Chapter 1
Introduction: Sustainable Birth in Disruptive Times

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Our volume addresses the ongoing crisis in maternity care in language that calls to mind a brief manifesto on sexual and reproductive health and justice in these disruptive times:

Only when public health responses to COVID-19 leverage intersectional, human-rights centered frameworks, transdisciplinary science-driven theories and methods, and community-driven approaches, will they sufficiently prevent complex health and social adversities for women, girls, and vulnerable populations. (Hall et al. 2020: 1176)

While this statement was composed in response to the raging COVID-19 pandemic, it applies as much to our volume. Our volume is intersectional, for we illustrate how different social hierarchies—of wealth, sexism, racism—intersect to produce suffering and harm for women, newborns, and providers across the globe. We adopt a human rights framework as every chapter shows, implicitly or explicitly, that women’s rights are human rights, that marginalized communities suffer the most when human rights are denied, or that human rights in healthcare are on a collision course with the privatization of health care. Our volume is transdisciplinary because our 50 authors include a range of researchers with clinical, academic, and policy expertise, including midwives, nurses, obstetricians, pediatricians, neonatologists, medical anthropologists, sociologists, public health researchers, social workers, activists, and policy makers. Our volume is science-driven, as it builds upon and reflects the recent scientific consensus on maternal and newborn health that we outline below. Last but not least, our approach is community-driven, as we provide models of birth or maternity care that are based in local and participatory knowledges and practices.

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The COVID-19 crisis reveals preexisting dysfunctionalities in maternity care that we address. Even more importantly, the disruptions of COVID-19 offer a turning point where practices can be shifted in dramatic ways that address long-standing problems and concerns. We know that hospitals are major sites of contagion, and yet for nearly 50 years, global health experts have advocated for hospital-based births across the world rather than advocating for a mix of sites including hospitals, maternity care clinics, freestanding birth centers, and home births. Similarly, the broad push for obstetric care in the twentieth century (Davis-Floyd and Cheney 2019; Devries et al. 2001; Berry 2010, Wendland 2010) has systematically sidelined midwives. Yet the recognition that midwifery care can avert 80% of the maternal and newborn deaths and stillbirths across the globe (Homer 2014) with higher-quality care and lower cost than existing obstetric models of care deserves our attention in this era of scarcity and disruption.

It is now obvious that a more decentralized approach to birth—involving freestanding birth centers or primary care clinics, home settings, and midwifery care for low-risk women with access to higher level facilities where needed—produces better outcomes and is more cost effective and woman-centered. In large world regions, such as sub-Saharan Africa and South Asia, only 57% and 72% of all births, respectively, are facility based. In most countries, there are large rural-urban and wealth disparities in maternal outcomes that midwifery care can address more sustainably than obstetric care, given the shortage of obstetricians and the high costs of training them and having them unnecessarily attend low-risk births (Homer 2014; UNICEF 2020).

Across the globe, in high-income countries (HIC) as well as low- and middle-income countries (LMIC), training midwives and promoting out-of-hospital (OOH) births at freestanding birth clinics or at home is more sustainable and feasible than hiring obstetricians and building costly hospitals. In sub-Saharan Africa alone, it was estimated that 300,000 more midwives would be needed by 2035 just to achieve 75% skilled attendance at birth (Hoope-Bender et al. 2014). This volume emphasizes innovative, resilient, and sustainable models of maternity care that can flourish amidst scarcity and disruption. It overturns conventional policies about maternity care that have become as pervasive as they are ineffective. It considers why lean, flexible midwifery-based models of care are needed now more than ever before.

1.1 Sustainability and Disruption

We privilege sustainability and disruption to highlight two rather different but coexisting social trends. We define sustainable as characterized by improving outcomes for mothers and newborns while lowering costs in human and financial terms. In accord with the focus on sustainability reflected in the Sustainable Development Goals (SDGs), we understand as sustainable those solutions that can be scaled up or across similar settings while adapting to local cultural contexts in ways that preserve an ecological balance between mothers, newborns, families, and
providers. Our order of importance is intentional: mothers’ and newborns’ rights and health come first, followed by the health and needs of families and providers (see our Appendix on the foundational principles of the International Childbirth Initiative or ICI). Many of our essays focus on providers’ rights and protocols, as we recognize that most healthcare settings privilege the authority of providers over mothers or their families (Davis-Floyd 2018). The maternity care models described in this volume are sustainable because they respond to and work with the ongoing social disruptions caused by shifting and intersectional dynamics of income, gender, sex, race, and power, as well as climate change, political conflict, and migration in many locations.

Each chapter in our volume explicitly addresses sustainability via a different paradigm or model of care. Sustainability can mean the ability to be scaled up or across a variety of settings from home to hospital as in our chapters on Nepal, India, Guatemala, or Mexico or across different cultural contexts such as in our chapters on Nepal, South Africa, and the United States. Sustainability should mean holistic and humanistic care that centers women’s needs and agency while mitigating provider burnout. Sustainability can imply lean and flexible maternity care that can be set up or shifted quickly when disasters or pandemics destroy or disable healthcare institutions as illustrated in Chap. 19 and during the COVID-19 pandemic (Davis-Floyd et al. 2020). Sustainability can mean adapting care so that midwives and obstetricians collaborate rather than compete, as demonstrated in Chap. 3 on sustainable breech care, Chap. 4 on sustainable transfers of care in the United States, Chaps. 5 and 14 on midwives and obstetricians collaborating in the Netherlands and India, and Chaps. 9 and 10 that describe innovative hospitals incorporating humanistic care and midwifery care in Chile and Argentina.

Sustainability should mean adopting practices that conserve costs, eliminate interventions, reduce redundancies in care, and recognize the knowledge and skill of midwives in supporting women’s health and rights. Sustainability can mean a model of doula care created by and for women of color that reduces interventions, helps women of color combat racism in hospitals, and provides employment to previously incarcerated women and women of color as illustrated in our chapter on innovative models of doula care in California, USA. Sustainability can mean improving provider skills or shifting provider practices through stakeholder participation and input, as illustrated in our chapters on India, the United States, South Africa, Argentina, and Guatemala. Sustainability can mean metrics that slowly shift maternity care in the United States towards evidence-based practices, thereby reducing iatrogenic harm and cutting costs in the United States, which has some of the highest maternity care costs and some of the worst maternal and neonatal outcomes in high-income countries (HIC) (WHO et al. 2015; UNICEF 2019). Sustainability can mean overcoming discrimination against indigenous women, women of color, and low-caste women via the provision of compassionate, skilled, and community-based care—as illustrated in our chapters on the United States, India, Mexico, Guatemala, South Africa, Nepal, Indonesia, and the Philippines. Sustainability can mean a femifocal model of care that emphasizes reproductive rights, women’s and
family’s joint needs, and continuity of care throughout the lifetime, as described in our chapter on Mexico, but echoed in many other chapters in our book.

We highlight disruption to signal that our models may disrupt the status quo or conventional balance of power between obstetricians and midwives, providers and childbearers, or hospital and home birth settings. The models of birth we describe disrupt or aim to mitigate growing health inequities, inaccessible or low-quality care, and other dysfunctions that produce excess maternal and neonatal deaths today. Our volume attends to how birth providers, mothers, and community members are disrupting conventional birth models that have never been optimal by collaborating on new practices, protocols, or ways of thinking. Every chapter in this volume responds to the systemic forces of poverty, marginalization, racism, or sexism. Our case studies adapt practices of maternity care to a fractured global landscape of rising scarcity, social inequality, and personal fragility that was only heightened by the COVID-19 pandemic or the Ebola epidemic of 2013–2015 (Davis-Floyd, Gutschow, and Schwartz 2020; Strong and Schwartz 2019; Strong and Schwartz 2016).

The birth models we explore aim to disrupt the unproductive binaries that pit people against one another instead of promoting their collaboration—providers versus patients, obstetricians versus midwives, home versus hospital providers, the state versus its citizens, public versus private healthcare, and high-resource versus low-resource communities. We present innovative birth practices, policies, and metrics that disrupt the institutional inertia that has perpetuated a landscape of shortages—of skilled providers, of evidence-based practices, or of humanized and compassionate care. Our chapters illustrate disruptive conflicts or situations yet move towards a sustainable consensus. They describe how ineffective practices are disrupted or abandoned in search of improved care that benefits and empowers women as well as providers. They privilege evidence-based solutions that disrupt outmoded medical traditions and bureaucratic hierarchies that have obstructed progress in reducing maternal and neonatal mortality and morbidity.

Our volume presents a range of community-based solutions, each adapted to specific local constraints and contexts, in order to illustrate diverse approaches to the unifying goal of improved maternal and newborn outcomes and experiences. Our volume showcases innovations that have spread from the Global South to the Global North, such as the movements against obstetric violence and abusive care that began in Latin America and have spread across the globe (Sadler et al. 2016; Bohren et al. 2015). We also address birth models that work in widely different countries, such as task shifting among midwives and obstetricians in the Netherlands, the United Kingdom, Canada, South Africa, India, Indonesia, and disaster settings. Our chapters foreground models of care that honor women’s agency and collaboration with providers and those that show collaboration among providers within existing hierarchies of institutional care. We illustrate cooperation among doulas, mothers, and communities in India and the United States and between community midwives and hospital-based midwives in the United States, the Netherlands, Canada, and South Africa. Our chapters explicitly address the need for continuity of
care between home and hospital settings or among a variety of providers such as midwives, both professional and traditional, obstetricians, nurses, and doulas.

Our birth models illustrate innovative and collaborative paradigms of maternity care that aim to center mothers, newborns, and providers in more humanized exchanges with each other. These birth models offer sustainable solutions that attend to the normal physiology of labor/delivery but also recognize obstetric emergencies while focusing on continuity of care between home and hospital, community and provider, and mother and newborn. We build on a growing awareness of the importance of compassionate care for the social and psychological well-being of mothers, families, and providers in communities shaped by the structural violence of poverty, racism, and sexism. Our volume describes the skill-building and communication required to create and manage collaborative models of care in ways that change behavior and outcomes.

We are interested in both the margins and the centers of birth work. We foreground women who have been most marginalized by conventional obstetrics—including low-income, indigenous, low-caste, and previously incarcerated women. We demonstrate the value of including community-based health workers, patient advocates, midwives, or doulas who can advocate and empower clients whose voices and agency have long been discounted by obstetric models of care. By putting midwifery care at the center of our analysis, we celebrate the holistic care that has been neglected within facilities and communities across the globe while enhancing their ability to help vulnerable mothers and their communities. We empower providers whose voices have long been discounted by medical hierarchies when we foreground midwives, nurses, dai (traditional Indian midwives), and doulas within care practices that respect their experiences as family members, community members, and workers. In short, we see the soul of midwifery as caring for others—an attitude and practice that has long been neglected in healthcare in the United States (Kleinman 2019).

We emphasize the agency and human rights of women when we illustrate how midwifery models of care can empower women and ensure birth safety even in the most remote or marginalized settings. We do not expect to overturn social and health inequalities overnight. But we do provide models that explicitly target discrimination or denial of access for the most vulnerable—usually women, newborns, and their families. When women step into healthcare facilities, they are already entering a space where their voices count less and their knowledges are less authoritative than those of the providers (Davis-Floyd and Cheney 2019; Davis-Floyd and Sargent 1997). Both the Ebola epidemic of 2013–2015 (Strong and Schwartz 2019; Strong and Schwartz 2016) and the COVID-19 crisis (Davis-Floyd et al. 2020) illustrated ways that disruptive times can make pregnant women even more vulnerable to discrimination by medical authorities, who may suspect them or their families as vectors of contagion or limit their ability to self-advocate given their need for care as well as scarcity of resources for all.

Put another way, rather than seeking a single recipe for success, we identify the key ingredients that make birth sustainable and adaptable in disruptive times. Our volume promotes a variety of models of care in which both providers and mothers
collaborate to improve outcomes and change their practices and prejudices about each other. We highlight ongoing debates over what kinds of care are most and least appropriate for improving maternal and neonatal health in communities that face high degrees of vulnerability and socioeconomic inequality. We describe models of care that can be scaled up across similar settings while offering lessons that can be applied in very different landscapes of maternity care elsewhere.

We would like to add a brief note on language. Our volume represents 50 authors describing models of birth in more than 18 countries, working with a wide range of populations, languages, and cultures. We respect the diversity of terms used to describe childbearers, mothers, and providers, by not seeking to impose uniform terms on our individual authors or within this volume. We appreciate the efforts to reduce marginalization and increase inclusivity by using nonbinary terms but also note that women are still denied voice and human rights across many parts of the globe. As such, we do not wish to abandon the term woman just yet.

### 1.2 Evidence-Based Consensus on Maternal and Newborn Health

We build on current efforts to correct previous gaps in knowledge and care provision that have privileged obstetric over midwifery care while producing excess morbidities and higher costs for low-risk women without significant benefit in maternal or neonatal outcomes. We build on a long-standing focus on “birth models that work” (Davis-Floyd et al. 2009), arguing that to understand successful models is more critical than mounting another extensive critique of birth models that produce iatrogenic harm due to lack of access, lack of high-quality care, or an overly technocratic approach (Davis-Floyd 2018). Instead, we briefly summarize a consensus around safe, respectful birth care that has shaped our findings in this volume. This consensus is articulated in a set of documents that summarize decades of research and practice within maternal and neonatal health:

- The *Lancet* series on Maternal Health 1–6 (September 2016)
- The *Lancet* series on Midwifery 1–4 (June 2014)
- The *Lancet* series on Every Newborn 1–5 (May 2014)
- The *International Childbirth Initiative (ICI): 12 Steps to Safe and Respectful MotherBaby-Family Maternity Care*

This introduction briefly describes the key principles that emerge from this consensus to illustrate the key features of sustainable models of childbirth. Rather than summarize the extensive research and findings here, we refer readers to several valuable lists:

- The 78 essential interventions in maternity care recommended for use and the 37 interventions in maternity care not recommended for use (Miller et al. 2016)
• The 72 out of 122 effective practices that fall within the midwifery scope of care (Renfrew et al. 2014) and that, if applied, could prevent 80% of global maternal and neonatal deaths (Homer 2014)
• The 20 critical interventions for newborn care (Bhutta et al. 2014)

All of these interventions have proven benefit for maternal and neonatal outcomes, yet many are still underused or inaccessible to the 140 million women who give birth every year. Despite extensive research and implementation efforts, we still have routine procedures and obstetric models of maternity care across the globe that produce known harm or little benefit for mothers and newborns. This volume calls for more sustainable models of maternity care that disrupt the previous failures of poor access, poor-quality care, and/or harmful experiences for mothers, newborns, and providers.

1.3 How the Models in This Volume Promote Maternal Health

The true engine of change in maternal health will not be the formal clinical guidelines, polished training curricula, model laws, or patient rights charters we produce. The engine will be the determination of people at the front lines of health systems—patients, providers, and managers—to find or take the power to transform their lived reality. (Freedman 2016: 2069)

Most of the chapters in our volume illustrate this claim, by showing how providers, mothers, and activists have transformed the landscape of maternity care within their region to make it more holistic, humane, and responsive to their needs. We asked our 50 contributors to describe sustainable models of birth that might solve what Freedman (2016: 2068, our emphasis) terms a “dangerous disconnect between the way the global health community has framed problems, proposed strategies, and pushed solutions, and the lived experience of people and providers.” Our volume very much follows the lived experiences of providers and families while addressing gaps in access and quality of care. Further, we attempt a “radical reappraisal” of maternal health priorities and strategies that Lancet editor Richard Horton (2016: 2068) calls for in this disruptive era of global pandemics, the climate crisis, and increasing scarcity.

Let us briefly review the four major drivers that influence current patterns of maternal mortality and morbidity (Graham et al. 2016):

1. Demographic transitions from high to low fertility and high to low mortality that still leave a high unmet need for contraception, especially in fragile settings
2. Epidemiological transitions from infectious diseases to chronic and noncommunicable diseases that influence an obstetric transition in which a declining proportion of maternal deaths are due to direct obstetric causes (i.e., postpartum hemorrhage, hypertension, sepsis, abortion, obstructed labor) while indirect
Causes of maternal mortality (i.e., preexisting medical conditions, poverty, poor nutrition) are on the rise.

3. Socioeconomic transitions including rising inequality, increased proportions of women in the workforce, and political disruptions that influence later childbearing and more chronic diseases, as noted above.

4. Environmental transitions of climate change, environmental degradation, natural and human-made disasters, and migrations that place a greater burden on women and marginalized communities.

These four shifts have produced a “grand divergence” in maternal mortality whereby the most vulnerable groups of women have been left behind (Graham and Hussein 2006). Our volume illustrates how marginalized women continue to be vulnerable to maternal mortality and morbidity and how their voices are often neglected in clinical protocols or policy frameworks. Our chapters present innovative approaches to maternity care that directly address unequal access or discrimination on the basis of race, language, ethnicity, and gender. We describe models of care that make it easier for indigenous women, women of color, and low-income women to access and afford care in India, Indonesia, the Philippines, South Africa, Nepal, Mexico, United States, Guatemala, Argentina, Germany, United Kingdom, Japan, Canada, Chile, the Netherlands, Israel, and Denmark. We just ranked our case countries according to total maternal deaths, from greatest to least, in 2017 (WHO et al. 2019). Each of our 50 contributors was asked to identify successful and sustainable models of maternity care from around the globe that promote best practices and evidence-based care.

We address the growing consensus that obstetric models alone often provide care that is either “too much too soon” (TMTS) or “too little too late” (TLTL), as Miller et al. (2016) so vividly argue. The push to provide care across thinly populated world regions with low infrastructure led to the spread of obstetric models of care without the skills to prevent overuse of interventions that cause iatrogenic harm. Given the widespread technocratic models of care that view birth as a pathology and mothers as patients whose pregnancies, labors, or deliveries require management and intervention, it is no accident that over-medicalization resulted (Davis-Floyd 2003, 2018; Wagner 2004; Davis-Floyd and Cheney 2019). Instead of TMTS or TLTL, we recommend RART maternity care, or the “right amount at the right time” (Davis-Floyd and Cheney 2019).

We will not list the 78 evidence-based interventions recommended during antepartum, intrapartum, and postpartum care, but we will dwell briefly on the 37 common interventions that are not recommended because they are so pervasive, despite the fact that they produce more harm than benefit, as Miller et al. (2016) remind us. We believe that every reader of this volume needs to be reminded that these interventions are not recommended yet a sizeable fraction of the 140 million women who give birth each year will suffer them, due to provider ignorance, disregard, or disrespect.

For antenatal care, the list of contraindicated interventions includes routine 24-week ultrasounds, many routine screening tests including for preterm pregnancy,
placental growth factor, gestational diabetes, Doppler velocimetry for uteroplacental circulation, and tests for bacterial vaginosis, chlamydia trachomatis, cytomegalovirus, periodontal disease, and for anti-A and anti-B antibodies in low-risk, asymptomatic women. Most tellingly, routine involvement of obstetricians or gynecologists during pregnancy is not recommended for improved perinatal results (Miller et al. 2016). As we see in our chapters on Latin America, the United States, and other high-resource countries, obstetricians still attend many pregnancies, and many of these routine screenings are applied to low-risk women with high costs but little benefit.

For **intrapartum care**, the interventions to be avoided include routine speculum exams, routine cardiotocography, routine fetal pulse oximetry, routine amniotomies, and routine oxytocin augmentation (Miller et al. 2016). Obstetrician and Professor of Maternal-Fetal Medicine at Harvard Michael Greene (2006) directly referenced the way that technocratic obstetrics was hoping for a deus ex machina (the title of his essay) from the recently adopted intervention of fetal pulse oximetry (which measures fetal oxygen levels during labor via a cap placed on the fetal scalp) that would replace the older, ineffective technology of electronic fetal monitoring (EFM). In an opinion piece for the *New England Journal of Medicine* that was widely picked up by the *New York Times* and other news sources across the United States, Greene argued (2006: 2248) against fetal pulse oximetry, doubting its ability to “mitigate the unintended and undesirable consequences of our last ineffective, but nonetheless persistent technological innovation.” In an interview I conducted shortly after his opinion piece was published, Greene implied that continuous EFM was a cost-saving protocol that contributed to an unfortunate rise in cesareans with little disregard for the maternal morbidity this involved.¹

As Gutschow, Dolma, and Gonbo describe in Chap. 14, the use of EFM has directly led to a rising cesarean rate at the award-winning hospital in Leh, India, where the maternal mortality ratio (MMR, maternal deaths/100,000 live births) over the past 20 years has been lower than Argentina’s and only a fraction of the all-India MMR for the same period (Gutschow and Dolma 2012, Gutschow 2011). Yet, unlike many public and private hospitals across India and the globe, where rising cesarean rates that remain under 30% are ignored, the team of obstetricians engaged in collaborative and concerted efforts to identify provider-related bias and address their cesarean rate and improve maternity care overall.

For **postpartum care**, routine palpation of the uterus in the absence of bleeding, routine antibiotics for low-risk women, aspirin for thromboprophylaxis, and vitamin A supplementation are not recommended. Despite significant evidence that all of these interventions cause harm or have little or no maternal or perinatal benefit, they are prevalent throughout low-, middle-, and high-income countries, while the guidelines around their use remain confusing (Miller et al. 2016).

¹ Gutschow interviewed Greene December 2006 about the overuse of EFM and other interventions in obstetrics. He acknowledged the predicament of reducing continuous EFM for women in labor with intermittent auscultation given the shortage of labor/delivery nurses, whose labor is more expensive than machines.
Our chapters illustrate some of the efforts to curtail the most dramatic examples of overused interventions that cause iatrogenic harm such as cesareans, labor induction, and labor augmentation in Latinx countries, India, and South Africa. Their overuse is not consistent but can vary considerably among countries, regions, individual facilities, or even providers. For instance, a single facility or region may have TMTS care for wealthy or elite women in the form of too many augmentations, inductions, and/or cesareans, even as marginalized women may be denied access to lifesaving care and treatment—as evidenced in our chapters on Guatemala, South Africa, India, and the United States. Our chapter on the dais (traditional midwives) of India indicates that tribal and Dalit women may be denied cesareans or other lifesaving interventions, even as they receive routine amniotomies or episiotomies that provide little or no benefit at the same facilities. Our chapter on Guatemala shows that indigenous women often do not receive timely care, as they are made to wait outside facilities or denied entrance even when presenting with life-threatening complications such as severe eclampsia. Our chapters on Mexico, Argentina, and Chile demonstrate that many women are treated with disrespect and abuse and/or are subjected to unnecessary cesareans and other interventions when they are deprived of midwifery care.

We cannot cover every country or every failure of care in this volume. But we do aim to build on existing knowledges, provide ways to correct past mistakes, and move beyond the bureaucratic inertias that have left so many women and newborns without adequate care.

1.4 How Our Volume Promotes the Midwifery Model of Care and Supports Marginalized Groups

Governments and policy makers can no longer pretend to provide life-saving care, using phrases such as skilled birth attendant and EmOC [Emergency Obstetric Care] to mask poor quality; skill and emergency care need to actually be provided, adequate numbers and training of staff should be ensured, capability and basic infrastructure of facilities should be improved, timely referral should be ensured where necessary, and women should get appropriate high quality content of care. (Campbell et al. 2016: 2203)

The state of affairs that Campbell et al. (2016) document across the globe is reflected in our volume as well. The policy of simply counting percentage of births in facilities or percentage taking place with a skilled birth attendant has proven unreliable at best and disastrous at worst, as there are too many places in the world where facilities lack skilled providers, essential medicines, proper protocols, or even the basic infrastructure of electricity and water. Our volume addresses these gaps by highlighting models that do include providers and community members in the design of and decision-making about their innovative models of care. For example, Chap. 11 and Chap. 16 describe new models that provide continuity of care between community and clinics, as well as between families, communities, and midwives in Mexico and Nepal, respectively. Our volume addresses the problems of
marginalization, referral, and collaboration between midwives and obstetricians, and other challenges that lurk under the surface of the more pervasive gaps in care identified by this and other global surveys. Chapter 12 and Chap. 15 describe systems that help indigenous women self-advocate and improve their access to care in countries where they often receive suboptimal care or are denied access to facilities such as Guatemala and India.

We know that a more universal application of the midwifery model of care could avert more than 80% of the world’s maternal deaths, newborn deaths, and stillbirths (Homer 2014). Even in high-income countries, skilled and compassionate midwifery care could reduce maternal deaths by 30%, a considerable feat given how low maternal mortality ratios already are in those countries (Shaw et al. 2016). This news should not be surprising, given the known iatrogenic harm and excess deaths produced by over-medicalized obstetric models of care in high-income countries (Koblinsky et al. 2016). Further, we know that many of the recommended interventions to improve maternal and neonatal outcomes lie within the midwifery scope of care (Renfrew et al. 2014; Hoope-Bender et al. 2014).

Yet midwives have been sidelined in the United States—which has the worst maternal outcomes in the OECD—as well as in India and Brazil, where cesareans in private facilities have risen to shocking levels and maternal mortality has not declined as rapidly as hoped (Renfrew et al. 2014). Three middle-income countries—India, China, and Brazil—which collectively account for one-third of the world’s births, have largely ignored midwifery care while promoting a culture of intervention and obstetric models of birth (Renfrew et al. 2014). More than 15 years of evidence-based studies proving the safety of planned, midwife-attended out-of-hospital births in North America (Cheney et al. 2014; Daviss and Johnson 2005) have made little impact on obstetric hegemony and dominance. Even as COVID-19 prompted women in the United States to seek out-of-hospital (OOH) births and some public hospitals in New York turned women away, ACOG failed to advocate for the safety of OOH births (Davis-Floyd et al. 2020).

We have two chapters on India, where an annual 27 million births and 35,000 maternal deaths account for one-fifth and one-eighth of the world’s births and maternal deaths, respectively (WHO et al. 2019). Both chapters illustrate high-quality models of care in rural India that promote reproductive rights, women’s agency, and experiences and integrate midwifery models of care in ways that promote excellent maternal and neonatal outcomes within indigenous communities who fall under designations known as Scheduled Tribe (ST) or Scheduled Caste (SC). Although these populations often have some of the worst maternal and newborn outcomes in India due to lack of access to care, one of our chapters on India illustrates highly humanistic community-based traditional midwives known as dais who produce better outcomes than regional or national averages. Our other chapter on Ladakh, India, highlights a humanistic hospital providing optimal care that has received India-wide recognition for its outstanding care in a remote mountain region where 90% of the population has ST status. Other chapters in our volume also highlight sustainable, scalable, community-based models of midwifery care that privilege the agency of
marginalized or indigenous communities while providing excellent outcomes in some of the most remote districts of Nepal, Guatemala, and Mexico.

We build on the awareness that the push towards facility-based birth and skilled birth attendance has often not focused on quality of care. The WHO (2006) has defined “quality of care” as care that is “safe, effective, timely, efficient, equitable, and people-centered.” Each of these terms can be further broken down to promote a multidimensional concept that is carried out within a healthcare system through service delivery, health workforce, information, medical products, vaccines, technologies, financing, and leadership/governance. Our chapters illustrate that improving quality will require addressing two “blind spots” in global maternal health policy and practice (Van Leberghe et al. 2014; Miller et al. 2016):

- Quality care means skilled, respectful, and person-centered care.
- Understanding and mitigating over-medicalization must become a key priority.

Our models go further in illustrating how collaborations among communities, providers, activists, and policy makers directly harness women’s agency, authority, and empowerment within the realm of maternity care. We recognize that women’s birth experiences, including medically induced traumas, can stay with them for a very long time (Gutschow 2016a; Gutschow 2011, Davis-Floyd 2018; Davis-Floyd and Cheney 2019; Strong and Schwartz 2019).

Our volume builds upon the key finding that for many middle- and low-income countries, “care led mostly by obstetricians without the balance that midwives bring to the health system might reduce mortality and morbidity but might also reduce quality and increase cost” (Renfrew et al. 2014: 1140). We argue that in both middle- and high-income settings, care by obstetricians alone has at times increased mortality and morbidity, as well as cost, at the expense of quality and woman-centered care. We also know that unnecessary interventions in maternity care cost the United States $18 billion each year (Conrad et al. 2010).

As Davis-Floyd et al. (2020) have shown, US maternity care providers responded to the COVID-19 crisis with radical shifts. Some hospital-based providers became more willing to acknowledge the safety of out-of-hospital births as clients inundated birth centers and OOH midwives with requests to transfer their care. Further, New York’s governor Cuomo issued executive orders to allow licensed home birth midwives from other states and Canada to practice in New York State, in order to increase OOH birthing options. Our volume demonstrates that when midwives, doulas, and birth activists work together with communities, they can create sustainable solutions that disrupt the dominant models of obstetric care that contribute to excess mortality, morbidity, and costs.

1.5 How We Promote Newborn Health and Survival

Our chapters on India, Nepal, and Guatemala each illustrate how universal rollout of essential newborn care (ENC) needs to intersect with improved maternal care, as there are interactive effects between maternal and neonatal complications. In many
low-resource settings, there may be only one (or no) skilled provider who can attend to both newborn and maternal emergencies, which causes delay or gaps in care. While ENC provision costs little, it requires training, motivation, and knowledge transfer to be systematically and universally applied across the developing world. Yet coverage is often lacking in the high mortality settings where ENC is needed most. In South Asia, less than 5% of all facility-based births have access to neonatal intensive care.

Globally in 2018, there were 2.5 million neonatal deaths and 2.6 million stillbirths (UNICEF 2019). The relationship between maternal deaths and neonatal deaths relates to cause and timing. Around 40% of all neonatal deaths, 40% of stillbirths, and 46% of maternal deaths occur during labor, delivery, or the first day of newborn life (Lawn et al. 2014). Half of all stillbirths occur intrapartum and are closely related to early neonatal deaths (Lawn et al. 2014). In 2018, the three leading causes of neonatal mortality—preterm birth complications (35%), intrapartum-related complications (24%), and sepsis (15%)—accounted for three-quarters of all newborn deaths (UNICEF 2019). The remaining quarter of newborn deaths were caused by congenital abnormalities (11%), pneumonia (6%), tetanus and diarrhea (1%), and other factors (7%), including iatrogenic factors related to poor newborn care (UNICEF 2019). Around three-fourths of newborn deaths occur in the first week of life. High-quality care during labor, delivery, and the immediate postpartum period is likely to have a triple return in reducing maternal deaths, neonatal deaths, and stillbirths (Tuncalp et al. 2015). Our chapters on India, Nepal, Argentina, Chile, Mexico, the Netherlands, and disaster settings each describe midwifery models of care that promote optimal maternal and newborn outcomes, including routine or basic intrapartum care, newborn resuscitation, essential newborn care, and breastfeeding.

Neonatal deaths (during the first 28 days of life) account for almost half (47%) of all under-five child deaths globally (UNICEF 2019). The share of under-five deaths that occur in the neonatal period varies: for South Asia it is 62%, for Europe and North America it is 54%, and for sub-Saharan Africa it is 36%. Survival hardly guarantees good health for the most vulnerable newborns. Besides mortality, each year roughly 19 million newborns develop life-threatening conditions that have long-term sequelae, including intrapartum-related brain injuries, severe sepsis, and pathological jaundice (Lawn et al. 2014).

In 2010, of the 15 million babies born preterm—before 37 weeks—more than one million died of preterm birth complications and another million died of causes where preterm birth is a risk factor, such as neonatal sepsis or intraventricular hemorrhage (Lawn et al. 2014). Of the 13 million preterm babies who survived, 4.4% will have mild neurodevelopmental impairment, and 2.7% will have severe impairment, often for life (Lawn et al. 2014). The long-term effects of being born preterm or small for gestational age (SGA) are still being quantified but include high risk of insulin resistance, greater glucose intolerance, hypertension, obesity, and other non-communicable diseases (Lawn et al. 2014). Chapter 14 on Ladakh, India, and Chap. 19 on Helping Babies Breathe explicitly discuss low-tech and low-cost training in
newborn resuscitation and essential care for preterm, small, or sick newborns that have saved millions of lives since their rollout in the past decade.

Being born SGA—defined as under 10% of the normal birth weight for a particular gestational age and sex—adds a further risk of mortality. There are roughly 20 million babies born each year with low birth weight, either because they are preterm or SGA (Lawn et al. 2014). In South Asia alone, 40% of all births are SGA. Preterm SGA babies are 15 times as likely to die, and SGA babies born at term are nearly twice as likely to die as babies born average for gestational age (Lawn et al. 2014). Roughly 800,000 neonatal deaths are due to SGA, and another 800,000 neonatal deaths are due to suboptimal breastfeeding (Lawn et al. 2014). Statistically, male babies have a higher biological risk of life-threatening neonatal complications such as prematurity, severe sepsis, and intrapartum-related encephalopathy. Yet in countries like India where female newborns receive less or suboptimal care, this advantage for female survival is cancelled out, and newborn survival is higher for males than for females (Lawn et al. 2014; Darmstadt et al. 2015).

Rates of prematurity are increasing in both high- and low-resource countries and ranged from an average of 5% across high-income countries (HIC) to 25% in low- and middle-income countries (LMIC) in 2010 (Simmons et al. 2010). The causes of preterm birth include a range of preconception risk factors such as birth spacing, maternal diet, maternal malnutrition, genetic and epigenetic factors, as well as the poor management of maternal risk factors such as diabetes, anemia, hypertension, obesity, smoking, urinary tract infections, HIV and other STDs, and poor mental health (WHO 2012; Blencowe et al. 2012). They also include a range of pregnancy-related complications such as multiple pregnancies, young or advanced maternal age, and the use of artificial reproductive technologies (WHO 2012).

As we discuss in Chaps. 14 and 19, the total costs of providing essential newborn care (ENC) are remarkably low and the survival benefits unquestionable, even as universal implementation is ignored in many low- and middle-income countries (LMIC). ENC is defined as immediate drying and stimulation of newborns, skin-to-skin care—often called kangaroo mother care (KMC)—hygienic cord care, delayed cord cutting, hand washing, immediate breastfeeding, vitamin K prophylaxis, and neonatal resuscitation for babies not breathing at birth (Lawn et al. 2014; St. Clair et al. 2014). Studies have shown that proper cord care can reduce neonatal mortality by 23%, that early breastfeeding reduces neonatal deaths by 44%, and that skin-to-skin care can reduce 20% of neonatal deaths caused by preterm complications in low-resource settings (Bhutta et al. 2014). The newborn resuscitation training that we explore in our chapter on Ladakh, India has been proven to reduce intrapartum-related neonatal deaths by 30% and early neonatal deaths by 38% (Bhutta et al. 2014) across the globe.

Our chapters on India, Nepal, and Guatemala each illustrate how the universal rollout of ENC needs to intersect with improved maternal care, as there are interactive effects between maternal and neonatal complications. In many low-resource settings, there may be only one (or no) skilled provider who can attend to both newborn and maternal emergencies, which causes delay or gaps in care. While ENC provision costs little, it requires training, motivation, and knowledge transfer to be systematically and universally applied across the developing world. Yet coverage is
often lacking in the high mortality settings where ENC is needed most. In South Asia, less than 5% of all facility-based births have access to neonatal intensive care.

1.6 Counting Maternal and Neonatal Mortality in Our Case Countries

Maternal and neonatal mortality have long been used to index the quality of maternal and neonatal health in given countries, as well as to express the magnitude of the problem to policy makers and the public. Indeed, maternal deaths are often thought of as representing a canary in a coal mine in terms of recognizing how well health systems are functioning (Declercq and Shah 2018). Put differently, if 295,000 women across the globe are still dying each year (WHO et al. 2019) from an ordinary physiologic process—childbirth—because of complications that are mostly treatable and/or preventable, something must be terribly wrong. Our volume explores the structural violence of poverty, sexism, racism, and other social factors that contribute to these maternal deaths. Before we discuss the maternal and neonatal mortality in our case countries, let us briefly discuss the counting of deaths, a topic that has only grown in significance during the COVID-19 pandemic.

The state of maternal mortality in the world today—mostly underestimated and mostly avoidable—is clear evidence that what you count is what you do. (Graham and Hussein 2006: 235, emphasis theirs)

Critically, the very countries and regions that produce the most maternal deaths also have the least reliable methods of counting those deaths, because those same countries also tend to have the weakest civil registration systems (Byass and Graham 2011; Gutschow 2016b). Whether it is maternal deaths or deaths from COVID-19, counting matters because governments and policy makers need to agree if deaths are rising (and policies may be failing) or if the deaths are falling (and policies perhaps succeeding) in a specific country, region, or city (Gutschow 2016b). Further, mortality estimates need to be contextualized with “bottom-up, community-based research” (Byass and Graham 2011: 1120), as our volume illustrates. As COVID-19 has shown, estimates of mortality themselves constitute a public health intervention with real and measurable effects. In maternal healthcare as in pandemics, to count deaths is to intervene in the policy realm where decisions are made (Gutschow 2016b). If a city, state, or the CDC undercounts maternal deaths or COVID-19 deaths and makes policies assuming deaths are declining when they are actually rising, then the initial act of undercounting is an intervention that forms the basis for future interventions that may not have their intended effects. In sum, inaccurate counting can lead to failed policies (Gutschow 2016a, b).

The WHO (2019: 10) defines a maternal death as “the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from unintentional or incidental causes.” It also defines a late maternal death as “direct or indirect maternal deaths occurring from 42 days to 1 year after termination of pregnancy.” Gutschow (2016b) discusses the salient issues surrounding these definitions and arguments for the more recent term, late maternal death.
Further, mortality averages—at global, country, or even regional levels—obscure further inequalities within those averages, which must be identified and named. Thus, the gaps in maternal mortality ratios and in skilled attendance at birth between the richest and poorest nations are as important as the gaps within a single country between the upper wealth quintile and the poorest wealth quintile. These in-country inequities are discussed in our volume and should be kept in mind as we turn to mortalities in our case countries. We consider the latest WHO estimates of annual maternal deaths and neonatal deaths (Figs. 1.1 and 1.3) across our case countries, as well as maternal mortality ratios (MMR, maternal deaths/100,000 live births) and neonatal mortality ratios (NMR, neonatal deaths/1000 live births) (Figs. 1.2 and 1.4). Total maternal deaths and MMR are directly influenced by a country’s total fertility rate (TFR), population size, and maternal mortality ratio. The log scales we provide illustrate the wide range of total annual maternal and neonatal deaths across our case countries (see Figs. 1.1 and 1.3).

Both India and the United States are outliers with outsized shares of maternal and neonatal deaths. India, with its 1.28 billion people, 27 million births, 35,000 maternal deaths, and 549,000 neonatal deaths per year (Figs. 1.1 and 1.3), is home to 17% of the world’s population, 20% of the world’s live births, 15% of its maternal deaths, and 27% of its neonatal deaths (WHO et al. 2019; UNICEF 2019). With its 750 maternal deaths, the United States had 14 times the maternal deaths of Japan in 2017, yet only triple the population (Fig. 1.1). With an MMR of 19, the United States ranks first in MMR in the OECD and roughly 3–7 times the MMR of our other high-income case countries like Israel, Japan, Germany, the Netherlands, Denmark, and Canada (Fig. 1.2). Further, unlike almost every high-income country where maternal mortality decreased between 2000 and 2017, in the United States the maternal mortality ratio increased by 58% (WHO et al. 2019).

![Fig. 1.1 Total maternal deaths in 2017 in our case countries. (Data from WHO 2019)](image-url)
Because the United States and India represent such outsized proportions of the global burden of maternal and newborn deaths (Figs. 1.1 and 1.3), they have been the focus of scrutiny and critique of their maternity care (Gutschow 2016b). Each has faced accusations of human rights abuses in their poor maternity care from the...
world’s leading human rights organizations—Amnesty International (2010) for the United States and Human Rights Watch (2009) for India. These two reports offer scathing testimony of the denial of access to care, poor quality of care, as well as systemic inequities in outcomes within these countries and systemic undercounting of maternal deaths (Amnesty International 2010; Human Rights Watch 2009).

India’s total newborn deaths are so much higher than those of any other nation that only a log scale could accommodate its numbers and those of the high-income countries (HIC) in our volume (Fig. 1.3). Because the Netherlands, Israel, and Denmark each had fewer than 1000 deaths in 2018, which are not rounded up, they show up as 0, while Japan and Chile show up as 1 on our log scale. The contrasts among neonatal mortality ratios in our case countries reveal that Chile ranks ahead of the United States and that the United States is not far ahead of Mexico or Argentina (Fig. 1.3). Besides producing more newborn deaths than Nepal or South Africa, the United States has far higher NMR and MMR than other HIC.

1.7 Conclusion: The Three Sections of Our Volume

The first section of our volume focuses on high-income countries (HIC) that illustrate the remaining challenges of building more inclusive, holistic, and collaborative models of care that transcend ongoing disparities and hierarchies. The chapter by Davis explains why and how holistic models of midwifery care and education enable
the collaboration and agency of both mother and midwife far more effectively than technocratic models of education or care. Daviss, Hedditch, Krishnan, and Barnes explore new models of upright breech delivery that involve cooperation and collaboration between midwives and obstetricians skilled in the knowledge of physiologic birth. Dunham and Hall’s chapter on sustainable transfers of care from home to hospital argues for improving collaborations between transferring and receiving providers, as well as for continuity of care and support personnel where possible, so as to avoid unnecessary duplication of care and unnecessary interventions. Bommarito explores the remarkable flexibility and collaboration achieved between midwives and obstetricians in the Netherlands that effectively maintains their well-integrated maternity care system. Bakal and McLemore show that doulas working among women of color, some previously incarcerated, can empower their clients and each other to begin to counter the systemic racism in maternity care in the United States. Pine and Morton argue that improved metrics for measuring the quality of maternity care can be used to improve maternal outcomes across the United States. Teman and Berend show how lessons from sustainable surrogacy in Israel might apply to the US context. Each of these chapters extends the lessons learned about how to promote woman-centered care and improve metrics on maternal outcome accountability and counting (Shaw et al. 2016; Gutschow 2016a, b).

Our second section on Latin American countries privileges a variety of radical solutions to a pattern of obstetric violence, disrespectful care, and overly medicalized care that does not provide equal access for indigenous or low-income women. Sadler, Leiva, and Gomez illustrate how the movement towards humanized childbirth and against obstetric violence in Latin America influenced Chile’s slow shift towards woman-centered, compassionate care. Jerez shows how activists and providers in Buenos Aires, Argentina are making radical changes in maternity wards to humanize birth, advocate for reproductive rights, and promote gender and sexual diversity, as well as to overcome gender-based violence. Alonso, Lopez, Lucas-Danch, and Tryon illustrate a “femifocal” model in Mexico that offers humanized, high-quality continuity of care across the life cycle that includes well-woman care, gynecological care, and alternative therapies. Austad, Chary, Hawkins, Martinez, and Rohloff show how trained patient advocates can help indigenous clients and their midwives negotiate for improved care at Guatemalan institutions where they often have been denied access or given substandard care.

Our third section addresses maternal and newborn care in low- and middle-income countries (LMIC). Macauley and van den Broek argue that global efforts to improve maternal care quality must include the use of midwifery models of care and quality audits to improve accountability in providing emergency obstetric care in rural and low-income settings. Aneji and Little explore the development of three sustainable, low-tech curricula: Helping Babies Breathe (HBB), Essential Care for Every Baby (ECEB), and Essential Care for Small Babies (ECSB); these programs are addressing the main causes of neonatal mortality in low-resource settings. Gutschow, Dolma, and Gonbo illustrate how two female obstetricians and one pediatrician in a remote Himalayan region of India have overseen 40 years of remarkable maternal and newborn outcomes—including the creation of the region’s most advanced special newborn care unit—at a humanistic and award-winning public
hospital. Roy, Qadeer, Chawla, Sadgopal, and Gautam show how dais in four Indian districts provide skilled, high-quality, responsive, and culturally safe humanized care to mothers and newborns that contrasts sharply with the poor-quality, often abusive care that regional facilities provide. Adams, Craig, Samen, and Bhatta describe a network of safety model that integrates maternal and newborn care while staying responsive to local community needs, cultural practices, and differing Hindu and Buddhist beliefs within the Nepal Himalayas. MacDougall traces how a midwifery model of care can transcend both public/private and Black/White binaries within the landscape of maternity care in post-apartheid South Africa. Davis-Floyd, Lim, Penwell, and Ivry describe a low-tech, flexible, and mobile model of midwifery care that has been sustainably applied in multiple disaster settings, such as the 2004 tsunami in Aceh, Indonesia, the 2017–2018 volcanic eruptions in Bali, Hurricane Yolanda in the Philippines, and after the Great Sendai earthquake and tsunami in northeast Japan on March 11, 2011.

In our conclusion, we coeditors (Gutschow, Davis-Floyd, and Daviss) discuss how low-tech, high touch, and flexible models of midwifery care offer woman-centered and humanized care that mothers and newborns need in these disruptive times of climate crisis and pandemics. We return to the themes of sustainability and disruption while extending the lessons learned in our chapters about sustainable birth models that can improve outcomes and experiences for mothers, newborns, and providers.

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Appendix: The 7 Foundational Principles and 12 Steps of the International Childbirth Initiative (ICI): Promoting MotherBaby-Family Maternity Care

Our volume builds upon a recent focus on woman-centered and family-centered care based on women’s rights that is epitomized in the International Childbirth Initiative (ICI): 12 Steps to Safe and Respectful MotherBaby-Family Maternity Care. In this Appendix, we briefly present these 12 Steps as well as the foundational principles that they are based on. The ICI was created by two global organizations—the International Federation of Gynecology and Obstetrics (FIGO) and the International MotherBaby Childbirth Organization (IMBCO)—and was formally launched in October 2018 at the FIGO World Congress in Brazil (Lalonde et al. 2019). The ICI, whose wording Davis-Floyd and others helped craft, has been endorsed and adopted internationally by multiple international organizations and
maternity care practices, including several described in this volume. Its proposed MotherBaby-Family Maternity Care Model embodies the following seven foundational principles:

1. **Advocate rights and access to care.** This principle recognizes women’s and children’s rights as human rights and attempts to ensure that all women, regardless of background, education, citizenship, age, or health status, have equal access to high-quality, affordable, or free maternity care. The principle uses the word “background” to index race, income, and ethnicity—three key variables that structure access to maternity care and produce significant health inequities within and between populations (Graham and Hussein 2006; Marmot et al. 2012).

2. **Ensuring respectful maternity care.** This principle insists on respect and compassion for all women as the foundation of maternity care and aims to protect women from abusive or disrespectful care, which remains prevalent and often unrecognized across the globe, in both high-income countries (HIC) and low- and middle-income countries (LMIC).

3. **Protecting the MotherBaby-Family triad.** This principle aims to treat the mother, baby, and family as a unified triad, even as it privileges the MotherBaby dyad as an essential unit. While the principle states that the woman should be the ultimate decision-maker and that shared decision-making is an aspiration, this principle could have more strongly worded guidance for when mothers and their families or communities disagree or where some women lack agency and informed choice in relation to reproductive rights, such as in extremely pronatalist societies or regimes (Goldberg 2009; Bongaarts and Guilmoto 2015).

4. **Promoting wellness, preventing illness and complications, and ensuring timely emergency referral and care.** This principle acknowledges that most labors and deliveries are normal physiologic events that most often require only supportive care for mother and newborn and that most pregnancy-related and newborn complications can be treated or prevented with timely emergency care.

5. **Supporting women’s autonomy and choices to facilitate a positive birthing experience.** This principle aims to assure laboring women continuity of supportive care, access to evidence-based information, and the ability to make informed choices, including about place of birth. The principle explicitly states that women with low-risk pregnancies can safely birth at home, birth centers, or clinics—which is where 65% of the world’s births still take place. Notably, this principle affirms low-risk women’s right to out-of-hospital (OOH) or community birth, their right to continuous labor support and information about evidence-based care, while trying to “reduce the risk of psychological trauma” (Lalonde et al. 2019: 67). The mention of psychological trauma hints at pervasive patterns of obstetric violence and abusive care, which are routine in many hospitals across the world today and which our volume addresses.

6. **Providing a healthy and positive birthing environment: The responsibilities of caregivers and health systems.** This principle affirms that the birthing environment and caregivers’ attitudes and practices influence a woman’s confidence and ability for a healthy birth and a healthy newborn, with potential lifelong conse-
quences for both. It expressly notes that a caring and supportive atmosphere can be enhanced or diminished by every caregiver she encounters, encouraging listening to the mother and her family and women’s self-expression. This principle also states that the needs of MotherBaby must take precedence over the needs of providers, even as it acknowledges that providers themselves require supportive maternity care systems within which to function. This principle reaffirms the importance of the relationships between mother and provider, between provider and family, as well as among the providers within a healthcare system. It recognizes that providers can vary—some can be respectful while others are not—and that the structural factors influencing quality of maternity care can be wide-ranging, including whether there are providers who have the skills, essential supplies, and support to care for the MotherBaby dyad.

7. Using an evidence-based approach to maternal health services based on the MotherBaby-Family Maternity Care Model. This principle insists that mother and newborn be given only evidence-based care and explicitly be “protected from unnecessary and potentially harmful interventions, practices, and procedures, and from both overuse and underuse of medical technology” (Lalonde et al. 2019: 67–68). It affirms a broader theme raised by Miller et al. (2016), who warn against care that is “too much too soon” (TMTS) and causes iatrogenic harm or “too little too late” (TLTL) and fails to offer timely benefit when it should have. This principle affirms the value of physiologic labor against the overuse of technology in an effort to save costs and optimize health outcomes for mother and baby. It also notes that the MotherBaby-Family care model can be used in all settings by all providers, even during obstetric or neonatal complications. As such, it affirms that compassionate, evidence-based care should always be the priority, regardless of birth setting or provider, and that even obstetricians can provide midwifery model care.

The ICI 12 Steps to Safe and Respectful MotherBaby-Family Maternity Care

(abridged, see www.internationalchildbirth.com for full text):

1. Provide respect, dignity, and informed choice in care to every woman and her family.
2. Provide free or affordable care with cost transparency for prepartum, intrapartum, and postpartum care.
3. Routinely provide MotherBaby-Family maternity care to all clients so as to optimize the biopsychosocial processes of childbirth, with multidisciplinary collaboration with other providers during obstetric or neonatal complications.
4. Offer continuous support in labor and delivery with doulas, partners, and/or TBAs so as to optimize safe vaginal delivery with fewer analgesics and better Apgar scores.
5. Provide drug-free pain relief measures such as breathing, touch, massage, relaxation, and water immersion if possible. If pharmacological pain relief options are available or requested, explain their benefits and risks.

6. Provide evidence-based practices including but not limited to:
   - Allowing labor to unfold at its own pace
   - Providing mothers access to food/drink as needed during labor
   - Ensuring that women have access to care and well-being in early labor but refrain from admitting women until they are in active labor
   - Supporting labor by allowing women to walk and move about freely and choose the birthing position of their choice as well as tools supportive of upright positions
   - Providing mothers with privacy during labor and delivery
   - Training staff to safely deliver breech babies vaginally or turning them to cephalic lie if possible
   - Facilitating immediate and sustained skin-to-skin contact between mother and newborn for warmth, stimulation, and breastfeeding
   - Delaying cord clamping to facilitate nutrient transfer from mother to newborn
   - Carrying out all elements of essential newborn care including allowing mothers to have skin-to-skin contact and breastfeed preterm babies where possible.

7. Avoid harmful practices such as:
   - Episiotomies
   - Enemas
   - Routine sweeping or artificial rupture of membranes
   - Frequent vaginal exams
   - Supine or lithotomy position
   - Keeping mother in bed or immobilized
   - Caregiver-directed pushing
   - Fundal pressure
   - Immediate cord clamping
   - Separation of mother/baby
   - Withholding of food/water from mother

8. Enhance wellness and prevent illness by providing access to:
   - Clean water, clean toilets, and WASH (water, sanitation, hygiene) measures
   - Education on and treatment or prevention of HIV, malaria, tetanus, syphilis, hepatitis B, and toxoplasmosis
   - Family planning services and reproductive rights
   - Culturally sensitive and competent prenatal education
   - Adequate education around postnatal and neonatal care before discharge

9. Provide emergency care and transport to skilled emergency care for life-threatening complications, including referral and consultation with tertiary centers as needed.
10. Have a supportive human resource policy that ensures a respectful and positive workplace to aid in retention of skilled staff.
11. Provide a continuum of care for mother and newborn during pregnancy, labor, and delivery that links mothers to all providers including traditional birth attendants and educators within a multidisciplinary care system.
12. Promote breastfeeding and skin-to-skin contact between mothers and newborns according to the 10 Steps of the Baby-Friendly Hospital Initiative.

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