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IFMSA Policy Proposal Obstetric Violence and Humanized Birth

Proposed by Team of Officials

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Policy Commission

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Draft Policy Proposals have to be sent to all National Member Organizations (nmos@ifmsa.org) by the proposer to request for feedback by **January 10 2020 23.59 GMT**. Policy Proposals to be discussed at 69th March Meeting General Assembly March Meeting 2020 have to be sent to gs@ifmsa.org by **February 1, 2020 @ 23.59 GMT** (please put the code **[POLICY]** in the beginning of the subject of your email).



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Policy Statement

Introduction

Obstetric Violence is a wide term for all actions that are harmful, demeaning towards pregnant women or in the postpartum period perpetrated by healthcare providers. The prevalence of obstetric violence is alarmingly high worldwide and results in negative health consequences and avoidance in seeking medical help by women who had experienced obstetric violence. To tackle this, the idea of humanized birth should be spread.

IFMSA Position

The IFMSA reaffirms its commitment to the defense of women's rights and gender equity. The IFMSA recognizes that most of the instances of Obstetric Violence occur in our health systems and medical education due to deep roots in gender-based stigma and discrimination. Therefore, as medical students, we stand for a nondiscriminatory obstetric practice that takes into account the patient in all of its assets and fulfils not only technical evidence-based efficiency but humane health support as well. IFMSA recognizes that humanization of childbirth is still a challenge in the current professional practice due to their overworked schedules and disregard of the maternal aspect of childbirth. IFMSA empathizes with the women all over the world who have gone through disrespectful and dangerous obstetric practice and is in duty to nurture a generation of healthcare providers that will change this reality.

Call to Action:

IFMSA calls on:

Governments to:

- Recognize obstetric violence as a public health issue that has the capacity to affect all women in society.
- Conduct and promote research into defining and measuring obstetric violence, as well as investigating the epidemiology, different forms and consequences to aid better understanding into its impact on women's health experiences and choices.
- Ensure that national guidelines follow/adhere to WHO childbirth guidelines and Statement on The Prevention and Elimination of Disrespect and Abuse During Facility-based Childbirth, and demand 'necessary repercussions should these principles not be adhered to.
- Review or create laws that condemn all Obstetric Violence practices that are committed by practitioners and healthcare personnel against pregnant patients in healthcare facilities and institutions. Guarantee law enforcement, prosecution of perpetrators and repercussions.
- Create policy that guarantees all women access to appropriate healthcare and maternal care practices and facilities and abolish any policies that involve impingement of women's rights during any point of pregnancy or the birthing process.
- Create and advocate for policies that impel spreading awareness among healthcare providers, institutions, and patients on the subject of Humanized Childbirth and the necessity of elimination of Obstetric Violence and over-medicalization of childbirth.



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- Include and promote sexual and reproductive health rights within school syllabi, especially among young girls exposed to higher risks of young age marriages.

UN Agencies and Non-Governmental Organizations to:

- Advocate, encourage and promote actions towards awareness within society about the terms of Obstetric Violence and Humanized Birth.
- Initiate solidarity movements towards supporting and empowering women worldwide regarding their sexual and reproductive health and rights as well as promoting discussions about pregnancy and obstetric health care.
- Collect data, work on reporting systems and supervision of healthcare facilities to create a picture of Obstetric Violence situation in the country that could be furtherly used as tools to develop the fighting Obstetric Violence strategies.
- Cooperate with governments to prevent Obstetric Violence through the development and implementation of preventative policies.
- Uphold human rights obligations and develop appropriate policies, national women's reproductive health strategies, and complaint mechanisms to ensure a human rights-based approach to health care and accountability for obstetric violations.

Medical universities and healthcare institutions to:

- Include the concept of Obstetrical Violence- a threat to Women's Health Rights, and Humanized birth practices as a solution, in the medical curriculum
- Introduce a protocol for humanization of childbirth process that is continually updated and communicated to the healthcare professionals, thus helping reduce the incidence of Obstetrical Violence and providing healthcare to receivers of such forms of violence.
- Include education on providing informed consent for all procedures and involving women in the decision-making process as well as education for and provision of humanized birthing procedures.
- Provide sufficient access to medical procedures and screening as well as adequate healthcare providers on maternal care units in order to avoid Obstetric Violence caused by healthcare system failures.
- Ensure access to any physical and/or psychological healthcare to receivers of such form of violence.

NMOs and Medical Students to:

- Acknowledge the legally defined term Obstetric Violence as an act of indignity against women, as well as a violation of their sexual and reproductive health rights.
- Promote the awareness of Obstetric Violence, and of Humanized Childbirth, through education by conducting lectures, workshops, and activities targeting medical students in an effort to train and empower them.
- Facilitate and encourage the activation of solidarity movements among medical students that aim for women's empowerment and awareness about their sexual and reproductive health rights.
- Elucidate faculties, healthcare institutions, colleges, and other stakeholders in the health care panorama to promote curricula changes and reinforce evidence-based approaches for education strategies within the field of obstetrics and sexual and reproductive health.



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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). Despite the relatively recent legal definition and adoption of the term, documented incidents of Obstetric Violence can be traced as far back as 1958 and anecdotal evidence suggests that this issue may have remained in the shadows for much longer (2). 'Cruelty in Maternity Wards' was the title of a shocking article published in the *Ladies' Home Journal* in 1958, which shed light on barbaric stories of Obstetric Violence in the US with instances of "a doctor cutting and suturing episiotomies without anesthetic" and "a woman having her legs tied together to prevent birth while her obstetrician had dinner" (3). The article triggered a landslide of reform surrounding childbirth practices in the US and led to the establishment of the American Society for Psychophylaxis in Obstetrics, currently known as Lamaze International.

Obstetric Violence is an umbrella term for a wide range of demeaning and derogatory actions by the healthcare community directed towards a pregnant woman. Despite legal reform in countries like Venezuela, Brazil and the US, many childbearing women are still subject to mistreatment and abusive practices in healthcare settings. These practices can range from subtle forms like insensitivity and disrespect to outright verbal, physical or sexual assault (4). The origins of these practices can not be accurately traced to a particular country. Literature from all across the world has substantial references of women subjected to physical torment, emotional trauma, and medical abuse during labour. However, the review of the literature suggests that the rapid increase in Obstetric Violence began due to the industrialization of labour (5).

A significant/notable factor that contributed to the industrialization of labour was the establishment and development of the field of obstetrics. With an increased medical and commercial interest surrounding labour and childbirth, it was in the interests of manufacturers and healthcare providers to develop better instruments and labour accelerants. These developments promoted a drastic change in the traditional birthing scenario. Birthing was shifted from the home to the hospital. In Spain, special labour homes were built for women who had conceived out of wedlock. These institutions documented strict rules that took away the women's fundamental rights like "Article 17: It will not be permitted that anyone, even their own parents, will be able to visit the patients within the premises." Increased industrialization of births made hospitals such an integral part of the birthing process that Obstetric Violence became acceptable as labour 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 (6).

Additional factors that contributed to increasing incidences of Obstetric Violence were religious and cultural in nature. The practice of symphysiotomy in Ireland during the 1940s elucidates the same. In this outdated medical practice, physicians expanded a pregnant woman's pelvis through the cutting of surrounding cartilage and ligaments, intending to assist in obstructed births. This practice was replaced by Caesarean sections. However, the prevailing medical opinion suggested that a woman could only undergo three C-sections in a



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lifetime before sterilization would become necessary. Nevertheless, the Irish catholic government still forced women to undergo symphysiotomy till the late '80s, despite the noted unnecessary and painfulness of the procedure. This was done in accordance with noted Catholic objection to procedures like contraception, sterilization, and abortion on the principle that these procedures did not respect the sanctity of fetal life (7).

Obstetric Violence as a Worldwide Issue

Currently, five Latin American countries have developed legislation around Obstetric Violence. After Venezuela, Argentinian law defined Obstetric Violence in 2009. This statute considers the abuse and mistreatment experienced by women during pregnancy, childbirth or postpartum period within a Violence Against Women (VAW) framework. It aims to raise awareness about the abuse, mistreatment and disrespectful care that women experience within the health sector. Lately, the poor quality of care, negligence, and failure to comply with current guidelines and evidence-based practices are also identified as mistreatment (8). Incidences of Obstetric Violence in Argentina range from the 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 non-medically indicated cesarean sections, episiotomies, and enemas (9).

In the United States of America, a principally accepted manifestation of Obstetric Violence is forced caesarian sections. Despite the unwillingness of women to undergo the surgical procedure, women in labour are threatened and coerced into opting for it. Legal notices and 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 that unpermitted touching, even for medical procedures, constitutes battery, no provision has been made in regards to pregnant women. Despite several lawsuits filed against physicians, most judgements rule in their favour keeping the fact that "physicians know best" as paramount (10).

The prevalence of Obstetric Violence in the European region still lacks robust studies and representative data considerably because of a failure to acknowledge this form of obstetric mistreatment (44). Nevertheless, a significant majority of European countries do have high-quality birth registers and collect data on sexual and reproductive healthcare services. The first national survey on Obstetric Violence was conducted in Italy in 2016 (11,12). A mixed quantitative and qualitative online survey, which followed a successful #bastatacere social media campaign, collected more than 3,000 responses. According to the following representative sample group (424 mothers) survey, 21% of respondents declare they suffered Obstetric Violence during childbirth. One-third of women felt that they were not appropriately assisted; hence they were not sufficiently involved in the childbirth process. On the other hand, 41% of women identified the received assistance as a violation of their dignity and psychophysical integrity. In terms of surgical interventions, more than half of women (54%) received episiotomy, and 61% of those childbearing women claimed that they were not given adequate information to give informed consent for this procedure (11,12).

As for the Eastern Mediterranean Region, unfortunately, it has for many years suffered from human-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,



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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 (13). A survey conducted in Morocco on Obstetrical Violence for a one year period highlighted that only 12.3% of women who faced physical violence ended up reporting such instances. Most of these women were uneducated, socio-economically disadvantaged and had a partner with toxic habits (14). When Jordanian women were surveyed regarding their birthing experience to understand the situation, the women perceive

d childbirth as a dehumanized experience, feeling that childbirth was processed technologically, experienced a lack of humane support as they were not permitted birthing partners and were in an inappropriate childbirth environment (15).

In the African continent, several studies explored disrespect and abuse among women in rural Tanzania southeastern Nigeria and Mozambique. According to women's self-reported experiences, 19,5-28,2% of all surveyed women reported experiencing any form of mistreatment during labour (16). Those figures were even higher in southeastern Nigeria. One study assessed that approximately 98% of women who gave birth in one of the teaching hospitals experienced mistreatment. Frequently women complained about physical abuse during childbirth (35.7%). Pertinent examples include "tied down during labour" (17.3%), being "beaten, slapped or pinched" (7.2%) and being sexually abused by a health worker (2.0%) (17). A recent study conducted in Mozambique found that the prevalence of mistreatment significantly ranged from 24% to 80% in the central hospital and the district hospitals, respectively (18). Social inequalities and intersectionality are also susceptible to the changes in gender perception in childbirth. In Tanzania, pregnant women living with HIV were not asked for consent before the vaginal examination (compared to 79.8% HIV-negative women). Furthermore, they were less likely to be provided with adequate privacy confirming the necessity of discussing the overlaid stigma that the different aspects of humanity leave (19). In some African countries, awareness and an increase in demand for the understatement of patient's rights have begun though the discussion of social and cultural values is still necessary (20).

The situation in Asia is not significantly different. A community-based study analyzing the prevalence of disrespect and abuse during facility-based childbirth in rural India showed that 84.3% recently delivered females have experienced it. The dominant forms of obstetric mistreatment were non-consented services and non-confidential care, affecting 71.1% and 62.3% of respondents, respectively (21). Similarly, data from 50 public and 50 private healthcare facilities located in remote Pakistan areas showed that any form of mistreatment was ubiquitous (97%), predominantly non-consented care (81%) and non-confidential care (69%) (22). Those rates of disrespect and abuse remained constant for both facility-based or home-based births (23). Overall, the prevalence of physical abuse during labour was approximately three-fold higher in Pakistan (15%) compared to India (5.9%). Likewise, women living in an urban slum in India were surveyed to assess the quality of maternal health care. Women reported a lack of essential drugs, being left unsupported and evidence of physical and verbal abuse (24). Afghanistan is one of the few countries consistently 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 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 inadequate quality of care (25).



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Clinical Aspects of the Obstetric Violence Panorama

Obstetric Violence manifests itself in a multitude of ways in clinical settings. It extends from violence by individual healthcare providers, to systemic failures within healthcare institutions and health systems. Types of mistreatment that constitute Obstetric Violence include physical, sexual and verbal abuse, stigma and discrimination, failure to meet professional standards of care, the poor rapport between women and providers, and health system conditions and constraints (26). These categories encompass issues such as verbal abuse, lack of privacy, lack of informed consent and denial of care, all of which have been shown to increase maternal morbidity and mortality because of their links to the development of complications (27).

Throughout history, we have seen a change in the culture of the birth process. Traditionally birth occurred at home, but nowadays with technological advancement, the majority of births occur in the hospital setting due to increased safety and presence of qualified professionals (28). With this medicalization of the birthing process, there has been an increase in the use of invasive and often not medically required procedures. However, as the rates of non-medically justified obstetric interventions have increased, there has not been an associated dramatic improvement in perinatal and maternal mortality and morbidity (29). The most pertinent of these are the use of routine episiotomy and the increase in cesarean births. The World Health Organization states cesarean section rates higher than 10% are not associated with lower maternal and newborn mortality (30). However, in some countries, the rates of cesarean section are as high as 54% (31). Similarly, restricted use of episiotomy is associated with better outcomes compared to routine use, although, in some countries, first-time mothers are routinely given episiotomies. Besides these, the world has encountered other examples of mistreatment such as abuse of oxytocin that may lead to complications for a mother and a newborn or symphysiotomy (32,33).

These non-medically justified procedures are performed despite the lack of evidence to support their practice and associated risks, with factors such as financial incentives, malpractice liability and doctor preference being contributing factors. Interestingly, a survey showed that about one-quarter of mothers who had induced their labours 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 (34), introducing the issue of informed consent and coercion.

While some women experience physical abuse, a more extensive group encounters more subtle forms of substandard care. Factors such as poor communication between patient and care provider, lack of informed consent for procedures and coercion to undergo certain procedures impinge on the patient’s right to choose proper guidance of medical care (35). Denial of a companion or not offering adequate options for pain alleviation also result in a negative birth experience and discourage women from seeking health care which has knock-on effects for perinatal morbidity and mortality. This identifies institutional and structural failures that affect a woman’s experience of a respectful and positive birth experience.

There is a persistent belief that physicians, instead of pregnant women, are the ones vested with the decision-making authority, thereby justifying threat and coercion (35). These forms of violence are built into the walls of medical institutions, health systems, and society, resulting in violence not always being recognized by those instigating or those experiencing



it. Many healthcare providers attempt to justify Obstetric Violence by putting the fetus' safety first but then in this situation putting at risk the life and wellbeing of the mother. Some of these unethical behaviours are 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 (36).

The Benefits of Humanized Birth

Humanized Birth is putting the woman giving birth in the centre, giving her the control and authority to make all the decisions about what will happen - not the doctors or anyone else. During the past decades, giving birth has been increasingly medicalized procedures in most of the countries. These procedures reinforce the perception of the mother's role as a patient and can reduce her sense of control over her body. Humanization of childbirth is a unique approach aiming to make childbirth a positive and satisfying experience for both the women and their families as a whole (37).

Although Humanized Birth is contrary to Obstetric Violence, the simple eradication of Obstetric Violence does not ultimately evoke the concept of Humanized Birth. Presently, the medical academy has not reached a full consensus about Obstetric Violence, but there are different perspectives in modern literature relevant to 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 complete unison of cultural, social and ethnicity aspects. As well, it is not simplified giving compassionate care to a pregnant individual (38). The concept arises in the aim of accepting and understanding these other aspects of humanity that determine birth in the way that physical and emotional privacy is accompanied by the preparation of a comfortable environment in the prenatal and postnatal care facilities enhancing the development of a healthy pregnancy and a successful delivery (39).

Most importantly, humanizing birth means giving women active participation in the whole process, allows women and healthcare providers to work together as equals and involves the use of evidence-based medical practices, not prioritizing practitioners' needs over those of our patients. In 2001 Misago et. al conducted a study that defined the needs of proper maternity in the northeastern Brazilian region. This study identified the following principles of Humanized Birth (40):

1. the fulfilment and empowerment of both women and their care providers. Empowering is related to the exercise of control over our actions, from access to information to the consequent full awareness of our rights (41);
2. the promotion of 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;
5. the location of birth attendants and institutions within the decentralized system with a high priority for community-based primary care (40).

As Humanized birth defends a community-based approach to childbirth, the discussion of a multi-professional approach comes into place. The presence of doulas during labour and the



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supportive role they provide, advocates for normal births and generally results in better maternal and neonatal outcomes as well as lowering the use of technology. This method/approach also leads to a reduction in the cesarean sections rate, a lower rate of analgesia use for pain relief and use of oxytocin, a decrease in the duration of labour, and an overall increase in maternal satisfaction regarding the birth experience (42).

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 (43). In fact, the data suggests that violence during pregnancy is more prevalent than many recognized maternal conditions, e.g. pre-eclampsia (45). Obstetric Violence emulates the stereotypes of the broader structural gender inequality that we hold against women as a social view and reinforces the systemic discrimination that characterizes women as fragile individuals, strictly mothers and incapable of making decisions (46).

Furthermore, it can lead to maternal depression and death due to trauma. During pregnancy, women can be exposed to psychological, physical or sexual violence. Commonly, violence can intensify or even begin when the woman gets pregnant. Social determinants such as low socioeconomic status, low level of social support, minority group members, young age, drug and alcohol abuse, and mental disorders are associated with Obstetric Violence (47,48). In one study, it was assessed that women with low socioeconomic status have 3.6 times higher chances of experiencing abuse or disrespect (21).

Regarding abortion, healthcare personnel must respect the woman's liberty, dignity, autonomy and moral 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 necessary medical treatment due to unsafe abortion; investigating the causes to the abortion; performing procedures, predominantly invasive ones, without explanation, consent or anaesthesia; threatening, accusing or blaming the woman; as well as forcing confession and denunciation to the police. This negative behaviour stems from cultural norms within our environment in which the woman's vulnerability during childbirth is exploited to further the prevailing notion that she is incapable of decision making and is thus stripped of autonomy.

Together with the clinical and social argumentation, further debate on a larger social scale must be mentioned as well. Obstetric Violence is not only rooted in systemic social hierarchy of male dominance but also in a lopsided power dynamic woven by healthcare providers and diverse stakeholders including pharmaceutical industries. Cesarean sections, for instance, represent a more complex procedure that requires a higher investment which translates in a greater gain for healthcare providers themselves, insurance and/or pharmaceutical companies and thus is done at very disproportionate rates (49). Hence aiming for a higher goal of tackling gender inequality and the accompanying cultural norms will no doubt be effective in reducing Obstetric Violence by increasing the inappropriately low allocation of resources to birthing centres and condemning the widespread acceptance of physical aggression to subdue women in labour (50).



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Obstetric Violence and Human Rights

As described above, Obstetric Violence is a form of gender-based violence and part of a continuum of the violations that occur in the broader context of structural inequality, discrimination, and patriarchy, and are also the result of a lack of proper education and training as well as lack of respect for women's equal status and human rights.

In the Statement on The Prevention and Elimination of Disrespect and Abuse During Facility-based Childbirth, The WHO declares that this type of violence "*violates the rights of women to respectful care, but can also threaten their rights to life, health, bodily integrity, and freedom from discrimination*" (51). 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 (52). 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 (51).

In some countries, women's voices are ignored, and they cannot decide themselves by requirements for spousal or third-party consent putting her choice under the decision of a family member or institutional authority (53). Another example of a violation of human rights is detention after childbirth until medical bills are paid. These practices make women less likely to use hospital facilities for childbirth and more likely to rely on traditional birth attendants who lack medical skills (54,55).

This Human Rights violation is exemplified by reports from several prisons in the USA, where pregnant women are routinely restrained or shackled during transportation to prenatal medical appointments, to delivery or even during the post-delivery recovery period even though armed watchmen accompany them all the time. In some states, women are immobilized and mouth gags are used. This also happens to women who are put in detention due to their immigration status (26,56). The Human Rights Committee and Committee against Torture are concerned about these practices as a violation of migrant women's reproductive rights (57).

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. In other words, they have the right and the duty to acquire, learn, practice, and get the proper education about the right ways to communicate with all patients, including pregnant women and all the medical and ethical consequences of doing or witnessing any form of abusive treatment towards patients.

Therefore, there must be universal awareness and comprehension among medical students regarding the importance of properly building rapport with their future patients ethically, and based on the fact that they should aim and be equipped to assist a natural, spontaneous and



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unrestrained process of childbirth in order for it to take its rightful place for every mother when a new human being is granted life (58).

Furthermore, it is even suggested that by the end of their medical education, medical students should be able to witness, follow up, and even have helped in an entire process of uncomplicated low-risk 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 (59).

Apart from the mental harm caused by abusive and disrespectful treatment of women in labour, such as detention of women and their babies in hospitals due to inability to pay, they are also more likely to suffer from life-threatening severe complications due to inhuman practices. Studies also report that a woman's race, ethnicity, marital status, socioeconomic status, HIV status are some important factors that influence the treatment they receive. (51). This behaviour is also overlooked and not acknowledged in society, which only contributes to the issue.. Also, healthcare 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 (60).

Implement scientific and evidence-based information in the curricula of medical schools and also on all postgraduate courses in obstetrics and gynaecology in order to understand the different manifestations of Obstetric Violence in different contexts, to prevent, treat, punish and eradicate violence towards women (61).

Further research methods are needed and can be applied; however, understanding how curriculum editions and processes can be reorganized to provide better women healthcare services ethically. 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 the Obstetric Violence phenomenon and the dehumanizing medicalized birth is discussed by WHO pointing out the unnecessary medical interventions (62).

In an attempt to combat the violation of human rights of women in labour, FIGO launched the project "Integrating Human Rights and Women's Health- an educational approach" in 2012. They aimed to educate doctors to be able to deliver quality health care and to apply and respect the principles of human rights (63). 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 nine 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 applies to pain management, birth induction and psychological support (5).

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Bylaws Paragraphs concerning Policy

17.2 Definitions

- a) **Policy Statement:** Short and concise document highlighting the position of IFMSA for specific field(s). A policy statement does not include background information, discussion related to the policy, a bibliography and neither does it quote facts and figures developed by outside sources. The maximum length of a policy statement is 2 pages, including introduction, IFMSA position and call to action.
- b) **Position Paper:** A detailed document supporting the related policy statement that contains background information and discussion in order to provide a more complete understanding of the issues involved and the rationale behind the position(s) set forth. A position paper must cite outside sources and include a bibliography.
- c) **Policy commission:** A policy commission is composed of three people, with 2 representatives of the NMOs and one Liaison Officer. The proposer of the draft is part of the policy commission and is responsible of appointing its members. The tasks of the policy commission are the following:
 - a. They are responsible of the quality of the policy document with the approval of the proposal.
 - b. Ensuring the content is based on global evidence.
 - c. Collecting and incorporating NMO feedback after the call for input.
 - d. Coordinating the discussion during the General Assembly.

Adoption of policies

17.3. A draft policy statement, position paper and the composition of the policy commission must be sent to the NMO mailing list by the proposer and in accordance with paragraph 9.4. Input from NMOs is to be collected between submission of the draft and submission to the General Secretariat.

17.4. The final policy statement and position paper are to be sent in accordance with paragraph 9.4, using the template provided in the call for proposals. The proposal must be co-submitted by two NMOs from different regions or the Team of Officials. A corrected version of this document may be submitted according to paragraph 9.5. Correction may not be used to add members to the policy commission.

17.5. Policy statements and position papers must be presented to NMOs during the first working day of the IFMSA General Assembly.

17.6. A motion to adopt the policy statements and position papers must be submitted the day before the relevant plenary by two NMOs from different regions or an IFMSA Official, the IFMSA Team of Officials or the IFMSA Executive Board. Adoption requires $\frac{2}{3}$ majority.

17.7. Amendments may be sent to the proposer in accordance with Annex 1. Amendments made during a General Assemblies or after the deadline stipulated in Annex 1, shall be submitted to the Chair at the latest 23:59 observed in the timezone of the relevant General Assembly on the day before the scheduled start of the session in which the policy will be voted on. These amendments require $\frac{2}{3}$ majority to pass.