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MATERNAL CARE ACROSS THE CONTINUUM OF PREGNANCY, LABOUR AND POSTPARTUM: A REGULATORY ANALYSIS AND IMPLEMENTATION IN PRACTICE – SERBIAN EXAMPLE

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Abstract This paper examines maternal care across the continuum of pregnancy, labour, and the postpartum period through a regulatory and policy lens. It analyzes international legal frameworks and clinical standards alongside documented experiences of women in practice, both globally and in Serbia. By comparing normative commitments and how they are implemented in Serbia, the paper identifies key gaps between formal regulations and lived experiences. It further explores structural, institutional and legal factors contributing to these discrepancies and concludes with policy and regulatory recommendations designed to improve compliance, accountability, and the quality of maternal care.

Keywords
maternal care, pregnancy and childbirth, obstetric violence, clinical standards, health care provision

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1 Introducton

The issue of mistreatment of women during pregnancy, childbirth, and the postpartum period has received increasing media attention in Serbia in recent years. A public testimony by one woman describing her negative experience in a maternity ward encouraged many others to come forward and share similar experiences. This paper provides a comparative analysis of maternal care in high-, middle-, and low-income countries (hereinafter: HICs and LMICs), with a particular focus on Serbia. The paper first analyzes the international legal framework and standards governing maternal care and examines women's experiences in practice through examples from selected HICs and LMICs. It then explores the Serbian legal framework to assess whether women during pregnancy, childbirth, and the postpartum period are subject to specific legal regulations or protected primarily under general legal norms. The subsequent section examines women's rights in practice, relevant case law, and judicial attitudes toward obstetric violence. Finally, the paper analyzes the structural and systemic factors influencing the (un)satisfactory level of maternal care in Serbia and offers recommendations for achieving adequate standards of maternal care. The research will be conducted using primarily the normative method, via analysing existing national and international legislation; the comparative method when assessing the level of harmonization of Serbian with the international framework; as well as an empirical analysis of collected case law and statistical information on how the existing framework is implemented in practice. The significance of this paper lies in its comparative analysis of maternal care and the gap between normative standards and lived experiences. The paper aims to encourage reflection on and reform of existing practices, potentially mitigating negative experiences related to family planning and childbirth, and to support policymakers, health care providers, and the judiciary in fostering a positive and rights-respecting environment for women during and after pregnancy.

2 International Regulation and General Contemporary Standards Related to Maternal Care

People have the right to be involved in discussions and make informed decisions about their health care (NICE, 2025), in line with WMA Declaration of Lisbon on the Rights of the Patient (WMA, 1981-2015), European Charter of Patients' Rights

(EC, 2002), the European Convention for the Protection of Human Rights and Dignity of the Human Being with Regard to the Application of Biology and Medicine (ETS No. 164) of 1997 (CE, 1997), as well as other international and European Acts, and with many Patients' Rights Acts around the world (German Gesetz zur Verbesserung der Rechte von Patientinnen und Patienten (2013); AMA Code of Medical Ethics (1847-2001); French Law No. 2002-303-The Kouchner Law (2002); Spanish Law 41/2002 Regulating Patient Autonomy and Health Documentation and Information-Related Rights and Obligations; Italian law 219/2017; Slovenian Law about Patient Rights (ZPacP), (2008-2022)).

The double vulnerability of women-child in this period increases the possibility for mistreatment. Therefore, different international and national acts and guidelines provide legally binding or soft regulations to ensure quality health care service and to prevent mistreatment, neglect or abuse. Some of the good examples are standards elabourated by the World Health Organization (hereinafter: WHO) (WHO, 2018) and the National Institute for Health and Care Excellence (hereinafter: NICE) (NICE, 2025).

Globally, women's and providers' perspectives on what constitutes respectful maternity care are consistent: being free from harm and mistreatment; having privacy and confidentiality; dignified care; receiving information and giving informed consent; continuous access to family and community support; high-quality physical environments and resources; equitable maternity care; effective communication; having choices and the right to make decisions; competent and motivated human resources; efficient, effective and continuous care (WHO, 2018, p. 21). These components are largely affected by the social determinants of health (Centers for Disease Control and Prevention - CDC, 2024) as well as the systems implemented to deal with illness. Therefore, as specific as they can be, standards have maintained a certain breadth or degree of flexibility in order to satisfactorily respond to different social circumstances.

Communication: The research results show that providing all pertinent information in a clear manner coupled with the staff's interest in addressing women's needs and fears are of key importance (Baranowska et al., 2021, p. 2). Feeling informed significantly enhances the woman's birth experience (Baranowska et al., 2021, p. 7).

Research findings indicate that women, especially those giving birth for the first time, appreciate health care staff's support. Where interventions are required, 'most women would like to receive relevant information from technically competent health care providers in a manner they can understand' (WHO, 2018, p. 26, p. 63). Also, women wish to be in control of their birth process and to be involved in the decision-making process (WHO, 2018, p. 65).

A woman with an experience of trauma should be spoken to 'about the future mode of birth, encompassing: current urgency or incontinence symptoms; the degree of previous trauma; risk of recurrence; the success of the repair undertaken; the psychological effect of the previous trauma; management of her labour'. These discussions provide the basis for her to make truly informed consent (NICE, 2025: Principles 1.9.17, 1.9.19.). Clear, plain language should be used in communication to confirm that women have understood the information (NICE, 2025: Principles 1.4.8. and 1.4.9.).

During 'natural childbirth', because womens' cognitive processes are somewhat blocked and their behavior is influenced by hormones, they tend to rely more on instinct. Then, a 'non-verbal form of communication' is more appropriate. In the 'postpartum period', the woman's attention is focused on the child and information relevant to child care, and accordingly, verbal communication is key. In case of instrumental birth or caesarean section (hereinafter CS), different communication skills are needed (Baranowska et al., 2021, p. 2).

Pregnant women should be counseled to 'drink during labour when they are thirsty, that isotonic drinks may be more beneficial than water, and that overconsumption may be harmful. Information should be given that they can eat a light diet in established labour if they wish, unless they have received opioids or they develop risk factors that make a caesarean birth more likely' (NICE, 2025, Principles 1.8.17, 1.8.18.).

Position and moving: Women should be 'encouraged and helped to move and adopt whatever positions they find most comfortable throughout labour, except lying flat on her back' (NICE, 2025, Principle 1.4.12.).

Pain relief: Women requesting pain relief medications should be informed of their effects and be supported to participate in the decision-making processes (WHO, 2018, p. 104). '*Epidural analgesia* (as well as parenteral opioids) are recommended for healthy pregnant women, depending on preferences' (WHO, 2018, p. 83). NICE provides a list of information women with (NICE, 2025, Principle 1.9.5.) and without an epidural in place should be given during the second stage of labour. If there is delay or excessive distress in the second stage of labour, 'support and sensitive encouragement should be provided and she should be asked if she needs analgesia or anesthesia' (NICE, 2025, Principle 1.9.29.). Health care staff should consider that 'every woman's experience of pain is unique and may be expressed in different ways, both verbally and non-verbally' (NICE, 2025, Principle 1.6.2.).

Companionship: Findings from a WHO review of qualitative studies indicate that women from both HIC LMIC countries value the non-pharmacological pain relief measures enabled by the companions, including a soothing touch, breathing, relaxation techniques and adopting alternative positions to ease pain (WHO, 2018, p. 31).

Use of oxytocin: *A*n obstetrician should offer a full assessment for all women with confirmed delay in the established first stage of labour. The use of oxytocin should be discussed and a decision made in collaboration with her. It is especially important that the woman be informed that although its use will hasten the time of birth it will not influence its mode or outcomes, and it will increase the frequency and strength of contractions and can cause hyperstimulation. The woman should be offered an epidural before oxytocin is started or if she requests it later (NICE, 2025, Principles 1.8.50 to 1.8.52.). WHO guidelines do not recommend the use of amniotomy alone, with early oxytocin augmentation and the use of antispasmodic agents, for prevention of delay in labour. They also do not recommend the use of oxytocin for prevention of delay in labour in women receiving epidural analgesia, or the use of intravenous fluids with the aim of shortening the duration of labour (WHO, 2025, pp. 117-119).

Use of Cardiotocography (CTG): CTG is a continuous electronic monitor used during pregnancy and labor both to track a baby's heart rate and the mother's uterine contractions. Though very useful in assessing the baby's well-being, detecting

potential distress, and managing risk during childbirth, continuous CTG during labour can have negative effects on a woman's sense of autonomy, by increasing discomfort and reducing mobility and pain relief options (WHO, 2025, p. 71). Periodical auscultation of the fetal heart rate 'with either a Doppler ultrasound device or a Pinard fetal stethoscope is recommended for healthy pregnant women in labour' (WHO, 2025, p. 74), as well as the new wireless methods of CTG, as they allow mobility during labour (WHO, 2025, p. 79).

Episiotomy and intrapartum interventions to reduce perineal trauma: Health staff should discuss with the woman her wishes for techniques to reduce perineal trauma and support her in it. An episiotomy should not be performed routinely during spontaneous vaginal birth nor after previous third- or fourth-degree trauma (NICE, 2025, Principles 1.9.16, 1.9.18; WHO, 2025, p. 150). Rather, it should be performed only 'if there is a clinical need and in the recommended manner with analgesia provided beforehand' (NICE, 2025, Principles 1.9.12.-1.9.23).

Manual fundal pressure (Kristeller maneuver): Application of manual fundal pressure to facilitate childbirth during the second stage of labour is not recommended and evidence suggests it leads to more pain after birth (WHO, 2025, p. 155).

Expediting birth: Birth with forceps or ventouse (vacuum extractor used to assist with vaginal birth by applying suction to the baby's head) should be offered if there is concern about the baby's well-being, a prolonged second stage or if the woman wants assistance. In this case, pain relief options should be explained to her. If a woman rejects such birth methods, options should be explained to her; she should be advised that her choice may be limited by safety or urgency; she should be supported in her decision (NICE, 2025, Principles 1.9.35-1.9.41.).

Cesarean birth: When CS is undertaken, there is a set of standards, all of which encompass woman's participation in decision making (NICE, 2013).

Management of the third stage: Antenatally, during the initial assessment, women should be advised of the different options for managing the third stage of labour and the benefits and risks associated with active and physiological management of

the third stage. She should be advised that it is linked with the risk of a postpartum haemorrhage, and consequently, need for blood transfusion. Women should be advised 'to change from physiological to active management in case of haemorrhage, placenta not being delivered or her wish to shorten the third stage' (NICE, 2025, Principles 1.10.5. - 1.10.18).

Retained placenta: If the placenta is retained, a vaginal examination should be offered to assess the need to undertake manual removal of the placenta. The woman should be advised that assessment can be painful and analgesia recommended, and the uterine exploration or manual removal of the placenta should not be performed without an anesthetic (NICE, 2025, Principles 1.10.25 - 1.10.28.).

Risk factors and management of postpartum haemorrhage: If a woman has risk factors for postpartum haemorrhage, that should be emphasized in her record. Health staff should, together with the woman, develop a care plan covering the third stage of labour and immediate clinical treatment should be given (NICE, 2025, Principles 1.10.32, 1.10.33.).

Perineal care: 'Before assessing genital trauma, the process should be explained and analgesia offered. The initial examination should be performed gently. All relevant health care professionals should attend training in perineal/genital assessment. Repair of the perineum should be undertaken as soon as possible to minimize the risk of infection and blood loss. If the woman reports inadequate pain relief at any point, it should be addressed immediately. Women should be given information about the extent of the trauma, pain relief, diet, hygiene and the importance of pelvic floor exercises, expectations in recovery and information on psychological support' (NICE, 2025, Principles 1.12.4. - 1.12.23.).

3 Global Experiences of Women During Delivery and in the Postnatal Period

In many, particularly limited-resource settings, women continue to give birth in facilities while denied the option of having a labour companion present, without access to adequate pain relief, or possibility to mobilize or adopt a chosen birth position. Interventions such as early amniotomy, oxytocin for augmentation and

continuous fetal monitoring are often routinely overused (Volgel et al., 2023, p. 2).

Practice and attitude towards women in labour, both in HIC and LMIC, sometimes result in various forms of abuse. In the obstetric setting, abusive behavior is often reffered to as 'obstetric violence', which WHO (although without using the exact term) recognizes as professional abuse, disrespect, and mistreatment of women during childbirth, which often consists of physical and verbal abuse, lack of confidentiality, and neglect (WHO, 2015, p. 1).

Bowser and Hill identified seven categories of disrespectful and abusive behavior reported during childbirth: i) physical abuse, ii) non-consented care, iii) non-confidential care, iv) non-dignified care, v) discrimination based on specific patient attributes, vi) abandonment of care, and vii) detention in facilities (Sando et al., 2017, p. 2). Results of literature review show that the attitude towards women in labour depends not only on the level of country development, but also on: cultural differences, first labour experience, extraordinary circumstances (f.e. COVID-19, Ebola), women's or health care providers' viewpoint. Despite the circumstances that raise feelings of neglect, disrespect or abuse being subjective, this does not diminish their importance.

Concerning LMIC, research conducted, for example in Ethiopia, shows that although access to health care facilities in general has dramatically improved over the past two decades, maternal care has remained considerably low (Baranowska et al., 2021, p. 10). Three in four women reported experiencing at least one form of disrespect and abuse (hereinafter: D&A) during labour. Other studies from sub-Saharan African countries similarly have reported high levels of D&A maternity care during childbirth (Baranowska et al., 2021, p. 10). Women giving birth to their first child were about two times more likely to report experiencing D&A compared to women who had three or more children, since the former are unfamiliar with how healthcare services are commonly provided. Women who gave birth at a higher-level health facility had a greater likelihood of experiencing D&A. While this seems intutively illogical, as one might expect higher rates of D&A at lower-level facilities, these findings could be the result of understaffing and a high volume of patients, making it difficult to adequately provide care (Baranowska et al., 2021, p. 10). D&A continues to be a serious concern in public health facilities in other parts of Africa,

as well (Mapumulo et al., 2021, p. 2; Adu-Bonsaffoh et al., 2022, p. 1). One study identified numerous systemic barriers to provision of quality, person-centred care for pre-eclampsia in hospitals in rural Ethiopia (Robbins et al., 2023, p. 1).

A common predictor for D&A was the absence of a companion in the labouring room. Providers are more cautious when a companion is present, suggesting that they are aware their behaviour is inappropriate, indicating that companions serve an important role as advocates for women in labour (Baranowska et al., 2021, p. 11).

Concerning Argentina as an example of MIC, research discovered that health care providers feel that they have been losing control over decision-making on birth modes and feel irritated by women's wishes to make autonomous decisions. Communication with patients, regarding the risks and benefits of vaginal birth and CS, seems difficult for them. Concurrently, providers perform an increasing number of CS without medical indication when it is convenient for them, which suggests that paternalistic practices still exist (Vila Ortiz et al., 2023, p. 2).

In Switzerland (HIC), an evaluation of patient satisfaction conducted at the maternity unit highlighted key areas for improvement – the lack of information, their homogeneity, and the multiplicity of intervening stakeholders (Maillefer et al., 2015, p. 3). However, in general, patients spoke positively about the welcoming environment and the staffs', especially midwives', competence (Maillefer et al., 2015, p. 5).

Research shows that, in Sweden, as a HIC, in the case of a woman's refusal 'to undergo an emergency CS for fetal reasons, most midwives (89%) thought that the obstetrician should try to persuade her.' Concerning a woman's request for a CS without any current medical indications, most midwives thought that the obstetrician should agree if the woman had previous maternal or fetal complications. The midwives at six university hospitals were less willing to accept the woman's autonomy in this situation (Danerek et al., 2011, p. 71).

Irish authors observed women-centered care through five major themes representing women's and clinicians' views, experiences and perspectives: protecting normality, education and decision making, continuity, empowerment for women-

centred care and building capacity for women-centred care, and as perceived by participants in the study, women centred-care is not routinely provided in Ireland (Hunter et al., 2017, p. 1).

While reviewing literature, we noticed that most of the articles about abuse and neglect of pregnant women come from LMIC. Articles from HIC mainly focus on changing management in hospitals during COVID-19, or the relationships between midwivery staff and obstetricians, but almost always with the emphasis on the benefit of women in birth (Burau & Overgaard, 2015; Sheil & McAuliffe, 2021; Danerek et al., 2011). Our research results show that the frequency of D&A is prevalent in LMIC, but is not necessarily limited to them and does occur in HIC as well.

4 The Legal Framework for Maternal Health Care in Serbia

In this part of our research, we will examine the legal framework for maternal health in the Republic of Serbia (hereinafter: RS), seeking to identify the norms which protect women during pregnancy, labour and the postpartum period. Our goal is to assess whether the existing framework recognizes the specific status of women in this period and, if it does, whether that framework adequately safeguards their rights.

The Constitution of the RS guarantees human and minority rights arising from 'generally accepted rules of international law, ratified international treaties and laws' (Constitution of RS, 2006, Article 18), so the international agreements previously mentioned apply. Although the WMA Declaration of Lisbon on the Rights of the Patient is not a legally binding Act, the Serbian Medical Society is a WMA member and accepts its fundamental principles within its ethical codes and the basic principles embedded in the European Charter of Patients' Rights, which have found their way into the Serbian Law on Patients' Rights. Serbia has ratified the Convention on Human Rights and Biomedicine.

In Serbia, the equality of all persons before the law is guaranteed and any form of (in)direct discrimination is prohibited, which includes women during pregnancy, childbirth and postpartum. 'Special measures that the Republic of Serbia may introduce in order to achieve full equality of persons or groups of persons who are

essentially in an unequal position with other citizens are not considered discrimination' (Constitution of RS, 2006, Article 21). This provision lays ground to the introduction of special forms of maternal health care. The right to life, the right to dignity which is inviolable, the inviolability of physical and psychological integrity, the right to liberty and security, guaranteeing the protection of personal data, guaranteeing the freedom of decision-making about childbirth (Constitution of RS, Articles 24, 25, 27, 42, 63) are all rights that should be protected in this period. The Constitution recognizes the special need to protect the family, mother, single parent and child, while special support and protection must be provided before and after childbirth (Constitution of RS, Article 66). Special attention within the Constitution is devoted to the 'healthcare of children, pregnant women, mothers during maternity leave, single parents with children up to the age of seven who receive health care from public revenues, if they do not receive it in another way, in accordance with the law' (Constitution of RS, Article 68). These constitutionally protected rights are enforced through appropriate legislative measures.

The health care system in Serbia is regulated by the Health Care Law from 2019, which, among other things, regulates the social care for the population's health care and explicitly states that it includes 'persons planning family, women during pregnancy, childbirth, and in maternity period up to 12 months after childbirth' (Health Care Law, 2019, Article 11). Health care in this period should be provided by mandatory health insurance, but if not, funds should be provided in the state budget (Article 11). This law promotes several principles of health care - respect for human rights and values and the rights of the child in health care, equity, comprehensiveness, affordability, continuity, efficiency and continuous improvement of quality and safety of health care (Articles 20-26). All of these apply to women during pregnancy and postpartum, but this is specifically emphasized within the first principle stating that pregnant women and women in postpartum have the 'right to the highest attainable standard of health and health care' (Article 20). From our analysis, we can conclude that the Health Care Law recognizes the special position and vulnerability of women during pregnancy and after childbirth.

The Health Insurance Law (2019) regulates the area of health insurance within which pregnant and postpartum women exercise their rights. This law provides that the right to health care includes 'examinations and treatment related to family planning,

during pregnancy, childbirth and up to 12 months after childbirth' (Health Insurance Law, 2019, see Articles 52, 54). We came to the same conclusion that special attention is provided for women in the period of planning the pregnancy, during and after it.

The Law on the Exercise of the Right to Health Care for Children, Pregnant Women and Mothers was adopted in 2013. This law regulates the right to health care and reimbursement of transportation costs related to the use of health care for children, pregnant women and mothers, if these rights cannot be exercised on the basis of mandatory health insurance (Law on the Exercise of the Right to Health Care for Children, Pregnant Women and Mothers, 2013, Article 1). Additional protection is provided by having access to health care based on a health insurance document issued by the Republic Fund, even if not certified, with precondition to have a report from a specialist in gynecology and obstetrics on the pregnancy or a discharge list from a health institution on the finalized labour (Article 4).

We also analyzed the Law on Patients' Rights (LPR) from 2013, which governs patients' rights in the context of health care provision, the mechanisms for exercising and protecting those rights, and other matters relating to patients' rights and obligations (LPR, 2013, Article 1). Implementing patients' rights in general applies to pregnant women as well as to those in labour and in the postpartum period. Importantly, according to law, patients have the right to affordable and quality health care, information related to their health status, service and the name and surname of the health care worker involved in their treatment (Articles 6, 7). Patients also have the right to 'appropriate health services for the preservation and improvement of health, prevention, suppression and early detection of diseases and other health disorders', as well as to timely and high-quality health care, which implies a 'humane attitude towards the patient' (Articles 8, 9). For women during pregnancy, labour and postpartum, the right to safety in the implementation of health care 'with the aim of achieving the most favorable treatment outcome and reducing the risk of unwanted consequences for the patient's health to the lowest possible extent' is especially important. Therefore, the 'health institution is obliged to take care of safety in the provision of health care, as well as to continuously monitor risk factors and take measures to reduce them, so the patient cannot suffer damage caused by inadequate functioning of the health service' (Article 10). This provision is very

important, as sometimes the lack of health care staff or organizational issues can pose a problem with multiple labours happening simultaneously, leading to the possibility that adequate care might not be provided for all women.

Although the right to receive information is explicitly regulated by the law (Article 11), our research findings reveal that the failure to provide women with pertinent information during and after childbirth is in fact one of the biggest problems in maternity hospitals. These failures can include, among others, not advising the woman about the medical staff's intention to take certain measures, and the failure to ask for, or explain consequences of their (non-)application.

The law grants patients the right to freely choose proposed medical measures and to seek a second expert opinion from a doctor not directly involved in their treatment (Article 12, 13). This freedom is particularly important regarding measures applied during the labour. According to law 'no medical measure may be taken against the patient without consent,' except in exceptional cases established by law, in accordance with medical ethics (Article 15). The law regulates in detail how the consent is given and withdrawn (Articles 16-18). If the notification is not given in such manner it shall be deemed that the consent is not given and consequently the health professional bears the risk of adverse consequences (Article 16). A factor that exacerbates a medical procedure without consent is the presence or active participation of several people in such internal procedure without the woman's consent. These are most often students of schools and higher education institutions of the health profession, present for the purpose of conducting practical classes, as well as health workers and health associates, during their internships and professional development (Simić, 2025, p. 62). Importantly, the law forbids their presence at the procedure if the woman requests their absence (Article 14).

The law also provides for other rights, such as the access to medical documentation, confidentiality of data, respect of patient's time, the right to object, and damage compensation. It stipulates the right to relief from suffering and pain, including pain therapy (Article 28). This right is of particular importance for women enduring the painful childbirth process and is one of the most often complained of problems during childbirth, as not all women are able to receive adequate pain relief therapy during and after labour.

Based on our research, we can conclude that although the Law on Patients' Rights does not distinguish pregnant women and women in childbirth as a special category of patients, the general provisions nevertheless still do apply to them. However, it may not be necessary to separate them into a special category, since adequate implementation of the existing provisions in practice would be sufficient to protect their rights and special position.

Our research results show that the legal framework in Serbia adequately protects women's rights before, during and after childbirth, and is harmonized with relevant international legislation. The problem, unfortunately, is not with the legal framework, but rather with how the regulations are implemented in practice. The deficiencies in how the regulations are implemented is a problem faced by a large number of women, and is the focus of the next sections.

5 Enforcement of Regulatory Framework in Judicial Practice - Case-Law Analysis

The existing case law on obstetric violence in Serbia is rudimentary, and the number of (publicly available) judgments is sparce. This phenomenon ties to the fact that most of the women who have had negative experiences during and after childbirth opt not to seek legal remedies. However, in the last few years Serbia has seen a rise in the media coverage of this issue with women coming forward and sharing their experiences.

When analyzing the limited case law in Serbia, it seems that courts are not necessarily creating a space that would encourage women to pursue legal remedies for rights breached during childbirth. As with any other, these legal proceedings are lengthy and costly. Moreover, as our research results show, the number of rulings in favor of plaintiffs is concerningly low. One of the main reasons lies in the way the courts interpret and apply existing regulations. The courts tend to focus on the so-called medical error,[1] which the case law commonly defines as a culpable deviation from the medical standard.

[1] 'In the retrial, the second-instance court will determine whether medical error occurred, as well as the causal link between the alleged error and the resulting harm.' Judgment of the Supreme Court of Cassation of 22 December 2022, *Rev 8926/2021*.

Plaintiffs often are unable to prove the existence of a medical error.[2] Thus, the case law allows for the defendants to be exonerated from liability if the plaintiff fails to prove the deviation from the standard. Considering the fact that the medical standard is not uniform and is oftentimes non-existent for every possible situation, women are put in an unfavorable position and discouraged from seeking legal remedies. Similarly, some harmful procedures, such as the Kristeller maneuver, are still 'commonly used' and thus present a medical standard, despite the WHO's opinion that it is harmful.

In relation to the unfavorable position of women as plaintiffs in these proceedings, even the Appellate Court in Novi Sad recognized it, stating: 'In this regard, the appeal reasonably points to a violation of the principle of equality of parties in the proceedings, since on one side there is the defendant – a healthcare institution and a professional medical expert – and on the other side there are parties who are laypersons.'[3]

The requirement for expert testimony in such cases in order to render a favorable judgment for the woman often presents an insurmountable hurdle. This is due to the unfortunate fact that such experts often render the opinion that there is no breach of the standard of care without detailed reasoning, out of professional solidarity among medical professionals.

For example, the expert opinion cited in the judgment of the Appellate Court in Niš states: '*According to the commission's findings, it cannot be denied that there was an oversight in the antenatal and intrapartum assessment of the fetal body weight*; however, the team of senior on-call physicians acted in a timely manner and in accordance with established procedures, doing everything necessary once shoulder dystocia was identified and when there was no other option for completing the delivery. *According to the conclusions*

[2] See f.e:"The plaintiff was admitted to the hospital in a timely manner, during the plaintiff's spontaneous labour the *Kristeller maneuver was applied as a method commonly used* in cases of arrest of fetal descent, but due to impending fetal asphyxia, the delivery was completed by cesarean section, during which a uterine rupture was observed and sutured, thereby being remedied. In such circumstances, even if the uterine rupture had occurred as a result of an inadequate, that is, excessively forceful Kristeller maneuver, as the plaintiff maintains, it was remedied in a timely manner and the causal chain was thereby interrupted. *The subsequent bleeding that led to reoperation and removal of the uterus was caused by the plaintiff's health condition, namely the condition of her reproductive organs, and cannot be linked to the actions of the defendant's employees*". Judgment of the Appellate Court in Novi Sad of 20 April 2016, *Gž. 1372/16*.
[3] Judgment of the Appellate Court in Novi Sad of 16 December 2015, *Gž. 3066/15*.

of the said commission, the physicians' conduct represented the only possible medical solution under the given circumstances.'[4]

It is clear that the medical personnel failed to adequately and diligently measure the fetus's weight, thereby failing to conduct the necessary intervention. Yet the expert witnesses nevertheless concluded the standard of care had not been breached.

When analyzing the criminal case law, it is important to note that obstetric violence is not recognized as a separate criminal offense in Serbia. Our case law research results show that obstetric violence is most commonly classified as a serious offense against human health (Criminal Code of the Republic of Serbia, Article 259(2)), which presupposes the occurrence of a human death. However, the courts generally absolve defendants from liability primarily on the grounds that the fetus or stillborn child is not legally recognized as a person and protected under this provision since 'birth is the legally relevant moment when the newborn becomes a "person" within the meaning of said provision'.[5]

Our previous analysis attests to the need for the courts to act as a catalyst to develop the case law on obstetric violence, by adequately interpreting the existing framework and by not further burdening plaintiffs' procedural position. The courts should also insist that expert witnesses deliver unequivocal and impartial opinions and create a safe environment for women to share their experiences. Importantly, however, there are some examples of good judicial practice, where the courts have adequately interpreted existing regulations so as to better protect the rights of women giving birth.

In the Judgement of the Supreme Court of Cassation Rev 3034/2021, the court correctly established the conditions of liability, such as the damage, harmful act, causation and fault, by determing: 'that the doctors who completed the delivery did not objectively assess the specific clinical situation, because they performed the delivery of an unexpectedly large fetus by vacuum extraction, which led to serious injuries to the newborn; doctors did not comply with the rules of the medical practice, primarily due to deficiencies in shift work, information exchange and

[4] Judgment of the Appellate Court in Niš of 3 December 2015, *11Gž- 1270/15*.
[5] Judgment of the Court of Appeals in Kragujevac of 15 August 2022, *Kž1-456/22*.

deficiencies in medical documentation; that the timely surgical removal of the fetus would have led to the birth of the baby without damage or with far less damage; that an ultrasound examination nor continuous CTG monitoring wasn't performed; and that there is a direct cause-and-effect relationship between the injuries and the methods and means used during childbirth'.[6] These decisions provide a good roadmap for future courts to rule in ways that will promote justice for women giving birth and help to ensure adequate maternal care.

6 Analysis of Maternal Care in Serbia in Practice - Women's Experiences

The problem of women receiving inadequate treatment both during and after childbirth was not widely discussed in the public sphere in Serbia until recently. Public awareness was heightened by the statements of two women who described their negative experiences in a maternity hospital in Belgrade in 2022. Since then, the issue of treatment during and after childbirth has become increasingly prominent in public discourse. Several studies have been conducted on this topic, including women's testimonies and the transmission of their experiences from various state hospitals. During 2022, three lawyers conducted an 'Analysis on the treatment of women in gynecological and obstetric institutions in Serbia' (Mijatović et al., 2022). The research included testimony from approximately 200 women about their experiences in maternity hospitals, out of which 110 gave consent for their statements to be quoted, considering their experience to be a form of obstetric violence (Mijatović et al., 2022, p. 4). Within these testimonies, 16 forms of violence and abuse, i.e., inhumane treatment of female patients, were identified. The largest number of reports analyzed in this research, 76.36%, related to verbal violence and poor communication (Mijatović et al., 2022, p. 22). Women complained about the frequent use of the Kristeller procedure and vacuum extraction, despite their numerous risks (Mijatović et al., 2022, p. 27). Even though the Law on Patients' Rights prescribes both the right to freely choose proposed medical measures and the need for informed consent, testimonies indicate that these provisions are unevenly applied. For example, medical staff often fail to inform women about their intention to apply a certain procedure and their rights to decline certain procedures. Women

[6] See f.e. Judgment of the Supreme Court of Cassation of 12 August 2021, *Rev. 3034/2021*, Judgment of the Court of Appeals in Belgrade of 28 August 2024, *Kž1 663/24*.

complained about forced episiotomy, physical injuries as a result of abuse during treatments, unwanted induction, not receiving anesthesia, and inhumane and degrading treatment (Mijatović et al., 2022). The complaints regarding consent emphasize that women were required to sign extensive documentation agreeing to various procedures in order to even be admitted to the hospital (Mijatović et al., 2022, pp. 36-37). The conclusion of the presented research is that the 'treatment of women in gynecological and obstetric institutions in the Republic of Serbia is not in accordance with international regulations and standards, nor with domestic norms' (Mijatović et al., 2022, p. 22).

According to the results of the research conducted by the Center for Investigative Journalism of Serbia (CINS), over 50% of women complained about verbal abuse (CINS, 2025). They also reported neglect during childbirth and receiving labour induction without adequate prior information. Denial of pain relief was reported by approximately one-third of the women. Violations of privacy were reported by approximately one-third of women, while physical abuse was reported by approximately one-quarter (CINS, 2025).

Of particular concern, and indicative of the historical neglect and taboo surrounding this issue, is that 97% of these women never reported the events they experienced. Some of the main reasons given for not reporting negative experiences included: awareness of future labour in the same institution (and fear of retribution), powerlessness, childcare as priority, lack of awareness and education on the issue (CINS, 2025). Among over one thousand surveyed women, only 33 reported their experiences to the authorities. Unfortunately, most of these reports resulted in no outcome or were still under investigation at the time of reporting; only one case led to the perpetrator being punished (CINS, 2025).

The results from research conducted by the United Nations sexual and reproductive health agency (UNFPA) in Serbia in 2024 are aligned with previously explored surveys. Women complained about being discharged without gynecological examination, the practice of accelerating labour through induction, routine oxytocin use and labour acceleration without previous explanation and disagreements among medical staff regarding interventions (Pantović et al., 2025, pp. 28-31). The degrading treatment of women during childbirth is emphasized with suturing often

performed without anesthesia, women being unable to change positions during labour as they were attached to a CTG monitor, and not being allowed to eat or drink anything during labour despite feeling thirsty or hungry (Pantović et al., 2025, pp. 35, 61, 62).

The use of epidural analgesia during labour in Serbia is concerningly low, considering its benefits and importance and as emphasized by WHO. None of the women in the survey who gave birth in Novi Sad or Novi Pazar received it, despite 22.5% of respondents who gave birth in Novi Sad explicitly requesting it. It appears that epidural analgesia is most widely available in Belgrade and mostly in the tertiary healthcare institutions (Pantović et al., 2025, p. 37). One potential reason for this may lie in the unavailability of resources and health care workers in provincial cities, especially in rural areas.

As did the previous ones, this survey showed that the right to information and informed consent is often ignored, as none of the respondents were able to have a discussion about the planned course of labour, or a birth plan, prior to delivery, except when a cesarean section was scheduled (Pantović et al., 2025, p. 51).

Significantly, the UNFPA survey found that before participating in the discussion, the respondents rated their communication with health care professionals as very satisfactory (26.4%) or completely satisfactory (33%) and more than half of the respondents reported being completely satisfied with the received care (Pantović et al., 2025, pp. 19-20). These findings indicate that the mistreatment of women during labour is so frequent that it has become common and expected.

Notably, the scope of the first two surveys is limited, as they were conducted online and focused on negative experiences. Despite these limitations, these studies are consequential as they raised public awareness about this crucial issue, gave women a space to talk and presented serious problems in practice to decision-makers.

The results of our analysis show that the human rights guaranteed by previously analyzed legal documents often exist only theoretically. Research results find that the most frequently violated rights are the right to information, privacy, dignity, quality health care and the right to freely choose proposed medical measures. Concerningly,

almost none of the WHO standards are adequately implemented in Serbia. Communication is poor, women are discouraged from choosing their preferred positions and moving, adequate pain relief is often not provided, both CTG and episiotomy are used excessively, unnecessarily expediting birth, while the Kristeller maneuver is often used injudiciously without adequate medical indications.

We believe that one of the main factors explaining these human rights violations is that maternal wards are understaffed, especially in light of their huge workload. In 2022, health care services for women's health were provided by 509 physicians. On average, one gynecologist was responsible for the reproductive health of 5,812 women aged over 15 (Beker et al., 2024, p. 81). Similarly, the lack of resources leads to inadequate maternal care, especially with providing pain relief options. The taboo surrounding this issue has led women into silence, which only perpetuates the cycle and leads to normalization of mistreatment during childbirth. On the other side, we believe that the reasons why women shun legal remedies lie in the courts' negative (dismissive) attitude towards these proceedings, fear of mistreatment during future childbirth especially in cities with only one maternal ward, emotional exhaustion, secondary victimization etc.

7 Alignment of the National Guide to Good Clinical Practice for Physiological Vaginal Birth with Contemporary Clinical Standards

Serbia has numerous legal Acts containing standards for maternal care.[7] The last enacted is the National Guide to Good Clinical Practice physiological vaginal birth from 2025.[8] This section of our paper will be devoted to analyzing and comparing this Act with international standards previously explored.

[7] See f.e Radunović, 2005; Ministry of Health of the Republic of Serbia, 2009a, *General Principles of Communication with Pregnant Women, Women in Childbirth and Their Families: A Guide for Midwives and Physicians*, Lozanović-Miladinović, D. (ed.). Belgrade; Ministry of Health of the Republic of Serbia, 2009b, *General Principles of Care and Treatment in Maternity Hospitals: A Guide for Midwives and Physicians*, Lozanović-Miladinović, D. (ed.). Belgrade; National Programme for the Promotion of Breastfeeding and Family and Developmental Care of the Newborn, Official Gazette of the Republic of Serbia, No. 53/2018; National Programme for the Healthcare Protection of Women, Children and Youth, Official Gazette of the Republic of Serbia, No. 28/2009; Strategy for Encouraging Childbearing 2018–2025, Government of the Republic of Serbia, Official Gazette of the Republic of Serbia, No. 56/2018.

[8] Ministry of Health of the Republic of Serbia, Academy of Medical Sciences of the Serbian Medical Society, Republican Expert Commission for Gynecology and Obstetrics (2025). *National Guide to Good Clinical Practice: Physiological Vaginal Birth*. Belgrade.

Communication: Every pregnant woman should be given information on the use of different methods of labour analgesia, complications during labour that may occur and communicated with in a dignified, kind, and respectful way and in clear, understandable language. They should be informed that they can take fluids and light meals during labour except if they have received opioids.[9]

Position and moving: Women should be encouraged to choose positions that suits them best during labour. However, the recommended position remains lithotomy, and other positions are allowed 'if conditions allow'.[10]

Pain relief: Opioid analgesia is recommended for healthy pregnant women but its use is dependent on their availability in the health care institution. If women opt for opioid analgesia they should be informed of possible side effects. Use of epidural analgesia is recommended and women who receive it should be encouraged to move if they can and discouraged from lying solely on their backs.[11]

Companionship: Women should be able to make a decision about the presence of a close person during labour, who should also be informed about the course of labour and all medical procedures to be undertaken.[12]

Use of Oxytocin: Routine rupture of membranes or combination of early amniotomy with oxytocin administration is not recommended. Use of oxytocin is recommended only with slow progress of labour in the active phase of the first stage and after amniotomy. Women should be able to make an informed decision and be advised about the side effects of oxytocin use. Epidural analgesia is recommended if a woman has received oxytocin.[13]

Use of CTG: Continuous CTG use during the second stage of labour can increase the rate of operative deliveries and is not recommended.[14]

[9] Ibid, Recommendations 1.2, 4.1, 4.4, 7.21, 7.22.
[10] Ibid, Recommendations 3.1, 7.23. 7.11, 8.8, 8.9.
[11] Ibid, Recommendations 5.1, 5.9, 5.12, 5.13, 5.24, 5.19, 5.18.
[12] Ibid, Recommendations 3.2, 3.6, 3.8.
[13] Ibid, Recommendations 7.33,7.34, 7.42, 7.43, 7.44.
[14] Ibid, Recommendation 8.5.

Episiotomy and intrapartum interventions to reduce perineal trauma: The risk of perineal trauma can be reduced by using water-soluble lubricants in the second stage, perineal massage, and manual perineal protection. Routine episiotomy is not recommended, and it should only be done if needed, especially for suspected fetal distress or instrumental delivery and only after the informed consent of a woman.[15]

Manual fundal pressure: Fundal pressure to facilitate or accelerate the labour is not recommended and may only be applied during the completion of delivery assisted by vacuum extraction, using controlled pressure on the uterine fundus.[16]

Expediting birth: Active management of labour is not recommended as a routine procedure and should be avoided if pregnancy is not high-risk. Women should be encouraged to make informed decisions on the course of labour.[17]

Our analysis of these recommendations shows that they are for the most part harmonized with the previously explored international ones, as guides contain almost identical provisions. Therefore, it seems logical to conclude that the various problems we have discussed that exist in practice are not caused by the lack of written standards or a deficient legal framework, but rather the way they are implemented in practice.

8 Recommendations and Concluding Remarks

This research was conducted with an aim to assess the state of the legal framework regulating women's rights during pregnancy, childbirth and in the postpartum period in Serbia, and how effective that framework is in practice. Moreover, we compared these findings with the international framework and its implementation in LMICs and HICs. On a positive note, we found that the Serbian legal framework is harmonized with international law and adequately protects women's rights in this vulnerable period. However, on a much more discouraging note, the provisions contained in the Serbian regime are being applied unsatisfactorily. Our research results show that women's rights provided by law are repeatedly breached. The most

[15] Ibid, Recommendations 8.15, 8.17, 8.18, 8.19.
[16] Ibid, Recommendations 8.30, 8.32.
[17] Ibid, Recommendations 7.35, 7.10, 7.5.

frequent breaches include women being denied of their rights to information, privacy, dignity, quality health care and to freely choose proposed medical measures. Similarly, we found that the standards proposed in international guides are not adequately implemented in practice in Serbia. This is particularly the case regarding standards on communication, choice of position and moving, adequate pain relief, and the over-reliance on the use of CTG, episiotomy, birth expedition, and the Kristeller maneuver, which instead should only be employed under special circumstances and with medical indications, and of course after a thorough discussion with the woman and her companion, if there is one. There is little practical value in having even the best laws, standards, and protocols if they are not followed in the clinical setting and, when they are not followed (as is too frequently the case in Serbia), if women do not have adequate opportunity in the law to seek recourse as a result of those breaches.

On an international level, our research results show significant differences in the quality of maternal care between HICs and LMICs. Women in LMICs are more likely to have negative experiences and be subjected to at least verbal mistreatment during childbirth. Resource constraints in LMICs often prevent women from accessing adequate pain relief, while understaffed workplaces increase stress among health care providers, making them less compassionate and attentive. High workloads can lead health care workers to adopt practices that deviate from international standards and WHO recommendations – such as expediting labour, performing episiotomies, or using the Kristeller maneuver – to hasten delivery. Epidural analgesia, for example, appears to be the most effective pain relief option but requires more resources to implement and to manage adverse effects. On the other hand, precisely because of workload pressures combined with poor staffing levels, CTG is being used in the continuous manner as a 'babysitter' (i.e., as the 'default practice' instead of when truly clinically necessary and appropriate) and as an inadequate substitute for woman-centered care (WHO, 2025, p. 73).

In comparison, these challenges exist in Serbia as well, some of which may be culturally influenced, such as paternalistic decision-making regarding childbirth without the woman's informed consent. These issues are intensified with the lack of judicial protection for women who experience trauma during childbirth, which may reflect judges' limited experience in such cases coupled with the high social status of

medical professionals, and consequently, the small number of complaints that reach the court. In conclusion, maternal health care in Serbia, as in many LMICs, remains unsatisfactory. Women's negative experiences in maternity hospitals often influence their decision to have a second child, especially if they experienced trauma during childbirth and in postpartum. Serbia, as with many other countries, is actively and urgently seeking to increase its childbirth numbers due to a severe demographic crisis. Providing women with more positive childbirth experiences is one way to advance this governmental objective. Maintaining the status quo will only hasten Serbia's population decline.

The way forward includes better equipping health care institutions, ensuring access to effective pain relief, ensuring the possibility of partners' attendance during childbirth, providing continuous training for health care staff, addressing understaffing, and encouraging women to share their experiences and seek legal remedies. In order to provide respectful care, health facilities and health systems must be structured in a way that supports providers in different ways, including adequate infrastructure and organization of the maternity wards. Also, it seems that women-centered care can best be facilitated through continuity of midwife models of care, which emphasize the continuous education of midwives, and their improved position in the health system. Given the vulnerable position of women during pregnancy, childbirth and the postpartum period, one of the concrete changes that should be introduced is psychological support for women in maternity hospitals. Namely, such a type of support would be extremely important, especially for women who have had complications during childbirth and particularly those who have had a traumatic experience during their first birth. The conversation about postpartum depression and support for women should start already in maternity hospitals, which also requires a partial reorganization of work and the employment of competent staff who could provide women with adequate psychological support. Similarly, professional support from midwives who help with lactation has to be more available in the maternity care.

Publicly raising awareness in Serbia is a crucial step, and this paper aims to contribute to ongoing efforts to improve maternal care, while also offering lessons that other LMICs can take into consideration.

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Povzetek v slovenskem jeziku

Članek preučuje oskrbo matere skozi celoten proces nosečnosti, poroda in poporodnega obdobja z vidika zakonodaje in politike. Analizirane so mednarodni pravni okviri in klinični standardi skupaj z dokumentiranimi izkušnjami žensk v praksi, tako na globalni ravni kot tudi v Srbiji. S primerjavo normativnih zavez in njihovega izvajanja v Srbiji članek opredeljuje ključne vrzeli med formalnimi predpisi in dejanskimi izkušnjami. Članek raziskuje tudi strukturne, institucionalne in pravne dejavnike, ki prispevajo k tem neskladjem, ter se zaključi s priporočili na področju politike in zakonodaje, namenjenimi izboljšanju skladnosti, odgovornosti in kakovosti oskrbe matere.