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THE IMPACT OF OBSTETRIC VIOLENCE ON WOMEN'S HEALTH AND FUTURE DECISIONS

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Abstract. Obstetric violence—disrespectful, abusive, or neglectful treatment during childbirth—is a gender-based human rights violation encompassing non-consensual procedures, discrimination, and neglect, often rooted in provider stress, staff shortages, and poor awareness of patient rights. This study (May–September 2025) examined its prevalence and effects. The findings indicate that over half of respondents reported inadequate pain management, including unanesthetized perineal procedures; one-fourth experienced pain during gynecological exams. Violations of autonomy and consent were common, including restricted choice of delivery position, compromised privacy, and insufficient information. Nearly half reported emotional abuse, while two-thirds had limited skin-to-skin contact and over half inadequate breastfeeding support. Consequences included fear of gynecological care, sexual dysfunction, postpartum depression, and PTSD, leading some women to avoid future pregnancies or change health care providers.

Keywords: obstetric violence; informed consent; reduced trust in healthcare; reduced reproductive intentions

INTRODUCTION

Although the global healthcare system is paying increasing attention to obstetric violence, this form of gender-based violence during childbirth remains a serious issue.The term "obstetric violence" is violation of human rights encompassing disrespectful, abusive, or neglectful treatment of women during childbirth. Such violations may include physical or verbal abuse, non-consensual procedures, discrimination, and neglect. Contributing factors include provider stress, lack of empathy, staff shortages, and limited awareness of patient rights. These practices undermine maternal and neonatal health, erode trust in healthcare systems, and have a significant impact on women's physical and emotional health, as well as on their reproductive decision-making. "My Birth" survey (2020) conducted in Lithuania by the *Union of Initiatives Protecting Motherhood* revealed key findings: approximately 16% of respondents reported *some form of violence* during childbirth care. In certain hospitals, up to 30% of women reported bullying, demeaning language, or feeling pressure into procedures they did not want. Around 20% reported lack of adequate pain relief during and after episiotomy. Comparative Analysis of Birth Rights Associated Factors-IMAgiNE EURO study (2022) revealed a growing emphasis on patient-centered care through the Respectful Maternity Care (RMC) framework, which emphasizes dignity, privacy, informed choice, and continuous support. Legal frameworks on patient rights, nondiscrimination, and gender-based or obstetric violence are often ineffective in ensuring women access justice. Lack of recognition of such violence reflects limited societal awareness. As a result, women's rights are frequently violated, complaints go unfiled, and barriers include fear of re-victimisation, low chances of success, costs, and difficulty finding specialized legal support (EU Parliament, 2024). The current regulation of the Criminal Code of the Republic of Lithuania (2000), with an overview of Articles 132, 137, 139, 229 in question contain features that can be applied in cases of obstetric violence. Other acts of obstetric violence, (psychological violence: insulting, shouting reproaches, ignoring), as well as manipulation of information and pressure to consent to unwanted procedures, would be more difficult to criminalize without a separate penal article that could regulate the liability for non-compliance with informed consent, or for attempting to obtain it by coercion or pressure, it would be difficult to prosecute a healthcare professional. However, negative obstetrical experience can have consequences. Multiparity, newborn NICU admission, those who received little support from their partner, and those who experienced verbal or psycho-affective obstetric violence during childbirth have a higher risk of postpartum depression (Martinez-Vázquez et al., 2022). Prior negative childbirth experiences can lead to decisions to not have another child, to delay a subsequent birth and maternal requests for caesarean section in subsequent pregnancies (Shorey, Yang, & Ang, 2018). It should be noted that no recent studies have been conducted in Lithuania examining the impacts of obstetric violence on women's health and reproductive decision-making.

The object of the study: the impact of obstetric violence on women's health and future decisions

Objective of the study: to evaluate the impact of obstetric violence on women's health and future decisions

Tasks of the study:

To identify physical forms of obstetric violence experienced by women during pregnancy, childbirth, and postpartum care;

To identify violation of autonomy experienced by women during pregnancy, childbirth, and postpartum care;

To reveal psychological and emotional forms of obstetric violence and neglect experienced by women during pregnancy, childbirth, and postpartum care;

To identify neglect experienced by women during pregnancy, childbirth, and postpartum care;

To examine the physical and psychological health impacts of obstetric violence on affected women;

To explore the influence of experienced obstetric violence on women's future reproductive decisions, including childbirth preferences and trust in the healthcare system.

THE RESEARCH METHOD

A quantitative research design was employed in this study. A questionnaire was developed based on the most recent findings in the scientific literature. The online survey was conducted between May and September 2025. The target population comprised randomly selected women aged 21–60 years who had given birth to biological children in Lithuania between 2015 and 2025. Ethical standards were followed throughout the study to ensure the privacy and confidentiality of all participants. Respondents were assured that their participation was voluntary, and that their responses would be anonymized and used solely for the purposes of the research. In total, 109 respondents participated in the online survey. Data from 102 questionnaires were included in the final analysis, as seven participants had delivered outside Lithuania and were therefore excluded. Each questionnaire included five subsections for each delivery of a particular respondent, regarding the possibility that respondents may have experienced multiple childbirths. The respondents reported a total of 186 deliveries, of which 84 occurred during the 2020–2025 period and 102 during the 2015–2019 period. Data was processed and analyzed using Microsoft Office Excel.

THE RESULTS AND DISCUSSION

The analysis of demographic data (n=102) indicated that the majority of respondents were aged between 31 and 50 years. Fewer than half of the participants had completed higher education and reported being both students and employees simultaneously. Approximately one quarter identified as employees only, while a smaller proportion indicated that they were students. Regarding the number of children in the family, the results indicate that less than half of the respondents had one child, while more than one-third had two children. Approximately one-fifth of the respondents reported having more than two children, most commonly three. Overall, it can be concluded that the majority of respondents had either one or two children (see Table 1).

Table 1

The demographic data

The age	%	The education	%	The social position	%
21-30	15	Secondary	53	Student and employee	44
31-40	32	Vocational bachelor	23	Employee	25
41-50	41	Bachelor	15	Student	15
51-60	12	Master	9	On maternity leave	9
The number of children	%			Unemployed	7
One	41				
Two	38				
Three	15				
Four	6				

The analysis of data from 186 deliveries was conducted to assess the behavior of medical staff before, during, and after childbirth. The results indicate that fewer than half of the respondents reported that their privacy was not respected. Additionally, medical staff were frequently observed speaking in raised voices or shouting. Approximately one-third of participants experienced intimidation, and fewer than one-fifth reported instances of bullying or humiliation during their care (see Table 2):

Table 2

The behaviour of medical staff

The behaviour	Agree, %	Don't know, %	Disagree, %
Bullying, humiliation	18	9	73
Intimidation	32	3	65
Violence	3	6	91
Speaking in a raised tone, screaming	41	-	59
Ensuring privacy	44	12	44

Assessing the way of delivery (n=186), the results indicated that the majority of respondents gave birth through

vaginal delivery, while 12% underwent Cesarean section due to prenatal, intrapartum complications, or planned surgical delivery, see Figure 1.

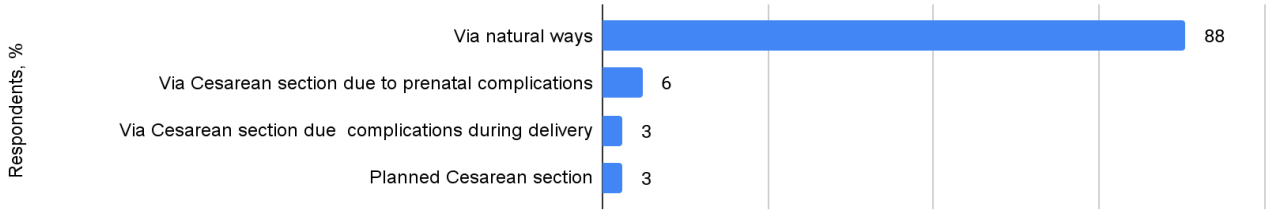

Figure 1. **The way of delivery**

Assessing the possibility to choose a companion for participation in delivery, the results (n=186) indicate that the majority of respondents had such a possibility, but only half reported having delivered with a companion, less than one-third were reluctant themselves. During COVID-19 shutdowns in maternity care services, contrary to the WHO/UNICEF Baby-Friendly Hospital Initiative guidance, some of restrictions included excluding a companion of choice and not allowing family members to visit (Beňová et al., 2022). The data, collected over the period of deliveries in 2015–2025, include shutdowns due to COVID-19, which may influence the findings, as well as the fact that 12% of respondents underwent Cesarean section, see Figure 2:

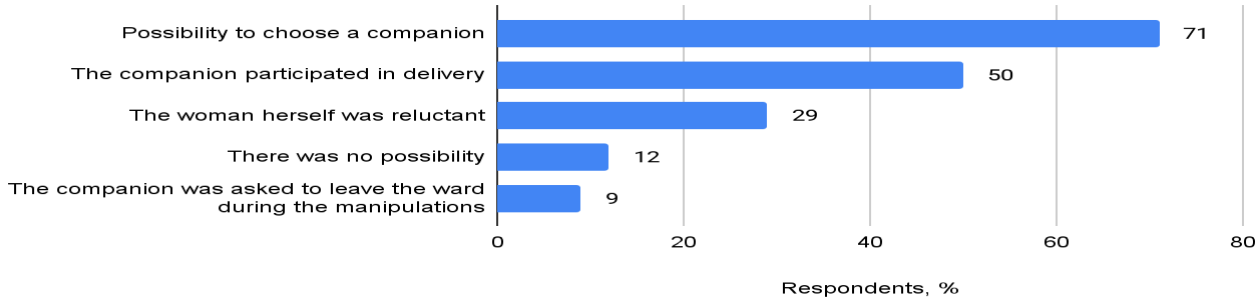

Figure 2. **The possibility to choose a companion**

According to the European Parliament (2024), consent was absent in 49% of medical procedures during obstetric care in Belgium; 100% of women reported being very or rather bothered by the fact that the abilities and competencies of the mother are belittled in maternity hospitals and that interventions are carried out without her consent in Czech Republic; 42.8% reported non-consented interventions in Denmark; 40% of women had an episiotomy, only half of whom gave their consent in Greece; 45.8% reported lack of informed consent and 37% were not requested to provide informed consent of an unnecessary and/or painful procedure in Estonia; 30% of interventions were performed without consent or in secret in Finland. The present survey results from 186 deliveries are consistent with findings from European studies and indicate that one-third of respondents reported insufficient information regarding interventions and medications, while one-quarter stated that information about the mother's condition was inadequate and that informed consent was either not obtained or improperly obtained (see Table 3). According to the Law on the Rights of Patients and Compensation for the Damage to Their Health of Republic of Lithuania Article 15 (2020): *if a patient's decision is influenced by: psychological pressure (e.g., "if you don't agree, your baby might die" – without clear medical grounds), unfounded threats or exaggerated risks, withholding information about alternatives or side effects, this violates the patient's right to informed and voluntary decision-making, and the so-called "consent" may be legally invalid.*

Table 3

The effective communication (n=186)

The communication	Agree, %	Don't know, %	Disagree, %
Interventions were performed only after informed consent obtained properly	59	15	26
Cord blood collection for stem cells after obtaining informed parental consent	24	59	17
Cord blood collection for stem cells without parents knowledge	12	56	32
Information about interventions was sufficient	29	32	39
Felt pressure regarding interventions	12	24	64
Information about medications was sufficient	53	12	35

The communication	Agree, %	Don't know, %	Disagree, %
Information about mother's condition was sufficient	56	18	26
Information about newborn's condition was sufficient	85	6	9

In Poland, 23% of women were not permitted to walk or change position during childbirth, while in Sweden, 35.4% of respondents reported not being given a choice of birth position (European Parliament, 2024). The findings of the present study (number of deliveries n=186) comply with results of European studies and indicate that the majority of participants delivered in the supine position and considered this posture acceptable. Nevertheless, only approximately half of the respondents reported being able to move freely during labor, and about one-quarter indicated that they changed position during delivery. Additionally, half of the interviewed women stated that they were instructed not to eat or drink during labor, see Figure 3:

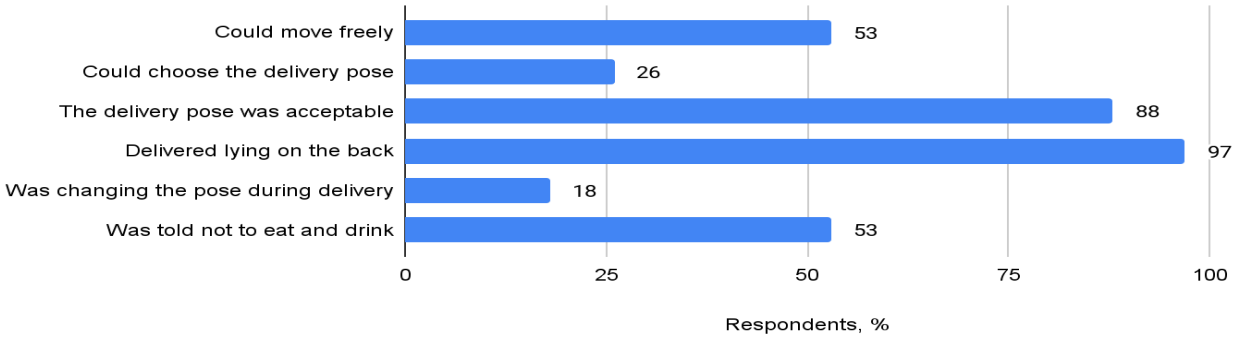

Figure 3. **The delivery pose and possibility to move**

According to the European Parliament (2024), 73.8% of respondents in Poland had limited skin-to-skin contact immediately after the birth, 32.7% mothers in Latvia reported inadequate breastfeeding support, 27% of mothers in Italy complained of a lack of support and information on breastfeeding initiation. Regarding the data (n=186) about favorable conditions for the newborn in the present study, the majority of respondents reported that appropriate arrangements for the first contact with the newborn were in place. However, two-thirds indicated that initial skin-to-skin contact was limited, as the baby was placed on the mother's chest already dressed. Fewer than half of respondents reported insufficient breastfeeding support, while more than one-quarter noted separation of the baby for medical reasons and a minority for non-medical reasons. During COVID-19-related shutdowns in maternity care services, some restrictions-contrary to WHO/UNICEF Baby-Friendly Hospital Initiative guidelines-included separation of mothers and newborns, even when COVID-19 infection was not suspected, and discouragement of breastfeeding (Beňová et al., 2022). These circumstances suggest that COVID-19 shutdowns may have influenced the data, see Figure 4.

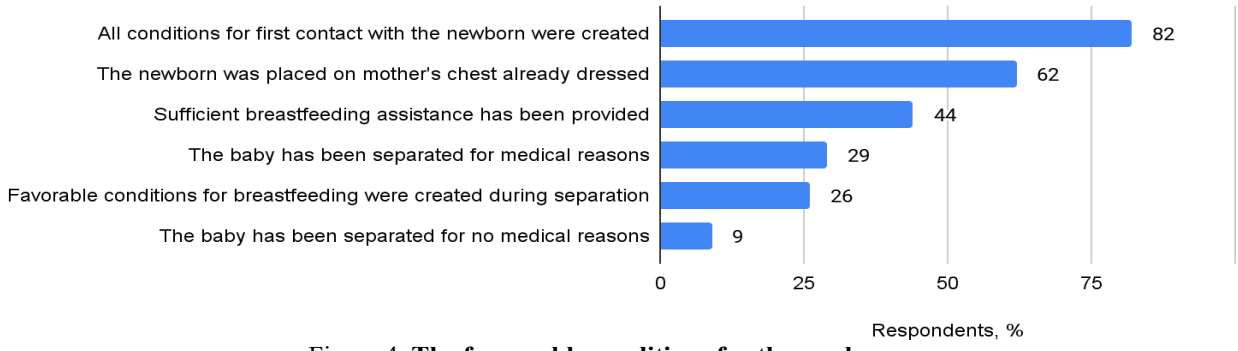

Figure 4. **The favourable conditions for the newborn**

According to the European Parliament (2024), 26% of women in Poland experienced a situation in the emergency room in which an examination was performed without consent, insensitively or in a painful way, 38% of women in Finland underwent a violent or painful procedure, 23% respondents in Finland were not given pain relief for overwhelming pain, 37% of women in Hungary reported that they did not have sufficient anaesthetic for vaginal suturing. The present research assessment of anesthesia practices during delivery revealed that approximately half of the respondents perceived the provided analgesia as ineffective, and that not all preferred analgesic methods were administered. Fewer than two-thirds of participants reported that analgesia was either not provided when required or was insufficiently effective during procedures such as perineal incision and suturing. Additionally, one-quarter of the women interviewed described their gynecological examinations as painful and performed roughly. Overall, the findings of the study demonstrate even higher rates of obstetrical violence than in other European countries (see Table 4).

Table 4

The pain management during delivery, n=186

The pain management	Agree, %	Don't know, %	Disagree, %
Non-medical pain control methods	24	6	70
Analgesia provided as needed	38	3	59
All desired analgesia methods applied	38	9	53
Analgesia was effective	32	20	48
Effective analgesia during perineal incision	24	18	58
Effective analgesia during perineal suturing	26	12	62
Gynecological examinations were rough, painful	26	6	68

A direct comparison of the incidence and forms of obstetric violence, as well as its impacts on women's health and reproductive decision-making, between the periods 2015–2019 and 2020–2025 was not feasible due to unequal numbers of deliveries. However, it was possible to assess trends in obstetric violence over these later and more recent periods. This analysis is particularly relevant given that various interventions and initiatives by the Association of Midwives and the Association of Mothers aimed at eradicating obstetric violence have been implemented since 2015. The results demonstrate notable differences in the reported frequency of non-caring behaviour and obstetrical violence across the two study periods (2015–2019 and 2020–2025). During 2015–2019, approximately one-third of respondents reported non-caring behaviour by medical staff during delivery, and one-quarter reported such behaviour during pregnancy and the postpartum period. In contrast, during 2020–2025, one-third of women reported non-caring behaviour during pregnancy and delivery, and two-thirds during the postpartum period. Similarly, cases of obstetrical violence were reported by one-third of respondents during pregnancy and delivery, and by one-half during the postpartum period in 2015–2019. In 2020–2025, more than half of respondents reported obstetrical violence during delivery and the postpartum period, while more than one-third reported such experiences during pregnancy. The increased numbers observed in 2020–2025 may be partially attributed to the COVID-19 pandemic and related healthcare system disruptions, which may have contributed to a higher incidence of psychological forms of obstetrical violence. Overall, the findings suggest an upward trend in the prevalence of obstetrical violence in the more recent time period (see Table 5).

Table 5

The trends of obstetric violence

Time period of delivery, years	2015-2019		2020-2025	
Number of deliveries	n=102		n=84	
The obstetrical violence	Yes, %	No, %	Yes, %	No, %
Caring behaviour of medical staff during pregnancy	71	29	64	36
Caring behaviour of medical staff during delivery	65	35	63	37
Caring behaviour of medical staff during postpartum period	74	26	37	63
Suffered once	38	62	29	71
Suffered few times	44	56	39	61
Suffered multiple times	3	97	21	79
During pregnancy	38	62	39	61
During delivery	32	68	61	39
During postpartum period	47	53	58	42

Higher levels of depression, PTSD, and impaired self-esteem were seen among women who experienced obstetric violence (Kohan, Mena-Tudela, & Youseflu, 2025). Episiotomy and instrumental delivery are linked to poor childbirth experience (Soriano-Vidal et al., 2023). Obstetric violence during childbirth decreases the probability for women to breastfeed exclusively, having a stronger effect on women who have vaginal birth and could indirectly affect those women's ability to breastfeed 43–180 days after birth (Leite et al., 2023). The lasting emotional injuries due to violence inflicted on women during childbirth disrupts the bonding and the long-term attachment between mother and baby as well as the emotional-sexual relationship between a woman and her husband. The women's distrust in the healthcare system became even more apparent when some participants described giving birth at the hospital as the bitterest memory and event of their lives (Kukura, 2018). Shorey et al., (2018) found that a negative birth experience is related to the decision not to have another child. The findings of the present study indicate comparable outcomes of experienced obstetrical violence among respondents (n=102). Fewer than half reported fear of subsequent gynecological examinations. More than one-third of the women reported experiencing mental health disorders such as postpartum depression or post-

traumatic stress disorder. Approximately one-third stated that they would choose a different hospital for their next delivery, while one-quarter reported sexual dysfunction. One-fifth of participants decided either to change their gynecologist or to alter their preferred mode of delivery from natural birth to Cesarean section. A smaller proportion of participants indicated that they had decided not to have any more children (see Table 6):

Table 6

The impact of experienced obstetrical violence

The consequences	Agree, %	Don't know, %	Disagree, %
Postpartum depression	18	15	67
Post-traumatic stress disorder	18	12	70
Unwilling to breastfeed	12	3	85
Fear of gynecological examinations	44	9	47
Sexual problems	24	26	50
Changing gynecologist	20	20	60
Choosing another hospital for next delivery	32	12	56
C section instead of next natural delivery	20	15	65
Decision not to have more children	9	29	62
Posting experiences on Facebook in women's forums	3	-	97
Initiating legal proceedings	3	-	97

The paper is not without limitations: like most online surveys, the sample of respondents is biased to those with internet access, and with time and willingness to answer questions about their birth experience and consequences. There are several gaps, making it hard to evaluate how common obstetric violence *truly is:* variation between hospitals and regions where some hospitals had higher reported rates, so the average might mask big differences locally. Self-report bias and awareness: some women may not label certain behaviours as abuse or violence; others might underreport due to shame, lack of knowledge, or distrust. Also, what exactly counts ("bullying", "pressure") may vary from person to person. As all EU members, Lithuania faces severely decreased birth rates (Lietuvos Respublikos Seimas, 2025) and needs to extend the retirement age. The numbers of late stage breast and uterine cancer are growing as women avoid regular checkups or participating in prevention programmes due to negative obstetrical experiences. The European Parliament (2021) adopted the Resolution on sexual and reproductive health and rights in the EU in the context of women's health, but there must be increasing public and government focus on addressing not only the problem but consequences such as *postpartum depression, post-traumatic stress disorder, reduced trust in healthcare and reduced desire for future pregnancies* and taking adequate measures including improved support systems for new mothers, training for healthcare professionals, and increased focus on legal regulation of patient rights and informed consent in childbirth.

CONCLUSIONS

1. **Physical Abuse and Inadequate Pain Management.** More than half of the respondents reported ineffective pain management during labor and delivery, commonly painful perineal incisions and suturing performed without adequate anesthesia, one-fourth of the participants reported experiencing pain during gynecological examinations.
2. **Violations of Autonomy and Informed Consent.** The majority of the respondents indicated that they were not given the opportunity to choose their preferred delivery position. More than half reported their privacy being not adequately ensured during labor and delivery. One-third of respondents were not provided with sufficient information regarding medical interventions and medications. One-fourth reported a lack of communication about their own health status and indicated that medical interventions were performed without obtaining informed consent.
3. **Emotional and Verbal Abuse.** Less than half of the participants described being spoken to in a raised tone or being screamed at by healthcare staff. One-third experienced intimidation, while less than one-fifth reported instances of bullying and humiliation during their care.
4. **Neglect and Inadequate Care.** Approximately two-thirds of respondents reported limiting immediate skin-to-skin contact as the newborn was placed on their chest already dressed. More than half indicated insufficient assistance with breastfeeding initiation.
5. **Significant physical and psychological health impacts.** The most commonly reported physical consequences included fear of gynecological examinations reported by less than half of respondents and sexual dysfunction reported by one-fourth of respondents. The most prevalent psychological outcomes were postpartum depression and post-traumatic stress disorder, each reported by about one-fifth of participants.
6. **Influence on women's future reproductive decisions and attitudes toward the healthcare system.** Approximately one-third of respondents indicated a preference to deliver at a different hospital in the future. Around one-fifth reported plans to either change their gynecologist or opt for a cesarean section in subsequent deliveries, a smaller

proportion decided to cease childbearing.

REFERENCES

Beňová, L., Lawn, J. E., Graham, W., Chapin, E. M., Afulani, P. A., Downe, S., Hailegebriel, T. D., Lincetto, O., & Sacks, E. (2022). IMAgiNE EURO: Data for action on quality of maternal and newborn care in 20 European countries during the COVID-19 pandemic. *International Journal of Gynaecology & Obstetrics.* Advance online publication. https://doi.org/10.1002/ijgo.14500

Criminal Code of the Republic of Lithuania, Law No VIII-1968 of 26 September 2000 (as amended). (2000/09/26). Republic of Lithuania. Retrieved from https://e-seimas.lrs.lt/portal/legalAct/lt/TAD/TAIS.111555

European Parliament. (2024). *Obstetric and gynaecological violence in the EU: Prevalence, legal frameworks and educational guidelines for prevention and elimination* (Study for the FEMM Committee, No. PE 761.478). Directorate-General for Internal Policies. https://www.europarl.europa.eu/RegData/etudes/STUD/2024/761478/IPOL_STU(2024)761478_EN.pdf

Initiatives Protecting Motherhood (MGIS). (2022). *"My Birth" survey*. https://mgis.lt/mano-gimdymas/

European Parliament resolution of 24 June 2021 on the situation of sexual and reproductive health and rights in the EU, in the frame of women's health (2020/2215(INI),https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=oj:JOC_2022_081_R_0005

Kohan, S., Mena-Tudela, D., & Youseflu, S. (2025). *The impact of obstetric violence on postpartum quality of life through psychological pathways*. *Scientific Reports, 15(1)*, Article 4799. https://doi.org/10.1038/s41598-025-88708-8

Kukura, E. (2018). *Obstetric violence*. *Georgetown Law Journal, 106*, 721–802. Drexel University Thomas R. Kline School of Law Research Paper No. 2018-A-09.https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3167375

Republic of Lithuania. (2020). *Law on the Rights of Patients and Compensation for the Damage to Their Health* (No. I-2348; as amended to 2020, Article 15) https://www.etar.lt/portal/it/legalAct/TAR.C6E4170DB704/skBcBMLBbQ

Leite, T. H., Marques, E. S., Mesenburg, M. A., Freitas da Silveira, M., & Leal, M. D. C. (2023). The effect of obstetric violence during childbirth on breastfeeding: findings from a perinatal cohort "Birth in Brazil". *Lancet regional health. Americas*, *19*, 100438. https://doi.org/10.1016/j.lana.2023.100438

Lietuvos Respublikos seimas. (2025). *Lietuvos demografinė situacija 1990–2025 m.: gimstamumo, mirtingumo ir migracijos tendencijos.* https://www.lrs.lt/sip/getFile3?p_fid=111021

Martinez-Vázquez, S., Hernández-Martínez, A., Rodríguez-Almagro, J., Delgado-Rodríguez, M., & Martínez-Galiano, J. M. (2022). Relationship between perceived obstetric violence and the risk of postpartum depression: An observational study. *Midwifery*, *108*, 103297. https://doi.org/10.1016/j.midw.2022.103297

Shorey, S., Yang, Y. Y., & Ang, E. (2018). The impact of negative childbirth experience on future reproductive decisions: A quantitative systematic review. *Journal of Advanced Nursing, 74*(6), 1236–1244. https://doi.org/10.1111/jan.13534

Soriano-Vidal, F. J., Oliver-Roig, A., Richart-Martínez, M., & Cabrero-García, J. (2023). Predictors of childbirth experience: Prospective observational study in eastern Spain. *Midwifery*, *124*, 103748. https://doi.org/10.1016/j.midw.2023.103748