Chapter 9
Childbirth in Chile: Winds of Change

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In 2017, Chile’s IMR (infant mortality ratio; infant deaths/1000 live births) was 6/1000 (UNICEF 2018), and its MMR (maternal mortality ratio, maternal deaths/100,000 live births) was 13/100,000 (WHO 2019). These figures are better than the average for Latin American and the Caribbean, where the IMR averaged 15/1000, and the MMR was 74/1000 in 2017 (UNICEF 2018; WHO 2019). They are undoubtedly excellent indicators, but they hide big gaps in access and quality of healthcare between private and public health facilities. Further, there are extremely high routine interventions during childbirth, as indicated by a national cesarean section rate of 50% in 2015 (INDH 2016). In the country, there are no out-of-hospital options for birth that are recognized by the health system and thus covered by health insurance.

In 2016, 99.7% of births were attended by health professionals in hospitals (DEIS 2018), where the hegemonic model of practice is the technocratic model of childbirth (Davis-Floyd 2001). A study conducted in nine major regional maternity hospitals, with primiparous and multiparous women who were admitted to the labor ward with 2–3 cm of cervical dilatation and whose physiologic labor was a minimum of 4 h, reported the following interventions: 91% had medically induced/augmented labors, 55% had continuous fetal intrapartum monitoring, 56% had episiotomies, and 80% delivered in the lithotomy position (Binfa et al. 2016). These high rates of interventions are harmful and against national and international guidelines (MINSAL 2008; WHO 2018).

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As elsewhere in Latin America, obstetric interventions are high in both public and private health facilities, but the rate of cesareans is much higher in private hospitals. In 2015, the cesarean rate was 41% in public hospitals and 69% in private hospitals (INDH 2016). This difference relates to the organization of care in each system (Angeja et al. 2006; Murray 2000) and the perverse financial incentives in the private domain leading doctors to conduct routine cesareans (Murray 2000; Sadler and Leiva 2016). In public facilities, the workload is organized and paid according to shifts. Professional midwives (called *matronas*) are the main caregivers for low-risk pregnancies and births, but they are supervised by on-duty obstetricians—who manage high-risk cases, instrumental deliveries (such as forceps), and cesareans. In private facilities, obstetricians are the main care providers for all women throughout pregnancy and delivery, though midwives also attend most births. The midwife stays with the mother throughout, while the obstetrician usually only comes in toward the end. The payment scheme operates per client, which means that shorter labor and elective cesarean increase the providers’ and hospitals’ profits (Murray 2000; Sadler and Leiva 2016).

The high rate of cesareans in the private sector is especially worrying given the rising privatization of childbirth. During the last decade, the number of births in the private sector grew from 21% to 32% (Sadler and Leiva 2016). This trend is driven by the deficiencies and inequities of the public health system, such as hospital infrastructure deficit, low privacy in patient care, impersonality in the treatment of patients, unfavorable working conditions, and low level of wages (Goic 2015). As elsewhere in the world, these factors lead to some marginalized women lacking access to lifesaving interventions, receiving care that is “too little too late” (TLTL), while many women are receiving unnecessary interventions too early in labor or “too much too soon” (TMTS) (see Miller et al. 2016).

Regarding women’s perceptions of care, the study by Binfa et al. (2016) indicated that women across many different regions did not feel heard, did not receive information, and were not considered in decision-making regarding procedures or interventions and in some cases felt mistreated (Binfa et al. 2016). Other studies have shown that cases of abuse and disrespect can be frequent, especially in public health. For example, a survey conducted by the Chilean Observatory of Obstetric Violence showed that in 43% of childbirth experiences in public hospitals, and 17% in private clinics for the period 2014–2017 (sample of 5697 births), women reported they had been criticized or repressed by health professionals for expressing emotions and/or pain during labor and birth (OVO Chile 2018).

Nevertheless, it is important to recognize that during the last decade there have been important efforts to improve the quality of maternity care in Chile. In 2007, a comprehensive program for children and their families, especially those most vulnerable, called “Chile Grows with You” [*Chile Crece Contigo*] was launched, with the mission of accompanying, protecting, and supporting all children and their families in the public healthcare sector. The program placed strong emphasis on promoting personalized care for women and their families during pregnancy and birth (MIDEPLAN 2009), including the Ministry of Health’s *Manual for Personalized Attention in the Reproductive Process*. The intention was to create a
woman-centered model of birth that would promote the psychological health of mothers and the physiologic processes of labor while minimizing the use of routine interventions (MINSAL 2008). These policies and recommendations have helped to improve some practices—mainly those that constitute indicators of goals from the “Chile Grows with You” program (such as the presence of a companion during labor and birth and skin-to-skin contact with the newborn). Thus, while we appreciate improvements in isolated indicators, we regret to note that there has not been a profound nationwide paradigm shift toward the humanization of care during labor and birth.

Thus, despite the government’s efforts, many women in Chile still do not receive evidence-based care. In practice there are problems such as insufficient health staff, inadequate infrastructure, lack of autonomy given to midwives to manage physiologic labors, and insufficient collaboration within health teams. Health professionals lack training in a midwifery or humanistic model of care, and women are not adequately informed about physiologic birth during antenatal care (Binfa et al. 2016). Universities have not adapted or updated their health curricula accordingly.

Yet there are several ongoing processes and experiences that hint at a crack in the system and allow us to predict times of change. We will refer first to the history and impact of childbirth activism in the country and then to recent changes regarding birth territories.

### 9.1 Childbirth Activism

In the year 2000, the “1st International Conference for the Humanization of Birth” took place in Fortaleza, Brazil, with almost 2000 attendees, including around 60 delegates from Chile. RELACAHUPAN (the Latin American and Caribbean Network for the Humanization of Childbirth) was founded at the Fortaleza meeting with the commitment to advance the right of every woman to access adequate information on childbirth and to promote the “rediscovery of what is normal during the reproductive and neonatal cycle” (Vera 2010: 233, our translation). Soon after the conference, the Chilean branch of RELACAHUPAN was born. In the same year, a landmark seminar on “Humanized Childbirth” took place in Santiago, Chile, organized by the Women’s Health Program of the Ministry of Health and the University of Chile.

“Humanized childbirth” became the slogan for a series of actions in Latin America, and Chile intended to put normal birth on the agenda, given rising rates of obstetric interventions and abusive care (Bohren et al. 2015; Freedman et al. 2014). From 2007 onwards, the concept of “obstetric violence” (OV) broke onto the Latin American agenda, giving emphasis to the gender violence component of the problem (Sadler et al. 2016). The concept was coined in the Venezuelan “Organic Law on the Right of Women to a Life Free of Violence” (Republica Bolivariana de Venezuela 2007), where it was codified as one of the 19 kinds of punishable forms of violence against women. It brought a dramatic shift in the discourse and tone of
the discussion, as well as a sense of urgency to the cause. To date, Argentina (2010), Bolivia (2013), Panama (2013), and Mexico (2014) have integrated obstetric violence—or broader concepts such as “violence against reproductive rights” in the case of Bolivia—into their laws (Williams et al. 2018).

In Chile, as mentioned above, the first decade of this new century arrived with a governmental push to reduce routine and nonevidence-based interventions in childbirth and place the woman at the center of care (Miller et al. 2016). As experiences of personalized birth took place within maternity units across Chile, there was great resistance to shifting standards of care. The main argument against change was the threat that it might compromise the positive health indicators that Chile already boasted. Yet it was absurd to believe that reducing routine unnecessary interventions while promoting respectful care could jeopardize the exceptional maternal health outcomes in Chile (Sadler and Leiva 2016). In this scenario, childbirth activism has been key to informing women and denouncing abuses.

The goals of childbirth organizations in Chile during the last 20 years have been similar to those in other Western countries: questioning medical interventions in birth; promoting natural labor and delivery; advocating for birth settings and practices that respect women’s and families’ agency; and advocating for the right to make informed choices (Akrich et al. 2014). It is necessary to consider that in Chile, “choice” is very constrained given the lack of options within the technocratic model of childbirth (Davis-Floyd 2001, 2018) and the asymmetry of knowledge, experience, and authority between women and their providers. Since 2010, a new wave of young activists got involved in these issues and founded several new organizations.

The National Coordinator for Rights in Childbirth was born in 2016, gathering 13 organizations working on the topic. It aims to coordinate actions around the following issues: respect during childbirth, adequate unbiased information and consent about procedures, alternatives to medicalized birth, implementation of evidence-based practices, and legal support after having experienced obstetric violence (OV).

During March 2017, one of these organizations—the Chilean Observatory of OV—launched an online survey on experiences of childbirth promoted through social media, which received 11,400 responses. In June 2018 the results were published, showing a steady improvement in standards of care since the 1970s to date. Although the quality of care has been improving, the study confirms the persistence of very high rates of unnecessary interventions and of abuse and disrespect in maternity care throughout the country, as well as ongoing huge gaps between public and private standards of care (OVO Chile 2018). The results of the survey were used as the basis for launching a working group on “respected childbirth,” convened by two congresswomen and civil society organizations working on the topic. The first objective of this group was to generate a bill on respected birth as a continuation of two earlier projects presented since 2015 that are still “sleeping” in congress. The project was submitted to congress on October 2, 2018.

This “evidence-based activism” (Rabeharisoa et al. 2014) implies that knowledge is no longer simply a resource for grounding political claims but can become a vehicle of activism. Patient knowledge and experiences can change the evidence that is available to policy makers and government organizations, who can then act
on behalf of those very patients. Put another way, credentialed knowledge and experiential knowledge are articulated together rather than being opposed against one another (Rabeharisoa et al. 2014). These organizations and groups have provoked a “shift in the space of rationality, dialogue, and arguments” by framing the debate in ways that have shown the “deep disagreement as to basic premises in factual, methodological, or conceptual matters” (Villarmea et al. 2015: 183, 169).

Evidence-based activism around childbirth in Chile and Latin America has influenced a growing demand, both in public and private hospitals, for normal physiologic labor and respectful care. The health sector is responding with a growing offer of hospital birthing options as well as a growing midwifery cadre to attend home births. While the options for respectful care during childbirth are more prevalent in the private health sector, they require midwives and obstetricians trained in these practices who are not yet fully integrated in both public and private sectors. Yet even within the public sector, there is change, as our innovative case study from La Florida hospital suggests.

9.2 Territories of Birth: The Case of La Florida Hospital

During the last decade, several projects for humanized childbirth have developed throughout the country within public maternity units. The few initiatives that have been successful have taken place in hospitals classified as Level 1 (< 600 births) or Level 2 (600–1200 births) (Ministerio de Sanidad y Política Social de España 2009). Attempts to implement the model in larger hospitals did not succeed because those trying to do so were unable to convince the entire healthcare staff, and midwives were not given autonomy to offer physiologic care for low-risk births (Sadler 2009). Despite the proven effectiveness of midwifery care models in reducing cesarean rates and unnecessary interventions, and in improving maternal and newborn outcomes as well as maternal satisfaction and well-being, there has been resistance to midwifery care in Chile (McLachlan et al. 2012; Miller et al. 2016; Sandall et al. 2016; Stapleton et al. 2013).

Yet, again, there is change. In May 2016, the maternity of La Florida Hospital—a Level 4 maternity unit as it deals with more than 2400 births per year (Ministerio de Sanidad y Política Social de España 2009)—began to implement a new, humanistic childbirth model on the southeast side of Santiago, Chile’s capital. This hospital’s obstetrics and gynecology unit has been responsible for around 3000 births per year since the opening of its emergency unit in 2015.¹ while the hospital provides services to families that attend one of the nine primary healthcare centers of La Florida, the third most populous community in the country.

¹ Based on Monthly Statistical Records of the Center for the Responsibility (CR) of Women, La Florida Hospital.
The La Florida “Safe Model of Personalized Childbirth” attempts to improve consumer satisfaction, reduce excess and unnecessary interventions (including cesareans), and improve maternal, fetal, and newborn outcomes. This model was initiated in response to a health audit of the maternity unit conducted in 2015 that included an analysis of elective and emergency surgeries—the cesarean rate was 44%—as well as of unnecessary interventions. The emphasis on “safety” aims to communicate that reducing maternal morbidity and mortality is a fundamental objective of respectful care. It also responds to a false assumption among Chilean health providers that normal birth is dangerous and that supporting normal physiologic labor produces worse rather than improved maternal and newborn outcomes.

The program was driven by the heads of the obstetric and midwifery units of the Center for Responsibility of Women (which houses the delivery unit) and managed by a midwife experienced in the humanistic model of childbirth (Davis-Floyd 2001) and familiar with the relevant research in evidence-based care. New clinical protocols were developed with the joint participation of the heads of all health units involved, who then familiarized their extended staff with these protocols during clinical meetings. This process attempted to integrate the entire maternity staff into the new protocols rather than simply allowing program managers to run the model separately. The inclusion criteria for women to access this model of care and the new delivery rooms were defined as women without pathology or with low-risk conditions such as mild anemia, noninsulin-dependent gestational diabetes, intrahepatic cholestasis of pregnancy, polyhydramnios, prolonged pregnancy, previous cesarean, and chronic or gestational hypertension without preeclampsia. The protocol was based on the evidence-based Guidelines for Mother–Baby Friendly Birthing Facilities developed by the International Federation of Gynecology and Obstetrics (FIGO) in 2015. The goal for 2020 is to join the International Childbirth Initiative (ICI): 12 Steps to Safe and Respectful Maternity Care, a merger of the 2015 FIGO Guidelines and the 2008 International MotherBaby Childbirth Initiative (IMBCI) (Davis-Floyd et al. 2010)—by fully implementing the 12 Steps of the ICI—a global human rights based and quality of care initiative (Lalonde et al. 2019).

The La Florida “Safe Model of Personalized Childbirth” aims to achieve humanized care via one-to-one continuous care where one midwife is available for each birthing woman. Communication between midwives and obstetricians is both verbal and written, and the protocols specify that the obstetrician only intervenes in situations of cardiotocographic (electronic fetal monitoring) traces that are judged to be “non-reassuring” or “abnormal” (according to the classification by NICE 2014), which represent a minority of cases. Currently, around 85% of births in this model are attended by midwives.

Laboring women are sent home if they present at the hospital before reaching the active stage of labor (defined as starting at 6 cm dilation), with the exception of those who turn up at the maternity three times and who are then registered into the hospital but not in the maternity unit. Once women are in active labor, they are registered into the maternity and attended in the four private birthing rooms following the “Safe Model of Personalized Childbirth” or in other rooms following the
traditional-interventionist model, depending on their risk factors and room availability.

Of the 3201 births that occurred within the model from May 2016 to November 2019, there was significant improvement compared to all obstetric outcomes in the hospital for 2018 and compared to the country’s indicators for 2018 (Table 9.1). From 2016 to 2019, the unit had a cesarean rate of 6% compared to the entire hospital’s cesarean rate of 26%, which has been the lowest institutional cesarean rate in Chile since 2016. Other notable outcomes for the same period in the unit include 0.7% third-degree perineal tear; 16.5% episiotomies; an average of 90 min of uninterrupted skin-to-skin contact after birth; and a 67% breastfeeding rate during the first hour after birth.

La Florida Hospital’s “Safe Model of Personalized Childbirth” has been recognized as a pillar of safe delivery and respectful care within Chile, and the hospital has been visited by the Minister of Health as well as used as an example of the path that maternity units across Chile should take. In 2017, it won the INNOVA Health award from the South East Metropolitan Health Service, in the “User Satisfaction” category.

### 9.3 Home Birth

Beginning in the nineteenth century, Chile tried to professionalize birth attendance to decrease maternal mortality by training skilled midwives and obstetricians and transferring birth from home to hospital. Over the course of the twentieth century, traditional midwives were progressively denied the authority to practice at home (Zárate 2007). The degree of skilled or professional birth attendance increased from 61% in 1957 to 99% in 1990 (Koch et al. 2012) and has remained above 99% since

| Table 9.1 Compared obstetric outcomes |
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|                                      | La Florida Hospital, Safe Model of Personalized Childbirth, births from May 2016 to Nov. 2019 (N = 3201) | La Florida Hospital, total births 2018 (N = 3151) | Chile, public health 2018 (DEIS 2019) |
| Cesareans                            | 6%                                               | 26%                                             | 42%                                           |
| Apgar <7 at 5’                       | 0.4%                                             | 1.2%                                            | 1.1%                                           |
| Companion labor/delivery             | 96.9%                                            | 89%                                             | 68.4%                                         |
| Skin-to-skin contact for >30 min     | 86.7%                                            | 80%                                             | 75.1%                                         |
| Blood transfusion rate               | 1.6%                                             | 2.1%                                            | No data                                       |

*Based on Monthly Statistical Records of the Center for the Responsibility of Women, La Florida Hospital

*The 3151 total births of 2018 include the 1080 births that occurred in the Safe Model of Personalized Childbirth during that year. (Data for 2019 for entire maternity not available yet)
then, with almost all births taking place in hospitals and no regulated out-of-hospital alternatives. Although home birth is unregulated and not covered by health insurance, it is not illegal, and around 0.3% of births occurred at home in 2016 (INE 2017). The Health Code (Article 117) regulates the practice of midwifery but not its “territory”—a gap that allows midwives to attend home births despite health authorities being against it. The Health Code states that:

The professional services of midwives include the care of normal pregnancy, birth and puerperium, and the care of the newborn, as well as activities related to breastfeeding, family planning and the execution of actions derived from the diagnosis and medical treatment and the duty to care for the best administration of health resources for the patient. (MINSAL 1997, our translation)

The debate around home birth became public in 2013, after the media dramatized a story of a home birth transfer that had complications. The health minister at the time and the president of the National College of Midwives both declared themselves against home birth but willing to promote integrated birthing rooms within hospitals to give women more respectful and higher-quality care. The discourse against home birth implied that it is a risk to human health and doesn’t allow for obstetric emergencies while emphasizing that labor and delivery can have unforeseen events (El Mercurio 2013). In focusing the debate on the place of birth rather than on the model of care, the discussion left the hegemonic technocratic model intact, positioning childbirth as so inherently dangerous that it requires more, not less, obstetric control (Ramírez 2015). An important newspaper referred to the trend of home birth as controversial and made several inaccurate statements. These included that birth has unpredictable complications requiring a professional in the context of a hospital facility, while an expert in maternal health stated that there were no reported models of home birth abroad with good maternal outcomes (Alarcón 2013). This latter statement ignores the wide population-based studies comparing planned home birth with planned hospital birth in North America and Europe that have found comparable newborn and maternal outcomes, far fewer interventions, less maternal morbidity, and fewer and shorter NICU stays for newborns (Anderson et al. 2021; de Jonge et al. 2009; Janssen et al. 2009; Johnson and Daviss 2005; NICE 2014).

Home birth midwives, who had recently organized themselves as “Maternas Chile,” responded by defending their practices and denouncing the obstetric abuse and excessive interventions in hospital births that have been damaging to mother and newborns (Schüller 2013). There have been no official changes in the government position on home birth, which is rising steadily in Chile in response to birth activism and the excessive interventions of hospital-based births (Márquez 2019; Ramírez 2015; Reischmann et al. 2015). The growing public discussion in the media and news about high rates of unnecessary interventions, obstetric violence, and cesareans in Chile has had a huge impact on a new generation of families who value autonomy, informed consent, and respectful care in childbirth. Numerous stories of families who experienced disrespectful care and unnecessary routine interventions, despite having overtly rejected them, are raising awareness that facility-based providers override patient concerns about interventions. Given the
absence of midwifery-led birth centers in Chile, home birth is a growing trend that guarantees midwifery care (Márquez 2019; Ramírez 2015; Reischmann et al. 2015).

Maternas Chile began working as a small group of midwives who gathered to share their experiences; by July 2018 the group had 27 members from 8 cities across Chile. It has been given legal status as a trade association and has developed a set of evidenced-based midwifery protocols based on the Guidelines for Home Births in Barcelona (Collegi Oficial Infermeria de Barcelona 2010), the UK’s NICE (2014) clinical guidelines, and the local experiences of Chile’s home birth midwives. The group has developed their own patient consent forms, hospital transfer forms, and birth outcome data forms so that they can systematically study the outcomes for home births. During 2016, home birth midwives were given access to birth certificates after 2 years of resistance from the Chilean Civil Registry. The members of Maternas Chile are currently analyzing data on their perinatal outcomes, scheduling training programs for new midwives entering the association, and reviewing their protocols.2

The only available indicators about home birth in Chile were published in a thesis of midwifery students who analyzed retrospective data from Maternas Chile midwives for 491 home births in 2 of the most populated regions of Chile (Metropolitan and Valparaíso) from 2003 to 2014. They reported a continuous rise in the number of home births attended by these midwives, from less than 20 per year in 2003 to around 30 per month in 2017. They characterized women who have home births as belonging mainly to the middle-upper socioeconomic level, with 70.7% of their sample having completed university studies. Given that home birth is not covered by health services or insurances, it is affordable only to upper-income families. The authors reported excellent outcomes for the sample: transfer to hospital 8.6%, episiotomies 2.2%, perineal tears 32.2% (of which 99.4% were first degree and 0.6% were second degree), neonatal complications 2%, and maternal complications 1.6% (Reischmann et al. 2015). These results contrast with the poor outcomes and poor treatment that many women receive during institutionalized childbirth.

9.4 Final Words

The encouraging processes and initiatives we have presented show how consumers, academics, clinicians, and policy makers are collaborating to bring about profound and sustainable changes in the landscape of childbirth in Chile. Why do we call them sustainable? Sustainability, as defined by the World Commission on Environment and Development (1987), is development that meets the needs of the present generation without compromising the ability of future generations to meet their needs. How are we protecting the present and caring for future generations through childbirth? Women- and family-centered childbirth can be found in

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2 Information from personal communications with Maternas Chile midwives.
societies that are able to put human beings first, attending to the integral needs of mothers and babies far beyond the technical aspects of care that privilege providers at the expense of mothers or bureaucratic institutions at the expense of midwives and other caregivers. Respectful childbirth empowers women, families, and providers, leaving all groups better prepared to care for the newborns who represent the future generations of caregivers. Further, the midwifery model of care empowers health providers, who feel part of a profound caregiving experience that connects them to mothers and the wider family and community. It protects the future health of communities and saves scarce resources that can be used for other healthcare needs. As an example, the 2016 Public Expenditure Review in Chile conducted by the World Bank identified excess annual expenses of US $9.2 million related to cesarean section (MINSAL 2018).

In Chile, we observe a growing awareness of the importance of protecting the normal physiology of childbirth and respectful care from within the health sector and from consumer groups. The model of midwifery and respectful care that is being implemented in La Florida Hospital is being touted as an example to follow. While few women and families once sought out home birth, it too is now a growing trend across the country, with organized midwives practicing with evidence-based protocols and tracking their outcomes. Obstetric abuses that seemed invisible have been placed in the media spotlight, and there are concerted efforts to raise awareness around and end obstetric violence in Chile, with a group of congresswomen and civil organizations working for a bill on respectful childbirth to be approved in Congress.

While promising, these advances are not enough. The national norms regarding childbirth, such as the “Manual for Personalized Attention in the Reproductive Process” (MINSAL 2008), need to be updated and given the status of clinical guidelines because until now they have been taken merely as recommendations, and not protocols, by health professionals around the country. This would need to go hand in hand with a mandatory inclusion of the personalized model of childbirth in the health curricula and training programs within universities, medical, and midwifery schools. Another important next step is to redirect resources within health services and institutions toward midwifery care and toward respectful care for women. Public maternity units need more resources to reach the one-to-one continuous model of care, in which one midwife cares for each woman, which has been the standard in the private healthcare sector.

Health authorities and the College of Midwives are opposing home birth despite the fact that there are no other out-of-hospital alternatives to institutional deliveries. The lack of choice regarding birth territories constitutes a troubling scenario, in which health authorities insist on improving maternity wards within hospitals and clinics in both the public and private healthcare sectors, instead of expanding the available options by creating birth centers or integrating and regulating home birth. This lack of choice has become even more evident during the COVID-19 epidemic, which has been a concern in Chile in March of 2020. As in the United States, according to Davis-Floyd et al. (2020), the situation has generated an escalating demand for home birth as women feel at risk of infection if they give birth in a
hospital, and yet health authorities have been emphatic in denying that option. Responding to media coverage on the increase of home birth in this scenario, the Chilean Society of Obstetrics and Gynecology issued a statement saying that “childbirth in a hospital or clinic turns out to be, regardless of the context, the safest option for the mother and the newborn” (SOCHOG 2020).

Some practices that seemed firmly installed are being threatened: there are reports of public and private maternities prohibiting women from being accompanied at birth and not allowing skin-to-skin contact after birth (OVO Chile 2020). This is happening despite the fact that central health authorities have issued a call not to do so; the updated protocols state that women should always have a companion of their choice, and the separation of newborns from their mothers is only justified in preterm births or maternal deterioration due to COVID-19 (Colegio de Matronas de Chile 2020; SOCHIPE 2020).

It is profoundly concerning that rights that were regulated and had taken years to install can be disregarded so quickly and easily. Organizations such as the Chilean Observatory for Obstetric Violence have issued statements reflecting on these issues and calling for a deeper discussion on birth territories that can protect women’s rights during childbirth (OVO Chile 2020). If people infected with COVID-19 are concentrated in hospital, to question whether this is the safest place of birth for low-risk women and their babies becomes urgent and more necessary than ever (Dahlen 2019). Thus, we believe that after this pandemic passes, the winds of change will continue to blow with renewed momentum!

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