

# Experiences of disrespect and abuse during childbirth in the World Health Organization European region: A mixed-method study among 22 countries

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## Abstract

**Objective:** Despite advancements in maternity quality care worldwide, mistreatment of women during childbirth persists. Currently, there is a gap of knowledge on the occurrence of disrespect and abuse during childbirth in the World Health Organization (WHO) European region.

**Methods:** Within the IMaGiNE EURO (Improving Maternal Newborn Care in the WHO European Region During COVID-19 Pandemic) study, women 18 years and older who gave birth in healthcare facilities in the WHO European region, were invited to complete an online validated questionnaire regarding quality of maternity care. Data were collected between March 2020 and May 2023, declared as the COVID-19 pandemic. A mixed-method analysis was conducted on women's experiences of abuse, involving

Ilaria Mariani and Maria Verdecchia shared authorship.

The members of the "IMaGiNE EURO Study Group" are listed at the end of the article.

For affiliations refer to page 1586.

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descriptives and multivariate logistic regression for quantitative data and thematic analysis for qualitative data.

**Results:** Of 50 617 participants among 22 countries, 7683 (15.2%) reported experiences of abuse ranging from 6.4% in Israel to 30.7% in Bosnia-Herzegovina, with significant differences by country, age, and birth mode. Emotional, verbal, and physical abuses were reported by 10.3%, 7.3%, and 2.4%, respectively. The thematic analysis, including 737 responses, identified several shortcomings in care that women perceived as abusive, the experience associated with abuse, and the elicited emotions. Experiences of disrespect and abuse were often linked to a sequence of actions, resulting in women feeling violated and treated as an object.

**Conclusion:** Disrespectful maternity care was common during the COVID-19 pandemic in the WHO European region. Efforts are needed to improve communication, implementation of evidence-based practices, and respect for women's rights. Constant monitoring of disrespect and abuse indicators is needed. A paradigm shift must happen, ensuring safe and respectful care for all.

#### KEYWORDS

childbirth, COVID-19, disrespect and abuse, maternal and newborn health care, quality of care

## 1 | BACKGROUND

The World Health Organization (WHO) acknowledges a positive childbirth experience as an ultimate goal for all women giving birth.<sup>1</sup> However, for some women, the transition to motherhood can be negatively impacted by experiences of disrespect and abuse.<sup>2-8</sup> While disrespectful care can occur in all stages of maternal health care (preconception, antenatal, intrapartum, and postpartum), the period surrounding childbirth seems most at risk.<sup>3,5,6</sup> Importantly, the COVID-19 pandemic was associated with an increase in disrespectful maternity care and a decrease in overall quality of care.<sup>9,10</sup>

Disrespectful care encompasses a spectrum of behaviors, including verbal abuse, physical mistreatment, neglect, and violations of privacy and autonomy. The frequency of women experiencing disrespectful care during childbirth in the WHO European region varies depending on the study population, the definitions used, and the related measures of abuse.<sup>11-14</sup> A common definition and/or validated measurement tool is currently lacking, hampering comparisons among countries and settings.<sup>6</sup> This can also partially explain the wide range in prevalence from 8% up to 77% among the WHO European region.<sup>2,5,11-14</sup>

The occurrence of disrespect and abuse during childbirth can have profound and long-lasting negative effects on women's physical and emotional well-being, as well as on their trust in health care and the future use of healthcare services.<sup>15,16</sup> Women experiencing disrespect and abuse during childbirth report the following negative consequences in the postpartum period: physical pain, fear and anxiety, depression and other mental health problems and difficulties in breastfeeding and bonding with their newborn.<sup>17-19</sup> Currently, disrespect and abuse in maternity care is mostly documented by quantitative studies using closed-ended questions.<sup>20,21</sup> Reports on women's

experiences of abuse and disrespect using their own words and perspective are scarce and mostly small in scale.<sup>17,18</sup> Nevertheless, such reports can offer insights into which events women experience as abusive, as well as the contextual factors shaping their experience. Furthermore, there is a gap of knowledge on the different forms of disrespect and abuse in the WHO European region.

The IMAGiNE EURO (Improving Maternal Newborn Care in the WHO European Region During COVID-19 Pandemic) study explores the perspectives of women and healthcare providers (HCPs) on the quality of maternal and newborn care at childbirth in hospital settings in the WHO European region.<sup>22</sup> This paper aims to document the different forms of disrespect and abuse during childbirth and women's experiences during the COVID-19 pandemic, among 22 countries participating in the IMAGiNE EURO study.

## 2 | MATERIALS AND METHODS

### 2.1 | Study design and participants

Women aged 18 years and older who gave birth in a health facility between March 2020 and May 2023 were eligible to participate in an online, voluntary, publicly available, anonymous survey (REDCap 8.5.21, Vanderbilt University). The study period corresponded to the timeframe officially designated by the WHO as the COVID-19 pandemic<sup>22</sup> and targeted women living in the WHO European region. We used a concurrent triangulation design, collecting quantitative and qualitative data simultaneously.<sup>23</sup> STROBE (Strengthening the Reporting of Observational Studies in Epidemiology) guidelines on cross-sectional studies were used for reporting<sup>24</sup> (File S1, Table S1).

## 2.2 | Data Collection

The survey was available in 27 languages and actively promoted by project partners through a predefined dissemination plan, which principally included social media, organizational websites, and local networks. Dissemination materials explicitly targeted women who gave birth in a hospital facility during the COVID-19 pandemic. The survey included questions on the individual characteristics of the participants, provision of care, experience of care, availability of human and physical resources, and organizational features related to the COVID-19 pandemic. All women were asked: "Did you suffer any forms of physical (e.g. have you been touched improperly and/or without asking your permission, have you been pushed, beaten, slapped, pinched, physically restrained or gagged), verbal (e.g. have you been shouted at, insulted, or talked rudely to), or emotional (e.g. have you been neglected, mocked, or forgotten by HCPs) abuse?" Women reporting an abuse had to classify it as physical, verbal, emotional, or "other." Women who reported "other" could optionally explain this type of abuse by responding to an open-ended question: "Please specify." The open text responses to this question were analyzed for the purposes of this paper.

## 2.3 | Used definitions

Throughout this paper, we use WHO terminology, describing the mistreatment of women as experiences of disrespect and abuse,<sup>5,25</sup> closely linked to how the questions were posed. However, we acknowledge that women and human rights' advocates, as well as some governments and institutions, including the European Commission and Council of Europe, have described these practices as (obstetric and gynecological) violence.<sup>26</sup> Importantly, we aim for the terminology used by WHO, not to minimize the gravity of the problem but to foster a dialogue that encourages engagement from all stakeholders. The discourse on these highly sensitive topics will likely continue in the literature and society at large, until a consensus on terminology is reached.<sup>27</sup>

With respect to gender-related terminology, the survey did not ask respondents' gender identity. Dissemination materials were targeted to "all women who gave birth within a hospital between March 2020 onward" and therefore, we use the terms "woman" and "mother" in this paper.

## 2.4 | Data analysis

Countries with a sample size of at least 100 participants were included in this study to have enough data to conduct a comparison among countries. Data cleaning was conducted according to predefined standardized operating procedures.<sup>28</sup> Cases with >20% missing values and suspected duplicates, identified using date and place of birth and sociodemographic and obstetric data, were identified and the most recent record was retained. We used a choropleth map to visualize

the geographical distribution of women's perceptions of any type of abuse among the included 22 countries with at least 100 participants. Frequencies of physical, verbal, emotional, or "other" reported abuse were also presented overall and by country. To assess the association between reported abuse (dependent variable) and sociodemographic and obstetric variables (independent variables), bivariate and multivariate logistic regression models were conducted, using the category with the highest frequency of each independent variable as the reference. Quantitative analysis was performed using Stata version 14 (StataCorp LLC) and R Statistical Software version 4.1.1 (R Core Team 2022).

The qualitative thematic analysis specifically focused on women who described experiencing abuse in the optional open text response. Open text responses about experiences of abuse were initially translated to English using software such as DeepL and Google Translate, after which translations were reviewed and corrected by country teams. The country teams consist of researchers with expertise on the topic, who are native speakers of the original language and are fluent in English. Data were then analyzed using thematic analysis by A.G. and H.B. Braun & Clarke's six-phase framework was used for thematic analysis and inductive coding was applied.<sup>29</sup> A.G. and H.B. independently coded the first 100 responses, after which they worked together to agree on a coding framework. The other responses were then coded by one researcher and revised by the second researcher with an interval of coding 100 responses, followed by a discussion of the intermediate results until all data were coded. The final coding tree was developed, and any disagreement was resolved through discussion. The last two phases of Braun & Clarke's six-phase framework involved refining the themes extracted from the data, adding quotes and double-checking whether the themes reflected the respondents' experiences and perceptions with feedback from the coauthor group.<sup>30,31</sup>

## 2.5 | Ethical aspects

Women consented to participation before completing the questionnaire. There were no incentives to participate in the survey. The survey was approved by the institutional review board of the coordinating center, IRCCS Burlo Garofolo Trieste (IRB-BURLO 05/2020 15.07.2020) and by ethics committees of several other participating countries as reported elsewhere.<sup>22</sup> No data elements that could disclose personal identity were collected and data were stored by the coordinating center. The survey met the General Data Protection Regulation requirements (<https://gdpr.eu/>).

## 3 | RESULTS

### 3.1 | Participants

A total of 74026 women accessed the online questionnaire in all participating countries. After exclusion of incomplete records and potential duplicates, 50617 women met all inclusion criteria and

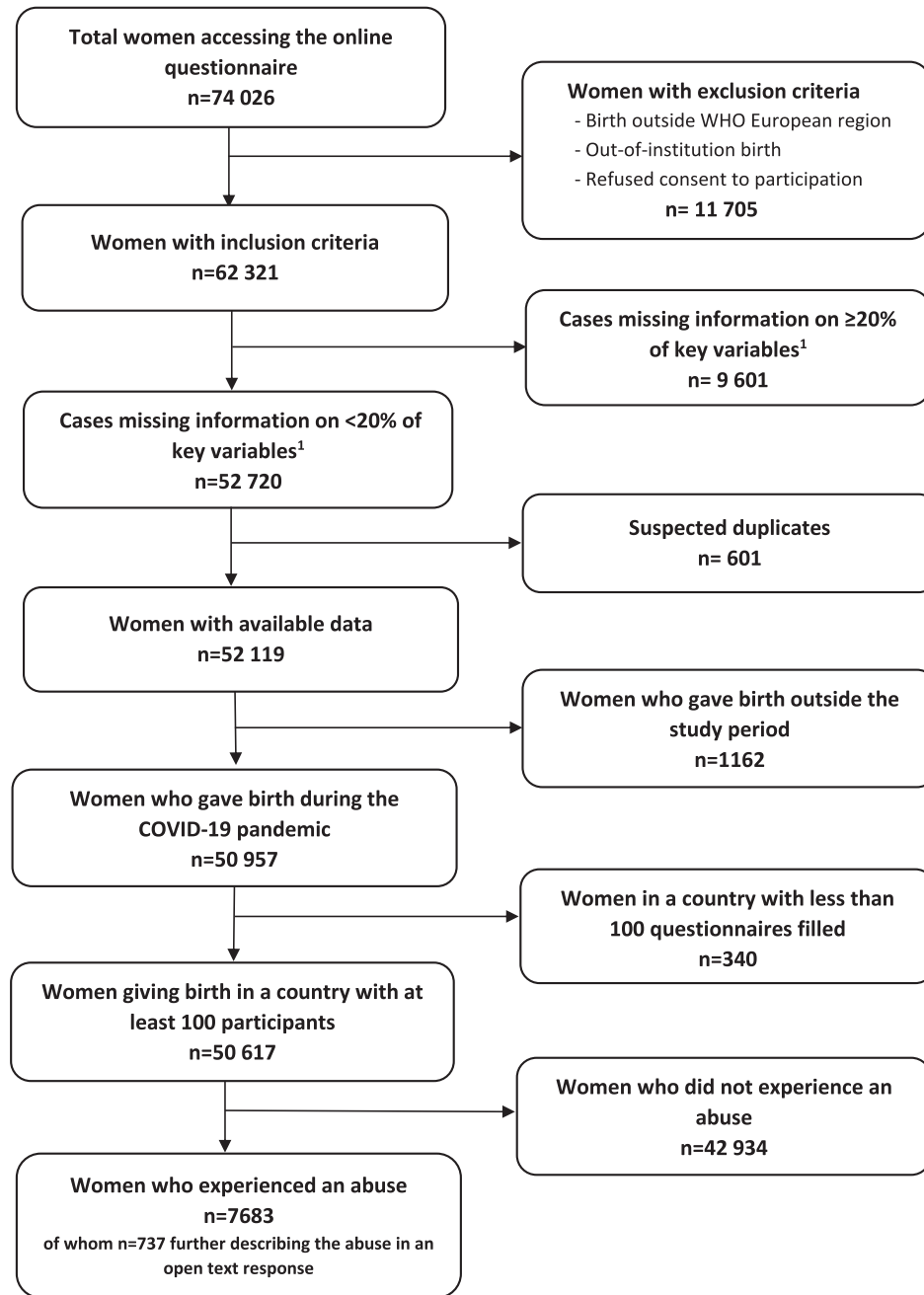


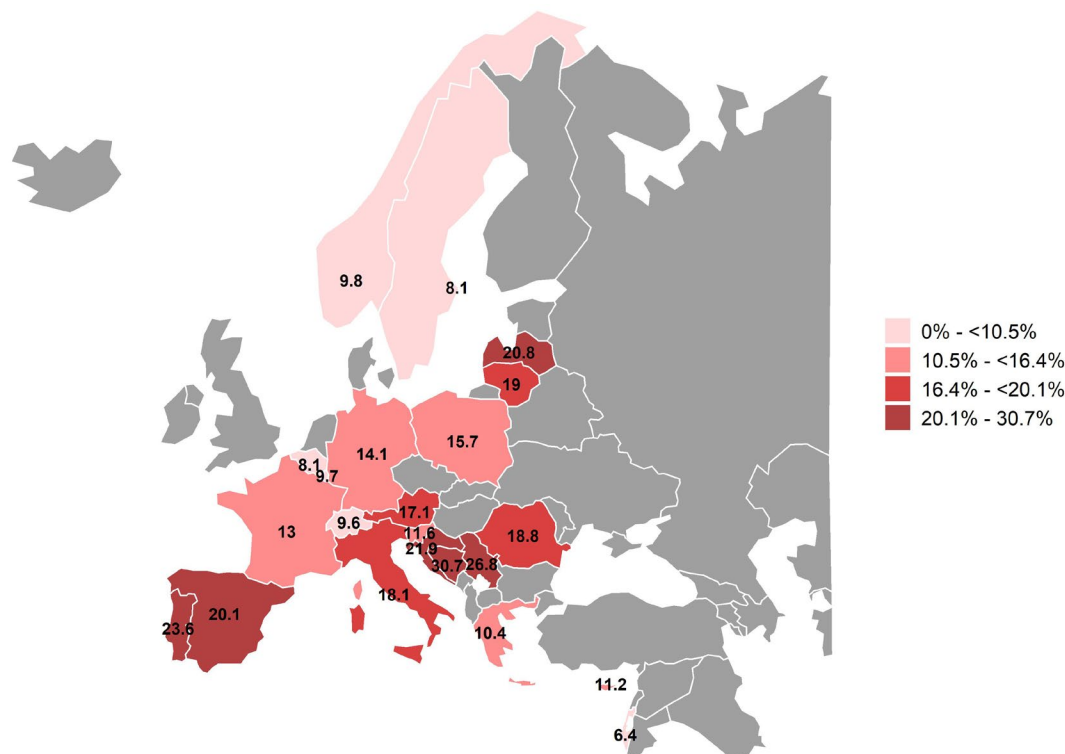
FIGURE 1 Flow diagram. WHO, World Health Organization.

were included in the quantitative analysis. Sociodemographic characteristics of all participants can be found in [File S2](#) and [Table S1](#). In total, 7683 (15.2%) women reported abuse, of whom 737 described the abuse in the open-ended question, included in the qualitative analysis ([Figure 1](#)).

### 3.2 | Type and frequency of abuse per country

The frequency of reported abuse varied among countries ([File S3](#), [Table S1](#)), with the percentage of women who reported at least one type of abuse exceeding 10% in 16 of the 22 countries ([Figure 2](#)). The

lowest frequencies of abuse were reported in Israel (6.4%,  $n=16$ ), Belgium (8.1%,  $n=73$ ), Switzerland (9.6%,  $n=136$ ), Luxembourg (9.7%,  $n=51$ ), and Scandinavia (Sweden 8.1%,  $n=621$ ; Norway 9.8%,  $n=538$ ), while frequencies  $>20\%$  were reported in some countries of the Balkans (Bosnia and Herzegovina 30.7%,  $n=170$ ; Serbia 26.7%,  $n=291$ ; Croatia 21.9%,  $n=704$ ), the Iberian Peninsula (Portugal 23.6%,  $n=572$ ; Spain 20.1%,  $n=71$ ), and the Baltic area (Latvia 20.8%,  $n=858$ ). Differences by countries were confirmed by bivariate and multivariate analysis ([File S3](#) and [Table S2](#)). Maternal age  $\leq 30$  years, instrumental vaginal birth, cesarean section, and giving birth in a country different from the mother's country of origin were significantly associated with an increased likelihood of abuse ([File S3](#) and [Table S2](#)).



**FIGURE 2** Percentage of women who experienced abuse around the time of childbirth in the IMAGiNE EURO study among 22 countries in the WHO European region ( $n = 50\,617$ ). Figure shows frequencies of women reporting abuse among those giving birth in a country with at least 100 participants ( $n = 50\,617$ ). IMAGiNE EURO, Improving Maternal Newborn Care in the WHO European Region During COVID-19 Pandemic; WHO, World Health Organization.

Overall, emotional and verbal abuse were the most frequently reported types of abuse, with a wide variation in frequencies among countries (Figure 3). Emotional abuse was reported by 10.3% ( $n = 5233$ ) of total respondents, with frequencies ranging from 2.4% ( $n = 6$ ) in Israel to up to 20.4% ( $n = 113$ ) in Bosnia and Herzegovina. Verbal abuse was reported by 7.3% ( $n = 3719$ ) of women, with frequencies ranging from 2.3% ( $n = 33$ ) in France to 19.5% ( $n = 108$ ) in Bosnia-Herzegovina. Physical abuse was reported by 1190 (2.4%) women, with two countries presenting frequencies  $<1\%$  (Norway 0.6%  $n = 35$ ; Poland 0.9%,  $n = 17$ ) and only one country with frequencies  $>5\%$  (Portugal 9.1%,  $n = 220$ ).

### 3.3 | Experiences of women regarding the occurrence of disrespect and abuse

The qualitative analysis included open text data of 737 of 774 (95.2%) women reporting abuse other than physical, verbal, or emotional abuse. Their sociodemographic characteristics are displayed in File S2 and Table S2. Most women gave birth in 2020 (57.1%,  $n = 421$ ) and 2021 (35.7%,  $n = 263$ ). The majority of women (73.1%,  $n = 539$ ) were between 25 and 35 years old and had a university degree or higher (69.3%,  $n = 511$ ). One in three women (31.1%,  $n = 229$ ) had a cesarean section, and most births were attended by a midwife (80.7%,  $n = 595$ ) and/or obstetrics/gynecology doctor (61.3%,  $n = 452$ ).

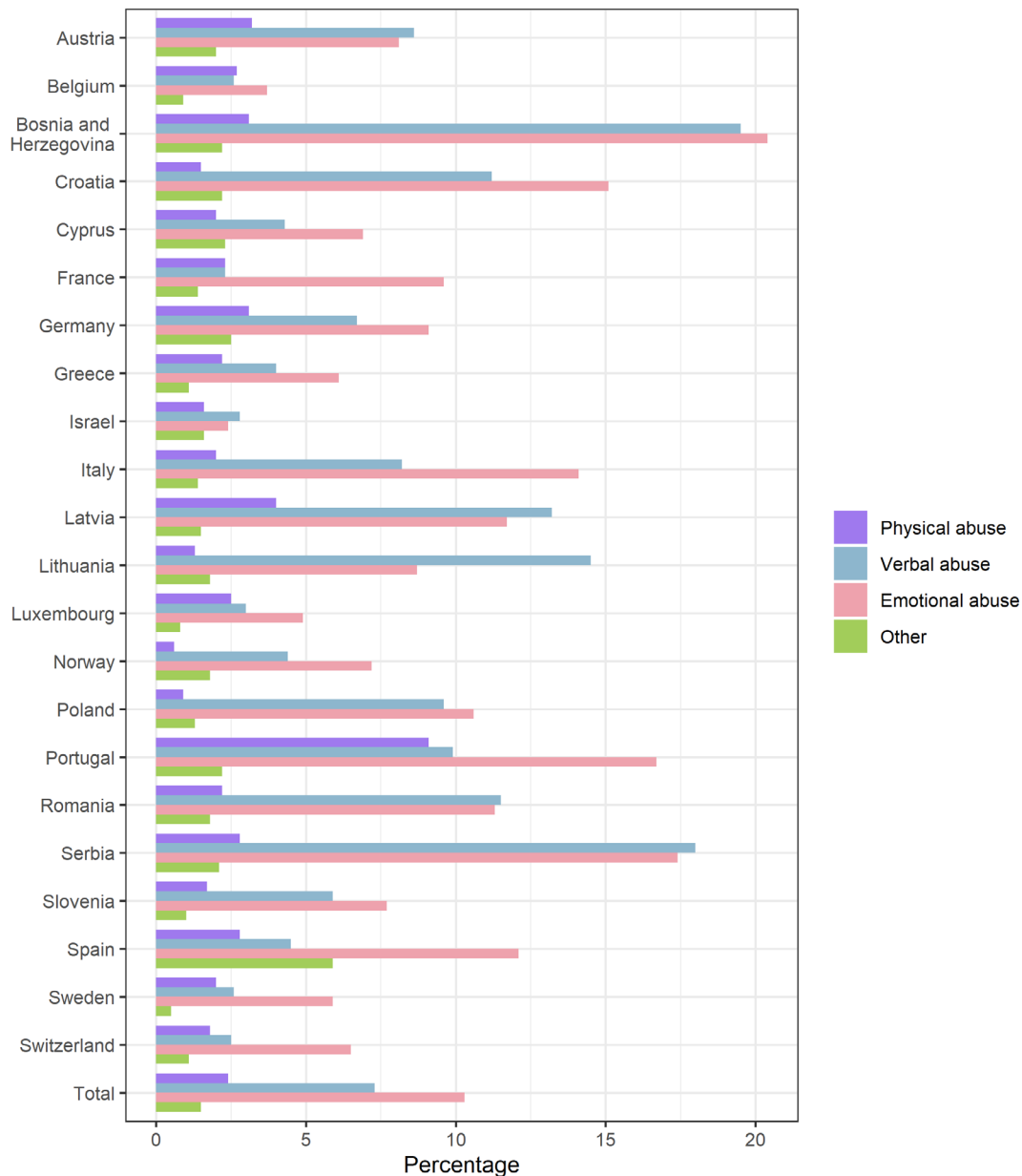
Informed by the thematic analysis, three interconnected overarching themes were found describing the experience of abuse in maternity care: the shortcomings in healthcare provision perceived as abusive by respondents, the experience associated with the abuse, and the elicited emotions (Figure 4).

#### Shortcomings in healthcare provision

Four shortcomings at the level of healthcare provision were perceived as abusive by women: (1) lack of information and consent, (2) refusing or denying care, (3) adherence to rigid protocols, and (4) rough or incorrect procedures. Importantly, shortcomings in healthcare provision often coincided, all contributing to an experience of abuse.

#### Lack of information and consent

The absence or inconsistency of information stood out as a problematic issue in healthcare provision, commonly reported regardless of country. Women reported that medical procedures such as vaginal examinations or induction of labor occurred without explanation and that health workers refused to address their questions or provided inaccurate information. For instance, a woman from Norway expressed:



**FIGURE 3** Type and frequency of abuse reported in the IMAGiNE EURO study among 22 countries in the WHO European region. Figure shows frequencies of women reporting abuse among those giving birth in a country with at least 100 participants ( $n = 50\,617$ ). IMAGiNE EURO, Improving Maternal Newborn Care in the WHO European Region During COVID-19 Pandemic; WHO, World Health Organization.

I was subjected to membrane sweeping without any warning. It was done along with a routine vaginal examination and verbal comment along the way, 'Yes, I know this hurts, but only for one more minute now.'  
(Norway)

each other. No consent or explanation was given for use of vacuum. I only understood what had happened after going to the postnatal ward and googling what that device was.  
(Cyprus)

Similarly, a woman from Cyprus expressed a negative experience around communication and consent:

Another woman from Serbia explained how she was given incorrect information on purpose.

The midwives used their fingers to 'check' several times without asking for consent, discussing only with

They induced me by saying it was glucose.  
(Serbia)

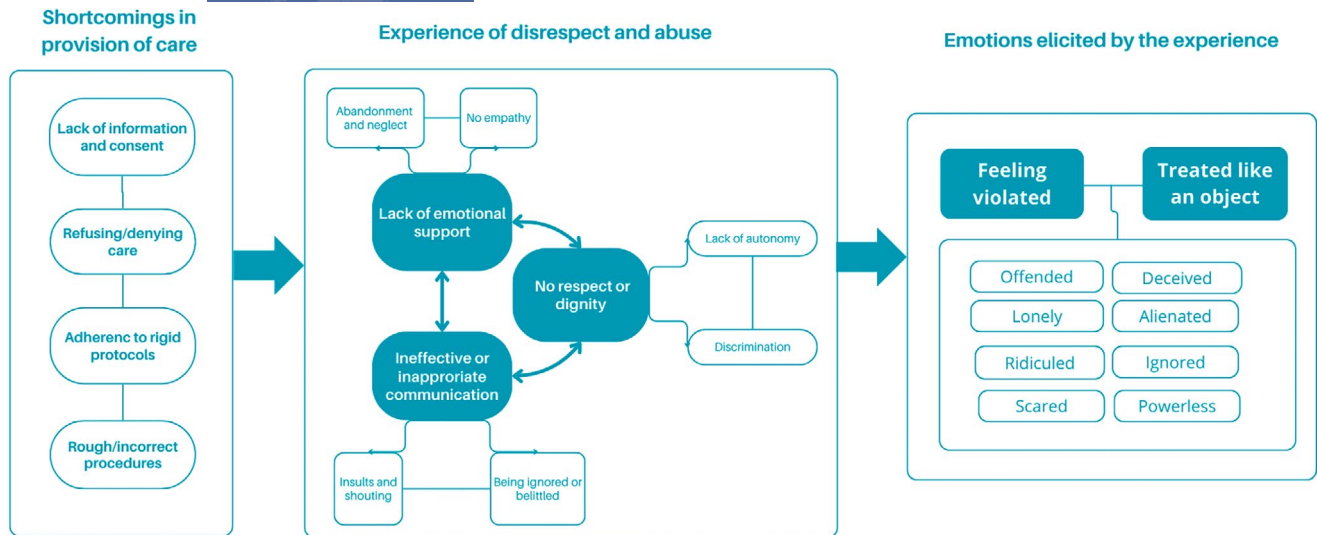


FIGURE 4 Thematic framework emerging from the qualitative analysis.

#### *Refusing or denying care*

Other shortcomings frequently raised by women were the disregard for requests and denial of care, accompanied by women being left alone for a prolonged period of time.

This was described as follows:

I was alone almost the entire time of giving birth and they refused to give me an epidural. One nurse even rudely told me, 'You just came and you're already asking for an epidural'.

(Croatia)

Requests to be seen by another HCP were also often denied. A woman from Romania explained:

One of the nurses didn't want to answer my questions and laughed derisively when I asked her to call a doctor to help me.

(Romania)

Another aspect frequently mentioned was the absence of pain relief. This was often also intertwined with neglect, especially postpartum, where women were left unattended for a prolonged period. During medical interventions, pain relief was not offered or not considered a priority. A woman from Germany described this as follows:

I had to have stitches due to an episiotomy. It took the doctor 1.5 hours.... I didn't get any anaesthetic!

(Germany)

Additionally, women recounted that they were often left unattended by HCPs for extended periods of time, even when they requested assistance.

I was alone in the room during the active phase of labor. I was literally screaming for them to come in the room and when they finally arrived the head of the baby was half out.

(Slovenia)

#### *Adherence to rigid protocols*

Several women complained about adherence to strict protocols and/or routines when they entered the hospital, without room for making their own choices about care. Women gave a wide range of examples such as the use of an oxytocin drip, receiving injections, not being allowed to eat or drink, receiving frequent vaginal examinations, and being compelled to give birth in a certain position. Women's preferences and choices were often not respected.

A woman from Spain explained how she was administered medication without a clear reason, only that it was in the protocol:

The first dose of oxytocin was administered justifying that it is 'protocol.' Second dose of oxytocin was given to finish my labor before shift change.

(Spain)

#### *Rough and incorrect procedures*

Another factor shaping the experience of abuse was the experience of rough and incorrect procedures performed by HCPs. Women often did not perceive medical procedures as essential, skillfully performed, and/or conducted with care. In almost all countries, women reported poor experiences with vaginal examinations:

The gynaecologist performed an extremely rough vaginal examination upon arrival at the hospital. She roughly pushed her hand into the birth canal without

any announcement, roughly squeezed my stomach to estimate where the child's head was...

(Croatia)

Women described rough interventions also in the immediate postpartum period, particularly in relation to breastfeeding.

Breasts were squeezed, pulled to 'express milk'.

(Latvia)

Sometimes these rough procedures were accompanied by feeling pressured to breastfeed.

Some nurses insisted on breastfeeding, and their argument was that we all have enough milk, which they proved by pulling my breasts roughly and without any warning. Due to the pain, cracked nipples and no support at the hospital, I gave up breastfeeding, and I was not allowed to give formula. I prepared it secretly in the kitchen when none of the staff was around.

(Croatia)

## Experience of disrespect and abuse

The analysis revealed three interconnected themes, characterizing the experience of abuse: (1) lack of emotional support, (2) ineffective or inappropriate communication, and (3) no respect or dignity.

### *Lack of emotional support*

*No empathy.* Women noted care was often provided "without empathy and feeling" (cited by a woman from Slovenia). According to respondents, HCPs did not seem to accommodate emotions and pain experienced by women during childbirth and women did not feel understood or supported by HCPs.

The health workers, the doctor and the midwife, laughed when I cried on the bed because I was worried about my child's health (jaundice, inability to wake the baby).

(Bosnia-Herzegovina)

This theme was often related with many other themes (e.g. incorrect procedures and lack of autonomy).

They didn't even wait for the spinal anaesthesia to take effect...they performed a cesarean section so that I felt everything, from the cutting to the stitching...they ripped the child out of me...while taking the child out, they even made fun of me, how would I "survive" then? natural childbirth... I moved my legs, told them I could feel everything, but they continued.

(Croatia)

*Abandonment and neglect.* Many women described a significant absence of emotional support during the childbirth process and overall neglect. They expressed feeling abandoned by HCPs who seemed to solely focus on executing medical procedures without attempting to build a connection with the woman.

They only entered my room to leave the medication and then left.

(Greece)

### *Ineffective and/or inappropriate communication*

*Being ignored or belittled.* Some women experienced being ignored or belittled, e.g. when expressing their concerns about their own health or that of their newborn.

Even though I pointed out that the baby had a fever, was crying inconsolably and sweating, I was told I was crazy and imagining things.

(Serbia)

*Insults and shouting.* A substantial number of women described inappropriate language, insults, and shouting as forms of abuse. For instance, a woman from Italia recounted how HCPs insulted her during a cesarean birth because of her body weight:

Outside the door my husband heard from the gynecologist that I was a whale and until the end they tried to demotivate me for a vaginal birth after cesarean.

(Italy)

### *No respect or dignity*

Women indicated experiencing a deficiency in respect and dignity throughout the different phases of childbirth.

*Lack of autonomy.* Women felt they had no control and/or their choices were not respected. HCPs disregarded their personal preferences throughout labor and childbirth. Such actions included the denial of activities such as free movement, access to food and water, and pain relief. Moreover, there were reports of HCPs not respecting the autonomy of decision-making and failing to uphold bodily integrity.

I was forced to stay in the delivery chair for no medical reason and was therefore unable to move as I wanted during the birth.

(Norway)

Women also described how their privacy was not respected:

The gynecologist on duty, aided by those present, against my express will, jumped on me and tried to

perform a very painful internal manoeuvre, I had pain in my ribs for months... Zero privacy, open door, people coming in and out, inappropriate comments about my appearance...

(Italy)

Women recalled a chain of negative experiences showing how several subthemes are often connected.

The attitude of the medical staff during the birth was terrible... Laying on my stomach, intimidation, threats of a vacuum, interventions without my consent, lying exclusively on my back, they didn't call an anaesthesiologist.

(Croatia)

*Discrimination.* Finally, various forms of (extended) discrimination against women were mentioned, both based on ethnic background and/or the choices women made.

They purposely did not bring me food pretending to forget because I defended a girl who had given birth the day before with her baby in the NICU [neonatal intensive care unit], whom they were treating badly just because she was a foreigner.

(Italy)

Also, concerning breastfeeding, women often felt pressured to do so and discriminated against if they chose to feed their newborns formula.

Only mothers who breastfed at the breast deserved a positive attitude.

(Slovenia)

## Emotions elicited by the experience

### *Treated like an object*

Women reported they felt disrespected and unheard, which was often accompanied by feelings of loneliness, betrayal, and fear. A woman from France described a sequence of actions that made her feel treated like an object:

I was treated like an object. I had no explanation about what was being done to me, they put a catheter in me without telling me, they told me to be quiet during the pushing, they prevented me from choosing the position, they used suction cup and forceps without telling me, the epidural did not work and nothing was done, they did not believe me, so much so that

they started the cesarean without anaesthesia. I felt the cut and only at that point I was put to sleep. It was the most horrible experience of my life.

(France)

A woman from Spain described a sequence of actions whereby her autonomy and own preferences were not respected. This was also mixed with not receiving the care she needed.

They paid no attention to either our preferences, our birth plan, my emotional state, or my needs. They did not let me relieve my pain in the bathtub in the delivery room, nor did they offer me a hot shower, nor did they respect that I wanted privacy (there were up to seven people in the delivery room at the same time and they did not respect that I did not want to have an IV [intravenous catheter] until it was absolutely necessary).

(Spain)

### *Feeling violated*

The combination of rough (vaginal) examinations without consent or explanation could also result in women feeling violated. Several women described how (subsequent) experiences of disrespect and abuse made them feel violated and treated inhuman.

They performed membrane sweeping without consent and without any explanation at 39 weeks... The gynecologist said 'let me examine you' and then said 'I am naughty'. It hurt so bad I was fainting. No explanation, no humanity, coming out of the hospital I started crying, I felt raped.

(Italy)

## 4 | DISCUSSION

This mixed-method study is the first reported multicountry study exploring disrespect and abuse during childbirth in the WHO European region using a validated standardized data collection tool. The frequency of reported disrespectful care and abuse during childbirth was substantial, exceeding 10% in 16 of the 22 countries. We found that the narratives of women on disrespect and abuse in maternity care in the WHO European region often revealed similar experiences involving neglect, loss of autonomy, discrimination, and/or rude treatment. We also found that the experience of disrespect and abuse is often formed by a sequence of events and seldomly related to an isolated incident.

Our analysis shows that many experiences of disrespect and abuse are related to hospital routines, tending to be protocolled, over-medicalized, and not always evidenced-based or conducted according to expected standards of care. In addition,

these routine interventions were often performed without information or consent. This highlights the need for more attention to woman-centered care and informed consent practices, as emphasized in other studies, including previous IMAGiNE EURO publications.<sup>4,22,32-36</sup> Concerted efforts should be made to ensure that hospital routines and protocols are based on robust evidence and prioritize respectful and women-centered care.<sup>26,37</sup> It is equally important to monitor implementation and adherence to evidence-based protocols, as well as their alignment to women's preferences and needs.<sup>38-41</sup>

Overall, respectful and timely communication seems to be challenging in maternity care in the WHO European region.<sup>42,43</sup> Our study shows that HCPs too often decide on interventions among themselves rather than in collaboration with the women. Particularly during invasive procedures affecting women's bodily integrity (such as performing a vaginal examination, an episiotomy, or vacuum extraction), women were not informed, nor asked for permission. This creates a perpetuating circle of violence, where women's rights to bodily autonomy and right to informed consent are violated. This can trigger stress and anxiety, which can have a detrimental effect on labor and birth, resulting in a breakdown in communications and more invasive interventions that women experience as abusive or violent.<sup>44</sup> Other studies reported women described feeling violated because of vaginal examinations without consent or explanation.<sup>45,46</sup> The importance of fully implementing informed consent practices and bodily autonomy at all times cannot be underestimated and health systems should embrace more personalized models of care, respecting women's rights.<sup>33</sup>

In our findings, women described situations in which HCPs appeared to prioritize the technical aspects of care while neglecting other elements such as building a trusting relationship and empathy. Importantly, high work pressure, staff shortages, and a lack of training and supervision might have contributed to these findings. Especially during the COVID-19 pandemic, the healthcare workforce faced significant pressure, which may have led to a decrease in empathetic and person-centered care.<sup>9,10,47</sup> Nevertheless, studies also report a structural lack of HCPs on maternity wards in several European countries regardless of the COVID-19 pandemic.<sup>37,48-50</sup> Guaranteeing an adequate number of qualified and motivated staff in maternity services is a challenge in several European countries and may become one of the biggest challenges for safeguarding the quality of maternal and newborn health care in the future. More research is required to discern whether improvements in respectful care also impact HCP retention and motivation.

Importantly, most research on effective prevention strategies for abuse in maternity care derives from low- and middle-income countries, and more context-specific studies are needed for the European region.<sup>51-53</sup> In addition, more research on the long-term consequences of disrespect and abuse on women's and newborns' health is needed to inform appropriate follow-up care for women with a negative experience.<sup>54,55</sup>

Notably, this study collected data over a timespan of more than 3 years, including different waves of the COVID-19 pandemic.<sup>56</sup> A

health crisis, such as the COVID-19 pandemic, likely aggravated existing problems and put more women at risk of experiencing disrespect and abuse during childbirth.<sup>9,57-59</sup> However, supported by the literature, we believe disrespect and abuse in maternity care is a structural problem in the WHO European region, regardless of the COVID-19 pandemic.<sup>14,16,60,61</sup> Follow-up research is needed to explore the occurrence and specific drivers of disrespect and abuse in maternity care in the postpandemic period.

## 5 | LIMITATIONS AND STRENGTHS

Limitations related to sampling and data collection in the IMAGiNE EURO study, such as recall bias and a nonrepresentative sample, have been reported elsewhere.<sup>22</sup> Specifically, to the research question that we report in this article, it is essential to note we solely relied on the perspectives of women, without the possibility of triangulating their reports with other sources such as direct observations of practices or patient files. When speaking of unnecessary interventions or unjustified interventions, we recall their words and experience, which are by nature biased towards their individual interpretation and cultural beliefs and specific context. We also acknowledge that women's interpretations are affected by contexts where there is poor communication and low levels of trust. The study also used open text data as part of a larger online survey, which cannot provide the same depth of analysis that can derive from in-depth individual interviews or focus group discussions on the topic.<sup>62</sup> Further research combining data from the IMAGiNE EURO and face-to-face surveys conducted by an independent researcher may provide more in-depth, detailed, and objective data. Last, we explicitly targeted women in our recruitment strategy, and, as a consequence, birthing people not identifying themselves as women may not have been included in the study population.

As a strength, we believe this study focuses on what women perceived as abuse rather than imposing predefined definitions of abuse. Women could respond to the question "other" and could describe the abuse in their own words, giving unique insights into their experiences and feelings. It also needs to be acknowledged that this is the first multicountry study to gather and analyze experiences of disrespect and abuse among the WHO European region using a validated standardized questionnaire.

## 6 | CONCLUSION

Disrespect and abuse during hospital-based maternity care were prevalent in many countries in the WHO European region during the COVID-19 pandemic. Poor communication, lack of consent, rough treatment, discrimination, and the adherence to rigid and nonevidence-based procedures were shown to lead to experiences of disrespect and abuse, resulting in women feeling violated, powerless, and scared. Overall, more efforts are needed to improve informed

consent practices in maternal and newborn health services. Quality improvement initiatives and continuous monitoring are needed at different levels to optimize the implementation of high-quality and respectful maternity care among the WHO European region.

## AUTHOR CONTRIBUTIONS

ML conceived the IMaGiNE EURO study. IM and SDV managed the data, IM analyzed qualitative data, and AG and HB translated and analyzed qualitative data with input from all the country teams. AG wrote a first draft with input from SDV for the methods and IM for the methods and results. AG wrote the final draft, with major input from all authors. All authors approved the final version of the manuscript for submission.

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## CONFLICT OF INTEREST STATEMENT

The authors have no conflicts of interest.

## DATA AVAILABILITY STATEMENT

Data are available upon reasonable request to the corresponding author.

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[ClinicalTrials.gov](https://clinicaltrials.gov) Identifier: NCT04847336.

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## SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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