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## IFMSA Policy Document

### Obstetric Violence and Humanized Birth

Proposed by DENEM Brazil and AMSA Austria

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#### Policy Statement

##### IFMSA Position

The International Federation of Medical Students Associations (IFMSA) reaffirms its commitment to the defense of women's rights and gender equity. Seeing in the world the current uprising of documented human right violations occurring in obstetric practices, the IFMSA passes to adopt the position of being against all forms and practices of Obstetric Violence. The IFMSA recognises that most of these scenarios are deeply rooted in our health systems, medical education and gender based stigma and discrimination we as medical students envision tackling in a proximate future. The IFMSA believes in healthcare providers that are ethical and committed to benefit the wellbeing of their communities using social based and evidence based health promotion strategies. Therefore, as medical students we stand for a nondiscriminatory obstetric practice that takes into account the patient in all of its assets and fulfills not only technical evidence-based efficiency but humane health support as well. We are committed to re discuss and redefine medical philosophy because we recognize the necessity among young doctors and medical students to welcome other modalities of practice that are primary health based and multi professional, needing the open minds of youth leaders today. IFMSA empathizes with the women all over the world that have gone through disrespectful obstetric practice and is in the work to nurture a generation of healthcare providers that will change this reality.

##### Call to Action:

In this scenario the International Federation of Medical Students Associations (IFMSA):

1. Calls governments to:
  - a. Hand greater support from governments and development partners for further research on defining and measuring disrespect and abuse in public and private facilities worldwide, and to better understand its impact on women's health experiences and choices.
  - b. Follow WHO childbirth guidelines and Statement on *The Prevention and Elimination of Disrespect and Abuse During Facility-based Childbirth* but also taking into account cultural and ethnical adaptations possible to do with prenatal and childbirth programs and the social determination of the health-disease process.
  - c. Promote for obstetric violence awareness and acknowledging the term of humanized childbirth as a superior priority to be reached and accomplished as a current and continuing goal.
  - d. Update or create laws that condemn all obstetric violence practices that are committed by practitioners and health care personnel against pregnant patients in healthcare facilities and institutions.
  - e. Encourage maternal health institutions to advocate for the rights of pregnant women.
  - f. Discuss and -if possible- make amendments to policies that involve impingement to the women's rights to gain access to appropriate health and maternal care practices and facilities.
  - g. Declare policies that impel spreading awareness among health care individuals, institutions, and patients on the subject of humanized childbirth and the necessity of elimination of obstetric violence.





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## Position Paper

### Introduction

The term obstetric violence was first defined and legally adopted by Venezuela in 2007. The law defines obstetric violence as "...the appropriation of the body and reproductive processes of women by health personnel, which is expressed as dehumanized treatment, an abuse of medication, and to convert the natural processes into pathological ones, bringing with it loss of autonomy and the ability to decide freely about their bodies and sexuality, negatively impacting the quality of life of women [1]." However this practice can be traced back in time. Obstetric violence being an umbrella term for a variety for demeaning and derogatory actions directed towards a pregnant woman can be exactly traced to a particular country. Literature from across the world has substantial references of women subjected to physical torment during labor. The rapid increase in obstetric violence began due to industrialization of labor [2].

A major factor that contributed to the industrialization of labor was the development of obstetrics. With increased interest of medical sciences into labor, better instruments and labor accelerants were developed. This promoted a drastic change in the traditional birthing scenario. Birthing was shifted from the home to the hospital. In Spain, the labor homes built for women who have conceived out of wedlock documented strict rules that took away women's basic rights. Increased industrialization of births made hospitals such an integral part of the birthing process that obstetric violence became acceptable as labor without professionals was believed to be impossible. With the advent of time, obstetric violence today stems from increased monetary gains and deficient skills of medical practitioners [3].

Additional factors that contributed to obstetric violence is religious and cultural practices. The practice of symphysiotomy in Ireland during the 1940s elucidates the same. In this outmoded medical practice, physicians expand a pregnant woman's pelvis through the cutting of surrounding cartilage and ligaments, with the goal of assisting in obstructed births. This practice was replaced by Caesarean sections. However the popular medical opinion suggested that a woman could only undergo three C-sections in a lifetime before sterilization would become necessary. Thus in Catholic country as Ireland, women were forced to undergo symphysiotomy [4].

### Obstetric Violence as a Worldwide Issue

After Venezuela, Argentinian law defined obstetric violence. The statute defines it as: [violence exercised by health personnel on the body and reproductive processes of pregnant women, expressed through dehumanizing treatment, medicalization abuse, and the conversion of natural processes of reproduction into pathological ones [5]. This statute considers the abuse and mistreatment experienced by women in different maternal health services (prenatal, labor, childbirth, postpartum, and abortion care) within a Violence Against Women (VAW) framework and aims to raise awareness about the abuse, mistreatment and disrespectful care that women experience within the health sector. Incidences of obstetric violence in Argentina range from dehumanization of care, over medicalization and conversion of physiological processes into pathological ones. While dehumanization of care refers to misconduct amounting to physical and psychological harm, over medicalization refers to unnecessary episiotomies, enemas etc. Women can also be subjected to obstetric violence during different phases of pregnancy, not just limited to labor [6].

In the United States of America, a largely accepted manifestation of obstetric violence is forced caesarian sections. Despite unwillingness of women to undergo the surgical procedure, women in labor are threatened and coerced into opting for it. Legal notices, complaints to child protection services are some of the methods used to distress pregnant women to submit to the will of the physicians. While US laws state unpermitted touching even for medical procedures as battery, no provision has been made in regards to pregnant women. Despite several lawsuits filed against physicians, most rule in their favor keeping the fact that "physicians know best" as paramount [7].



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As for the Eastern Mediterranean Region, unfortunately, it has for many years suffered from man-made conflicts that widely affected the general population's health in some countries, especially the most vulnerable groups - children and mothers. Physical and verbal abuse, lack of previous consent and poor communication are seen in the region. Rates of maternal mortality are shown to be significantly high in Islamic countries, and some reasons include low average age of marriage, illiteracy, lack of prenatal care, and obstetric complications [8]. In Morocco, the result of a survey found women who reported physical abuse have a frequency of 12.3%. Most of these women were uneducated, socio-economically disadvantaged and had a partner with toxic habits [9]. When Jordanian women were surveyed regarding their birthing experience to understand the situation, the women saw childbirth as a dehumanized experience, feeling that childbirth was processed technologically, experienced a lack of human support as they were not permitted birthing partners and were in an inappropriate childbirth environment [10].

In the African continent social inequalities and intersectionality are also susceptible to the changes of gender perception in childbirth. In Tanzania, pregnant women living with HIV were less asked for consent before vaginal examination as well as given less privacy spaces confirming the necessity of discussing overlaid stigma that the different aspects of humanity leave [11]. In southeastern Nigeria, a study by Okafor et. al revealed that frequently women complained about mistreatment scenarios during childbirth (35.7%) and that within the manifestations, the ones that stood out were "tied down during labor" (17.3%) "being slapped or pinched" (7.2%) and being sexually abused by a health worker (2.0%) [12]. In some African countries awareness and an increase in a demand for the understatement of patient's rights has begun though the rediscussion of social and cultural values is still necessary [13].

The scenario in Asia isn't much different. Owing to high maternal mortality and failure of women to pick institutionalized birth, Bangladesh Rural Advancement Committee (BRAC) instituted services for birthing women in 21 health facilities in each Thana. A study was done to compare the birthing experience at home vs such services. Most women only attended the BRAC Health Centre due to complications and were referred to government hospitals where the health care was poor. The women reported that the female paramedics made women deliver lying down, did not always use aseptic procedures and were too busy to give information, making birth a passive experience [14]. Similarly in India, an urban slum was surveyed to assess the quality of maternal healthcare. Women reported lack of essential drugs, being left unsupported and evidence of physical and verbal abuse

1. Afghanistan is one of the few countries constantly labelled at being ill-equipped in providing appropriate ante- and perinatal care. Women reported dissatisfaction with childbirth services, particularly the poor attitudes and behavior of health workers, including discrimination, neglect, and verbal and physical abuse. Despite negative experiences with the health services, women appreciated having any access to health services. Health workers reported that low salaries, high stress and poor working conditions contributed to the poor quality of care [16].

### **Clinical Aspects of the Obstetric Violence Panorama**

Obstetric violences are not only simple consequences of obstetric procedures but actually develop a pathological state that harms both mother life and fetal development. In 2010 Browser and Hill identified initial verbal abuse, lack of privacy, lack of consent, and denial of care as factors that affected significantly maternal morbidity and mortality because of its links to the development of complications [17]. Besides these, the world has encountered other examples of mistreatment such as unnecessary episiotomy that leads to the loss of sphincter control, abuse of oxytocin levels for partum induction and also the denial to safe abortion by multiple barriers that lead to complications of unsafe abortion procedures such as sepsis and hemorrhage [18, 19, 20].

In 2014, Roth et.al found out of a survey conducted to birth care personal (doctors, doulas, nurses, etc.) that more than half of health workers involved in birth care have witnessed physician engage in a procedure against the women will and two thirds have witnessed engaging in procedures without appropriate time to consider the procedure [21]. This is especially important seeing the current upscale in cesarean sections over natural birth procedures in maternal care settings. On the same



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year, Declercq et. al created the “Listening to Mothers III” survey where more facts about the induction of birth were considered. This survey showed that about one quarter of mothers who had induced their labors felt pressure to do so and that 63% of women who had a primary cesarean identified their doctor as the “decision maker” of the procedure [22]. The recommendation from the international community and the WHO regarding cesarean procedures is to have an idea rate of 10-15% due to the objectives of being a complementary procedure to complicated births through vaginal delivery [23]. Mental health also comes into discussion when we see a rising prevalence of postpartum PTSD [24].

Obstetric Violence are not only found in large or complex procedures but as well in the pre and postpartum care. One example are routine enemas for the clearance of intestinal content previous to delivery. This practice aims to improve sanitary conditions of partum stances but there is still no evidence on its real benefit while it is very uncomfortable for the patient and generally done without consent [25]. The denial of companion and alternative pain alleviation strategies also take out the patient’s rights to choose proper guidance of medical care. Most of the prenatal factors that make a partum longer or the forcing of partum using kristeller maneuvers (which are contraindicated currently) show a high risk potential of complications such as obstetric fistula that affects over 2 million women in Africa and Asia and that has a low resolution rate depending on the deficient comprehensive care systems that systematically allow obstetric violence to occur without legal consequences [26].

From the legal perspective many discussions are yet to be done for many countries in the world. Many healthcare providers attempt to justify obstetric violence by allocating goodwill to the fetus but then in this situation putting at risk the potential life of the mother which under a governmental law would be more evident. Some of this unethical behavior is likely related to the fact that the law has failed to directly rectify the lingering controversy among practitioners as to the appropriateness of overriding the decisions of pregnant patients in all jurisdictions. The ACOG Committee on Ethics is clear and directive in its opinion that forced surgeries and litigation over medical interventions are virtually never ethically justifiable [27].

### **The Benefits of Humanized Birth**

Humanized birth is putting the woman giving birth in the center, giving her the control and authority to make all the decisions about what will happen - not the doctors or anyone else [28]. Although humanized birth is contrary to obstetric violence, the simple eradication of obstetric violence does not completely evoke the concept of humanized birth. As per now, the medical academy has not reached to a full consensus about obstetric violence, but there are different perspectives in modern literature relevant for the knowledge and advocacy of medical students.

The first aspect is that Humanized Birth is not only attributed to specific technical skills and the process of birth, but rather a whole unison of cultural, social and ethnicity aspects. As well, it is not simplified giving humanitarian care to a pregnant individual [29]. The concept rises in the aim of accepting and understanding these other faces of humanity that determine birth in such a way that physical and emotional privacy together with preparation of a comfortable environment in the prenatal and postnatal care aids in the development of a healthy pregnancy and a successful delivery [30].

Most importantly, humanizing birth means giving women the center of will within a clinical setting and it does involve the further analysis of women empowerment within a health system instead of prioritizing technicians needs over those of our patients. In 2001 Misago et. al conducted a study that defined the needs of a proper maternity in the Brazilian northeastern region. This study identified the following principles of humanized birth [31]:

1. the fulfillment and empowerment of both women and their care providers;
2. the promotion of the active participation and decision making by women in all aspects of their own care;
3. the provision of care by both physicians and non-physicians working together as equals;
4. the inclusion of the use of evidence-based technology; and
5. the location of birth attendants and institutions within the decentralized system with a high priority for community based primary care



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As Humanized birth defends a community based approach to childbirth, the discussion of multiprofessional approach comes into place. The presence of doulas during labor, and the supportive role they provide, advocates for normal births and generally result in better maternal and neonatal outcomes as well as lowering the use of technology. This also leads to a reduction in the caesarean rate, a lower rate of analgesia use for pain relief and use of oxytocin, a decrease in the duration of labor, and an overall increase in maternal satisfaction regarding the birth experience [32].

### **Social Interactions of Obstetric Violence**

Obstetric violence is a form of gender based violence, which is widely acknowledged as an important problem for women's health [33]. Here, especially domestic violence by an intimate partner is reported as a problem leading to miscarriage, perinatal death, preterm delivery and low birthweight [34]. Obstetric Violence express the stereotypes that we hold against women as a social view and reinforces the systemic discrimination that puts women into a position that categorizes women as fragile individuals, strictly mothers and incapable to make decisions [35].

Furthermore, it can lead to maternal depression and death due to the trauma. During pregnancy, women can be exposed to both psychological violence and physical/sexual violence. Not seldom, the violence will be intensified or even begin when the women gets pregnant. Social determinants as low socioeconomic status, low level of social support, black race/ethnic group, young age, drug and alcohol abuse and mental disorders is dispoating to obstetric violence.

Regarding abortion, health care personnel must respect the woman's liberty, dignity, autonomy and ethical authority to decide when and how many children to have. Women can be met with prejudice and discrimination that can dehumanize the treatment, including denying or delaying abortion or medical treatment due to unsafe abortion; questioning the woman about causes to the abortion; performing procedures, predominantly invasive ones, without explanation, consent or anesthesia; threatening, accusing or blaming the woman; as well as forcing confession and denunciation to the police.

Together with the clinical and social argumentation, a further debate on a larger social scale must be mentioned as well. Obstetric Violence is not only rooted on a systemic social hierarchy but as well in a market control context that is woven by healthcare providers and diverse stakeholders like pharmaceutical industries. Cesarean sections, for instance, represent a more complex procedure that requires a higher investment which translates in many ways a greater gain for healthcare providers themselves, insurance and/or pharmaceutical companies [36].

### **Obstetric Violence and Human Rights**

As described earlier, obstetric violence is a way of gender based violence. When allocating this type of sanction to these actions, women are prevented from enjoying Human Rights as a whole principally by the violation of the right to health but as well by violating the general recommendation #19 of the CEDAW [37]. The WHO also addresses this issue within the lack of health rights in its statement "The prevention and elimination of disrespect and abuse during facility-based childbirth" declaring that "*Such treatment not only violates the rights of women to respectful care, but can also threaten their rights to life, health, bodily integrity, and freedom from discrimination*" [38].

Every woman is equally free to exercise her human rights and freedoms which include: The right to respect for life; The right to respect for physical, psychological and moral integrity; The right to freedom and personal safety; The right to not be subjected to torture; The right to have her dignity respected and her family protected; The right to equality of protection from the law and by the law; the right to freedom of association; The right to profess her own religion and beliefs within the framework of the law [39]. Abuse, neglect or disrespect during childbirth can amount to a violation of a woman's fundamental human rights, as described in internationally adopted human rights standards and principles [38].



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## Relevance to Medical Students

As early as the first day of medical school, students must be encouraged not only to build up their medical knowledge but also their identities and personalities as future practitioners. This means that they have the right and the duty to acquire, learn, practice, and get the proper education about the right ways to communicate with patients of all types and orientations, including pregnant women and all the medical and ethical consequences of doing or witnessing any kind of abusive treatment towards patients.

Therefore, there must be general awareness among medical students about the importance of properly gaining the trust of their future patients, statistically, ethically, and based on the fact that they should aim and be totally equipped to be able to transform the process of child delivery into a natural, spontaneous and unrestrained process in order for it to take its right place in every mother as the moment she were able to grant life to a new human being [40].

Furthermore, it is even suggested that medical students should by the end of their medical education years be able to witness, follow up, and even have helped in an entire process of normal child delivery. Medical students, according to institutions such as James Cook University, shall start developing awareness in a general way - regardless of their specialty of choice in their academic future - that midwives and obstetricians play a crucial role in women's health and women's reproductive health rights. The integration of awareness also stimulates more medical students to follow this academic pathway in a more ethical way [41].

On the other hand, it is fairly common that in public hospitals, pregnant women are abused basically due to the fact that they are probably from a vulnerable background and lack the proper education or awareness of their own sexual and reproductive health rights. Nevertheless, society does not even try to make any better, and such acts of obstetric violence are usually overlooked by social security as well. Also, health care personnel and practitioners are generally not interested in playing key roles in the promotion of women's rights, since the lack of impelling laws and constitutions as well as policies that forbid obstetric violence altogether combine to make it worse [42].

Implement scientific and evidence-based information in the curricula of medical schools and also on all postgraduate courses in obstetrics and gynecology in order to understand the danger of such practice, to prevent, treat, punish and eradicate violence towards women. Training of the teachers in this procedure is essential, so that they can correctly teach the students.

The lack of knowledge about the dimensions of obstetric violence phenomenon and the dehumanizing medicalized birth are discussed by WHO after a perinatal study group in Europe: *"Most health care providers no longer know what "non-medicalized" birth is. The entire modern obstetric and neonatological literature is essentially based on 'observations' of medicalized birth"* [43].

FIGO's concerning on the serious and systematic abuses of women's human rights in various countries launched in 2012 the project "Integrating Human Rights and Women's health into your educational and clinical practice". Their aim was to educate doctors to be able to deliver quality healthcare and to apply and respect the principles of human rights [44]. FIGO's representative of the Venezuelan Society of Obstetrics and Gynecology also evaluated a gap in academic development when in 2012 analyzed that in all 9 medical schools of Venezuela the supine position for vaginal delivery was the only one taught and therefore few medical students are exposed to other types of delivery and the same can apply to pain management, birth induction and psychological support [45].



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