inform the competent state authorities of the systemic nature of the problem in obstetric and gynaecological institutions, where women have been exposed to maltreatment, a legal team was established to prepare a legal analysis concerning violations of women's rights in the context of reproductive healthcare. The analysis of the treatment of women in obstetric and gynaecological institutions identified numerous breaches of both international and domestic legal provisions and, as such, provides a basis for the competent authorities to adopt comprehensive measures aimed at the elimination of obstetric violence.

2. Methodology

Publicly disclosed testimonies of women concerning obstetric violence in obstetric and gynaecological facilities indicated that medical interventions intended to protect women's reproductive health were not performed in accordance with applicable regulations. The competent health authorities, including judicial authorities, failed to respond to publicly reported allegations of obstetric violence.

In light of the foregoing, the analysis commenced with the systematic collection of cases and testimonies of women who had experienced any form of violence in obstetric and gynaecological facilities. The initial step was undertaken by Milica Filipović and Maja Simić Simeunović, who publicly shared their respective experiences through social media platforms, television appearances, online portals, and podcasts. Both individuals submitted reports to the competent authorities with the intention of pursuing available legal mechanisms to safeguard their rights.

The subsequent step involved the establishment of a Facebook group entitled "Stop Violence at Maternity Wards!", within which women were invited to share their experiences in obstetric and gynaecological facilities. Based on the testimonies collected through this platform, it was concluded that systemic obstetric violence was present and continued to persist.

Thereafter, on 25th February 2022, a legal team established a dedicated email address to enable women to submit reports concerning obstetric violence. The deadline for submissions was set for April, 1st 2022. By that date, approximately two hundred reports had been received, further confirming the systemic nature of obstetric violence. The women who submitted their testimonies provided consent for their statements to be quoted, subject to the protection of their personal data. Specifically, 110 women consented to the quotation of their statements.

The analysis encompassed sixteen distinct forms of violence and abuse, including any conduct constituting cruel and/or inhuman treatment of patients. The findings in respect

of all sixteen forms are presented through graphical representations, with the results expressed as percentages set out below.

Research and analyses conducted by international authorities, including the World Health Organization, the Parliamentary Assembly of the Council of Europe, and the United Nations, have demonstrated that efforts aimed at the elimination of obstetric violence have been ongoing for more than a decade. The intensity of such efforts has increased in parallel with the empowerment of women who have experienced obstetric violence to report such conduct. The relevant research findings and analyses are presented in this Report hereunder.

3. International Legal Framework for Protection against Obstetric Violence

At the international level, women's rights relating to reproductive health are regulated by numerous legal instruments. International provisions protecting women's reproductive health rights may be broadly categorised into two groups. The first group comprises general norms governing human rights, whereas the second group consists of provisions that specifically define reproductive health and recognise women's rights to make independent decisions regarding medical treatment, both directly and comprehensively.

3.1. Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (Hereinafter: CEDAW) establishes measures aimed at preventing any form of direct and/or indirect discrimination against women. States Parties are under an obligation to ensure that women enjoy civil, political, economic, social, and cultural rights on an equal basis with men. Within the category of social rights, the Convention recognises the right to healthcare.²

One of the underlying reasons for the adoption of the Convention was the international concern arising from the fact that women living in conditions of poverty generally have the most limited access to healthcare. Pursuant to CEDAW, all States Parties are required to adopt appropriate measures to ensure that women have access to specific educational information necessary to safeguard health and ensure the well-being of the family, including information and counselling on family planning.³ Pursuant to the Convention, States Parties are obliged to ensure the protection of women's biological and

² The Convention on the Elimination of All Forms of Discrimination against Women, adopted by UN General Assembly Resolution 34/180 on December 18, 1979, entered into force on September 3, 1981 in accordance with Article 27. The SFRY ratified it in 1981 ("Official Gazette of the SFRY" - International Treaties, No. 11/81), and it entered into force in 1982. In addition to the Convention, the FRY also became a member of the Optional Protocol to the Convention, which was adopted by the UN in October 1999, and which entered into force in 2000 ("Official Gazette of the FRY" - International Agreements, No. 13/2002)

³ Article 10 of the CEDAW

reproductive functions.⁴ CEDAW tackles Health Care the most thoroughly within Article 12, wherein the prohibition of discrimination of women and full equality between men and women in terms of ensuring access to Health Services, including those related to family planning. Women must be provided with special Health Care during pregnancy, childbirth and the post-natal period, and all health services must be available to them during this period. Furthermore, States are under obligation to provide adequate nutrition to women during pregnancy and breastfeeding.

To facilitate the implementation of CEDAW's Article 12, General Recommendation No.24 was adopted (hereinafter referred to as Recommendation 24), whereby women's rights, in terms of availability, scope and quality of Health Care must not depend on men, meaning that the treatment of the woman at any Ob -Gyn Facility must not be any different regardless of the man being present or not. It is particularly pointed out in Recommendation 24 that the Signatory States must submit to the CEDAW Committee their reports containing data on measures which provide women with adequate treatments regarding pregnancy, child birth and the post-natal period. The reports should include information on measures based on which maternal mortality and morbidity rates have been decreased.

In situations where women are exposed to life-threatening conditions or a risk of permanent disability arising from pregnancy, each State Party is obliged to ensure access to emergency obstetric services that are adequately equipped and resourced so as to provide a satisfactory standard of healthcare. This standard, as established under CEDAW, underscores the necessity of examining healthcare systems in which gynaecologists are permitted to practise simultaneously in both the public and private healthcare sectors, as is the case in Serbia. The issue may also be considered from the perspective of availability and accessibility of healthcare, particularly in relation to dual financial burdens, namely mandatory health insurance contributions and additional "out-of-pocket" payments for services provided in the private sector. The cost of healthcare services constitutes a relevant concern, insofar as the requirement to pay substantial fees for the majority of services (including diagnostic analyses, medical imaging, and similar procedures) may indicate that healthcare is not equally accessible to all women, contrary to CEDAW standards.

CEDAW and General Recommendation No. 24 emphasise that the quality of healthcare services may be assessed on the basis of whether a woman is enabled to provide full and informed consent, whether her dignity is respected, and whether the confidentiality of sensitive personal data is ensured. Furthermore, both instruments explicitly provide that States Parties must prohibit and prevent any form of coercion that would violate a woman's dignity.

⁴ Article 11 of the CEDAW

Given that women may be subjected to various medical interventions within healthcare facilities that could violate their dignity and amount to inhuman or degrading treatment, it is essential to refer to international legal instruments adopted for the purpose of preventing abuse, torture, and inhuman or degrading treatment. When such forms of treatment are considered in conjunction with norms governing patients' rights, it becomes evident that patients must provide informed consent for any medical intervention, and that healthcare services must be directed toward the reduction of pain and suffering.

The universally recognised prohibition of torture, as well as the principle that medical services must aim to reduce or eliminate pain and suffering in female patients, is reflected in several international legal instruments.

3.2. Universal Declaration of Human Rights⁵ proclaims that all human beings are born free and equal in dignity and rights⁶, and no one shall be subjected to torture or cruel, inhuman and degrading treatment or punishment.⁷

3.3. The International Covenant on Civil and Political Rights⁸ The prohibition of torture has been further defined in more specific terms, extending its scope beyond traditional settings such as prisons and detention centres and encompassing the prohibition of medical interventions carried out without consent.

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his or her free consent to medical or scientific experimentation.

3.4. United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UNCAT) (hereinafter referred to as UNCAT)⁹ includes the definition of the prohibition of torture,¹⁰ but it explicitly prohibits States Parties to refer to extraordinary circumstances to justify torture.¹¹ That is, the absolute prohibition of torture is stipulated under any circumstances.

3.5. European Convention on Human Rights (ECHR) (hereinafter referred to as: ECHR)¹² was adopted in 1950 and contains the norm prohibiting torture

⁵ <https://www.un.org/en/about-us/universal-declaration-of-human-rights>.

⁶ Article 1 of the Universal Declaration of Human Rights.

⁷ Article 5 of the Universal Declaration of Human Rights.

⁸ 1966

⁹ "Official Gazette of the SFRY" - International Agreements, No. 9/91; adopted in 1984 in the UN General Assembly

¹⁰ Article 1 of the UNCAT

¹¹ The possibility of invoking some exceptional circumstance, regardless of whether it is a state of war, threat of war, internal political instability or any other state of emergency, to justify torture is excluded.

¹² "SCG Official Gazette" - International Agreements, no. 9/2003, 5/2005 and "RS Official Gazette" - International Agreements, No. 12/2010. Law on Ratification of Protocol No. 14. - "SCG Official Gazette" -

No one shall be subjected to torture or to inhuman or degrading treatment or punishment.¹³

3.6. European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (ECPT),¹⁴ On the basis of Article 3 of the European Convention on Human Rights (ECHR), the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment was adopted in 1987 under the auspices of the Council of Europe. The advancement of protection against torture is reflected in the establishment of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), which was created by this Convention.

3.7. European Charter of Patients' Rights (hereinafter referred to as EU Charter)¹⁵ The European Charter of Patients' Rights was proclaimed in Rome in 2002. Its primary objective is to promote the protection of patients' rights and to ensure the continuity and quality of healthcare services. In addition to the right to information and informed consent, the Charter recognises the right to safety.

Each individual has the right to be free from harm caused by the poor functioning of health services, medical malpractice and errors, and the right to access health services and treatments which meet high safety standards.¹⁶

3.8. The Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence (hereinafter: the Istanbul Convention)¹⁷ does not explicitly include the term "obstetric violence." However, Article 39 expressly prohibits forced abortion and forced sterilisation..¹⁸

This Convention establishes a comprehensive legal framework aimed at preventing and combating violence against women in all its forms, which may also encompass obstetric violence occurring in obstetric and gynaecological institutions. Accordingly, it is essential that the standards set forth in the Istanbul Convention be applied to the prevention of violence against women irrespective of the setting in which such violence occurs.

International Agreements, No. 5/2005 and 7/2005. Law on Ratification of Protocol No. 15. – "RS Official Gazette" - International Agreement, no. 10/2015;
https://www.echr.coe.int/Documents/Convention_SRP.pdf.

¹³ Article 3 of the ECHR

¹⁴ "SCG Official Gazette" – International Treaties, No. 9/2003.

¹⁵ https://ec.europa.eu/health/ph_overview/co_operation/mobility/docs/health_services_co108_en.pdf

¹⁶ Article 9 of the EU Charter

¹⁷ "RS Official Gazette" – International Treaties, No. 12/2013; <https://pace.coe.int/en/files/28017/html>

¹⁸ Article 39 – Forced abortion and forced sterilisation

"Parties shall take the necessary legislative or other measures to ensure that the following intentional conducts are criminalised:

- a. performing an abortion on a woman without her prior and informed consent;
- b. performing surgery which has the purpose or effect of terminating a woman's natural capacity to reproduce without her prior and informed consent or understanding of the procedure."

3.9. Relevant Reports on the Position of Women with Regard to Reproductive Health - The issue of obstetric violence and unconscionable treatment of women in obstetric and gynaecological institutions has been raised at both national and international levels. Reports issued by the World Health Organization and the Parliamentary Assembly of the Council of Europe have identified significant deficiencies in the treatment of women within obstetric and gynaecological institutions, as well as the need to undertake appropriate measures aimed at ensuring the protection of women's health.

3.9.1. World Health Organization (hereinafter: WHO)¹⁹ adopted Recommendations on Intrapartum Care for a Positive Childbirth Experience (hereinafter: WHO Recommendations).²⁰

The World Health Organization (WHO), in its *WHO Recommendations: Intrapartum Care for a Positive Childbirth Experience*, emphasises that risk assessment during pregnancy and childbirth must be regarded as a continuous clinical process rather than a single prenatal evaluation. Risk assessment should be undertaken during the antenatal period and must take into account relevant clinical factors, including maternal age, height, parity, history of complications in previous births (such as stillbirths or prior caesarean sections), abnormalities identified in the current pregnancy, anaemia, fetal presentation and position, and other pertinent medical considerations.

A birth plan should be developed in accordance with the clinical assessment, specifying the planned place of birth and the healthcare professionals responsible for providing care. However, even where an antenatal risk assessment has been duly performed and a birth plan established accordingly, reassessment is required at the onset of labour, as changes in the clinical condition of the woman or the fetus, including fetal position or other obstetric factors, may necessitate modification of the initial plan.

The WHO categorises clinical practices during childbirth into four groups:

1. Practices that are recommended and should be encouraged, as they are supported by evidence of benefit;
2. Practices that are not recommended because they are harmful or ineffective;
3. Practices for which evidence is insufficient to support a clear recommendation and which should therefore be applied with caution;
4. Practices that are frequently used inappropriately.

¹⁹ <https://www.who.int/>

²⁰ <https://www.mhtf.org/document/care-in-normal-birth-a-practical-guide/>

In 2020, the WHO issued further Guidance on childbirth care²¹, developed in response to global data demonstrating that complications arising during labour and delivery contribute to a significant proportion of adverse outcomes, including

1. more than one-third of maternal deaths,
2. approximately one-half of stillbirths,
3. and one-quarter of neonatal deaths.

Such guidance is intended to be implemented in obstetric and gynaecological institutions at all levels of healthcare.

In 2015, the World Health Organization (WHO) issued the *WHO Statement on the Prevention and Elimination of Disrespect and Abuse during Facility-Based Childbirth*, based on documented testimonies and evidence concerning women's experiences in obstetric and gynaecological facilities. The Statement recognised that women worldwide experience disrespectful and abusive treatment during facility-based childbirth, including physical abuse, humiliation, and verbal abuse.²² It further identified practices such as non-consented medical procedures, including sterilisation, breaches of confidentiality, violations of informed consent, and the unnecessary infliction of pain and suffering, including through the failure to provide appropriate pain relief when indicated. The Statement also addressed violations of privacy, denial of admission to health facilities, and neglect during childbirth, practices which may endanger women's lives and contribute to preventable complications.

3.9.2. The United Nations (hereinafter: UN)²³ in 2019, the United Nations published the Report of the Special Rapporteur on violence against women, its causes and consequences, on a human rights-based approach to mistreatment and violence against women in reproductive health services, with a focus on childbirth and obstetric violence (hereinafter: UN Report on obstetric violence).²⁴

The UN Report states that obstetric mistreatment and violence against women occur worldwide and are widespread across different social and institutional contexts. Within the Report, the term "obstetric violence" refers to violence experienced by women in healthcare facilities during childbirth. The Report further notes that, in certain Latin American countries, obstetric violence has been recognised as a distinct legal concept and criminalised, with an emerging tendency towards broader recognition and criminalisation of such conduct.

²¹ <https://apps.who.int/iris/bitstream/handle/10665/337693/9789240017566-eng.pdf>

²² https://apps.who.int/iris/bitstream/handle/10665/134588/WHO_RHR_14.23_eng.pdf

²³ <https://www.un.org/en/>

²⁴ <https://digitallibrary.un.org/record/3823698?ln=en>

Particular concern is expressed regarding the overuse and misuse of caesarean sections and episiotomies, especially where such procedures are performed without a woman's prior and informed consent or without the provision of adequate information. The Report also highlights situations in which obstetric care is provided by medical personnel lacking sufficient knowledge or experience, particularly in the field of childbirth, resulting in adverse consequences for women's health and lives.

Additionally, the continued use of the Kristeller manoeuvre is identified, despite WHO recommendations advising against its practice. A further form of maltreatment described in obstetric and gynaecological institutions concerns post-partum suturing performed without the administration of anaesthesia.

The Report also addresses degrading and inhuman treatment manifested through communication, including the use of derogatory language, insults, shouting, threats of physical violence, and the attribution of blame to women for adverse outcomes, particularly in relation to their newborns' health.

The violation of the right to informed consent is identified as a widespread practice. In many instances, women are required, upon admission to an obstetric and gynaecological institution, to sign blanket consent forms authorising all medical interventions without adequate explanation or individual assessment. In other cases, consent forms are presented during labour, at a time when women are unable to seek clarification, ask questions, or make a free and informed decision regarding a specific medical procedure.

3.9.3. In 2019, the Parliamentary Assembly of the Council of Europe adopted Resolution 2306 (2019), entitled "Obstetrical and gynaecological violence"²⁵ determined that women have been subjected to various forms of violence in healthcare settings, including inappropriate or non-consensual medical acts such as episiotomies, vaginal examinations performed without consent, the application of fundal pressure, and painful interventions carried out without anaesthesia.

The Resolution further refers to reports of sexist behaviour during medical consultations and recognises that obstetrical and gynaecological violence are closely interconnected and cannot be considered in isolation. The Parliamentary Assembly unequivocally condemns all forms of violence against women, including obstetrical and gynaecological violence. It further emphasises that difficult working conditions within certain healthcare facilities cannot serve as justification for violence or degrading treatment.

To this end, the Parliamentary Assembly calls upon member States to undertake all necessary preventive measures and to ensure full respect for human rights, particularly in the field of healthcare.

²⁵ <http://assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-en.asp?fileid=28236&lang=en>

3.9.4. The international organisation **Human Rights in Childbirth (hereinafter: HRIC)** published the report entitled *“Maltreatment and Violence against Women during Reproductive Health Care, with a Focus on Childbirth.”*²⁶ In May 2019, Human Rights in Childbirth (hereinafter: HRIC) presented a report addressing the position of women during pregnancy, childbirth, and the postnatal period. The report emphasises that maltreatment and abuse of women within reproductive healthcare are global phenomena and that identifiable patterns of violations of women’s rights can be observed across different healthcare systems.

The report further indicates that obstetric violence occurs on a continuous basis and that such treatment is often sustained by the public stigmatisation of women who seek to assert and protect their rights. This condemnation most frequently arises in situations where women request medical interventions aimed at minimising pain and suffering.

Particular concern is expressed regarding the process of obtaining informed consent. The report identifies recurring problems at the stage when a woman seeks an explanation of a proposed medical intervention, its potential consequences, and her current health condition. In the absence of genuine informed consent, women are deprived of the ability to make independent decisions regarding medical treatment and to participate actively in their own healthcare.

The report further documents that women in healthcare facilities are frequently exposed to abuse and disrespect, manifested through the misuse of professional authority. Such conduct includes offensive remarks, verbal abuse, threats, expressions of contempt, violations of bodily integrity, public humiliation, and physical abuse. Women perceived as “disobedient,” including those who decline to comply unquestioningly with medical instructions, are often subjected to punitive treatment.

In addition, the performance of painful procedures without adequate explanation or consent is reported as common practice, including the refusal of healthcare professionals to implement measures aimed at reducing pain.

3.9.5. The National Center for Biotechnology Information (NCBI) published an analysis entitled *“Operationalizing a Human Rights-Based Approach to Address Mistreatment against Women.”*²⁷ The terms “obstetric violence,” “inhuman care,” “disrespect,” and “abuse” are used in practice; however, in the analysis, these concepts are collectively encompassed under the expression “mistreatment of women during childbirth.”

According to the analysis, mistreatment may be categorised into several groups:

²⁶ https://www.ohchr.org/sites/default/files/Documents/Issues/Women/SR/ReproductiveHealthCare/Human_Rights_in_Childbirth.pdf

²⁷ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7348458/>

1. **Physical mistreatment:** acts such as beating, hitting, slapping, kicking, or pinching by nurses, midwives, or physicians; the application of painful and medically unjustified procedures; and repeated or unnecessary vaginal examinations during childbirth.
2. **Verbal mistreatment:** offensive, discriminatory, rude, or contemptuous forms of communication directed at women during labour and childbirth.
3. **Lack of informed consent and deprivation of freedom of choice:** failure to obtain valid informed consent and restriction of women's autonomy in decision-making regarding medical interventions.
4. **Neglect and institutional practices:** deliberate delay in the provision of care (including post-partum suturing), segregation of women based on nationality or other status, and removal or detention practices, such as holding women and newborns in hospital facilities due to an inability to pay childbirth-related costs.

3.9.6. The IRCCS Materno Infantile “Burlo Garofolo” Pediatric Institute (Trieste, Italy)²⁸ conducted research within the framework of the IMAGINE EURO project (*Improving Maternal Newborn Care in the WHO European Region*). The study encompassed twelve European countries, including Serbia, and assessed the quality of maternal and newborn care across four domains: provision of care; experience of care; availability of human and physical resources; and changes associated with the COVID-19 pandemic.²⁹

According to the findings, 46.2% of women respondents in Serbia reported that they did not receive pain relief during childbirth. Serbia ranked second among the participating countries with regard to the rate of episiotomy, with such procedures reported in 59.3% of cases. Furthermore, when asked whether they had the opportunity to make choices regarding their care and treatment, 77.2% of women respondents in Serbia indicated that they had been deprived of such choice.

²⁸ <https://www.burlo.trieste.it/>

²⁹ <https://www.burlo.trieste.it/ricerca/imagine-euro-improving-maternal-newborn-care-euro-region> (survey) <https://www.sciencedirect.com/science/article/pii/S2666776221002544> (research results)

4.National Regulations

Within the national legal framework, there are provisions that ensure the protection of women in the context of healthcare service delivery. Violations of women's rights, including reproductive health rights, may be subsumed under the term "obstetric violence." This term encompasses various forms of mistreatment and violence against women, ranging from verbal abuse to physical violence.

4.1. The Constitution of the Republic of Serbia (hereinafter: the RS Constitution)³⁰ The RS Constitution guarantees human and minority rights and freedoms, which shall be directly applicable.³¹ It further provides that human and minority rights guaranteed by generally accepted rules of international law, ratified international treaties, and domestic legislation shall be directly implemented. Human rights serve to protect human dignity and ensure the full exercise of freedom and equality for every individual within a just, open, and democratic society founded on the principle of the rule of law.³²

Human and minority rights guaranteed by the RS Constitution may be restricted by law. Any such restriction must be permitted by the RS Constitution and must pursue a constitutionally legitimate aim. The scope of the restriction must be proportionate and necessary, and it must not affect the essence of the guaranteed right. The achieved level of human and minority rights may not be reduced.

When restricting human and minority rights, all state authorities are obliged to take into consideration:

1. the nature and substance of the right being restricted;
2. the importance, nature, and scope of the legitimate aim pursued;
3. the proportionality of the restriction in relation to its purpose;
4. the possibility of achieving the intended purpose through less restrictive means.³³

The RS Constitution guarantees equality before the law and the right to equal legal protection without discrimination. Any direct or indirect discrimination on any grounds, including race, sex, nationality, religion, political or other opinion, property status, culture, language, age, or mental or physical integrity, is prohibited.

Measures introduced for the purpose of achieving full equality of individuals or groups who are in a substantially unequal position compared to others, including special health

³⁰ "RS Official Gazette", No. 98/2006 and 115/2021

³¹ Article 18 of the Constitution of the Republic of Serbia

³² Article 19 of the Constitution of the Republic of Serbia

³³ Article 20 of the Constitution of the Republic of Serbia

protection afforded to women, pregnant women, or women in labour, shall not be considered discrimination.³⁴

In the event of a violation or denial of human and minority rights, everyone shall be entitled to judicial protection and to the elimination of consequences arising from such violations. Every citizen shall have the right to address international institutions for the purpose of protecting the freedoms and rights guaranteed by the RS Constitution.³⁵

The RS Constitution guarantees the protection of human dignity and the free development of personality. Human dignity is inviolable, and all persons are obliged to respect and protect it. Everyone shall have the right to the free development of his or her personality, provided that such development does not infringe upon the rights of others guaranteed by the RS Constitution.³⁶

The RS Constitution further guarantees the protection of human life³⁷ and the inviolability of physical and mental integrity³⁸. Human life is inviolable. No person shall be subjected to torture, inhuman or degrading treatment or punishment, nor shall anyone be subjected to medical or scientific experimentation without his or her freely given consent.

Everyone shall have the right to personal liberty and security. Deprivation of liberty shall be permissible only under conditions prescribed by law. Accordingly, no person may be unlawfully detained in a healthcare institution, including an obstetric and gynaecological facility.³⁹

Judicial protection shall be independent, impartial, fair, and provided within a reasonable time. Everyone shall have the right to a tribunal established by law, which shall publicly examine and decide on their rights and obligations, on the grounds for instituting proceedings, and on any charges brought against them.⁴⁰ Protection of rights before courts and other state authorities, holders of public powers, bodies of autonomous provinces, and units of local self-government shall be equal for all. The RS Constitution further guarantees the right to appeal or to another legal remedy against any decision concerning one's rights, obligations, or legally based interests.⁴¹

The protection of personal data is guaranteed by the RS Constitution. The collection, storage, processing, and use of personal data shall be regulated by law. The use of personal data for purposes other than those for which they were collected shall be prohibited and subject to sanction. Everyone shall have the right to be informed of

³⁴ Article 21 of the Constitution of the Republic of Serbia

³⁵ Article 22 of the Constitution of the Republic of Serbia

³⁶ Article 23 of the Constitution of the Republic of Serbia

³⁷ Article 24 of the Constitution of the Republic of Serbia

³⁸ Article 25 of the Constitution of the Republic of Serbia

³⁹ Article 27 of the Constitution of the Republic of Serbia

⁴⁰ Article 32 of the Constitution of the Republic of Serbia

⁴¹ Article 36 of the Constitution of the Republic of Serbia

personal data collected about them in accordance with the law and to judicial protection in the event of misuse.⁴²

Freedom to decide on childbirth shall be guaranteed by the RS Constitution.⁴³

The RS Constitution provides special protection to the family, the mother, the single parent, and the child. The mother shall be entitled to special support and protection before and after childbirth.⁴⁴

Everyone shall have the right to healthcare, including physical and mental healthcare. The RS Constitution guarantees healthcare to children, pregnant women, mothers during maternity leave, single parents with children up to seven years of age, and elderly persons.⁴⁵

4.2. The Law on Healthcare (hereinafter: the LoH - ZZZ in Serbian)⁴⁶ The Law on Healthcare represents one of the principal regulatory frameworks governing the organisation and functioning of the healthcare system. It regulates healthcare as an organised and comprehensive social activity aimed at safeguarding and improving public health.

The primary objective of healthcare is the achievement of the highest attainable standard of preservation and enhancement of the health of citizens. Healthcare encompasses measures for the prevention, control, and early detection of diseases, injuries, and other health disorders, as well as timely, effective, and efficient treatment, medical care, and rehabilitation.⁴⁷

The right to healthcare shall be guaranteed to every citizen of the Republic of Serbia, as well as to foreign nationals and stateless persons who are temporarily or permanently residing in the Republic of Serbia.⁴⁸ Healthcare providers constitute one of the key participants within the healthcare system.⁴⁹

Social care for health is exercised through the provision of healthcare services to population groups exposed to increased health risks, as well as to individuals requiring prevention, control, early detection, and treatment of conditions of particular importance to public health. Such care shall be provided under equal conditions throughout the territory of the Republic of Serbia. Social care for health includes individuals who are

⁴² Article 42 of the Constitution of the Republic of Serbia

⁴³ Article 63 of the Constitution of the Republic of Serbia

⁴⁴ Article 66 of the Constitution of the Republic of Serbia

⁴⁵ Article 68 of the Constitution of the Republic of Serbia

⁴⁶ "RS Official Gazette" No.25/19

⁴⁷ Article 2 of the LoH

⁴⁸ Article 3 of the LoH

⁴⁹ Article 4 of the LoH

planning a family, as well as women during pregnancy, childbirth, and the maternity period up to twelve months after childbirth.⁵⁰

Healthcare provision in the Republic of Serbia is based on the following principles:

1. **The Principle of Respect for Human Rights and Values and Children's Rights in Healthcare**, which ensures the highest standard of protection of human rights and values in the provision of healthcare. This includes the right to life, the inviolability of physical and mental integrity, the inviolability of human dignity, the promotion of sex and gender equality, and respect for moral, cultural, religious, and philosophical affiliations, including the prohibition of human cloning.⁵¹
2. **The Principle of Equity in Healthcare**, which refers to the prohibition of discrimination. In accordance with the Constitution, measures introduced to achieve full equality, protection, and advancement of individuals or groups in a substantially unequal position shall not be considered discrimination.⁵²
3. **The Principle of Comprehensiveness of Healthcare**, which ensures that all citizens are included in the healthcare system. It encompasses coordinated measures and activities relating to health promotion, disease prevention, early diagnosis, treatment, medical care, and rehabilitation.⁵³
4. **The Principle of Accessibility of Healthcare**, which requires that adequate healthcare be provided to all citizens. Healthcare services must be physically, geographically, economically, and communicatively accessible, and culturally acceptable, including accessibility for persons with disabilities.⁵⁴
5. **The Principle of Continuity of Healthcare**, which is exercised throughout the healthcare system. Continuity is ensured through functional coordination and integration between primary, secondary, and tertiary levels of healthcare.⁵⁵
6. **The Principle of Continuous Improvement of Quality and Safety in Healthcare**, which is implemented through measures and activities aligned with contemporary developments in medical science and practice. Its objective is to increase the likelihood of favourable health outcomes and to minimise risks and adverse consequences for the health of individuals and the community.⁵⁶

⁵⁰ Article 11, paragraph 2, item 3 of the LoH

⁵¹ Article 20 of the LoH

⁵² Article 21 of the LoH

⁵³ Article 22 of the LoH

⁵⁴ Article 23 of the LoH

⁵⁵ Article 24 of the LoH

⁵⁶ Article 25 of the LoH

7. **The Principle of Efficiency in Healthcare**, which is achieved by attaining the best possible health outcomes in relation to available financial resources, that is, by providing the highest attainable level of healthcare with the optimal use of resources.⁵⁷

Healthcare for women is organised across all three levels of the healthcare system. At the primary level, community health centres provide healthcare services for women.⁵⁸ At the secondary level, general hospitals perform healthcare activities in the field of obstetrics and gynaecology.⁵⁹ At the tertiary level, women's healthcare is organised within university clinical centres, clinical centres, and specialised institutes and clinics.

4.3. The Health Insurance Act (hereinafter: the HIA – ZZO in Serbian)⁶⁰ The Health Insurance Act regulates the rights arising from compulsory health insurance and the conditions for their exercise, the financing of compulsory health insurance, the contracting and provision of healthcare services, the organisation of the health insurance system, and other matters relevant to the functioning of compulsory health insurance. The Act further regulates voluntary health insurance.⁶¹

Compulsory health insurance is based on the following principles:

1. **The Principle of Mandatory Participation**, which establishes compulsory enrolment in the health insurance system as a legal obligation.
2. **The Principle of Solidarity and Reciprocity**, which provides that the costs of compulsory health insurance are financed by insured persons and other contributors through mandatory contributions, while the rights arising from compulsory health insurance are exercised by individuals who are affected by illness or other circumstances covered by insurance.
3. **The Principle of Transparency**, which guarantees the right of insured persons to receive comprehensive information concerning compulsory health insurance and ensures the transparency of the work of the Republic Health Insurance Fund (RHIF).
4. **The Principle of Protection of Insured Persons' Rights and the Public Interest**, which requires the RHIF to enable insured persons to exercise and protect their rights in the most accessible and efficient manner possible, ensuring that the exercise of such rights does not infringe upon the rights of others or contravene the legally established public interest.

⁵⁷ Article 26 of the LoH

⁵⁸ Article 75, paragraph 1, item 3 of the LoH

⁵⁹ Article 91, paragraph 3, item 2 of the LoH

⁶⁰ "RS Official Gazette" No.25/2019

⁶¹ Article 2 of the HIA

5. **The Principle of Continuous Quality Improvement**, which entails monitoring contemporary developments in health insurance systems and enhancing the functioning of compulsory health insurance accordingly.
6. **The Principle of Cost-Effectiveness and Efficiency**, which requires that rights arising from compulsory health insurance be exercised in their full scope and content, and in accordance with established standards, while ensuring the optimal use of financial and other resources.

Healthcare services covered under compulsory health insurance include examinations and treatment related to family planning, pregnancy, the postnatal period, and termination of pregnancy for medical reasons.⁶² Women shall be entitled to rights arising from compulsory health insurance in relation to family planning, pregnancy, childbirth, and up to twelve months following childbirth, irrespective of the basis of insurance.⁶³ The chosen physician, namely a gynaecologist, shall determine the gestational age relevant for the exercise of rights relating to maternity leave.⁶⁴

Women shall also be entitled to healthcare in the event of illness or injury occurring outside the workplace.⁶⁵ Such entitlement includes examinations and treatment related to family planning, pregnancy, childbirth, and the postnatal period up to twelve months after delivery.⁶⁶ For the purposes of preserving and improving health, preventing, early detecting, and controlling diseases and other health disorders, women shall be provided with preventive and educational measures, including health education concerning family planning, prevention of unwanted pregnancy, contraception, female sterilisation, pregnancy testing, as well as testing and treatment for sexually transmitted infections, including HIV.⁶⁷

Examinations and treatment relating to family planning, pregnancy, childbirth, and the postnatal period include, in particular:

1. Medical diagnosis and treatment of infertility;
2. Examinations and treatment during pregnancy (including the antenatal, intrapartum, and postnatal periods), management of conditions that may lead to pregnancy-related complications, and termination of pregnancy for medical reasons, including prenatal and genetic testing and other preventive measures;
3. Inpatient treatment when medically indicated, including childbirth in a healthcare institution;

⁶² Article 131 of the HIA

⁶³ Article 16 of the HIA

⁶⁴ Article 143 of the HIA

⁶⁵ Article 51 of the HIA

⁶⁶ Article 52, paragraph 1, item 2 of the HIA

⁶⁷ Article 53, paragraph 1, item 4 of the HIA

4. Home visits by community nurses and the provision of assistance to women in labour, as well as routine care of the newborn provided by community nursing services.⁶⁸

Women shall also be entitled to wage compensation in cases of temporary incapacity for work due to illness or pregnancy-related complications.⁶⁹

4.4. The Law on Exercising Healthcare Rights for Children, Pregnant Women and Women in Labour (hereinafter: the LCPL - ZDTP in Serbian)⁷⁰ regulates the right to healthcare and reimbursement of transportation costs arising from the use of healthcare services for children, pregnant women, and women in labour, irrespective of the basis of their insurance, in situations where such rights cannot be exercised under compulsory health insurance pursuant to the law governing health insurance. The LCPL defines the terms “pregnant woman” and “woman in labour.” A pregnant woman shall be a woman whose pregnancy has been confirmed by a specialist in obstetrics and gynaecology. A woman in labour, within the meaning of this Law, shall be a woman up to twelve months following the birth of a live child.⁷¹

Pregnant women shall exercise the rights prescribed by the LCPL on the basis of a health insurance card issued by the Republic Health Insurance Fund (RHIF), irrespective of the validity of that card, and on the basis of a specialist’s report confirming the pregnancy. Women in labour shall exercise the rights prescribed by the LCPL on the basis of a health insurance card issued by the RHIF, irrespective of its validity, and on the basis of a discharge report issued by the healthcare institution in which the childbirth was conducted.⁷²

4.5. The Law on Patients’ Rights (hereinafter: the LPP – ZoPP in Serbian)⁷³ The Law on Patients’ Rights (hereinafter: the LPP) regulates patients’ rights in the context of healthcare service delivery, the manner of their exercise and protection, as well as other matters relating to patients’ rights and responsibilities. For every female patient, the exercise of the right to quality and continuous healthcare is of particular importance. This right is guaranteed by the RS Constitution, the Law on Healthcare, the Health Insurance Act, and the LPP.

Quality and continuity of healthcare must be aligned with the patient’s health condition, generally accepted professional standards, and ethical principles, and must be provided in her best interest, with due respect for her personal values and integrity.⁷⁴ One of the essential preconditions for ensuring quality and continuity of healthcare is the

⁶⁸ Article 54 of the HIA

⁶⁹ Article 73, paragraph 1, item 2 of the HIA

⁷⁰ “RS Official Gazette” No. 104/2013

⁷¹ Article 2 of the LCPL

⁷² Article 4 of the LCPL

⁷³ “RS Official Gazette” No. 45/2013 and 25/2019

⁷⁴ Article 2 of the LPP

establishment of a partnership-based relationship between healthcare professionals and the patient.

Each female patient has the right to receive comprehensive information regarding her health condition, proposed healthcare services, and the manner of their use, as well as information derived from relevant scientific research and technological advancements. This includes information concerning health insurance rights and the procedure for exercising such rights. The patient must receive such information in a timely manner and in a way that is understandable and consistent with her best interests. The information shall also include the names, professional titles, and status of the healthcare professionals involved in her treatment.⁷⁵

In the context of preserving and improving reproductive health, a female patient has the right to preventive measures aimed at preventing, controlling, and ensuring early detection of diseases and other health disorders. In accordance with the Law on Healthcare and the concept of social care for health, healthcare institutions in general, and obstetric and gynaecological institutions in particular, are obliged to implement preventive measures through awareness-raising activities and the provision of healthcare services at appropriate intervals.⁷⁶

A female patient shall be treated with dignity and humanity at all times.⁷⁷

The patient's right to safety in the use of healthcare services must be ensured in accordance with contemporary developments in medical science and practice, with the aim of achieving the most favourable treatment outcome and minimising adverse consequences. Healthcare institutions are obliged to ensure patient safety in the provision of healthcare and to continuously monitor risk factors and undertake measures to reduce such risks.⁷⁸

Under no circumstances shall a patient suffer harm resulting from the inadequate functioning of healthcare services.

Healthcare professionals are obliged to provide timely and adequate information so that the female patient has sufficient time to make an informed decision regarding consent to or refusal of a proposed medical measure. The content of such information is prescribed by the LPP and must be fully comprehensible to the patient. Only where a healthcare professional assesses that the patient is unable to understand the information may it be communicated to a member of her immediate family.⁷⁹

⁷⁵ Article 7 of the LPP

⁷⁶ Article 8 of the LPP

⁷⁷ Article 9 of the LPP

⁷⁸ Article 10 of the LPP

⁷⁹ Article 11 of the LPP

Every female patient has the right to choose a doctor of medicine or doctor of dental medicine, a healthcare institution, and the proposed medical measures⁸⁰, as well as the right to obtain a second professional opinion from a physician who has not directly participated in her treatment.⁸¹

The right to consent entails the patient's freedom to decide on matters concerning her life and health. The LPP provides that no medical measure may be undertaken without the patient's consent.⁸² Consent to a proposed medical intervention may be expressed explicitly (verbally or in writing) or implicitly, provided that the patient has not expressly refused the intervention. In the case of invasive diagnostic or therapeutic procedures, consent must be given in writing.⁸³ The female patient is entitled to the highest attainable level of pain relief and reduction of suffering, in accordance with generally accepted professional standards and ethical principles.⁸⁴

4.6. The Law on the Prohibition of Discrimination (hereinafter: the LPD)⁸⁵ regulates the general prohibition of discrimination. Pursuant to the LPD, discrimination exists where an act or omission constitutes a violation of the principle of gender equality, that is, the principle of equal rights and freedoms of women and men. The rights of women and men must be fully equal in all spheres of social life.⁸⁶ The LPD further prohibits any form of violence, harassment, or degrading treatment on the grounds of sex, gender, or pregnancy.

4.7. The Code of Medical Ethics of the Medical Chamber of Serbia (hereinafter: the MCS Code)⁸⁷ The Code of Medical Ethics of the Medical Chamber of Serbia (hereinafter: the MCS Code) regulates the ethical principles governing the professional conduct of members of the Medical Chamber of Serbia (hereinafter: MCS), as well as their rights and responsibilities in relation to patients, colleagues, the community, and the Chamber itself.

Pursuant to the principles of conscientiousness and equality, medical doctors are obliged to perform their professional duties diligently, in accordance with the rules of the medical profession, and to provide necessary care in line with the principles of medical ethics and

⁸⁰ Article 12 of the LPP

⁸¹ Article 13 of the LPP

⁸² Article 15 of the LPP

⁸³ Article 16 of the LPP

⁸⁴ Article 28 of the LPP

⁸⁵ "RS Official Gazette" No. 22/2009 and 52/2021

⁸⁶ Article 20 of the LPD provides: "Discrimination exists where conduct is contrary to the principle of gender equality, that is, the principle of respect for the equal rights and freedoms of women and men in the political, economic, cultural and other spheres of public, professional, private and family life. The denial of rights or the granting of advantages, whether openly or covertly, on the basis of sex, gender or gender identity, or on the grounds of sex reassignment, that is, the alignment of sex with gender identity, as well as on the grounds of pregnancy, maternity leave, leave for child care or special child care, shall be prohibited. Physical and other forms of violence, exploitation, expressions of hatred, disparagement, blackmail and harassment on the grounds of sex, gender or gender identity shall also be prohibited, as well as public advocacy, support or conduct based on prejudices, customs or other social patterns of behaviour founded on the idea of the inferiority or superiority of sexes, or stereotypical gender roles."

⁸⁷ "RS Official Gazette" No. 104/2016

humanity. One of the fundamental principles of medical ethics is *primum non nocere* (“first, do no harm”).⁸⁸

A medical doctor must provide healthcare services in a manner that respects the prohibition of discrimination.⁸⁹

The prohibition of torture and other inhuman or degrading treatment is guaranteed by the RS Constitution and reaffirmed by the MCS Code. Accordingly, a medical doctor must not permit his or her professional knowledge and skills to be used for inhuman purposes, nor participate in acts of torture, humiliation, degrading treatment, or severe mistreatment of any human being.⁹⁰ The treatment of a female patient must ensure that she is not placed in a position of inferiority or subjected to maltreatment, torture, or inhuman or degrading treatment.

A medical doctor may undertake medical intervention only with the informed consent of the female patient.⁹¹ This obligation is consistent with the provisions of the Law on Patients’ Rights regulating the right to consent.⁹²

4.8. The Code of Ethics of the Chamber of Nurses and Medical Technicians of Serbia⁹³ establishes the fundamental ethical principles governing the professional conduct of nurses and medical technicians in the performance of their duties. Nurses and medical technicians are obliged to recognise and respect the needs of patients, as well as their dignity and integrity. They are further required to inform patients about the availability of healthcare services and to provide accurate, clear, and comprehensible information regarding the manner in which healthcare rights may be exercised.

4.9. The Business Code of Conduct of the Gynaecological–Obstetrical Clinic “Narodni Front” (hereinafter: the GAK Code of Conduct)⁹⁴ regulates the general standards of professional and organisational conduct within the healthcare institution. Employees, in their communication with patients, must not behave aggressively, arrogantly, or in an excessively emotional manner, nor engage in verbal disputes⁹⁵ or any form of discriminatory conduct.⁹⁶ Furthermore, in communication with patients, their companions, colleagues, or business partners, employees must maintain a professional tone and must not raise their voices.⁹⁷

4.10. Business Codes of Conduct of University Clinical Centres The business codes of conduct adopted by university clinical centres regulate the general standards of

⁸⁸ Article 4 of the Code of Medical Ethics of the Medical Chamber of Serbia

⁸⁹ Article 5 of the Code of Medical Ethics of the Medical Chamber of Serbia

⁹⁰ Article 36 of the Code of Medical Ethics of the Medical Chamber of Serbia

⁹¹ Article 49 of the Code of Medical Ethics of the Medical Chamber of Serbia

⁹² Article 51 of the Code of Medical Ethics of the Medical Chamber of Serbia

⁹³ “RS Official Gazette” No. 67/2007

⁹⁴ <http://gakfront.org/A3d2HmiN/assets/files/00000%20dokumenti%20vesti/poslovniki%20kodeksi%2028062021/Poslovniki%20kodeksi%202008.pdf>

⁹⁵ Article 17 of the GAK Code

⁹⁶ Article 45 of the GAK Code

⁹⁷ Article 50 of the GAK Code

professional and organisational behaviour within healthcare institutions. All four university clinical centres in the Republic of Serbia have adopted their own internal codes of conduct. The Business Code of the University Clinical Centre of Serbia (hereinafter: the UCCS Code)⁹⁸, adopted in 2021, establishes rules governing professional conduct. Employees are obliged to treat patients and business partners with the highest level of professional respect. Healthcare professionals must respect the dignity of every individual, refrain from conduct that may violate human dignity,⁹⁹ and inform patients of their rights.¹⁰⁰ When introducing themselves, employees are required to state their full name and surname.¹⁰¹

The Business Code of the University Clinical Centre of Vojvodina¹⁰² (hereinafter: the UCCV Code), although not yet harmonised with the institution's updated name, remains in force. The UCCV Code obliges employees to treat patients with respect and to provide all necessary information required for the exercise of their right to healthcare. Employees must refer patients to the appropriate healthcare professional and provide any additional assistance as required.¹⁰³ The Code further prescribes standards of communication, including the obligation to address patients respectfully, irrespective of age or personal characteristics, and expressly prohibits shouting, the use of offensive language, and other inappropriate forms of communication.¹⁰⁴

The Business Code of Employees of the University Clinical Centre of Niš (hereinafter: the UCCN Code)¹⁰⁵, adopted in March 2022, requires employees to act respectfully towards patients¹⁰⁶, to refrain from displaying personal dissatisfaction or negative emotions¹⁰⁷, and to avoid any form of aggressive behaviour.¹⁰⁸

The Business Code of Employees of the University Clinical Centre of Kragujevac (hereinafter: the UCCKG Code)¹⁰⁹, in force since 2021, prohibits discriminatory conduct, requires respect for patients¹¹⁰, and forbids aggressive behaviour.¹¹¹

⁹⁸ <http://www.kcs.ac.rs/images/Pravilnici/PoslovniKodeksUKCS.pdf>

⁹⁹ Article 45 the UCCS Code

¹⁰⁰ Article 15 of the UCCS Code

¹⁰¹ Article 54 the UCCS Code

¹⁰² <https://www.kcv.rs/wp-content/uploads/2018/08/Poslovni-kodeks-KCV.pdf>

¹⁰³ Article 16 of the Business Code of the University Clinical Centre of Vojvodina (UCCV Code).

¹⁰⁴ Article 24 of the Business Code of the University Clinical Centre of Vojvodina (UCCV Code).

¹⁰⁵

http://www.kcnis.rs/files/normativni_akti/Poslovni%20kodeks%20zaposlenih%20u%20UKC%20Nis_opt.pdf

¹⁰⁶ Article 15 of the UCCN Code

¹⁰⁷ Article 16 of the UCCN Code

¹⁰⁸ Article 17 of the UCCN Code

¹⁰⁹ <https://ukck.rs/wp-content/uploads/2022/03/poslovni.kodeks.20210901.pdf>

¹¹⁰ Article 15 of the UCCKG Code

¹¹¹ Article 17 of the UCCN Code

5. Obstetric Violence in Practice

The treatment of women in obstetric and gynaecological facilities in the Republic of Serbia does not, in numerous reported instances, comply with applicable international standards and domestic legal norms. Women who have received care in such institutions have publicly shared accounts of negative experiences in the course of medical treatment, from the moment of admission to the completion of healthcare services. According to these testimonies, manifestations of obstetric violence occur not only during medical interventions but also in communication between healthcare professionals and patients. Such conduct may vary in intensity and, in certain cases, escalate into physical abuse, including the infliction of unnecessary pain and suffering resulting in harm to health and, in some instances, endangerment of life. Based on patient experiences in obstetric and gynaecological facilities, obstetric violence may be categorised into several distinct groups.

5.1. Verbal Abuse and Inadequate Communication - Communication between patients and healthcare professionals constitutes a fundamental component of healthcare provision during family planning, pregnancy, and childbirth. In the course of such communication, patients disclose sensitive information concerning their health condition. At this stage, it is essential that communication be conducted in a reciprocal and respectful manner, fostering trust between the healthcare provider and the patient. Trust and mutual respect are indispensable for accurate data collection, appropriate clinical assessment, and the implementation of adequate medical interventions.

However, numerous reports indicate persistent difficulties in communication between female patients and healthcare professionals, particularly in the context of pregnancy and childbirth. Of the total number of analysed reports, 76.36% concerned instances of verbal abuse and inadequate communication experienced by patients in obstetric and gynaecological facilities.

The testimonies of patients demonstrate the seriousness of deteriorated communication practices, including disrespect for personal dignity and various forms of verbal abuse occurring within obstetric and gynaecological institutions.

Among the patients who shared their experiences was a pregnant woman who noticed slight bleeding following a routine medical examination. She contacted the emergency medical service, which advised her to seek immediate evaluation at the nearest hospital. In accordance with those instructions, she presented at the Clinical Hospital Centre Zvezdara and requested an examination by the duty physician, a gynaecologist. Given her symptoms and the fear of potential pregnancy loss, she reasonably expected to receive prompt medical assessment, clear information regarding her health condition, and professional communication delivered with understanding and respect. However, instead of reassurance and appropriate explanation, the patient reported that she was met with reproach and condemnation.

Case Example 1 – Clinical Hospital Centre Zvezdara

*“The doctor was, to say the least, rude and addressed me in a raised voice. She examined me in a dimly lit room without switching on the main light; the only sources of light were the computer and ultrasound monitors and a lamp beside the examination table. **She told me that nothing was wrong and that I had come in vain, wasting her time, which she could have otherwise used to operate on another patient instead of ‘wasting time’ with me.** She further stated that I should not have come for examination and that she did not understand why the emergency department had advised me to attend at night. According to her, I should have waited until the following morning to see my primary care physician and returned only if problems recurred. In addition, she informed me that my cervix was closed, which she indicated should not have been the case. I emphasise that two other doctors had previously informed me that this finding was entirely normal.”*

Instead of receiving an appropriate clinical assessment, diagnosis, and explanation regarding the prognosis of her condition, the patient in this case reported that she was reprimanded for seeking medical assistance at a healthcare facility due to bleeding during pregnancy. The only advice allegedly provided was that, in the future, she should remain at home until the following morning and consult her primary care physician.

In a situation potentially indicative of a serious obstetric complication, rather than receiving medical reassurance and structured guidance, the patient reported experiencing additional psychological distress arising from communication that did not meet minimum standards of professional conduct and respect for patient dignity. It is noteworthy that gynaecologists frequently emphasise, in public health messaging, the importance of timely medical consultation in order to ensure adequate healthcare and prevent complications. However, discrepancies between such guidance and reported clinical practice may reasonably give rise to confusion among patients regarding when and how to seek urgent medical assistance. This also raises questions concerning professional accountability in situations involving alleged negligent or dismissive treatment.

Patient testimonies further indicate that verbal abuse and inappropriate communication may occur at various stages of healthcare delivery, from admission procedures to the performance of invasive medical interventions.

For example, a woman who received care at the University Clinical Centre in Niš, at the Clinic for Gynaecology and Obstetrics, reported experiencing psychological trauma resulting from aggressive communication between healthcare staff and patients.

Case Example 2 – University Clinical Centre Niš, Clinic for Gynaecology and Obstetrics

"I had an ovarian tumour for 10 years, which I did not wish to remove surgically and because of which I had been unable to become pregnant. During a consultation with the gynaecologist, I attempted to explain my medical history and the fact that the baby was developing alongside the tumour.

*After performing an ultrasound examination, the doctor asked about my occupation. When I replied that I was a professor of philosophy, his attitude changed. He began yelling at me, saying: **'Who do you think you are? You think you're smart because you're a philosophy professor? What do you want, a Caesarean section? Are you some kind of queen? Do you want to give birth before the other women here? I studied for six years, and now you think you can trick me into performing an urgent Caesarean section? There is no tumour. It's a good thing I'm not a fool you can deceive.'** He then made further derogatory remarks to a nurse about people from the Faculty of Philosophy, suggesting that they believed they knew everything.*

*My requests not to be repeatedly examined were ignored. Each vaginal examination caused severe pain; it felt as though a knife was being inserted. I covered my face with my hands to suppress my screams during the examinations, and when I removed them, my hands were soaked in sweat. **I felt violated each time I was examined.***

*My baby was without amniotic fluid for 15 hours. After 37 hours, a female anaesthesiologist passed by the room, saw my condition, and informed the Head of the Department that a woman was dying. At approximately the same time, my parents, concerned because I was not answering calls, contacted a nurse and asked her kindly to examine me and inform them about my health condition. That took place at the same time. The Head of the Department then examined me, induced labour, **and was the first doctor who treated me as a patient and showed understanding for my pain.** However, the induction was unsuccessful because the tumour, which had grown to the size of the baby's head, obstructed delivery and had caused premature rupture of membranes. I received two injections in my spine and only when the doctor tried to deliver me did she bewilderedly say: "What is this?" I was eventually given documentation to sign and taken for emergency general anaesthesia and a Caesarean section, which, in my opinion, should have been performed 37 hours earlier. My parents were later informed that both "the mother and the baby came within a hair's breadth of losing their lives." The tumour, as large as the baby's head, was removed, together with one ovary and part of the other.*

I also witnessed the treatment of two Albanian women from Kosovo. In one case, pus was squeezed from a wound without prior administration of anaesthesia, for approximately one hour. Over time, I have come to feel that parts of me were permanently damaged by this experience and that I may never fully recover."

The above example demonstrates that, within the course of a single episode of medical treatment, a female patient may be exposed simultaneously to verbal insults and painful examinations, resulting in additional suffering and potential inhuman or degrading treatment. The testimonies indicate that, in certain obstetric and gynaecological facilities, patients are not meaningfully involved in decisions concerning the medical measures to be undertaken. The absence of effective communication with healthcare professionals contributes to a perception of power imbalance, whereby patients may feel placed in a position of inferiority and compelled to acquiesce due to fear for their own health and lives, as well as for the well-being of their unborn or newborn children. In the case described above, attempts by the patient to engage in communication allegedly resulted in further escalation of verbal insults, belittlement, and humiliation.

Fear may be further intensified in circumstances where patients are warned that failure to accept proposed medical interventions will result in increased pain or deterioration of their health condition, particularly where such warnings are not accompanied by adequate explanation or informed discussion. A similar pattern is reflected in the experience reported by a female patient treated at the University Clinical Centre of Vojvodina, at the Clinic for Gynaecology and Obstetrics “Betanija” in Novi Sad, who indicated that threats of worsening health outcomes and the absence of clear information generated additional psychological distress.

Case Example 3 – University Clinical Centre of Vojvodina, Clinic for Gynaecology and Obstetrics “Betanija”

*“I arrived at the maternity ward around 10 p.m., experiencing contractions at three-minute intervals. Upon admission, we were met by an impolite nurse and an even more impolite doctor, who, during the initial examination, told me: ‘**What’s the matter? Why are you whining? This is nothing, the real pain is yet to come.**’ I was then taken to the delivery room without being provided with any additional information.”*

Pursuant to applicable constitutional, statutory, and professional regulations, healthcare services provided to women during pregnancy and childbirth should meet the highest attainable standards, particularly when delivered at the tertiary level of healthcare. Tertiary institutions are expected to ensure advanced medical expertise, adequate infrastructure, and full compliance with international and domestic standards. However, patients’ testimonies indicate significant discrepancies between normative standards and reported practice. In particular, the conditions relating to the quality of hospital stay, including communication, dignity, and overall care, have been described as falling below the minimum standards articulated by the World Health Organization concerning respectful maternity care.

The experience reported by a female patient treated at the Obstetrics and Gynaecology Clinic “Narodni Front” further illustrates these concerns.

Case Example 4 – Obstetrics and Gynaecology Clinic “Narodni Front”

“I was accommodated on the third floor, at the High-Risk Pregnancy Department. The conditions were inhumane, and no one seemed to pay attention to the patients. The women placed there had serious medical problems.

*What disturbed me the most was the condition of the toilet. The flushing mechanism would occasionally malfunction, and there was a notice posted on the door stating: **‘Future mums, take a basket, fill it with water and flush the toilet.’** It read something along those lines, and I now regret not taking a photograph of it. Women in the eighth or ninth month of pregnancy were expected to carry a basket filled with several litres of water in order to ‘flush the toilet’.*

When nurses were called, they would not come for prolonged periods of time and appeared indifferent to patients’ needs. During examinations, the doctors were impolite, extremely rude, and rough.”

Case Example 5 – Clinical Hospital Centre “Dr Dragiša Mišović”, Hospital for Gynaecology and Obstetrics

*“I cannot help wondering how it is possible that a woman cannot receive the treatment **she deserves without having to pay in order to be treated humanely, rather than as if she was an animal.** Why does childbirth seem like a punishment, instead of the most beautiful occasion to be remembered for a lifetime? This speaks volumes about the allegedly elite maternity unit ‘Dr Dragiša Mišović’ and its doctors.”*

Case Example 6 – Obstetrics and Gynaecology Clinic “Narodni Front”

*“I had asked for an epidural before I arrived in the delivery room. However, when I was transferred there, **labour was induced without any prior consultation. I repeatedly begged for an epidural, but they would not even look at me,** or they told me that the anaesthesiologist was in surgery.*

*When I began to feel extremely unwell, a midwife passed by. I told her that I was not feeling well, and she replied: **‘Don’t worry, if you faint, we will wake you up by slapping you.’***

Case Example 7 – General Hospital Loznica, Department of Gynaecology and Obstetrics with Neonatology

“When it comes to the nurses, only a few sentences are sufficient to describe their behaviour toward women in labour: ‘Why are you moaning? You were able to endure that thing, and now you cannot endure two fingers of mine, thinner than that thing!’ No woman was addressed by her name; everyone was referred to as ‘a mother.’ It was common for nurses to enter the room during the night and shout if one of the women had switched off the lamp above her bed, even though there was no notice prohibiting it.

On one occasion, a nurse yelled at me because I was unable to sit upright in bed. I had a cannula inserted in my hand and was experiencing low blood pressure. I fell to the floor. The nurse began complaining that her back hurt and that she now had to help me stand up. As if that were not enough, she splashed water on me after I lost consciousness.”

Case Example 8 – General Hospital Novi Pazar, Department of Gynaecology and Obstetrics

“I had a small wound. I asked the doctor to examine it, but he told me that it was minor and that suturing was not necessary. I nevertheless requested that it be sutured. The doctor behaved appropriately and agreed to perform the procedure.

However, the ‘lady’, more precisely, the nurse, stated in his presence: ‘Stitch her wound, for God’s sake, make her lady parts beautiful.’

Verbal abuse may also manifest in the refusal of healthcare professionals to consider or discuss a female patient’s preferences regarding the manner of childbirth. While clinical decisions must be guided by medical indication, a patient’s expressed wishes and concerns must be addressed respectfully and without ridicule or humiliation. The reasons underlying a patient’s preference must not serve as grounds for disparagement.

The experience reported by a female patient who gave birth at the Clinical Hospital Centre “Dr Dragiša Mišović”, at the Centre for Gynaecology and Obstetrics, illustrates alleged deviations from these standards and potential non-compliance with applicable legal and professional regulations.

Case Example 9 – Clinical Hospital Centre “Dr Dragiša Mišović”, Hospital for Gynaecology and Obstetrics

*“She asked me why I wanted a Caesarean section. I explained that I suffer from panic attacks and that my primary doctor and I had agreed that I would give birth by Caesarean section under general anaesthesia. The doctor replied: **‘Nonsense. You are afraid of childbirth. You will never get general anaesthesia!’** I was standing in the examination room while she was hesitating whether to perform a CTG. As I was bent over due to pain, she said to me: **‘Why did you get pregnant in the first place if you didn’t know that pregnancy can be painful?’** She also noticed that I had varicose veins and told me, in a threatening manner, that anything could happen during a Caesarean section because of my veins.”*

Case Example 10 – Obstetrics and Gynaecology Clinic “Narodni Front”

*“I asked the doctor, the one who was pressing on my abdomen, almost jumping on it, how much longer it would last, because I could no longer endure it. He was cold and rough, a young doctor who showed no empathy. He said: **‘Since you did not want to help your child be born, now shut up and endure the pain!’**”*

5.2. Frequent Application of the Kristeller Manoeuvre and Vacuum-Assisted Delivery - The Law on Patients’ Rights (LPP) stipulates that a female patient has the right to freely decide on matters concerning her life and health. Accordingly, no medical measure, particularly an invasive one, may be undertaken without the patient’s informed consent. Such consent must be obtained only after the patient has received all necessary information regarding the nature, purpose, risks, and possible consequences of the proposed intervention, and after she has been given sufficient time to make an informed decision. The testimonies collected indicate numerous alleged violations of both international and domestic standards in this respect.

One of the most frequently reported procedures during childbirth in obstetric and gynaecological clinics is the application of the so-called Kristeller manoeuvre, which consists of applying fundal pressure during the second stage of labour. Many patients described traumatic experiences associated with this procedure. Numerous examples were reported in which the Kristeller manoeuvre was allegedly performed despite the patient’s explicit objection..

The application of the Kristeller manoeuvre may result in significant consequences for maternal health. Scientific research has raised concerns regarding its safety and questioned the clinical benefits of its routine use.

In the study entitled “Fundal pressure in the second stage of labour (Kristeller manoeuvre) is associated with increased risk of levator ani muscle avulsion” (2018), physicians from Bologna examined primiparous women, comparing 134 women in labour in whom the Kristeller manoeuvre was applied with 128 women in whom it was not applied. The findings demonstrated that 28.4% of women subjected to the Kristeller manoeuvre experienced levator ani muscle avulsion, compared to 14.1% of women in whom the manoeuvre was not performed. The authors concluded that the Kristeller manoeuvre is directly associated with an increased risk of levator ani muscle injury in first-time mothers. They emphasised that all available options should be carefully considered when counselling women in labour regarding the potential application of this procedure.¹¹²

In addition to the Kristeller manoeuvre, vacuum-assisted delivery is frequently performed during childbirth. According to the testimonies collected, the application of these procedures has, in certain cases, been followed by serious maternal complications, including uterine rupture and large haematomas. Reported neonatal consequences include the occurrence of cephalohaematoma and other forms of head trauma.

The following testimonies of women in labour illustrate the aforementioned concerns.

Case Example 11 – University Clinical Centre Niš, Clinic for Gynaecology and Obstetrics

“I received an epidural, followed by induction, and was then more or less left to give birth on my own, as if there were no need for anyone to be present since I was not feeling pain. For me, the time passed quickly, as I was scared and alone.

Around 9 a.m., someone decided that it was time to ‘finish with me,’ and the situation suddenly escalated. Someone shouted from another room: ‘Section! It is urgent!’

*They realised that they could not be present in two places at once, so they began attempting to deliver my baby at any cost. **The abovementioned obstetrician pulled my nightgown above my ribs, tied it tightly, and began applying forceful fundal pressure, effectively jumping on my abdomen. I was struggling to breathe and tried to push him away or defend myself, but I had no strength left.***

They then reached for the vacuum extractor. It was applied for the first time and activated, but the attempt failed. The baby developed a haematoma. The vacuum was applied a second time, after which the baby was delivered immediately, with another haematoma on the head.”

¹¹² <https://obgyn.onlinelibrary.wiley.com/doi/epdf/10.1002/uog.19085>

Case Example 12 – General Hospital Zaječar, Department of Gynaecology and Obstetrics

“I was taken to the delivery room, and a cannula was inserted into my hand. I was administered Buscopan, followed by an oxytocin infusion, which intensified the contractions. I could not breathe and did not have the strength to push. At one point, the only thing I could hear was that the baby’s heart rate was decreasing, and vacuum extraction became urgent. I was given oxygen only after the baby was delivered.

*They brought the instrument with the metal cup. Under pressure, together with an episiotomy and **three doctors pressing on my abdomen, which later left my ribs bruised**, my son was delivered at 9:30 a.m., after almost ten hours of what I experienced as torture. **He did not cry. His heart sounds were 10. Almost dead. One of the doctors told the doctor who had led my pregnancy: ‘It is not your fault.’ I did not know what was happening. They were resuscitating the baby, and he did not react. He was urgently transferred to the University Children’s Clinic “Tiršova”. My placenta did not detach completely. The doctor first removed parts of it manually and then used a curette to remove the retained tissue from the uterus. Suturing followed.***

*All of this was performed without anaesthesia, as the anaesthesiologist was allegedly occupied with the baby. There were three doctors present, and the others could have waited half an hour. **While I was screaming in excruciating pain, far stronger than labour contractions, one of the doctors approached me and said: ‘While you were fu... you were not screaming, were you?’”***

Case Example 13 – Clinical Hospital Centre Zemun, Hospital for Gynaecology and Obstetrics

*“**The doctor forcefully pressed on my abdomen, telling me that he was helping me and that I should stop acting up. While I was trying to push him away in order to catch my breath, he told me that I wanted to kill my child and that I only cared about myself. Even though I begged him to wait for a contraction so that I could push, he did not stop applying pressure to my abdomen until I finally delivered the baby.**”*

Case Example 14 – Obstetrics and Gynaecology Clinic “Narodni Front”

*“I later heard from the doctor who had managed my pregnancy that it was quite possible that **the doctor who lay on my abdomen and almost suffocated me most likely caused the uterine rupture and displaced my intestines upward toward my chest, justifying his actions by saying: ‘Well, that is what we usually do, by doing so, we help women give birth faster.’”***

5.3. Forced Episiotomy -Episiotomy is a surgical procedure involving an incision of the perineum during the second stage of labour, traditionally performed with the stated aim of preventing severe spontaneous perineal tears and facilitating childbirth. Episiotomy remains widely practised in maternity hospitals in the Republic of Serbia, in contrast to significantly lower rates reported in several European countries.

An increasing number of scientific evidence indicates that routine episiotomy may cause more harm to women in labour to spontaneous perineal tearing, particularly due to the higher likelihood of injury to blood vessels, nerves, and surrounding tissues.¹¹³

The World Health Organization has recommended that episiotomy should only be performed in specific clinical indications and not routinely, as is being done in Serbian maternity hospitals. Worldwide, the lowest percentage of episiotomy is reported in Sweden (9.7% of cases), and the highest in Taiwan (100%).¹¹⁴

Case Example 15 – Obstetrics and Gynaecology Clinic “Narodni Front”

*At one point, I was instructed to push whenever I felt contractions. I had been pushing for approximately an hour, but the baby was still positioned too high. I was losing strength, and I felt as though the hands of at least ten different people were alternately inside me at every moment, until one of the doctors (I cannot remember his name, but I have it in the messages exchanged with my maid of honour) said: “**This woman cannot push, cut her down there, she will not be able to push the baby out.**” I was completely exhausted when, all of a sudden, I was surrounded by about ten of them. Two were holding my shoulders, **two were holding my legs, which were tied to the bed, and no one told me what was happening.** The doctor, I believe he was one of the Heads of the Department, was the only one who addressed me in a humane manner. He was explaining to the resident doctor how to deliver the baby by applying pressure to my abdomen. **They performed a rather deep episiotomy and extracted the baby using a vacuum extractor.** This lasted for quite some time. On several occasions, I almost fainted because I was unable to breathe properly. I could hear the doctor telling the resident that I must not lose consciousness under any circumstances, as I would otherwise have to undergo an urgent Caesarean section, and there might not be enough time for that.*

¹¹³ <https://pubmed.ncbi.nlm.nih.gov/15870418/>

¹¹⁴

https://www.researchgate.net/publication/318884979_Retrospective_analysis_of_episiotomy_prevalence

Case Example 16 – General Hospital Valjevo, Department of Gynaecology and Obstetrics

“Again, I was told by a senior midwife that everything was progressing well and that induction was not necessary, yet the doctor angrily ordered that I be given induction nonetheless. What followed, the image of her menacing facial expression while holding large scissors, is something I still cannot erase from my mind. It was utter horror. I tried to resist, but they were holding my legs as if I was a raging animal. I was aware that in Serbia it is common practice to perform episiotomy on women giving birth for the first time, even though, for example, in Scandinavian countries it is performed in only 6% of cases. Evidently, it is carried out only in urgent situations there, not routinely as in our country.”

Case Example 17 – General Hospital Valjevo, Department of Gynaecology and Obstetrics

“At some point during labour, she began yelling at me, accusing me of being rude and unwilling to cooperate. She then deliberately took the scissors and performed a severe incision, cutting me extensively toward the anus.”

Case Example 18 – University Clinical Centre Kragujevac, Clinic for Gynaecology and Obstetrics

“Suturing followed and, instead of lasting 15 minutes, it took an entire hour. I was crying in pain, but they cold-heartedly refused to administer any form of anaesthesia, telling me that ‘I was to blame’ because the suturing was taking longer than usual due to ‘my unwillingness to cooperate’, ‘me making the whole procedure more difficult’, ‘my unwillingness to keep my lower body still’, and similar remarks, whereas in reality I was shaking from severe pain and had developed a fever as a result of everything that had taken place beforehand.”

Case Example 19 – Obstetrics and Gynaecology Clinic “Narodni Front”

“The perineal tear that occurred during contractions, as well as the episiotomy performed by the midwife who had an unforgettable, sinister grin on her face due to the vacuum extraction required extensive suturing, which was carried out without any anaesthesia. No anaesthesia at all, not even local anaesthesia. Prior to that, a manual revision of the uterine cavity had been performed, again without any anaesthesia. The pain was unbearable. Everything felt as though I was on fire with each contraction.”

5.4 Physical injuries - Physical injuries frequently occur as a consequence of torture and abuse during the performance of medical procedures. Patients who reported physical abuse stated that they left obstetrics and gynaecology facilities with severe injuries to their reproductive organs, and in some cases with removal of the uterus and ovaries. One female patient who experienced obstetric violence left the obstetrics and gynaecology facility after undergoing removal of her ovaries.¹¹⁵

Case Example 20

"It was time for what they referred to as the 'fourth stage of labour,' the so-called delivery of the placenta (I am not sure what the correct medical term is). At that point, they began jumping on my abdomen. When they saw that it was ineffective, the doctor called the anaesthesiologist to manually remove the placenta. However, in the meantime, she decided to call what she described as 'a more experienced midwife,' who continued jumping and pressing on my abdomen. I begged her to stop because it was more painful than the labour itself, but instead of stopping, she started yelling at me.

*I was then moved onto a table and taken to the operating theatre. Later that day, the doctor on duty came to see me, he was the one who had operated on me. **He told me that there had been a uterine inversion and that it had been removed. He also told me that my ovaries had been removed due to abnormal haemorrhage** (I believe this may have been due to lack of knowledge or experience, although I am not certain). He said that the doctor who admitted me did not know what she was doing, that I had haemorrhaged heavily, and that for a few minutes I had shown no signs of life."*

Case Example 21 – Obstetrics and Gynaecology Clinic “Narodni Front”

*"At 9 o'clock, I managed to call the doctor and, after begging him, finally convinced him to attempt delivery. He summoned the obstetric staff, and my labour progressed. The midwives yelled at me each time I screamed in pain, telling me to shut up and stop acting up. After my first attempt at pushing, the doctor immediately concluded that 'I did not know how to push' and forcefully pressed on my abdomen with his clenched fist in order to push the baby out. Ten minutes later, the baby's head and one shoulder were delivered. At that point, an episiotomy was performed, and the baby was fully delivered. After wrapping the baby in a cloth, they handed the baby to me. The staff then proceeded with delivery of the placenta. At that moment, they realised there was a problem and that my uterus was not contracting. After approximately five minutes of painful manual stimulation and abdominal pressure intended to trigger uterine contractions, accompanied by heavy haemorrhage, **they discovered that a blood vessel had been cut during the episiotomy and that they were unable to stop the bleeding.** When a specialist arrived, the doctor administered anaesthesia. However, due to the abnormal haemorrhage, they could not wait for the anaesthesia to take effect and began suturing immediately.*

¹¹⁵ The health institution where the violence took place is not specified by the decision of the patient.

*Exhausted and in agonising pain of every kind, I was unable to remain still, particularly while holding my baby. I moved reflexively and instinctively tightened my grip on the baby. I asked them to take the baby and put me to sleep because I could no longer endure the pain. A nurse immediately took the baby, and **the obstetric staff instructed the nurses to restrain me**. As a nurse approached holding straps to tie my legs, I was screaming, swearing, and crying in distress. Only the anaesthesiologist showed any understanding and immediately administered general anaesthesia.”*

Case Example 22 – General Hospital Gornji Milanovac, Department of Gynaecology and Obstetrics

“After being transferred to the ward, I was informed that during the Caesarean section my colon had been cut, my small intestine had been damaged, faecal matter had spread throughout my abdomen, and I had developed sepsis. The doctor had to create an ileostomy over the small intestine, as everything inside my abdomen was so severely damaged that he had to suture multiple areas.”

Case Example 23 – General Hospital Sremska Mitrovica, Department of Gynaecology and Obstetrics

*“By the time the Caesarean section was finally performed, **my baby girl was no longer alive, as she had suffocated in blood due to uterine rupture**. In fact, she had died before the procedure even began. I was deprived of my baby and of the opportunity to have another child.”*

Practice shows that not only are patients subjected to torture and abuse, but newborns as well. Numerous examples indicate that babies have been victims of physical injuries, including, in some cases, severe damage

Case Example 24 – University Clinical Centre of Serbia, Clinic for Gynaecology and Obstetrics “Višegradska”

*“A month ago, we found out that **the baby had developed brain atrophy as a result of labour**, which again raises suspicion that the baby was deprived of oxygen during labour and that something had gone wrong (**after all, being without amniotic fluid for 20 hours was too long**).”*

Case Example 25 – Obstetrics and Gynaecology Clinic “Narodni Front”

*“During pushing, I experienced a uterine rupture, and the Caesarean-section scar from two years and eight months earlier (the birth of my older child) began to reopen. The pain intensified whenever my abdomen was touched. **The same doctor who was present in the room then began to ‘squeeze my uterus’ in other words, he started pressing and compressing my abdomen, which was already in severe pain, in order to force the blood out.** It was petrifying for me, and I believe it must have been equally terrifying for the other women in the room who could hear me screaming.”*

5.5. Physical Abuse - There are documented examples in which patients at healthcare facilities have experienced physical abuse by doctors and nurses involved in labour or obstetric and gynaecological procedures. Such conduct is often accompanied by verbal abuse and may represent a demonstration of authority and power over the patient.

Most patients do not have the courage to report this type of abuse, fearing potentially life- and health-threatening behaviour by healthcare workers in future interactions at obstetrics and gynaecology facilities. This fear appears justified in light of testimonies indicating that some patients have been physically struck during labour.

Case Example 26 – University Clinical Centre of Vojvodina, Clinic for Gynaecology and Obstetrics “Betanija”

*“The pain, of course, did not subside, so I began shouting at them, asking them to do something because I could no longer endure it. **The only response I received was a slap across my nose. I was not allowed to stand up, to hold onto the bed, or even to make a sound. The only instruction I was given was: ‘Shut up and breathe!’**”*

Case Example 27 – Obstetrics and Gynaecology Clinic “Narodni Front” (an act of violence committed by the anaesthesiologist)

*“As soon as he approached me, to clarify, ‘he’ refers to the anaesthesiologist, **he first struck my hands, angrily telling me not to rest them on my knees.** My hands jerked away immediately from the force of the blow. He then ordered me to sit down and move my legs to the right, which I did. At that moment, he began shouting commands: ‘Not there! Here! Not to the right, I said, to the left!’ **while forcefully hitting me on the shoulders.**”*

5.6. Other Forms of Inhuman and Degrading Treatment - International instruments and domestic regulations stipulate that a doctor is under an obligation to perform his or her professional duties conscientiously and is prohibited from using professional knowledge and experience for any purpose other than humane treatment, including participation in torture or any form of humiliation, belittlement, or cruel treatment of another human being.

However, prohibitions against torture and abuse within healthcare facilities have not yielded effective results in practice, as it is evident that victims are not afforded adequate protection against such treatment.

In line with the foregoing, numerous patients have testified to having been subjected to inhuman and degrading treatment by both doctors and nurses. Obstetric violence manifested through torture and abuse is reflected, inter alia, in cases where patients were restrained during labour, forced to remain in a specific position without the possibility of changing position or moving.

**Case Example 28 – University Clinical Centre of Vojvodina, Clinic for Gynaecology and Obstetrics “Betanija”
(the first labour experience)**

*“I spent a night that felt like hell in the maternity ward. The doctors would check on me only if I called them, overwhelmed with fear and not knowing what was happening (it was my first labour, so I had no previous experience). Of course, everyone was openly insolent throughout the entire labour. I was unable to move, and **I was not given any water until 7 a.m., when I gave birth.** Even when someone came to examine me (because I had called them), I received no information other than how dilated I was. **When the contractions finally intensified and I called for help, the doctor and nurse stayed with me only briefly. I was told that I could push when I felt a contraction, or perhaps not. Shortly afterwards, they left, as I was apparently not ready for delivery, so why waste time on me when it was time to drink COFFEE.** Yes, I could smell the coffee. No one came for the next thirty minutes while I was in excruciating pain, they were drinking coffee. I did not know when to push or when to breathe; no one had instructed me. Naturally, I was terrified, as there was no one to reassure me that everything would be all right. **On the delivery table, they tied my legs (perhaps that is standard procedure, but no one told me, ‘We are going to tie your legs’) and performed an episiotomy without prior consent or even warning. Needless to say, no anaesthesia was administered, it was apparently too much to ask for at the time.”***

Treatment in obstetrics and gynaecology facilities does not end with the completion of labour; rather, it continues throughout the stay of the female patient and her newborn at the healthcare facility. It is therefore essential that all patients receive comprehensive information and clear guidance from healthcare professionals regarding breastfeeding, lactation difficulties, newborn care, diaper changing, and all other procedures necessary after discharge.

Women's experiences in obstetrics and gynaecology facilities indicate that, instead of receiving answers to their questions and appropriate instruction or advice, they are often met with reprimands, condemnation, and profanity.

Case Example 29 – General Hospital Subotica, Department of Gynaecology

*"The baby stayed with me day and night, and I kept praying that he would not cry because I was unable to hold him properly. **While I was waiting for the baby to be brought to my room, the day before they finally brought him, neonatal nurses visited me and did nothing but pinch and squeeze my nipples, eventually causing fissures even before my baby had started nursing.** I was constantly crying in pain; my nipples were completely cracked. The baby and I managed to bond. I immediately put him to the breast, and breastfeeding began, although the milk supply was insufficient on that first day (it was the third day after childbirth). He slept with me in bed and on my chest the entire time. **No one came to check on us or to show me or explain anything. I did not know how to change my baby, and when I asked, a nurse yelled at me, asking what kind of mother I was if I did not know how to do it.** That was the first time she came, sometime around noon, and she returned in the evening to take the baby away for care, bringing him back half an hour later. **They did the same thing the following evening and additionally introduced supplementary feeding. As a result, the baby refused to nurse throughout the night. I was discharged from the hospital suffering from mastitis and struggled with it day and night until the sixth day, when a visiting nurse came and 'eased' the pain by massaging my breasts. It became clear that there was sufficient milk, more than enough. I have successfully breastfed my baby ever since.**"*

Subjecting patients to additional suffering and pain through degrading and humiliating treatment also occurs during frequent vaginal examinations performed by multiple gynaecologists at short intervals. During such examinations, patients report experiencing highly unpleasant and painful procedures. A number of patients stated that they repeatedly begged doctors not to examine them, but their pleas were ignored, which led them to feel violated.

Case Example 30 – General Hospital Valjevo, Department of Gynaecology and Obstetrics

*"Suturing was the most painful part of the entire process, but it was performed by a kind female intern, which made it somewhat bearable. She did her job flawlessly, **although she commented that I should endure the pain so that she could do it properly, so that I would be 'the same as before' for my husband.** The most miserable moment of my life took place in the hallway of the maternity ward in Valjevo. There were seven or eight of us standing there in worn-out hospital gowns, trying to see whether the doctor in the office was the gentle young one or the other doctor, the rude one. **So much depended on that: whether someone would mistreat us and reopen the wounds in the most sensitive part of our bodies, or whether they would show at least a little consideration and respect.** That day, I was lucky. The first woman came out of the office after her examination and gave us a thumbs-up as a sign of relief, it was the gentle doctor. I almost cried with joy and relief."*

Case Example 31 - Clinical Hospital Centre “Dr Dragiša Mišović”, Hospital for Gynaecology and Obstetrics

*“I gave birth to my baby, who weighed 4,980 grams, although his weight had previously been estimated at 3,300 grams. They failed to recognise that my membranes had ruptured and allowed the baby to remain without amniotic fluid for 18 hours, as a result of which he had to stay in hospital and receive treatment for an infection. I had been crying in the hospital for 10 hours. I cannot imagine what would have happened if I had delivered vaginally. **Neonatal nurses would come to examine me without prior notice, pull aside my hospital gown, and squeeze my nipples to check whether there was a flow of milk. I was shocked by such treatment. Ever since then, I have not dared to consider giving birth again. I felt as though I had been violated.**”*

Case Example 32 – Obstetrics and Gynaecology Clinic “Narodni Front”

*“**The vaginal examination felt like sexual violation. He inserted his entire fist into me, as a result of which I began to haemorrhage heavily,** and I was immediately transferred to the operating theatre. While blood was pouring from me, I was packing my belongings and crying out in pain and distress. I feared for my baby’s life, as my doctor had previously made it clear that, due to the seriousness of my pregnancy, I might not be able to deliver vaginally because of the risk of bleeding (owing to a haematoma and the proximity of the placenta). The doctor who performed the examination was not aware of this. I called my doctor in the meantime, but it was pointless, as she kept trying to reassure me that everything would be fine, which it was not. My membranes were artificially ruptured without my consent. The female anaesthesiologist administered an epidural only on the third attempt. She yelled at me because she was unable to administer it properly.”*

Case Example 33 – General Hospital Ćuprija, Department of Gynaecology

“I shouted at them to tell me what was happening. The doctor informed me that the umbilical cord had prolapsed when the midwife ruptured my membranes and that they were attempting to reposition both the cord and the baby, as I was unable to deliver vaginally and would require a Caesarean section. However, the operating theatre had not yet been sterilised or prepared for surgery, so she was trying to maintain the situation until she was informed that the room was ready.”

Women who suffered a miscarriage were subjected to particular trauma, including inhuman and degrading treatment.

Case Example 34 – General Hospital Novi Pazar, Department of Gynaecology and Obstetrics

*“On Friday, two days after I had been discharged from the hospital, the fetus died in the fourth month of pregnancy due to bleeding. I returned to the hospital, where I was told that labour would most likely be induced on Monday, as the doctors would not be working over the weekend, that is what I was told. On Saturday, around 5 a.m., contractions began, and by 11 a.m., pieces of clots were coming out of my uterus, similar to haematomas. I was overwhelmed by pain and uncertainty about what would happen next, at which point the fetus began to descend. The head and abdomen were outside, while the legs remained inside. I was screaming and afraid to pull the fetus out, fearing I might break the legs. **I was shouting, calling for nurses, crying for help... Even so, nobody came. Within approximately ten minutes, I delivered the fetus myself in the toilet, without any assistance, petrified and anguished.**”*

*My husband stopped the doctor in the hallway and told her that if I required curettage and there was no anaesthesia available (which, unfortunately, could happen), he would purchase it himself, as long as anaesthesia was administered. They did not respond to him; they simply removed him from the hallway. The doctor entered the intervention room where I had been placed, **and only then did I realise that they were going to perform the curettage without anaesthesia. The procedure was carried out in the most excruciating pain, while my hands and legs were being held. I was screaming and moving in unbearable pain, and the doctor yelled at me: ‘Stop! I will rupture your abdomen! I will ruin your uterus!’ When I cried, ‘But it hurts a lot...’, she responded: ‘What do you mean, it hurts?!’”***

Case Example 35 – University Clinical Centre Niš, Clinic for Gynaecology and Obstetrics

*“Shortly before 12 o’clock, I delivered the baby myself in front of the other women in the room, without any hospital staff present. **I gave birth completely alone, ‘like a dog’.** The fetus remained on the bed until a nurse came and wrapped him in a cloth. I then got up by myself and sat in a wheelchair, and only after that was I taken to the maternity ward, where the umbilical cord was cut. All the women were crying out loud. Having endured trauma themselves, they could hardly bear witnessing what was happening to me or listening to my cries and wailing.”*

5.7. Consent - The Law on Patients’ Rights (LPP) stipulates that a female patient must give consent prior to the performance of any medical procedure; otherwise, such a procedure must not be undertaken under any circumstances. The common practice of presenting consent forms to patients while they are in the delivery room, in severe pain and/or under the influence of analgesics, and not fully aware of the contents of the document they are signing, is improper and prohibited.

In accordance with the LPP, every female patient is entitled to ask questions regarding the procedures being undertaken, their consequences, potential complications, and alternative options. Healthcare professionals may not deprive patients of this right. Conversely, a doctor and a nurse are under an obligation to provide answers to all questions posed by the patient.

However, in practice, there are numerous instances of violations of the right to consent, particularly the right to informed consent, within obstetrics and gynaecology facilities.

Case Example 36 – Obstetrics and Gynaecology Clinic “Narodni Front”

*“Upon admission, we were presented with a number of documents for signature, one of which was a consent form authorising all possible procedures (forceps delivery, vacuum extraction, episiotomy, etc.). **When I inquired what would occur if I refused to sign, as I did not agree with all of the listed procedures, the nurse at admission informed me that she would not be able to admit me without such consent.**”*

Case Example 37 – Obstetrics and Gynaecology Clinic “Narodni Front”

*“I was admitted to the maternity ward on February, 1.. On the same day, during a vaginal examination, the Head of the Department manually **detached my placenta as a form of induction, an extremely painful procedure, without any prior question or warning.** Vaginal examinations (which were very painful and increased the risk of infection) were sometimes performed by three doctors consecutively in order to ‘confirm and see for themselves’, measuring whether I was dilated by one or two fingertip-widths. **The most frequent response to my questions about what was happening, what they were doing to me, and why, was: ‘What is your profession?’, as though that would affect my right to know what was happening to my body and my baby.***

*Around midnight, they told me that I would receive a vaginal tablet. They were condescending and rude when I asked them to explain what they were administering and for what purpose. **When I asked, ‘What if I do not want induction?’, because I did not want it, I was told not to interfere in their work, why had I come in the first place, that I had to give birth, and that they did not have time to waste convincing me.** I agreed to the vaginal tablet. The following morning, I underwent numerous vaginal examinations, after which they proceeded to prepare me for labour even though I was barely three fingertip-widths dilated. The baby was not positioned low enough, nor was I sufficiently dilated, yet I was required to lie there, thirsty and hungry. **They immediately started intravenous infusions, and when I asked what they were administering, the nurse deliberately ignored me and said: ‘Mind your own business.’ They ruptured my membranes prematurely, within the first hour, while I was still insufficiently dilated, and without any prior warning.***

*I was not given any water, and I had an oxygen mask over my mouth, which made my throat extremely dry. A cleaning lady soaked a napkin in water and gave it to me to moisten my lips when everyone else had left. Throughout the entire time, **I remained cooperative because I did not want to endanger my baby. I breathed as instructed and clearly stated whenever I did not consent to something. No one paid any attention to this. Moreover, when I expressed that I did not want a particular procedure, I was told that I would endanger or kill my baby, that I should not teach them how to do their job, and that ‘the educated ones are the worst ones’, among other similar remarks.***

Case Example 38 – Obstetrics and Gynaecology Clinic “Narodni Front”

*“Upon admission to the hospital, I was handed a document to sign stating that I thereby gave consent to childbirth, epidural anaesthesia, episiotomy, forceps delivery, vacuum extraction, etc. When I told the nurse that I did not wish to give consent for episiotomy, forceps, or vacuum extraction, **she informed me that in that case they would not be able to admit me to the hospital and told me to go to another facility.** Having no other choice, I signed the consent.”*

Case Example 39 – Obstetrics and Gynaecology Clinic “Narodni Front”

*“I would like to emphasise that, when they told me they were going to tie my legs, I was fully conscious, and at that moment **I clearly stated that they were not permitted to do so. The doctor then called a psychiatrist, and my medical record was updated (that is presumably how it works) with a prominent note stating: ‘THE PATIENT UNWILLING TO COOPERATE’.** However, what they failed to record was that my birth canal had shortened.”*

Case Example 40 – Obstetrics and Gynaecology Clinic “Narodni Front”

“In a state of utter chaos, one of the midwives asked whether the operating theatre staff should be called to prepare for a Caesarean section, to which the doctor responded contemptuously: ‘No way!’

*They continued pressing and jumping on my abdomen, and when they realised that the baby was not coming out, they decided to perform vacuum extraction. Using the same vacuum device, they also extracted my ruptured uterus. At that point, the situation descended into complete chaos, **and I was urgently transferred to the operating theatre for surgery, having previously signed a blank sheet of paper.**”*

5.8. Recording of Incorrect Data in Hospital Discharge Summaries - A considerable number of patients have reported that the information contained in their hospital discharge summaries was inaccurate, particularly with regard to the time of admission, the course of labour or surgery, and especially in situations where “unforeseen circumstances” had occurred.

In view of such altered data, patients conclude that accurate documentation would reveal irregularities in treatment and negligent performance of medical procedures.

Case Example 41 – University Clinical Centre Niš, Clinic for Gynaecology and Obstetrics

*“My pregnancy had been regular from the outset, and all examinations were normal. I reached my due date without being dilated, and CTG findings were normal. On the fifth day after the due date, contractions began, so I went to the maternity ward. **They barely examined me, as it was Sunday, and questioned why I had come to the hospital given that Sunday was not a day for scheduled appointments.** Everything was allegedly normal there as well. That day, I went back and forth to the maternity ward, and **they repeatedly sent me home, stating that I was not dilated,** regardless of the pain I was experiencing.*

*Late at night, I noticed blood spotting and returned once again, at which point I was admitted. **That was the only time I was examined during that night.** They performed a CTG once, took me to a room, and left me there without anyone checking on me, examining me, or providing any information. I remained lying there, in pain, waiting for someone to attend to me.*

*The following morning, around 5:30 a.m., a midwife came, performed another CTG, and there were no fetal heart sounds. She informed the doctor, who came to me and told her to call other colleagues, who replied: ‘Let her come to us.’ The doctor and the midwife then took me upstairs, where an ultrasound examination confirmed that the baby was no longer alive. An autopsy was subsequently performed, **which stated that the baby had aspirated meconium and that the amniotic fluid was green.***

In their medical reports, it was recorded that I had been examined regularly, and three to four gynaecologists signed those reports. This was entirely incorrect, as I had not seen any doctor or other member of the medical staff during the night, except for the midwife who performed the single CT. The report stated that I had been regularly monitored and that no failures had occurred on their part.”

6. Good Practices from Comparative International Systems

Women who participated in this research and whose deliveries took place in other European countries reported significantly different experiences. All of them confirmed that, in obstetrics and gynaecology facilities abroad, care was organised around the patient and tailored to respond to her needs. Women in labour were provided with comprehensive prenatal and postnatal care. They were permitted to drink water and eat prior to delivery, and their decisions regarding the preferred mode and position of childbirth were acknowledged and respected.

Routine practices such as enemas and shaving were not commonly performed. Episiotomy and the Kristeller manoeuvre were undertaken only in exceptional circumstances and strictly on the basis of medical indications. The Kristeller manoeuvre, where performed, was carried out only after explicit consent had been obtained from the patient, in cooperation with her, and without the use of forceful pressure or jumping onto the abdomen.

A doctor from Serbia described her two childbirth experiences, both of which took place in Germany.

"I have given birth twice, both times in Germany.

My experience was completely different from what I had previously witnessed, first as a student at the Belgrade Medical High School (paediatric nursing module), and later during my studies at the Faculty of Medicine, University of Belgrade. My experience as an observer filled me with fear and led me to believe that, when the time came for me to give birth, I would rather pay for delivery in a private hospital than undergo the trauma that appears to affect almost every woman in maternity wards across Serbia.

My first delivery was considered high-risk. My membranes ruptured before contractions began. The amniotic fluid was black, and, being a doctor myself, I knew this was not a good sign. I was overwhelmed with fear, as I was aware that it could indicate the need for an urgent Caesarean section, for which I was not psychologically prepared, since my pregnancy had progressed normally and had been described as N.A.D. (no abnormalities detected) in medical terminology. Upon arrival at the maternity ward, the midwife managed to transform my panic into a sense of calm and safety. Labour was induced, and contractions began shortly thereafter. I was free to move, drink water, tea, or juice, and I was offered food if I felt hungry. A few hours into labour, I was told that, if I wished, I could use a birthing pool, which I accepted. I had expected the tub to be located in a bathroom, but instead it was placed in a dimly lit room with candles and essential oils. The tub was filled with warm water, and I spent four hours there while labour progressed. I then returned to the delivery room, which resembled anything but a conventional clinical setting. The greatest value of my experience lay in the fact that I was allowed to give birth in the position my body instinctively adopted, rather than in a position imposed by a doctor or midwife. The umbilical cord was wrapped around my son's neck four times, yet at no point did I perceive panic from the medical staff who supported me throughout labour. I delivered my baby while lying on my side.

“The second time I gave birth was even less stressful. There was music and laughter. Labour was treated as a celebration. My son was born in a squatting position. I felt as though I was in the safest place in the world. I will remember both deliveries for the rest of my life as the most beautiful events of my life. That is how childbirth is meant to be — and how it should be for every woman.

In Germany, approximately 770,000 babies are born annually, of whom around 44,000 are delivered using vacuum extraction. The use of the Kristeller manoeuvre varies from one maternity ward to another. In some facilities, it is entirely prohibited, whereas in others, typically high-volume maternity wards, it is not prohibited. However, where it is performed, it takes place only in cooperation with the woman in labour. The woman indicates when she feels a contraction and when to push, and gentle fundal pressure may be applied to facilitate delivery. Under no circumstances is forceful jumping onto the abdomen permitted.

The treatment of women in labour is such that each woman is treated with utmost respect and support. She is assisted in every possible way. There is no shouting, noise, or insulting behaviour. Typically, the midwife is the only healthcare professional present during childbirth and calls a doctor only if necessary. A doctor was present during my first labour, whereas during the second, I did not see any doctors at all.

The presence of a birth partner is standard practice and is not subject to additional charges. The partner may be the husband, mother, sister, friend, or any other person chosen by the woman.

With regard to episiotomy, it has largely fallen out of routine practice for several decades. Spontaneous perineal tearing is preferred and, if necessary, sutured after childbirth. It is considered preferable because spontaneous tearing is less likely to cause damage to blood vessels and nerves, whereas episiotomy involves surgical incision of such structures.”

The following experience was shared by a woman who gave birth, twice, at the Obstetrics and Gynaecology Hospital Wilhelminenspital in Vienna.

“My experience throughout the entire process, from the moment I found out I was pregnant until the delivery, was entirely positive.

The pregnancy was managed by my chosen gynaecologist and included one examination per month, with all appointments scheduled in advance. The treatment was consistently of a high standard; both nurses and doctors were kind at all times, and all examinations were conducted according to the monthly plan. There was no need to undergo additional tests elsewhere, as everything was covered by my health insurance. Prior to labour, I was referred to the hospital in a timely manner, where CTG examinations were performed in accordance with the pre-established schedule.

When labour began, I was admitted to the hospital and examined by a doctor, after which the midwife took over the management of the delivery. I was accommodated in a suite equipped with a bathtub, as there was the option of water birth. Throughout the entire process, the midwife was the only healthcare professional present, managing the delivery. A doctor was not present, as there were no complications. I still remember the midwife's dedication, care, and professional attitude during childbirth. I recall the entire experience, including the postpartum period, in a very positive light.

The second delivery, similarly to the first, took place in a suite attended by several midwives, who ensured that everything proceeded in the best possible manner. I can state that my experience regarding the relationship with and treatment by all healthcare professionals involved in the labour process was extremely positive. Their conduct contributed to making these already joyful events even more meaningful for me.

Both deliveries were conducted as part of standard hospital practice, without any special arrangements or preferential treatment. I believe that additional options may exist, but they were not necessary in my case, as a regular patient.”

7. Conclusion and Recommendations

Obstetric violence represents a global issue affecting women in obstetrics and gynaecology institutions.

International research demonstrates that obstetric violence manifests in various forms, ranging from verbal abuse to conduct resulting in serious bodily injury or even fatal outcomes for women and newborns. Each form reflects a different degree of severity and produces consequences of varying magnitude.

Inhuman and degrading treatment in obstetrics and gynaecology institutions is also reflected in cases concerning lost or “missing” babies, as confirmed by the judgment of the European Court of Human Rights (hereinafter: ECHR) in *Zorica Jovanović v. Serbia* (Application no. 21794/08, Judgment of 26 March 2013)¹¹⁶. In that case, the ECHR found a violation of the applicant's rights and obliged the Republic of Serbia to take appropriate measures aimed at establishing mechanisms to ensure individual redress for all parents in the same or a sufficiently similar situation.

Subsequently, the Republic of Serbia adopted the Law on Determining the Facts Regarding the Status of Newborn Children Suspected to Have Disappeared from Maternity Wards in the Republic of Serbia.¹¹⁷ However, the issue of “missing babies” has not been resolved in practice. To date, no healthcare institution has issued a public statement addressing this matter.

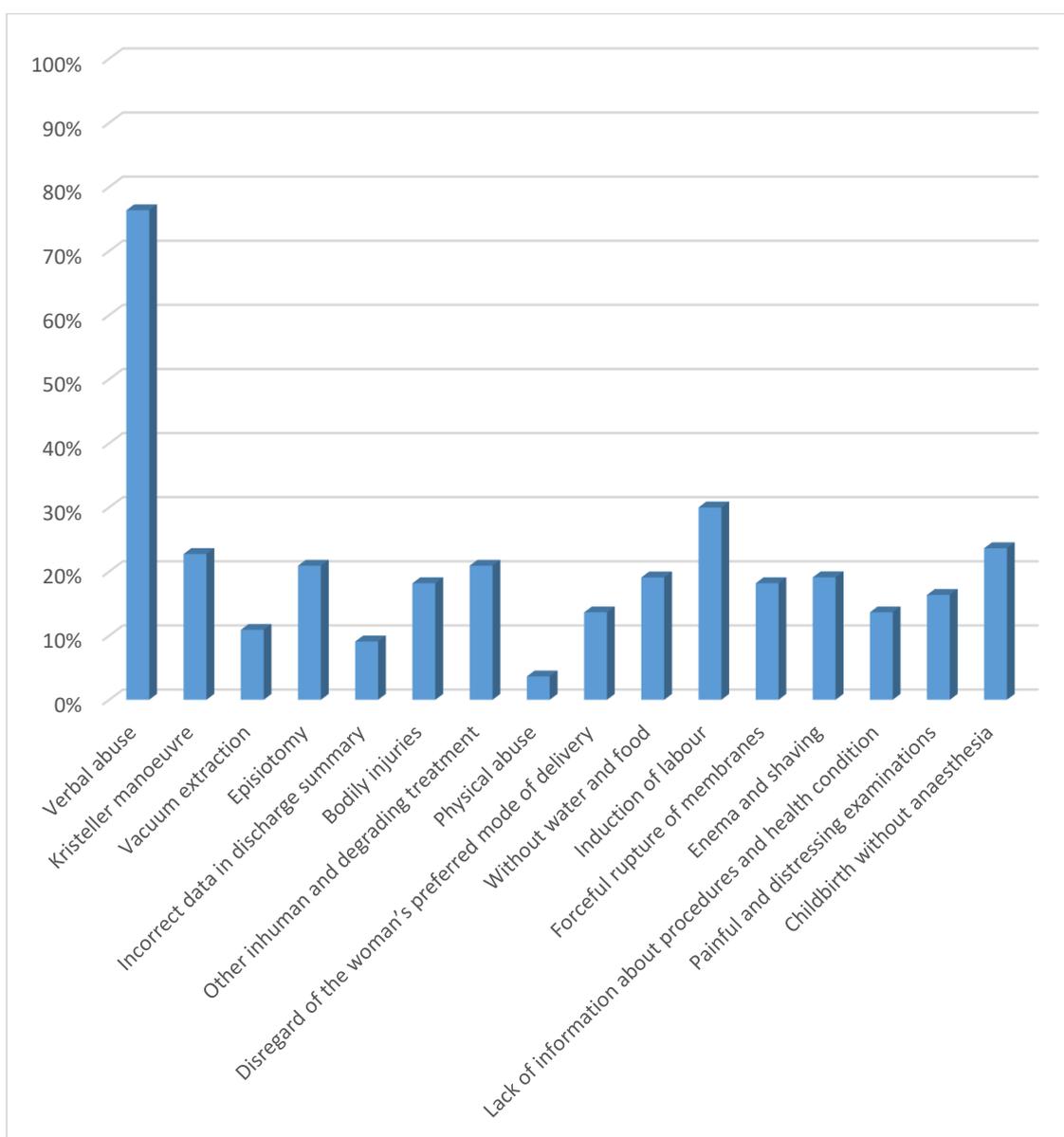
¹¹⁶European Court of Human Rights, *Zorica Jovanović v. Serbia*, Application no. 21794/08, Judgment of 26 March 2013, available at: <http://www.zastupnik.gov.rs/cr/articles/presude/u-odnosu-na-rs/presuda-zorica-jovanovic-protiv-srbije-predstavka-br.-21794-08.html>

¹¹⁷ “RS Official Gazette” No. 18/2020

Despite the ECHR’s finding of a rights violation and the obligation imposed on the Republic of Serbia to undertake corrective measures, no obstetrics and gynaecology institution within the national healthcare system has demonstrably contributed to facilitating resolution of this issue. Consequently, such institutions cannot be presumed to have taken adequate steps toward eliminating obstetric violence in practice.

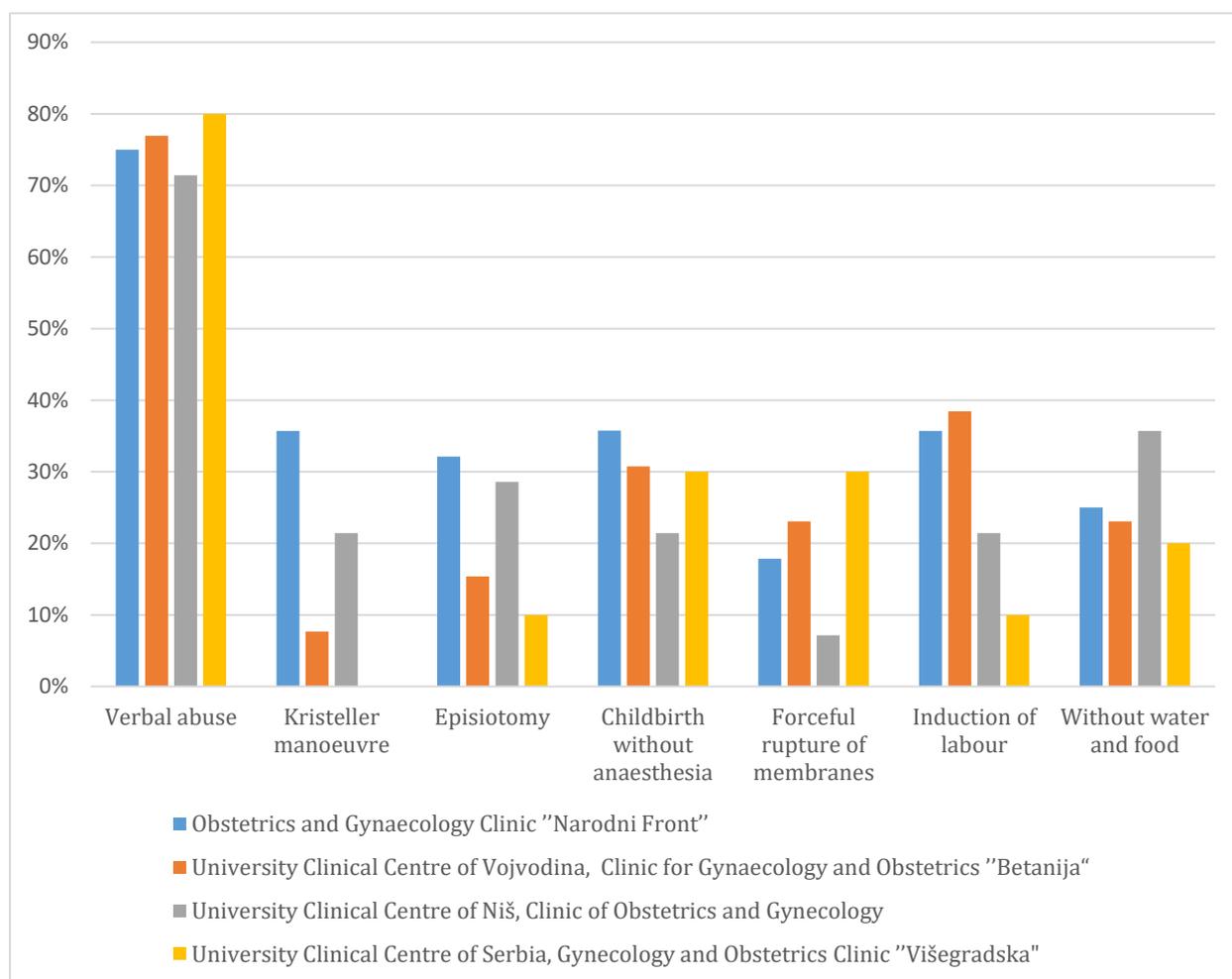
In the Republic of Serbia, women reported experiencing 16 distinct forms of abuse during various medical interventions in obstetrics and gynaecology institutions. Women were subjected to medical procedures of an abusive nature (including the Kristeller manoeuvre, episiotomy, and similar interventions) when such procedures were performed without the patient’s consent and despite her explicit refusal. These interventions caused excruciating pain and suffering and, in certain cases, resulted in severe, life- and health-threatening consequences.

Graph 1. Categories of Violence in Obstetrics and Gynaecology Institutions



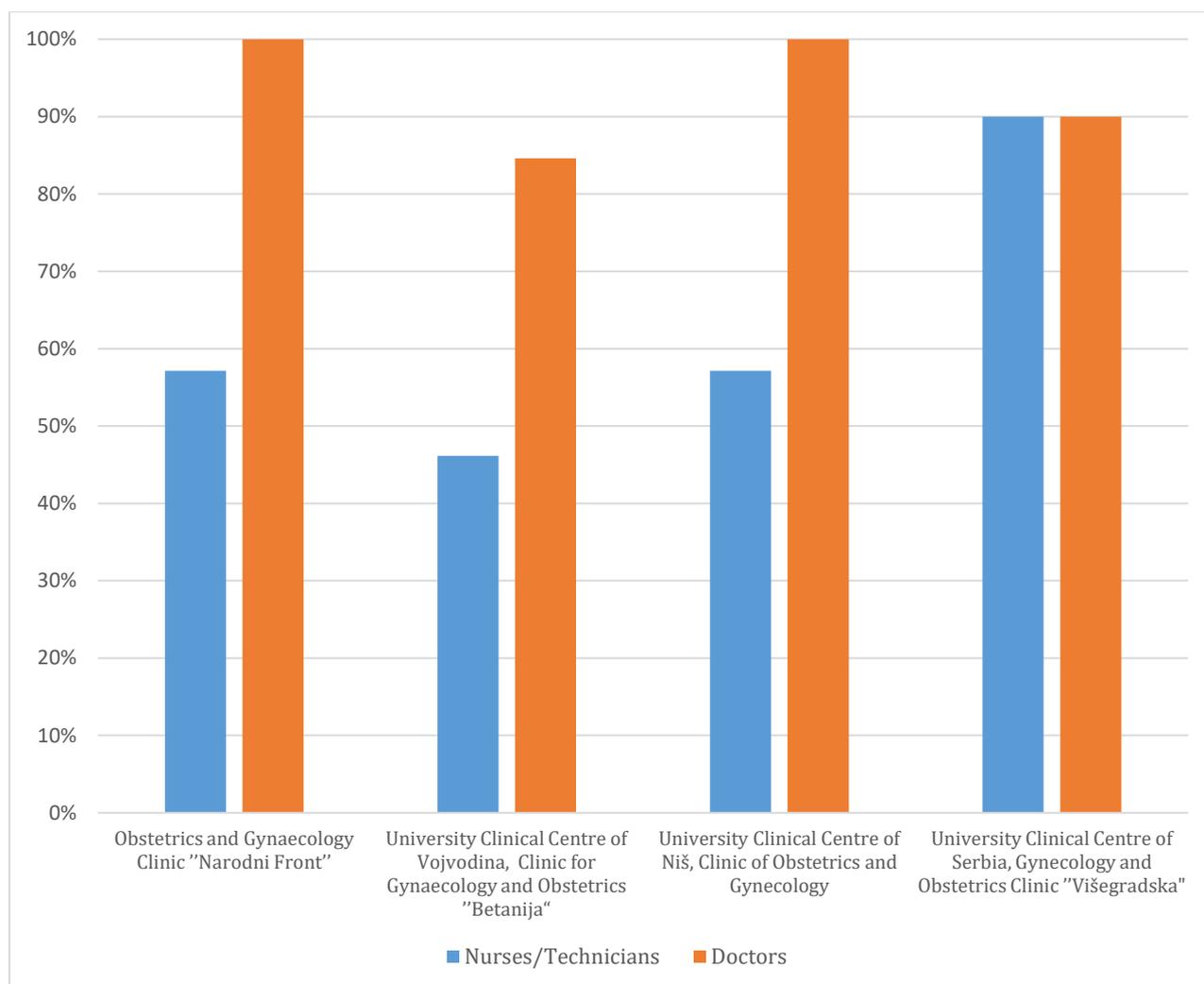
Most reports of obstetric violence concerned four healthcare institutions: the Obstetrics and Gynaecology Clinic “Narodni Front”; the University Clinical Centre of Vojvodina, Clinic for Gynaecology and Obstetrics “Betanija”; the University Clinical Centre of Niš, Clinic of Obstetrics and Gynaecology; and the University Clinical Centre of Serbia, Clinic for Gynaecology and Obstetrics “Višegradska”.

Graph 2. Most Frequently Reported Forms of Violence in the Four Obstetrics and Gynaecology Institutions with the Highest Number of Reports



Obstetric violence reports concern both doctors and nurses/medical technicians. According to the data collected, in the majority of cases, doctors were identified as the perpetrators of abuse. The exception is the University Clinical Centre of Serbia, Clinic for Gynaecology and Obstetrics “Višegradska”, where the number of reported cases involving doctors and those involving nurses and medical technicians is equal.

Graph 3. Distribution of Complaints by Perpetrators of Obstetric Violence



At obstetrics and gynaecology institutions, communication between medical staff and patients is at an unacceptably low level, frequently resulting in verbal abuse, including insults, profanity, humiliation, shouting, and the use of derogatory forms of address.

Medical procedures are undertaken without prior informed consent, and patients are deprived of essential information regarding their health condition, proposed medical interventions, and potential consequences.

In a considerable number of cases, healthcare professionals perform medical interventions such as the Kristeller manoeuvre, vacuum extraction, episiotomy, induction of labour, artificial rupture of membranes, and enemas against the patient's expressed will. The performance of such violent medical procedures may result in serious harm to the patient's health.

Patients are restrained with belts during labour when they express pain or distress. Following childbirth, suturing is frequently performed without the administration of anaesthesia, accompanied by degrading remarks such as “so that they will be like new for their husbands”, “to make their husbands satisfied”, or “to be pretty for their husbands”, and similar statements.

Medical procedures are conducted in a manner that exposes patients to additional suffering and pain, while no adequate measures are undertaken to alleviate such suffering.

It is a common practice that doctors who initiate the childbirth process subsequently abandon the patient due to “other obligations”, transferring responsibility for the delivery to another physician. In cases involving potential pregnancy complications, the doctor assuming responsibility for the delivery is often not sufficiently acquainted with the patient’s medical history, which may result in life-threatening consequences.

In cases of miscarriage, it has been observed that patients are left without supervision by healthcare personnel. They are effectively compelled to miscarry in hospital beds in the presence of other pregnant women or women in labour, or in bathrooms, with instances reported of fetuses being expelled into toilets or bedpans.

Patients are advised to refrain from consuming food and water “for their own well-being”, and in many instances are entirely prohibited from food and fluid intake. A significant number of patients were deprived of food and water during labour, despite labour lasting longer than 12 hours.

With regard to hospital accommodation conditions and capacities, it is important to emphasise that sanitary facilities are frequently non-functional, basic hygiene products are unavailable, and bed linen and hospital gowns are not changed for several days, often remaining stained with blood.

It has been established that patients hospitalised in obstetrics and gynaecology institutions for childbirth are not separated from those hospitalised due to miscarriage.

Obstetrics and gynaecology institutions are frequently designated as “baby-friendly maternity wards”; however, patients’ testimonies indicate that this designation is not substantiated in practice, as essential elements required to meet baby-friendly standards are lacking.

The Republic of Serbia should undertake the following measures:

1. Conduct comprehensive oversight of the work of obstetrics and gynaecology institutions;
2. Verify the capacity and organisational adequacy of obstetrics and gynaecology institutions;
3. Examine the quality and lawfulness of medical procedures performed at obstetrics and gynaecology institutions;

4. Allocate sufficient funds to ensure that reproductive healthcare services are provided at a high standard and in accordance with WHO standards;
5. Identify the causes of systemic obstetric violence within obstetrics and gynaecology institutions;
6. Implement adequate measures to ensure respect for and protection of women's human rights;
7. Guarantee the highest attainable standard of physical and mental health in the provision of reproductive healthcare services;
8. Ensure that reproductive healthcare services are delivered free from obstetric violence and gender-based discrimination;
9. Take into account all public reports and indications of obstetric violence in obstetrics and gynaecology institutions and conduct independent and impartial investigations;
10. Adopt and implement effective preventive measures aimed at eliminating obstetric violence.
11. Implement adequate measures to ensure accountability and impose sanctions on perpetrators of obstetric violence;
12. Establish cooperation with all relevant stakeholders outside the healthcare system who may contribute to the elimination of obstetric violence;
13. Initiate the development and adoption of a national strategy for the prevention and elimination of obstetric violence;
14. Provide continuous education and professional training for healthcare workers regarding the provision of services in obstetrics and gynaecology institutions in accordance with human rights standards.

Women shall be entitled to:

1. Receive reproductive healthcare services in obstetrics and gynaecology institutions;
2. Be provided with obstetric care delivered with respect for their dignity and personality;
3. Receive medical treatment in obstetrics and gynaecology institutions free from discrimination and any form of abuse, torture, inhuman or degrading treatment;

4. Receive medical services in obstetrics and gynaecology institutions free from coercion.

Medical services in obstetrics and gynaecology institutions should be:

1. Provided in full compliance with the principles of informed consent;
2. Accompanied by mandatory written informed consent for all invasive procedures;
3. Delivered in accordance with human rights standards, with due respect for the patient's autonomy and decision-making;
4. Provided together with adequate measures aimed at alleviating suffering and pain;
5. Aligned with applicable WHO standards.