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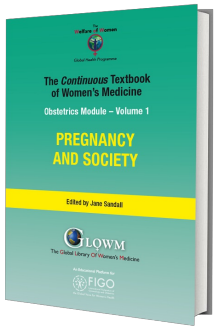

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Chapter

Birth Systems across the World: Variations in Maternity Policy and Services across Countries

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INTRODUCTION

Contemporary formalized birth systems vary greatly across the world, expressing underlying national or regional political, economic and cultural variations. The roots of the oldest of contemporary birth systems lie in the emergence of modern states and their often pronatalist population policies. 'Pronatalism' in social policy refers to measures intended to stimulate a higher birth rate in the interest of the nation. Maternity policies were among the first social policies that early welfare states launched in Northern Europe and North America under governments that wanted to improve children's and mothers' chances for survival and, more recently, increase the birth rate.[1,2] Non-health measures included modest maternity benefits that lowered the cost of birth services and perhaps even compensation for lost income during the postpartum period. Most importantly from a contemporary perspective early maternity policies formalized maternity care service provision through regulation, state subsidies or compulsory insurance schemes.[3]

On a global perspective, these developments were largely limited to high-income countries. Most affluent countries, with the notable exception of the United States of America (USA), have long established systems (some are more than 100 years old) that universally cover much of the cost of midwifery and obstetric care for all women.[4] The birth systems in middle- and low-income countries generally involve a similar promise, but tend to fall short on providing quality care, or even access to care at all.[5] In the USA, where the health care systems builds largely on private insurance, dominant

national policies tend not to recognize childbearing as a social issue. Rather, maternity care and health care policies treat childbearing as a medical issue and the provision of services is much more focused on a medical model of pregnancy and childbirth than a more social one.[6] When recognition of the social aspects of childbearing are missing, it is not surprising that access to maternity care tends to be structured by similar inequalities as medical care.

This chapter examines the global variation of birth systems in order to explain why maternity policy and service provision varies across countries. We begin by discussing (1) the politics of childbearing, moving on to (2) the funding of birth systems; and (3) the culture of maternity care. We analyze birth systems by identifying these three dimensions; however, this separation is largely analytical, as economy and politics do not exist 'outside' of culture, and both cultural and funding decisions are often political. While we develop our argument at a general level, no single birth system can be treated as the norm. To address the need to emphasize global variation rather than similarities, each section includes examples from countries across the world. We conclude by considering birth systems from the perspective of social justice, considering the dynamics of convergence and divergence in contemporary birth systems. We end by arguing that persisting, deep-rooted inequalities in birth systems need to be accounted for in obstetric and midwifery practice. Finally, we offer a set of recommendations for practice.

POLITICS OF CHILDBEARING

The politics of childbearing differ greatly globally, as do birth systems, that is, the social, political, economic and cultural arrangements surrounding childbirth.[4,5] Addressing the politics of childbearing which underpin contemporary European state-centered birth systems, we argue that several of their political tensions can be found in other types of birth systems, too. This is relevant from a social justice perspective, as the sophisticated maternity care approaches of the state-centered birth systems in countries like the United Kingdom (UK), The Netherlands and Finland (for an example, see Fact sheet 1, *Childbearing and maternity care in Finland*) tend to constitute the gold standard of maternity care, thanks to the impressive results achieved in maternal and infant health. We then move on to consider tensions in politics of childbearing in countries where birth systems are not so homogeneous in terms of quality and accessibility of the services provided.

Fact sheet 1 Childbearing and maternity care in Finland

When a woman becomes pregnant for the first time in Finland she is likely to be around 29 years old and live in an urban or semi-urban area, a city or a town. In 2018 nearly 1 in four expectant mothers was older than 35, but only 1.3% were under 20 years of age. At the total fertility rate prevailing that year, a woman would give birth to an average of 1.41 children which is the lowest of all times. Maternity care for pregnant woman and her household is covered by the mandatory health insurance. The out-of-pocket costs are limited to a subsidized user fee (39€/44$ per day) for labor and birth in the hospital. The antenatal and postnatal maternity care in maternal health centers is provided by public health nurses (of which about a quarter also have midwifery training) and general practitioners. Pregnant women are offered minimum of nine (9) antenatal public health nurse/midwife appointments including two with a doctor. If a pregnant woman is referred from the primary level to a maternity hospital or a clinic, she is attended by a midwife. Additional visits in maternity care, either in primary level or in hospital, are scheduled if a need arises.

Normal births in hospitals are attended by midwives. The cesarean section rate remains low in international perspective, as less than 17 percent of babies were born via C-section in 2018. Some midwives also attend homebirths, but as homebirths are not subsidized, women and families who opt for homebirth need to cover the full cost out-of-pocket leaving that option open for few people only. The mainstream birth experience is giving birth at a large hospital as Finland has gradually decreased the number of maternity hospitals to 23, which is less than half the number of facilities in 1990s. In rural Finland distances to maternal hospitals are long, which is reflected by the fact that unplanned out of hospital and *en route*- births have nearly quadrupled in two decades.

Maternity care is considered an important public health measure the focus of which is linked to the pregnancy. In addition to the visits to the maternal health center first-time mothers receive one antenatal home visit and both first-time mothers and mothers with several children receive a postnatal home visit. After this the focus of the public

health measures shift to the newborn. The health of children is regularly monitored at child health centers until school age, when the school health care takes over this task. Parallel to the public health measures, families with children are supported through family policies which include paid maternity and family leaves, a publicly funded day care system and other child care benefits as well as child allowances. These measures have not been enough to counter the rapid decline of the birth rate from 2010 onwards. It has been speculated that both the relatively high age of primipara women and the declining birth rate are related to the precarious labor market conditions that particularly concern young people entering the labor market. The parallel substantial decline in the abortion rate, 21.8% in ten years, witnesses careful planning of pregnancies. While there are calls for measures to increase the number of births, the complex reasons for the low birth rate make succeeding in this goal a tricky problem for decision makers.

Tensions between pronatalist state policies and demands for women's autonomous reproductive rights

Historians have argued that starting in the nineteenth century and coming to fruition after the First World War, a new way of thinking about population resources and their importance to national power took shape.[7] The new population politics focused on childbearing, making it an object of state action.[8] The rise of demography, statistics (censuses), sociology, and other social sciences facilitated making reproduction a subject of rational study and scientific management.[7] While such ideologies were salient globally, the extent to which they became rooted vary greatly. Variations in approaches to maternity care reflect not only the extent of social policies aiming at greater equality among childbearing women but political recognition of women's rights as well as women's access to political participation. Maternity care was one of the key aims for which early women's movements, regardless of political orientation, rallied.[3] Particularly in the social democratic welfare states in the Nordic countries, these movements succeeded in putting gender-equality oriented politics of childbearing on the political agenda. Elsewhere in Northern Europe, pronatalist paternalism prevailed over egalitarian feminism, the former political approach supported the building of comparatively generous birth systems.[8,9] The post-war welfare states of Northern Europe are united in the fact that their maternity care was designed to manage the medical and sometimes even the social risks associated with childbearing by placing it in the context of regulated, often publicly provided service provision.[4]

On an international perspective, the welfare policies of the early 20th century that underpinned the emergence of publicly provided antenatal, childbirth and postpartum services are largely a phenomenon of high-income countries.[4] Many European states expanded service provision in relation to childbirth early on to include preventive health care for both mothers and infants.[8,9] Similar developments were aimed at in the Soviet Union, where the state rallied for liberating women from their traditional homemaking roles.[7] The women's movements of the 1960s and the 1970s in both North America and Northern Europe critiqued the paternalistic fundaments of the early birth systems, demanding, among other things, more woman-centered and less medicalized maternity care.[4] In the Nordic countries in particular, women's groups rallied for family policies that would countervail the impact of childbearing for women's position in the labor market, aiming at a cultural change towards greater gender equality, so that the implications of the politics of childbearing would not fall exclusively on women in ways that define gender roles in society.[2,4] In the contemporary context, the proponents of pronatalist ideologies continue to target women; however, charging them with a particular responsibility for childbearing. Indeed, falling fertility and rising immigration has brought pronatalist sentiments back to the center of public debates in the 2000s in many Western European countries with falling birth rates, such as the UK or Spain[10,11] as well as in post-socialist countries.[12] Such sentiments are reflected in the often judgmental views regarding issues like women's voluntary childlessness.[13]

While pronatalism in different guises continues to influence birth systems, abortion legislation and access to birth control have in many affluent countries given women greater autonomy in making decisions about childbearing, even though women's autonomy in reproductive decision-making tends to remain a contested issue.[14] Woman-centered practices in maternity care that consumer movements and other forms of birth activism have championed might appear less contentious, but debates on maternity care and birth care practices are complex. While most proponents tend to share the idea that childbirth should be seen as a healthy, normal physiologic phenomenon in which professionals should not

intervene without good reasons, different stakeholders still tend to define woman-centeredness in maternity care in different ways, particularly when it comes to empowerment of the childbearing women. Perhaps more saliently, as the ideas of woman-centeredness in the past have been used to challenge dominant practices, for instance by promoting midwifery-led care and even home birth, woman-centeredness has become synonym for models that challenge the often self-evidently technocratic and medicalized and paternalistic care.[4] Only more recently woman-centered models have started to be raised as not only more humane, but also more cost-efficient and possibly safer care.[15] It is still common for opposing stake holders of health policy to construct woman-centeredness as a 'soft' or misguided approach that does not make full use of the potential of obstetric medicine. Proponents of more 'hard' approaches to maternity care tend to polemically weigh woman-centeredness against unquestioned moral issues such as concerns for the safety of the child. We return to the conceptions of safety and skill in the section on cultures of maternity care.

In addition to being framed as a social right in contemporary welfare states, public involvement in maternity care and family policy may also be framed with conservative arguments. Gender conservatism that emphasizes traditional nuclear families as foundational elements of a nation is often associated with nation-state nationalism and patriotism.[9] Using similar arguments, pronatalist policies have been on the rise in contemporary conservative and authoritarian regimes. These policies tend to define women's role in society through motherhood. For instance, family policies in contemporary Russia provide ample examples of measures aimed at shaping childbearing.[12] In particular, Russian measures include the introduction of non-recurrent payments to mothers who give birth to a second or subsequent child (so-called 'maternity capital'), a 'childbirth voucher' program, which allows women to choose the place of birth. Furthermore, policies include other moderations to maternity care provision and regulation.[16]

Birth systems between markets and civil society

On a global perspective, the central role of the state in birth systems tends to be limited. State-centered policies may lack political support or the state may lack the capacity to pursue any larger aims in maternity care. Even in affluent countries, maternity care may remain a private issue. For instance in the United States family policies remain rudimentary, if compared with those of many European countries. There is a noticeable lack of popular support for a publicly funded health care system, which is central to the notion of exceptionalism in the US system.[6] That is not surprising, as the role of the state in the US political system has been subject to long-standing political struggles. The general trend has been against state-funded maternity care, apart from a brief period of in the early 1920s when so-called maternalist feminists succeeded in lifting the health of mothers and children to the state agenda.[1] The more successful political campaigns have had a liberalist emphasis on choice in health care. Moreover, this ethos has by default included maternity care which in the context of social policy appears to be a private rather than public issue. Public debates in the US tend to frame state involvement in social and health policy as "interventions" in markets and as such measures limiting consumer choice.[17] Choice has also been a key theme in maternity care debates in the US where more or less radical home birth movements questioned what has been perceived as medical dominance in maternity care.[6] It could be said that the issue of choice has overshadowed the issue of access. Before 2014, maternity coverage was not a guaranteed benefit in private health insurance and access to affordable maternity health coverage remains conditioned, as, for instance, becoming pregnant is not a qualifying life event that makes a woman eligible to enroll in or change your health plan at any other time of year. The patchy system of accessing maternity care reflects a situation where, unlike in most other affluent countries, equal access to maternity care has not been raised as a key issue in health policy despite of highly segregated birth outcomes. The Medicaid and CHIP Payment and Access Commission MACPAC[18] recently highlighted the inequalities related to the highly limited access to Medicaid, a government insurance program providing health insurance for low-income people. It has long played an important role in providing maternity-related services for pregnant women, paying for nearly half of all births in the United States. The commission traces the much better birth outcomes of privately insured women to the eligibility mechanisms of Medicaid. Women with low incomes tend to have an unstable source of insurance coverage and therefore may experience interrupted care and delayed access to services. In the US a woman's insurance status directly predicts her access and patterns of antenatal care as well as her birth outcomes, adding particularly to the vulnerability of poor, non-white women.[18]

The politics of childbearing in poor countries with high birth rates tend to be shaped by global concerns about poor maternal and infant health outcomes on the one hand and overpopulation on the other hand. Transnational policy

actors have during the past two decades waged visible campaigns for reaching the United Nations Millennium Development Goals (MDGs) and the current Sustainable Development Goals (SDGs) that target these issues.[19] The measures aimed at improving maternity care are constrained not only by the infrastructure of systems that are wrought with inequalities, but also by the economic and social vulnerability of pregnant women.[20] Not surprisingly, the success of international and national measures to build accessible maternity care globally vary. Indeed, maternal health needs to be viewed in a broad perspective and the broader strategies aimed at improving it include poverty reduction and women's empowerment as well as considering outcomes beyond mortality.[20]

FUNDING OF MATERNITY CARE

Funding of maternity care is intrinsically linked to that of health care systems in general. Funding systems can be classified with a typology the logic of which builds on whether maternity care is considered a public or a private issue. If the cost of childbearing is considered a public issue, it is important to identify the different consequences of whether maternity care is considered to be a public health issue or whether it is considered to be one part of medical care the costs of which need to be covered with a logic similar to that of compulsory sickness insurance. In countries like the Nordic countries and the UK, where maternity care became defined as a public health issue in the early 1900s, state-funded maternity care prevails. In continental Europe, for example in the Netherlands and Germany, maternity care is covered by basic health insurance. In market-based health care systems, such as the USA, maternity care is not self-evidently recognized as a public issue and maternity care is by default covered either by the often employer-based private health insurance or, for women with low incomes, by Medicaid, the governmental program that provides last resort maternity care of sorts.[18] Many maternity care funding systems are hybrids. Maternity care in Russia (see Fact sheet 2, *Childbearing and maternity care in Russia*) is an example of such a hybrid, where compulsory governmental programs exist side by side with insurance-based and out-of-pocket private care provision.

Fact sheet 2 Childbearing and maternity care in in Russia

When a woman becomes pregnant for the first time in Russia, she is likely to be around 28 years old and live in an urban area, a city or a town. At the total fertility rate prevailing in 2017, a Russian woman would give birth to an average of 1.61 children. Maternity care for a pregnant woman and her household is mostly free-of-charge, as they are covered through the system of mandatory health insurance. In general, maternity care in Russia is based on a medicalized, risk-oriented approach. Antenatal care is provided by obstetrician-gynecologists working in state-funded district 'women's consultations' (antenatal and gynecological clinics). Antenatal care consists of compulsory regular check-ups, consultations with different medical specialists, at least three antenatal ultrasounds and regular control of blood and urine counts. Any complication or pathology detected during pregnancy constitutes a basis for referral to give birth in a technically advanced facility, like specialized maternity hospital or perinatal center. Midwives have no independent role in the official maternity care system in Russia. The authorities define midwifery primarily as a hospital occupation and midwives work there as doctors' assistants.

Although the contemporary system of maternity care in Russia builds on the Soviet way of organizing and providing care, private clinics and commercial maternity units have emerged, offering additional options for antenatal and intranatal care. The paid services offer those women who are able to pay for their care out-of-pocket to give birth in a setting of her choice. This choice may also include the certainty of a partner or other support person to be permitted to attend the birth, as well as the choice of having a particular doctor or a midwife providing maternity care. Affluent people in bigger cities wishing to avoid the predominant medicalization may opt for homebirth, but outside the official medical realm. The law prohibits homebirth attendance from all types of medical professionals. Independent midwifery is not legalized and the relatively small number of midwives who rally for legitimization of independent midwifery are a rather unorganized and diverse group, united largely only by their shared goal of professionalizing midwifery in Russia. In the contemporary context, however, this phenomenon is limited to the very largest cities and within maternity care that the majority of women encounter medical dominance remains largely unchallenged. Concerning mainstream care, it is noteworthy that the range of choice regarding childbirth is shrinking as the provision of maternity care is regionally centralized to large units located in the bigger cities. Women living in

rural villages or small towns are losing easy-to-reach access to birth care as authorities are closing smaller birth units. In the resulting situation, maternity care units are sometimes recommending women be hospitalized in advance, in order to prevent childbirth on the road.

Regardless of the type of funding system in place in any given country, there will be a shortage of funding for health care, and therefore there is bound to be an element of rationing. This can be through waiting lists, limiting access to certain services (i.e. IVF (in vitro fertilization) in certain countries), or through user fees for choosing particular services without a medical indication. For instance in the Netherlands where the basic health insurance covers a home birth, opting for a hospital birth without a medical indication incurs a private contribution.[21] In most countries, of course, the situation regarding the service provided would be the reverse: the state guarantees the universal access to a hospital-based maternity case but any alternative form (including homebirth or at least home-like setting) would be available as a commercial service only.

The type of funding system has direct consequences on maternity care. A recent study of the provision of birthing services in two provinces in China reviewed the services in a policy context. The costs of childbirth are proportionally high and government subsidies cover less than one-third of the costs making hospital birth unaffordable for many women in these provinces, particularly as informal payments may be expected.[22] The researchers also argue that in the context of a neoliberal health economy and poorly developed government regulatory policies, those with the ability to pay for maternity care out-of-pocket may be vulnerable to a new range of risks related to overuse and misuse of avoidable intervention, risking an increase in maternal morbidity and even mortality.[22] Market-based, loosely regulated maternity care thus presents a paradoxical risk for both poor and affluent pregnant women. While poor communities and women with low incomes may lack access to services or get too little too late, the more affluent women and those with access to generous private insurance may be vulnerable in the context of for-profit maternity care.

Even in the context of public health facilities, user fees can cause catastrophic health expenditure for poor women. There is overwhelming evidence that the high costs of maternity care are not only an important barrier to maternity care, but also related to abusive treatment, even predatory practices such as being forced to pay bribes that poor women are subjected to when seeking maternity care.[23,24,25,26] An even more fundamental problem in many poor countries is that many women totally lack access to maternity care services (see Fact sheet 3, *Childbearing and maternity care in Malawi*.)

Fact sheet 3 Childbearing and maternity care in Malawi

When a woman becomes pregnant for the first time in Malawi, sub-Saharan Africa, she is likely to be around 19 years old if she lives in rural areas and a year older if in the urban areas. At the total fertility rate prevailing in 2017, a Malawi woman would give birth to an average of 5.49 children. However, nearly one-third of young women aged between 15 and 19 years have already begun childbearing. Maternity care for pregnant and birthing women is free of charge in public health centers and facilities, but the resources and staff are inadequate even in urban centers and often non-existent in rural and remote areas. Government has liaised with the not-for-profit private sector (religious institutions and non-governmental organizations) in areas that have no public facilities by covering the user fee, but that still does not guarantee women adequate care during pregnancy and birth in vast parts of the country.

Although accessing maternity care can be challenging in and near urban centers, in rural areas distances to services pose an even higher obstacle. Malawi bases its health service delivery on primary care centers meant to cater for a population of 10,000 people, but often the coverage can extend to over 200,000 people. Malawi has managed to advance successfully many development goals, but maternal health care lags behind. Rural areas need the most experienced health care professionals, but receive the least amount of resources and staff. In rural Malawi most births take place at home with traditional birth attendant (TBA). In efforts to create a shift to professional birth attendants and births at health care facility a ban on TBAs was placed in 2007 causing even higher rise in non-attended births. The ban was lifted in 2010, but securing of safe maternity care in Malawi remains an unsolved acute public health problem.

CULTURES OF MATERNITY CARE

On a global perspective, the professional cultures in maternity care vary greatly. Greatest differences in maternity care cultures can be seen between social models of care and medical models of maternity care.[27] The medical model is based on medical science and claims (ideology) to rely largely on objective measurement of symptoms and clinical observation. It offers individual treatment solutions for individual clients. Public discourse tends to portray the medical model as the most appropriate and hence 'safe' approach to pregnancy and childbirth. The medical model seeks to control and manage these phenomena and the roles of women, their families, friends and health care providers accordingly. The social model, on the other hand, argues that there is interdependency between the person in need of care and their immediate and wider environment. The social model focuses on everyday life and the social, socio-economic, cultural and environmental aspects of health.[28,29] It considers a wider range of factors that affect health, such as lifestyle, gender, poverty (or health inequality more generally), discrimination, and where and how we live. The social model is generally not individualist, but complex and multi-dimensional and often does not offer easy solutions.[30,31] Solutions to health issues can be found at a population level and hence can be political or social as well as, for example, changes in the individual's lifestyle.[30] The medical model portrays a different view, namely that childbirth is potentially pathological, and therefore every woman is potentially at risk when she is pregnant and/or in labor. In short, within the medical model, pregnancy and childbirth are treated as only safe in retrospect.[28,30] In many health system contexts, medical models tend to be physician-led, whereas when health systems lean more towards a social model of childbearing, they often involve midwife-led services for women whose pregnancies and births are not regarded as involving medical risks. Understanding which of the two models is dominant in their own thinking and that of others can help politicians, journalists, policy-makers, midwives, doctors, other health care providers, and childbirth activists as well as pregnant women and new mothers (and their partners) to put issues around 'normal birth' into perspective.[30,31] Indeed, awareness of the multiple unintended consequences of medical interventions both for childbirth and for the health of childbearing women in the long run is particularly important.[32]

Whether maternity care is organized according to medical or a social model is associated with other ideologies that shape not only health care but the wider society. For instance, the cultural understandings of regional (in) equality, both historically and in the present, shape the organization of practical provisions of maternity care in rural areas. Rural areas are often at the political periphery as well as geographically distant. As the global population is still moving towards cities, rural areas are becoming less politically important and poor in terms of infrastructure. Russia, with its huge territory represents a case which illustrates the process of considerable medicalization, technologization and centralization of maternity care, creating all together unsafe peripheral spaces for childbirth with no alternatives for such a medical approach and no nearby facilities in which to give birth.[33]

The discussion about social versus medical models of maternity care already indicated that the conception of what constitutes 'good' maternity care is embedded in broad cultural ideas about childbearing, contraception and women's autonomy. In recent years, researchers and policymakers alike have begun to recognize that the neglectful, abusive, and disrespectful treatment of women in health facilities, for example, during childbirth, is a globally spread phenomenon of which there still is only unsatisfactory research evidence.[34,35] Nevertheless, it is evident that the mistreatment of women during childbirth in health facilities is a global cultural problem. A recent mixed-methods systematic review categorized the types of mistreatment women are exposed to as physical abuse, verbal abuse, stigma and discrimination, sub-standard care, poor rapport between women and providers, and poorly performing health care systems that lack resources and policies regarding the accountability of professionals in the context of unprofessional, even predatory facility culture.[35]

The fact that the discussion about the mistreatment of women in maternity care has reached global attention bears witness of problematic cultural legacies that shape professional practice in maternity care.[36] Future discussions about respectful models of maternity care can learn from the experiences of developing the content and scope of midwife-led models in ways that center the childbearing woman. A recent systematic review of studies that examined what women value in continuity of care in maternity services serves as an example of women's often unmet expectations of personalized care, trust and empowerment.[37] It is evident that maternity care culture is associated with the general status of women in society and, therefore, the improvement of maternity care demands the improvement also of the social location of midwifery and midwives. Indeed, treating birth as a normal event requires redirecting of investments. Midwives, obstetricians and even pregnant women themselves need to receive education with specific focus on ethics,

communication and philosophy of care to enable normalization and humanization of birth.[27] This model does not deny the need of emergency obstetric care. Such care should be developed in an integrated way so that it supports midwifery care by providing the ability to diagnose and act upon obstetric complications before they become emergencies, adapt known technologies to identify fetuses at risk, and care for the complicated emergencies.[38]

IMPLICATIONS OF BIRTH SYSTEMS FOR WOMEN'S RIGHTS

This discussion of maternity care has drawn attention to access to quality maternity care as a basic right that remains out of reach for many women globally. When birth systems are considered from the perspective of social justice, it is evident that the persisting inequalities are related to social divisions and poverty. Women's status in society in general shapes the position of maternity care. When the state does not prioritize access to maternity care or is not able to efficiently build adequate services, women from lower social classes, living in underprivileged areas or belonging to minority groups are more likely to suffer poor access to services. Both urban and rural poor are at risk of exclusion from adequate care, but poor women in rural areas living further away from facilities are particularly vulnerable.

The total fertility rate in a country is a foundational circumstance for a birthing system and closely linked to poverty. Generally, it is highest in the poorest countries of the world and lowest in the richest countries of the world. While the total fertility rate is also low in a number of poorer countries, there are no rich countries among the countries with high total fertility rates. Affluence structures total fertility within countries, as people in conditions where people can choose to control the number of births people choose to do so, as their children's opportunities in life improve.

Finally, the value of *quality* maternity care needs to be emphasized as a basic right for all women. Childbearing is potentially a vulnerable situation for any woman, making the culture of maternity care a vital issue for securing women's autonomy and empowerment.

PRACTICE RECOMMENDATIONS

- **The organization of quality maternity care accounts for the economic, psychological and social vulnerability of pregnant women and supports social justice. Quality maternity care should be available to all women, preferably without out-of-pocket payments. If that is not possible, maternity care should include means-testing, to ensure freely available quality care for the poorest women in society.Quality maternity care treats childbearing as a normal, social process that nevertheless requires the attention of professional midwives trained for caring for normal pregnancy or birth. Midwives can help reduce unnecessary medical interventions in the childbearing process.**
- **Quality maternity care has the capacity to identify pathologies of pregnancy and childbirth and offer adequate medical care. Physicians should refrain from extending the medical approach beyond the care needed for securing the health and well-being of the mother and the child.**
- **Quality maternity care supports a woman's autonomy and empowerment regarding her childbearing and her subsequent reproductive health. This entails encountering childbearing women in a respectful and friendly manner, which aims at normalizing and humanizing birth.**
- **Quality maternity care takes into account of a multipara woman's situation as mother. Maternity care should be supported by family-community care that can reach and support families in situations where the mother suffers pregnancy or birth-related complications.**
- **Quality maternity care takes account of a woman's reproductive history and supports her in accessing reproductive health services postnatally.**

CONFLICTS OF INTEREST

The authors of this chapter declare that they have no interests that conflict with the contents of the chapter.

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