

IFMSA Policy Document Obstetric Violence and Humanized Birth

Proposed by Team of Officials

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Policy Commission

- Aída Ramos García - IFMSA-Spain - aida.ramos.garcia00@gmail.com
- Razan Faisal Abdallah Mohammed - MedSIN-Sudan - razanf900@gmail.com
- Klaudia Szymuś - IFMSA Liaison Officer for Sexual and Reproductive Health and Rights Issues, incl. HIV and AIDS - lra@ifmsa.org

Policy Small Working Group

- Isarinade David Timilehin - NiMSA - Nigeria
- Israa Ashraf Fathy - IFMSA-Egypt
- Zeina Chehade - LeMSIC-Lebanon
- Alideea Maria Opra - FASMR Romania
- Iris Kučinić - AECS Spain, Catalonia

Policy Statement

Introduction:

Obstetric violence (OV) is a term used to describe people's unjust and abusive treatment during pregnancy, delivery, and the postpartum period. It contains a spectrum of behaviors, including but not limited to physical and verbal abuse, failure to gain consent for all medical interventions, violations of confidentiality and privacy, and neglect. OV is estimated to affect 67% of people giving birth worldwide, and the idea of humanized birth that prioritizes the individual giving birth's dignity and autonomy and the natural process of delivery should be promoted.

IFMSA position:

The IFMSA condemns any form of obstetric violence toward all people bearing children during any period of their pregnancy, delivery, and post-partum. The IFMSA recognizes the impact OV has on individuals' physical and mental health and the risk factors that predispose individuals to OV and is committed to promoting patient-centered and humanized care. The IFMSA supports all informed decisions made by individuals with the mental capacity to make their own decisions in regard to their pregnancy, delivery process, and postpartum, including medical interventions. The IFMSA recognizes that at times, emergency decisions have to be made when individuals lose the capacity to make decisions for their care. In such cases, decisions should be made in consultation with family members and multidisciplinary teams, with priority given to the safety and dignity of the individuals bearing children.

Call to Action:

Therefore, the IFMSA calls for:

Governments to:

- Recognize OV as a public health issue that can affect all birthing people in society.
- Establish and ensure national guidelines/adhere to WHO childbirth guidelines for eliminating abuse during childbearing and childbirth, and demand repercussions should these principles not be followed.
- Review or create laws that condemn OV practices committed by healthcare practitioners toward pregnant patients in healthcare facilities and institutions. Assure law enforcement, prosecution of perpetrators and repercussions.
- Increase funding and conduct more research into measuring OV in different communities and the effects of it in the long-term, as well as the epidemiology, the presentation, and the consequences, to understand better the impact on people's health and prevent traumatic experiences.
- Create policies that assure quality healthcare and maternal care practices and conduct from healthcare providers guaranteeing humanized care during pregnancy or birthing.
- Create policies that advocate awareness in healthcare providers and facilities, medical schools, and general communities about Obstetric Violence and Humanized Childbirth (OVHB) with the needed tools to identify them and break the cycle.
- Ensure proactive engagement of society, particularly of childbearing people and within marginalized communities, in developing all policies and programs related to obstetric and maternal health to understand all perspectives and recognize the community's necessities.
- Promote intersectionality within the medical syllabus and the healthcare worker's curriculum to ensure discrimination-free and non-biased practices with their patients.
- Create a safe and anonymous way for patients, medical professionals, and other parties involved to report cases of OV to an unbiased third party responsible for analyzing each case and taking the appropriate measures to prosecute and/or prevent further cases.

NGO and International agencies to:

- Create and propagate institutional policies that abhor practices that enable OV, and these policies should be binding on them and their affiliate organizations and member countries.

- Advocate, support, and abolish OV and the establishment of humanized birth while recognizing and treating humanized birth as a fundamental human right and enforcing the same.
- Commit to adequate provision for and protection of the fundamental human rights of childbearing persons even in the face of humanitarian crises, rural areas, LGBTQIA+, refugees and internally displaced person situations.
- Engage more in sensitization of the general public on education to remove cultural factors and increase awareness about the patient's bill of rights, the Respectful Maternity Care Charter, sexual and reproductive health and rights and other conventions that exist to protect them from OV.
- Support governments by sourcing funds to help combat the personnel and institutional factors implicated in OV and dehumanized birth.
- Engage in research and a wide base collection of data to show OV as a public health issue and help develop policies and guidelines to curtail the phenomenon.

Medical schools to:

- Introduce the concept of both OVHB in the medical curriculum through comprehensive modules and make them obligatory courses.
- Provide training courses for the relevant facilities working staff, including but not limited to the deans, the heads of departments, and assistant Lecturers.
- Ensure the quality of the training and academic courses provided for medical and para-medical students and introduce medical ethics, including informed consent, patients' human rights, and more, in every year's curriculum to root it deeply in the medical students' minds.
- Review the obstetric curriculum and have close supervision on the clinical rounds to ensure they don't contribute to increasing obstetric violence and discrimination toward the patients.

Healthcare professionals to:

- Condemn all practices associated with OV and escalate behaviors of colleagues that violate the human-rights-based approaches to medicine and inflict OV on patients.
- Participate in continuous learning and training programs to capacitate healthcare professionals with the skills and knowledge necessary to provide humanized birth.
- Play an active role in patient education in order to encourage the general public to take the initiative in their own health.
- Prioritize the health, autonomy, and dignity of the individual bearing children throughout their pregnancy, delivery, and post-partum, as well as ask for consent before interventions.
- Be aware of the unique needs of populations like LGBTQIA+ communities, youth, refugees and migrants, people with disabilities, indigenous people, people of color and more, and be able to provide culturally-sensitive obstetric care.

IFMSA National Member Organizations and medical students to:

- Recognize the concept of OV as a violation of fundamental human rights, especially sexual and reproductive health rights.
- Contribute to awareness around OV and advocate for humanized childbirth through workshops and activities targeting and training medical students.
- Facilitate activities, initiatives, and movements among medical students that aim to empower birthing persons by teaching them about their sexual and reproductive rights.
- Actively engage stakeholders, such as faculty and healthcare institutions, to promote the inclusion of OVHB and sexual and reproductive health rights into curricula and research.
- Advocate for the reinforcement of evidence-based practices in the field of obstetrics and sexual and reproductive health.
- Collaborate with NGOs, youth organizations, and civil society in raising awareness and demanding change in national and international legislation and guidelines.

Position Paper

Background information:

The term “obstetric violence” refers to the violence that people encounter in obstetric care facilities that are practiced by the healthcare providers that may occur during pregnancy, birth and the puerperium, and in situations such as miscarriage, post-miscarriage and reproductive cycle. Obstetric violence (OV) ranges from complete physical abuse to humiliation caused by lack of confidentiality, neglect, or verbal abuse that results in preventable needless pain and preventable complications, thus dispiriting them from using institutional health care in the future [1][2][3]. Although female patients have always been victims of violence in health facilities, such as neglect, disrespect, abuse, or mistreatment, it was only over the past two decades obstetric violence in health care has gained growing attention globally as a result of persistent policy and legal structure changes with more. More awareness and attention have especially been raised toward human rights and women’s fundamental rights. [3] And according to the Universal Declaration of Human Rights (UDHR), obstetric violence violates human rights as well as fundamental women’s rights [4], and evidence of OV has been found in both low- and high-income countries. [1]

Although humanized childbirth might seem like the opposite of OV, the former does not simply exist by the elimination of the latter. The humanized childbirth approach emphasizes the importance of putting pregnant individuals at the center of care to grant them positive childbirth experiences through a holistic, human-rights-based approach, which is highlighted in WHO’s “Intrapartum care for a positive childbirth experience” guideline in 2018 [5].

Obstetric Violence: An Overview

Obstetric Violence is considered a human rights violation, public health problem and a form of Gender-Based Violence, and due to the history of normalizing GBV, women in general, those of lower socioeconomic status specifically, have lower levels of assurance of appropriate and quality treatment during their obstetric period. Thus, it is essential to consider the other factors that intersect in the performance of OV, such as socioeconomic class, religion, and deep-rooted patriarchy [1][6]. These violent acts are performed by health professionals, mostly doctors, and to a high extent, nurses also are found in a widespread rate to ask for bribes to conduct skillful delivery. Both took advantage of their scientific and technical knowledge, hierarchical and unequal authority and power relations, and the societal norm that takes away the autonomy of individuals who are pregnant. Meanwhile, health professionals often fail to identify themselves as the hand of OV in its different forms. [1][7]

According to studies, the prevalence of obstetric violence varies drastically from country to country due to differences in the definition adopted, the commonly used instrument and method of delivery, common forms of OV, and other factors. [8] And according to the studies mentioned above, the unequal distribution of OV needs to be targeted with a human rights approach. this rate is necessary to be handled according to human rights.

Even though there was a huge delay in reaching global recognition of the phenomenon of OV, it has been present for centuries and in different countries. The earliest recorded use of the term OV was traced back to 1827, describing the use of forceps unnecessarily during delivery [9]. Despite the plethora of reports of incidences and mass practices of OV, there was a delay in the emergence of legal action against OV.

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in 1979 was the first international convention to address access to maternity care as a human right [10]. It did not specifically mention OV as it was not yet a well-established concept; however, it highlighted the right to adequate access to healthcare services for pregnant individuals, family planning, consent and postpartum services. CEDAW constructed a foundation upon which many future treaties, legislation, and organizations were created and provided a legal framework for the conceptualization of OV as a form of GBV and a human rights violation.

The concept of OV started gaining traction in Latin America in the early 2000s and was rooted in the concerted efforts of the social movements that had been speaking up against GBV, overmedicalization of the birthing process, and mistreatment of pregnant and birthing people [11]. An essential milestone in this process was the International Conference on the Humanization of Childbirth which was held in Brazil in 2000. At this conference, a group of researchers and healthcare professionals from 12 countries founded the Latin American and Caribbean Network for the Humanization of Childbirth (RELACAHUPAN), leading the conversation on the right to respectful care within the region [12].

In 2007, Venezuela became the first country in the world to formally define OV within its national law, describing it 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 their quality of life” [13]. It has also addressed other acts that constitute OV, such as unnecessary C-sections without informed consent, inadequate attention during obstetric emergencies, and forcing birthing people into supine positions when vertical delivery is possible. Other countries followed suit shortly after, including Argentina in 2009, some states of Mexico from 2007 to 2017, Bolivia and Panama in 2013, and Uruguay and the state of Santa Catarina in Brazil in 2017 [11] [14]. The provision of these national laws is a good start and establishes solid foundations for societies that value respectful maternity care. However, their efficiency has not been evaluated in practice yet.

Humanized birth and its impact

Humanized birth is a rich, respectful, and positive experience in which the expectations of a pregnant person are met or exceeded and in which a baby can be delivered in a safe environment with access to practical and emotional support from their companion(s) and competent healthcare staff. It entails not only access to dignified and respectful care but also stresses the importance of helping pregnant people feel a sense of control over their medical outcomes by involving them in decision-making, which can also be termed the “horizontalization of childbirth care” [15]. Thus, the humanization of childbirth care aims to reshape the infrastructure of the healthcare system and ensure the quality of care received by pregnant people, babies, and family members.

A meta-synthesis done by Miyauchi et al. in 2021 showed that in interactions with healthcare providers, pregnant people highly valued being listened to, feeling understood, being encouraged, receiving proper communication and information, being involved in decision-making, and having family support [16]. The feeling of being in good hands when it comes to their healthcare providers empowers them and helps them feel confident and in control. On the contrary, when pregnant people sense disrespect, such as through neglect, mistreatment, abandonment, and dehumanized care, they view their childbirth experiences as overwhelming and fearful.[17]

Additionally, there has been increasing acknowledgment of the value of transdisciplinarity in childbirth care, which is highlighted by WHO's recommendation to increase the ratio of skilled birth attendants (SBAs) [18]. SBAs are competent to provide evidence-based and human-rights-based dignified care to pregnant individuals and newborns, provide emotional support, and properly manage or refer pregnant individuals or newborns with complications [19]. In fact, a Cochrane meta-analysis of 27 randomized clinical trials showed that individuals who had continuous support throughout pregnancy were more likely to have spontaneous vaginal births, less likely to have negative feelings about their childbirth

experiences, had shorter labors, less likely to have cesarean sections and instrumental vaginal births, and had reduced need for analgesia [20].

Another cornerstone of the humanization of childbirth is the focus on evidence-based medicine to guide care routines. Among the recommended practices are non-invasive methods of analgesia for pain relief, oral supply of food and fluids, freedom of mobility and birth position, skin-to-skin contact, and breastfeeding [5]. On the other hand, harmful or ineffective practices include the use of an enema, routine episiotomy, early amniotomy, the Valsalva maneuver during the second stage of labor, frequent vaginal exams, and early clamping of the umbilical cord. However, even with the growing recognition of the importance of addressing these issues, there still exist significant gaps to translate guidelines into real, meaningful action.

Obstetric Violence and Mental health

A study from Brazil in 2016 showed that women who experienced mistreatment during childbirth had a higher prevalence of postpartum depression as well as other mental health problems, such as Post Traumatic Disorder. [21,22] WHO also found that experiencing disrespectful treatment and abuse can lead to the patient losing confidence in the healthcare provider. [23] Thus, the trauma from experiencing obstetric violence can lead to serious consequences in mental health, feelings of disempowerment, fear and lack of confidence. [22]

Obstetric violence and humanized birth in humanitarian emergencies

A humanitarian emergency, crisis, situation or setting is an event or a series of events that are threatening in terms of the health, safety or well-being of a community or large population of people [24]. These could be public health emergencies (e.g., an epidemic), wars and conflicts, and natural or human-made disasters. Over the years, several humanitarian crises like the COVID-19 pandemic, climate-related shocks in Ethiopia, and the ongoing Ukraine war, among others, have been witnessed globally, and they always leave a sad trail in all aspects of living - economy, health, education, etc.

These certainly have significant effects on the way of life of people in the regions affected, and it has not spared the delivery of respectful maternal care and humanized birth. Respectful maternity care, which seeks to uphold respect for the basic human rights of childbearing individuals and their newborns, is often trampled on in humanitarian settings, affecting the recognition of and support for birthing individuals' right to autonomy, dignity, feelings, choices, and preferences. The effects could be a result of the crises themselves or as a result of measures put in place to curtail the crises [25].

A United Nations Population Fund (UNFPA) report on Sexual and Reproductive Health in emergencies highlighted that at least one in five women of childbearing age in humanitarian settings is likely to be pregnant. It further states that pregnancy and childbirth complications that could otherwise be prevented or adequately managed can become fatal due to the destruction and/or disruption of healthcare services [26].

In a study involving 21,027 people who had given birth in 12 countries of the WHO European Region within the first year of the COVID-19 pandemic, it was discovered that 9,008 (49.9%) of these people perceived a reduction in quality maternal newborn care due to the COVID-19 pandemic [27].

Some of the identified problems in obstetric care services provision during crises include:

1. Heightened vulnerability: Conflicts, crises and pandemics cause a situation where many more people are at risk of obstetric violence. In a crisis, there is often unavailability of skilled healthcare professionals' attendance during birth and basic emergency obstetric care, exacerbating the vulnerability of pregnant individuals.[28]
2. Humanitarian crises have led to increased disrespect and abuse of childbearing individuals: The process of childbirth in humanitarian settings has been linked to an increase in non-evidence-based practices such as:
 - a. Poor communication of information to the childbearing individuals, which should help inform their decisions;
 - b. Lack of privacy, especially when one-room tents are converted to clinics in many humanitarian settings;
 - c. Lack of consent for interventions which has been traced to cultural and language barriers, discrimination and overwhelmed health service providers;
 - d. Delay or denial of care due to regulations that are meant to protect the safe zones as lack of needed identity can prevent a childbearing people from accessing proper maternal care;
 - e. Neglect and abandonment due to scarcity of resources and discrimination.
3. Prohibition of companionship during labor: One of the components of the Respectful Maternity Care Charter is the right of a woman in childbirth to choice of companionship during labor. In most humanitarian settings, this is usually a luxury that cannot be afforded. In response to the COVID-19 pandemic, many hospitals restricted the number of persons allowed on their premises, and this included birth partners of people in labor. The impact of this was a reduction in the satisfaction of women in labor as their right to choose a companion, which was often denied, made the process lonely and more burdensome.[29]
4. Inadequate care during labor and care inequalities: Lack of skilled birth attendance, limited facilities, short-term and make-shift staffing arrangements, poverty and inadequate resources that come with humanitarian crises all contribute to obstetric violence experienced by women in humanitarian settings because they do not have the basic standard care. Crises also aggravate underlying care inequities as many more people are prevented from accessing maternal healthcare. [22][24][27]
5. Immediate isolation of the person who has given birth to the newborn. One of the rights of childbearing people is to bond with their newborn as early after birth as possible. However, in humanitarian settings, this is often not achievable. The consequences of this are that it can disturb the newborn's transition to life and disrupt the newborn's immunity, breastfeeding, and normal physiological processes [29].

All of these contribute to the obstetric violence experienced by childbearing individuals in humanitarian settings [25]. The COVID-19 pandemic, for example, was linked to an increase in unnecessary interventions like cesarean section without medical premises, which went as high as 92% among COVID-positive patients who were pregnant in a survey done in China, most of which did not have a convincing medical indication. This is due to limited facilities, the level of training of professionals, inadequate resources and lack of clearly defined protocol.[29]

Left-behind populations

Obstetric violence and non-humanized childbirth are both violence based on gender and sex bias and reflect the structural, political, and economic inequality of governments and societies. Global

organizations find the roots of Obstetric Violence are rooted in the patriarchal and capitalist system that we live in, which is based on female oppression, discrimination of minorities, and the invisibility of their problems, resulting in the violation of women's rights, which are on the bigger picture, human rights.[1]

A study conducted in India showed that women from lower socioeconomic backgrounds are the ones at risk of suffering obstetric violence and are forced to seek medical attention at public and lower-qualifying facilities, where illegal and violent procedures, mistreatment, and ethically wrong conduct from their medical health providers are common. [1]

To understand why this is happening, not only in India but also in other countries and continents, it is important to know that intersectionality plays a huge role in obstetric violence. It also explains how the child-birthing experience of two individuals from the same city can vary in so many ways due to class, race, religion, social status, education, and economic status, reinforced by unequal systems such as patriarchy and capitalism.

People who give birth are most often subjects of overlapping discriminations, which offers a different experience for each individual that cannot be comprehended by only looking individually at the parts.[30]

Despite being from different social and cultural backgrounds, women from all over the world share the common experience of discrimination based on factors such as race, ethnicity, skin complexion, language, immigration status, and the historical and political context in which they lived. The importance of more high-quality research in reducing racial inequities in maternal healthcare is emphasized by these findings.

Rural and regional communities

Some problems are not perceived by individuals in high-income countries or city-centered communities but are prevalent among their counterparts in rural and marginalized communities. For example, in rural Africa, there was a higher risk of retained placenta (77%), obstructed labor (76%), malpresentation (71%), antepartum and postpartum hemorrhage (70% each), and pre-eclampsia (56%). [31] These problems are all avoidable in some measure by routine checkups, individualized obstetric care and support from the health system with education and tools. Women in Tanzania face a one in 24 chance of dying in their lifetimes from maternal causes, compared to a one in 7300 chance for women in the Global North. [32]

Another example is Assam in India. Despite its maternal health interventions emphasizing on increasing institutional deliveries to reduce maternal mortality, this rural state has the highest recorded rate of maternal deaths, often characterized by obstetric violence [33]. Women with lower income and indigenous women disproportionately use state facilities and reported both tangible and symbolic violence, including iatrogenic procedures such as episiotomies, sometimes performed without anesthesia, improper pelvic examinations, beating, and verbal abuse during labor.

This research shows that while increasing institutional deliveries may help to reduce maternal mortality, the lack of humane care during childbirth for poor and indigenous individuals calls into question the notion of "safe" institutional deliveries.[33] It highlights the unequal and complex relationship between these individuals and reproductive governance, underscoring the need for improved care during childbirth.

BIPOC Individuals (Black, Indigenous, People of Color)

When discussing obstetric violence among Black or Indigenous individuals and people of color, it is crucial to understand the concept of obstetric racism, which describes the difference in treatment of childbearing people in these communities get because of their race or ethnicity [34].

A study from the USA had a sample of 2700 multi-ethnic birthing women, and an online cross-sectional survey was distributed to know the experiences of maternity and childcare [35]. The indicators the women included were: verbal and physical abuse, lack of autonomy - decision taking without their consideration or inclusion -, discrimination, and poor conditions in the health system. Of them, 2138 completed all sections of the survey. One in six women had experienced mistreatment by healthcare providers, but mistreatment varied by race/ethnicity—greater proportions of Indigenous (38%), Hispanic (25%), and Black (22.5%) women reported experiencing mistreatment compared to White women (14.1%).

For individuals from low socioeconomic status, black women's (27.2%) mistreatment was higher than white women's (18.7%), highlighting race discrimination. Regardless of maternal race, having a partner who was Black also was an influential factor in the increased risk of experiencing violence and abuse. [35]

Black women were the most targeted by stereotypes and racialized pregnancy stigma: a study of African American women reported that society often associates African American women with the assumption of low-income status, single parent, multiple children, and biologically more endurance to obstetric violent procedures. [36]

Indigenous Peoples

Historically, Indigenous individuals bearing children have been experiencing significantly higher rates of disrespect and abuse, including physical abuse, non-consented care, detainment, discrimination, and neglect, especially during facility-based birth.[37] As Indigenous individuals often face more financial, physical, language, and cultural barriers when accessing healthcare services in general, especially humanized obstetric care. At the same time, pregnant Indigenous individuals living in remote regions have been relocated to urban hospitals for childbirth as a result of colonial government policies. This forced maternal relocation has had long-term negative impacts on Indigenous women, their families, and their communities.

An article following the pregnancy journey of Wixárika women highlights how indigenous women in Mexico are treated by medical institutions and the colonialist structure.[38]

Wixárika women give birth at home and typically do so alone or with physical support from a family member or spouse. However, clinical healthcare facilities remove the role of non-medical support, not fulfilling the needs of the birthing individuals and thus, impacting their mental and physical health, which may lead to avoidable deaths.

Another study involving Indigenous adolescents from Guatemala analyzed obstetric practices during childbirth and found that a high proportion (42.5%) of these adolescents underwent episiotomies without their understanding and approval [39]. The barrier in sexual and reproductive education and routine checkups among Indigenous people leads to a lack of understanding about the ethics and necessities of clinical medical procedures, leaving decision-making power in the hands of clinicians and oppressive policies and protocols. More often than not, this barrier is due to systematic infrastructure, living in isolated locations and sometimes language barriers. This is a systemic problem, as resources are not made available to Indigenous communities, and healthcare workers and educators assume that the

same methods used to reach non-Indigenous communities will be effective for Indigenous communities as well.

Healthcare professionals need to acknowledge the diversity there exists between different indigenous groups and be mindful of the spiritual beliefs Indigenous individuals hold.[40] Respecting patients' connections to their families, communities, land, and water is the key to establishing rapport and protecting their mental well-being. Additionally, the importance of more high-quality research in reducing racial inequities in maternal healthcare is emphasized by these findings.

People with disabilities

Approximately 15% of the global population has some form of disability, with physical disabilities being the most common one. Around 10% of people with disabilities are of childbearing age. However, due to the assumption that individuals with disabilities are less likely to have children, access to maternity care is often limited for this population, and pregnancy and childbirth can be challenging due to physical barriers, lack of access to information, difficulties with communication, and negative attitudes from healthcare providers. [41]

While individuals with disabilities still constitute a small proportion of individuals giving birth, that proportion may be growing. However, there is currently no data on changes over time in the number of individuals with disabilities giving birth, highlighting the problems that research has when it comes to some vulnerable populations and their needs. [42]

This study, conducted in Brazil in all 606 health facilities linked to the "Rede Cegonha" network, aimed to describe the physical structure of hospital units regarding accessibility for pregnant and puerperal people with motor, visual or hearing impairments [43].

The research described that only 4.3% of the facilities had motor accessibility (handrails, ramps, wheelchair-sized doors, and accessible bathrooms with bars), 3.3% had visual accessibility (tactile signage and visual and text-based signage in the facilities), and none had hearing accessibility [a broad range of assistive technology both for the individual and/or society in order to remove barriers]

It is likely that there has been a corresponding increase in cesarean deliveries among this population, as pregnancies may be viewed as high-risk by the clinicians, confirming the lack of data, research and representability. This is also supported by studies that have found higher proportions of cesarean deliveries among individuals with intellectual and developmental disabilities, physical disabilities, and sensory disabilities (for these conditions without evidence-based premise to conduct the caesarian section) compared to those without disabilities. [44] It is important to adequately train clinicians to address the perinatal care needs of this growing population.

Youth

As of 2019, it was estimated that there were 21 million pregnancies each year among adolescents aged 15–19 years in low- and middle-income countries, with approximately 50% being unintended. [45] These pregnancies resulted in an estimated 12 million births, and only about 30% of pregnant adolescents receive adequate prenatal care.

A Turkish study conducted in a public hospital highlighted the importance of social support for pregnant adolescents, particularly considering that the social support received from a spouse was found to be relatively lower among adolescent women with lower gestational age [46]. Healthcare professionals

should evaluate the social support provided by the families and partners of pregnant adolescents and provide the necessary counseling to support these adolescents.

The research on young pregnant individuals is limited, likely due to legal concerns around the protection of minors and the role of parents or legal guardians in decision-making regarding their bodies [46]. In addition, education on sexual and reproductive health is often limited and not effectively targeted toward this population, resulting in non-informed decision-making when it comes to their pregnancies and child-giving experiences.

Refugees, Migrants, and Internally Displaced Communities

In the WHO European region, over 50% of the migrant population is now made up of women, many of whom are pregnant and have fled their home countries and support networks [47]. Births to migrants are also not evenly distributed geographically, presenting challenges and the need for changes in healthcare delivery in affected areas.

According to the 2018 report *Improving the Health Care of Pregnant Refugee and Migrant Women and Newborn Children: Technical Guidance* by the WHO Regional Office for Europe, there is a marked trend of worse pregnancy-related indicators among migrants compared to the general statistics of pregnant individuals, such as higher rates of maternal death and severe morbidity, under-treated mental health problems (such as postpartum depression), perinatal and neonatal morbidity and mortality (including more preterm births and a higher incidence of congenital abnormalities), and suboptimal overall quality of care [47]. Many refugee and migrant individuals also have additional needs (e.g., economic and social) that can interfere with or compete for priority with their pregnancy care. [48]

A report exposing abuses at a Georgia Detention Center was issued in 2020, stating that forced hysterectomies were done to immigrant women along the US-Mexico border and in Colombian hospitals, among many other unethical, violent, and not prescribed obstetric and gynecology procedures [49].

This is not an isolated incident, and one factor at play is the connection between obstetric violence against pregnant migrants and immigration injustice.

The Minimal Initial Service Package for sexual and reproductive health provides international guidelines for healthcare providers in crisis situations to assess the quality of antenatal, pregnancy, and postpartum care for birthing individuals and their newborns using the appropriate tools.

LGBTQIA+

The visibility of LGBTQ+ communities, particularly transgender and nonbinary individuals, has increased in recent years. However, there is limited information and guidance on how to provide optimal pregnancy-related care for this population.

When providing care to a childbearing transgender man, professionals should focus on meeting the individual's needs and those of their partner, as they would with any other patient [50]. This includes using the patient's pronouns (and, in some languages - grammatical forms) and terms to identify their body parts, obtaining consent for procedures and touching, ensuring privacy, and supporting their choices during labor and birth. Care during childbearing and obstetric checkups for pregnant transgender men, and nonbinary people should be as valid and respectful as those for cisgender women, free of any judgment and personal beliefs.

As previously mentioned, intersectionality plays a huge role in these cases. A study from Chicago highlighted that LGBTQ+ individuals from ethnic or racial minority groups might be at greater risk of marginalization and co-morbid risk factors (such as depression, hazardous drinking and unintended pregnancies) for higher-risk births and pregnancies [51]. These individuals will have less access and possibilities to childcare, safe birthing facilities and an overall humanized birth experience. However, these risk factors are not inherent to their identities but rather are the result of the stigma and social discrimination from the institutions and societies, such as homophobia, transphobia, lack of acceptance, and disrespect for diversity.

To provide optimal care for patients who are of sexual and gender-diverse groups during childbirth, healthcare takers should take a holistic approach that includes standardized education, the development of LGBTQIA+-affirming policies and practices, flexibility, self-reflection on potential biases, and individualized, compassionate care [50]. This will help create a welcoming and inclusive environment for those individuals and ensure that their needs are met during childbirth and childcare.

In order to create a healthcare environment that prioritizes human rights and patient-centered care, it is important to understand the challenges facing birthing people within the healthcare system. This includes considering the role of healthcare facilities, government policies, and education for healthcare workers by analyzing what judgments and biases we have when it comes to patient care. By addressing these issues and developing targeted solutions, we can improve the quality of care for birthing individuals and ensure that their needs are met, bringing their necessities into light and respecting the natural diversity of patients and communities.

Medical professional's role in prevention

The practice of obstetric violence is found to be based on relations of power and authority applied mainly by health professionals. This can occur in both the hospital setting or in any public or private setting where acts on the patient's body or their sexuality can be done in a direct or indirect way, depriving birthing individuals of their human rights granted by the law.[1]

As mentioned before, as obstetric violence is practiced by health professionals generally, especially by doctors and nurses, it makes sense that the relationship of trust between birthing individuals and health professionals is fragile, which in turn may weaken the rapport between the two sides and impair the delivery of personalized care. [7]

The reasons why medical professionals practice OV can be divided into individual and institutional factors [1][3][7][52].

1. The individual factors:

- A deeply rooted gender discriminatory concepts adopted by the professionals,
- Under- and untrained staff & birth attendants
- A lack of commitment from health professionals
- Significant power imbalances between medical professionals and patients.
- Hierarchy among staff
- Discrimination based on caste, class, religion or other factors

On many occasions, medical professionals may attempt to silence patients who lack an understanding of their basic rights. As a result, medical professionals and patients often justify OV as something that has been done for the "good" of the people who were pregnant and their

babies. In other words, it's justified by medical knowledge. However, many times these actions do not follow a human rights-based approach.

2. The institutional factors:

- Lack of adequate infrastructure in institutions.
- Lack of necessary medicines and equipment
- Lack of infrastructure facilities
- High workload
- Physical and mental exhaustion of professionals
- Scarce human resources
- Misallocation of the resources
- The precariousness of the conditions for care provision
- Unfavorable working circumstances
- Hygiene issues in health facilities

All these factors are found to contribute to the continuity and high prevalence of OV practices by creating an abusive environment and culture within health institutions. For healthcare professionals, poor working conditions, which may lead to stress and frustration, significantly affect the wait times for patients and the quality of care. Therefore, even though overworking and personnel shortage should never be used as excuses for OV, it is still important to acknowledge and address these factors in order to eliminate OV. At the same time, a lack of facilities and basic medical infrastructure makes it difficult for each and every single patient to have full autonomy over their medical interventions, for example, vaginal and abdominal examinations in a single bedroom, to ensure privacy. These factors can all contribute to dehumanizing care for women during their obstetric care period.[7]

Solutions for improvement

It is important for intense changes in the training modules of health professionals in obstetric health institutions for both undergraduate and postgraduate training programs. Topics that should be included in these training programs include comprehensive sexual and reproductive health and rights disciplinary studies, gender-based violence, gender equality issues, ethical standards, mental well-being management for people during pregnancy and postpartum, and humanized obstetric procedures.[2] It's also important to be mindful that the entire process of the medical curriculum should adopt an evidence-based approach, and regular reflections on progress and updates of new research areas should be prompted among faculty members and students. These are necessary for the construction of respectful, human and comprehensive assistance investments required for the training of obstetrical nurses and obstetricians who assist in physiological deliveries and positively affect the reduction of iatrogenic procedures, the promotion of humanized labor and the reduction of unnecessary cesarean sections. Fundamental rights in obstetric care should be guaranteed and grounded on demedicalization of birth and evidence-based practice. Issues such as the presence of a companion, the possibility of birth in a vertical position, compliance with the woman's birth plan, and free and informed consent before performing medical procedures (such as episiotomy and cesarean section) [7].

Education on obstetric violence and humanized birth

Every year, complications from pregnancy and birth result in about 500,000 maternal deaths, 7 million people having severe long-term issues, and 50 million people having bad health effects following delivery. Most of these happen in low- and middle-income countries. Particular complications include obstructed labor, postpartum trauma, eclampsia, and postpartum transmission. Complications for the child may include lack of oxygen during birth, first trauma, prematurity, and infections.

Giving birth as an adolescent raises a woman's risk for cardiovascular disease, researches have highlighted the need for comprehensive sexuality education and sufficient access to contraceptives for adolescents in order to prevent adolescent childbearing and any negative long-term and short-term health consequences. [53]

There are numerous causes for why health professionals should listen more to patients. As patients spend more time in healthcare environments than any regulators, patients are more capable of recognizing issues, such as delivery delays, poor hygiene, routine and unnecessary interventions and medicalization (on the person who gave birth or the infant), verbal abuse, humiliation or physical aggression, lack of material and inadequate facilities, practices performed by residents and professionals without the consent of the people who give birth after providing them truthful and sufficient information, discrimination on gender-related, cultural, economic, religious and ethnic backgrounds [7][7,23,54]. Patients are especially better at identifying soft issues, such as attitudes, connection, and caring neglect, that are tough to catch with institutional observation.

The key to patient empowerment is education. A patient must know their rights and responsibility to get the care they need.[55] Patients having access to their rights is a relevant behavior in combating mistreatment and lack of care from doctors and nurses. [56] The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) has mandated that client and family education be a part of comprehensive care since 1993. However, unfortunately, although it has developed many standards for the provision and coordination of health education efforts, JCAHO does not suggest methods of delivering that education.

Positive Country-level Solutions

Senegal

Since 2009, Japan International Cooperation Agency, in collaboration with the Senegalese Ministry of Health and regional health centers, has worked on Project for Reinforcement for Maternal and New Born Care that shares the concept of humanized maternity care. The aim of the project is to support facility improvement to create a safe and clean environment for delivery and train healthcare workers on respecting pregnant individuals, such as not rushing delivery through pushing, among other violent acts. The JICA's work is present also in other French-speaking African countries [57].

Canada

In Canada, the Obstetric Justice Project provides victims a platform for them to share their lived experience with obstetric violence and in combating it.[58] It also funds various research and advocacy projects across local communities and conducted surveys to better understand the prevalence and risk factors for obstetric violence. The Project offers a window for victims to file direct complaints to the College of Physicians and Surgeons, College of Midwives, College of Nurses, and other Colleges in 13 States and Regions across Canada.

Venezuela

Venezuela was the first country in Latin America, which adopted a law to protect from obstetric violence. In 2007, the Venezuelan government issued a law on women's right to a life free from violence. Article 51 explicitly describes acts of obstetric violence to which the perpetrators are subjected to pay a fine [59,60].

India

Evita Fernandez, an obstetrician working on reforming maternal health care in India, established the Professional Midwifery Education and Training program in 2011. This initiative aims to develop midwives' capacities in compassionate and women-centered care as well as question discriminatory practices of medical doctors by breaking the hierarchies in healthcare workers' teams. This training was followed by a campaign and a one-day interprofessional workshop that emphasizes humanized birth and making pregnancy safe [61].

European Union

The European Union's Horizon 2020 research and innovation program under the Marie Skłodowska-Curie grant agreement funded a variety of projects targeting obstetric violence in Europe [62]. Examples include funding scholars to attend conferences to present their research on obstetric violence and country-level reports on the prevalence of obstetric violence. The European Commission also has set as one of the goals for research and policy since 2018.

Egypt

In Egypt, a not-for-profit organization called YourEgyptianDoula, offers extensive birthing services, including doula support, childbirth education for the new parents-to-be, and birth trauma therapy [63]. It not only distributes factsheets on OV in both English and Arabic but also has a page dedicated to telling patients what "respectful birth" entails. It also emphasizes youth empowerment in combatting OV and promoting shared decision-making in the birthing planning process.

Western Pacific

Countries in Western Pacific are culturally and linguistically diverse, so the lack of enough education programs and skills regarding maternal health is also influenced by cultural different cultural beliefs and backgrounds. Furthermore, the lack of respectful and dignified care is particularly problematic, and only a few interventions are focused on women's experience of the care they receive. Most of the initiatives were focused on Papua Nueva Guinea, with actions such as the Women's and Children's Health Project, with the aim to increase quality and coverage of maternal health in rural areas, with one of their objectives being fighting for respectful and dignified care [64].

IFMSA Contributions to Combatting OV

IFMSA has multiple policies that aim to address the health inequality associated with OV and poor maternal outcomes experienced by pregnant individuals

- Reproductive Health
- Ending Gender-Based Violence

Other policies that acknowledge the intersectionality associated with obstetric violence with other factors addressed in this policy, such as gender and age, include:

- Health of LGBTQIA+ Individuals
- Migrants' Health
- Forced Displacement and Health
- Adolescent Health
- Health Literacy

Policies make up an integral component of all advocacy work IFMSA does and serve as the backbones for all IFMSA campaigns and the statements IFMSA delivers during external meetings.

In 2021, IFMSA conducted an extensive social media campaign in alignment with the annual international campaign of 16 Days of Activism Against Gender-Based Violence with a combination of infographics, Open Space Discussions, and publications. On the local and regional levels, NMOs have also worked to address the bigger problem of gender-based violence.

In April 2021, IFMSA conducted a maternal health and rights campaign named #EveryMotherCounts for the International Day for Maternal Health and Rights. The campaign included a webinar on *The role of health systems in shaping adequate maternal care* and infographics, multiple infographics published on the main IFMSA social media pages and distributed through groups of different regions. Alongside campaigns, IFMSA's Standing Committee on Sexual and Reproductive Health and Rights, incl. HIV and AIDS also holds an annual Maternal Health Camp to promote the idea of humanized birth and equip members with skills to assist birthing individuals with a human-rights-based approach.

According to IFMSA Program Reports, during the 2021-2022 term, three activities named obstetric violence and humanized birth as their focus areas, with one from the African regions and two from the EMR region. At the same time, *The Obstetric Violence and Humanised Birth Manual* has been under development since March 2021. One SWG was established on Obstetric Violence and Humanized Birth, and OVHB was named a regional priority for Africa. During the 2020-2021 term, two activities named obstetric violence and humanized birth as their focus areas, with one from the African region and one from the EMR region.

On the national level, the Maternal Health and Access to Safe Abortion Workshop from IFMSA Iraq aimed to target medical students through a series of workshops in order to raise awareness around maternal health and access to safe abortion.

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