Midwifery 93 (2021) 102882

Contents lists available at ScienceDirect

Midwifery

journal homepage: www.elsevier.com/locate/midw

Short Communication

Developing operational standards for Midwifery Centers ☆

Jennifer R Stevens, DrPHc, CNM, MS [a,b,c,†], Cristina Alonso, MPH, CPM [b,d,†,*]

[a] Boston University, School of Public Health, 715 Albany St., Boston MA 02118 USA
[b] GoodBirth Network, California, 2577 Post Street, San Francisco, CA 94115 USA
[c] United Nations Population Fund (UNFPA), Bangladesh, Sher-e-Bangla Nagar, 8/A Begum Rokeya Sharani, IDB Bhaban (15th floor), E, Dhaka, 1207 Bangladesh
[d] Harvard University, Chan School of Public Health, 677 Huntington Ave, Boston MA 02115 USA

ARTICLE INFO

Keywords:
Midwifery
birth centre
quality improvement
global health
safe motherhood
community health

ABSTRACT

Background: Midwifery centres have been identified in over 56 countries. Consensus was reached on a global definition for midwifery centres, yet there is a lack of standards to assure consistent quality of care is provided.

Methods: Evidence-based standards and guidelines developed from American Association of Birth Centres (USA), Midwifery Unity Network (UK/EU), World Health Organization, International Childbirth Initiative, and White Ribbon Alliance, were gathered, duplicate standards were removed, and language was adapted for global use with sensitivity to low and middle countries (LMIC). An initial list of 52 midwifery centre standards were identified. Through an informal modified Delphi process these were reviewed by global midwifery centres experts, researchers, and midwifery centre staff at focus groups in Haiti, Mexico and Bangladesh for significance, language, and usability. The standards were then piloted at midwifery centres in eight countries (Sierra Leone, Cambodia, Bangladesh, Mexico, Haiti, Peru, Uganda and Trinidad). All feedback was incorporated into the final standards.

Results: A final list of 43 standards, organized into 3 domains including quality standards for care providers, dignity standards for women, and community standards for administration, were agreed on.

Conclusion: Midwifery centres are prevalent around the globe. Identifying standards for quality of care provides a foundation for the midwifery centre model to be replicated and ensure consistent quality of care. Evidence based standards for midwifery centres in LMIC, allows systems to embrace and encourage the implementation and growth of midwifery centres to address accessible, acceptable, respectful, woman-centred, community-engaged maternal health care that participates fully in the health care system.

Midwifery centres definition and global reach

Midwifery centres are health care facilities that provide sexual and reproductive health and birth services using the midwifery model of care. (Kirkham, 2003) They vary in services offered, and their integration within the health system. In the last few decades, midwifery centres have opened all over the world as a way to improve access and quality in maternal health care (Stevens and Alonso, 2020). Often, they are not identified or understood as the unique model they are. This can limit their potential positive impact on a health system, and their provision of a consistent program of care.

What is a midwifery centre?

Through a global consensus process, a formal definition for a midwifery centre was developed in March 2018 (Stevens and Alonso, 2020).

> "A **midwifery centre** (MC) is a healthcare facility, which can provide sexual and reproductive health (SRH) for women, and newborn care, rooted in midwifery philosophy and model of care, in a home-like shared space, ensuring basic emergency maternal and neonatal care for all births, integrated within the healthcare system, aligning the level of care to optimal outcome, responsive to needs of its community, with the woman's experience at its heart and centre."

Midwifery-centres offer "woman-centred care" (While we acknowledge that more people than women have a uterus and become pregnant)

☆ Acknowledgements: The authors would like to thank Stan Shaffer for his leadership and all of the midwifery centers who participated in the development of the midwifery centre standards across the globe.

* Correspondence: Cristina Alonso, 122 Bowdoin St, Apt 107, Boston MA, 02108.

† Both Authors report:1. Conflict of Interest: None declared2. Ethical Approval: Not applicable3. Funding Sources: None receivedThis research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors

https://doi.org/10.1016/j.midw.2020.102882
Received 12 August 2020; Received in revised form 21 October 2020; Accepted 9 November 2020
0266-6138/© 2020 Elsevier Ltd. All rights reserved.

in a collaborative environment between women and midwives, meeting the local community's needs while remaining connected to the health care system. The World Health Organization has identified midwifery as a critical strategy for meeting women's health needs globally while addressing Sustainable Development Goal (SDG) (United Nations General Assembly 2005) #3. The midwifery centres' unique model is education-rich, relationship-focused care for healthy women. They enable the optimal use of resources by matching health needs with the appropriate health provider and facility. The model differs from home birth in that midwifery centres, as healthcare facilities, are part of the healthcare system and part of the woman's community. Easily placed rurally and in humanitarian settings, midwifery-centres also address SDG #5, gender equality and SDG #10, reducing inequities. Their services address their community's needs, often providing well woman care, and well child services, including family planning, cancer screening, breastfeeding support, nutrition education and immunizations.

Midwifery centres are present in high, middle, and low-income countries. In many high-income countries they are integrated within health systems using evidence-based standards of care. Prospective studies have found midwifery-centres to be safe, cost effective care that is highly satisfying to women. (Stapleton et al., 2013, Christensen and Overgaard, 2017, Scarf et al., July 1, 2018) Midwifery centres are increasing in middle and low income countries. (Goodbirth map) In Haiti, for example, a 2017 Goodbirth survey of midwifery centres found that midwifery centres collectively birthed 3% of all facility-based births in the country. There were no maternal deaths in the midwifery centres, and just 16% required transfer for a higher level of care. These women would otherwise have given birth at home, as many centres are rural. However, unlike midwifery centres in high income countries, centres in middle-and-low income countries are not yet incorporated into national systems of healthcare where national regulatory systems lack clearly defined operating standards, and licensure pathways for midwifery centres.

Because there is diversity among midwifery centres in different countries and contexts, global standards for midwifery centres are essential to ensure safety, enable research, and promote the integration of this model of care into health systems.

Quality improvement in midwifery centres

Standards are necessary to define, monitor, and improve quality of care in any healthcare facility, including midwifery centres. Quality has been described as the missing link to decreasing maternal mortality and increasing the acceptability of care. (Tunçalp et al., 2015) Quality of care includes the promotion and protection of human rights. To enable the measurement of quality of care, a facility needs evidence-based standards identifying its model, scope of practice, and ensuring high quality of care is consistently provided. The administration of a midwifery-centre is unique and involves participating in a network that enables referrals to ensure pregnant women are being provided with the right care at the right time. Operational process standards address systems needed for quality, risk assessment, collaborative care and drills to improve the provision and experience of care. (World Health Organization 2018) The implementation of these standards provides a global framework for identifying how quality will be maintained and measured for future benchmarking.

Operational process standards

Operational process standards, and measurements of compliance with those standards, are strong management tools to support quality assurance and evaluation. (Lilford et al., 2007) Operational process standards are not clinical practice guidelines, rather they offer governance and workflow processes to support a culture of quality. They are guidelines for how care is provided, reflecting a respectful, women-centred, midwifery model of care. They reflect not just what you do, but how it is done. Measurement of health outcomes focuses on the evaluation of outcomes of care and offers little insight into how outcomes can be improved. Process standards provide guidance on how to improve quality within a system, which should result in improved health outcomes.

Operational process standards for woman centred physiological birth

There are a limited number of global standards addressing the process of care to enable healthy women to have a physiological birth. Most guidelines and process standards come from high income countries such as Australia, Canada, (Government of Canada 2017) UK, EU (Rayment et al., February 20, 2020) and US and usually involve midwives, midwifery centres, or are focused on one aspect such as continuous support during labour, or woman-centred care. (Bohren et al., 2017)

Awareness of disrespect and abuse of women in childbirth has inspired WHOs guidelines that increasingly address the process of care. WHO's 2015 quality of care framework placed equal value on the experience of care and the provision of care, creating an opportunity for a Human Rights based approach that considers that human rights, process standards, facility-based birth and midwifery care should occur together. (Scarf et al., July 1, 2018) Global standards, such as WHO's 2016 Antenatal care for a Positive Pregnancy Experience, (World Health Organization 2016) promoted midwifery and its continuity of care model. Similarly, the 2018 WHO Intrapartum Care for a Positive Childbirth Experience (World Health Organization 2018) provided concrete ways to consider quality in the provision and experience of care through a standardized framework.

The urgent need for midwifery centre standards

Many midwifery centres globally have grown out of immediate community-based needs and often operate outside of the national health care system. Developing a global definition and standards allows for increased awareness and visibility of these centres among the global audience and improved awareness of the importance of global standardization from within the midwifery centre community. Operational process standards will continue to support the integration and growth of midwifery centres to address accessible, acceptable, respectful, woman-centred, that can be evaluated for quality.

Many low-and-middle income countries have not developed national standards for operating midwifery centres. This leaves many midwifery centres marginalized from the health care system and unable to participate in safety regulation. In some cases, countries expect midwifery centres to adhere to obstetric hospital guidelines and will close or fine midwifery centres for not complying with hospital-based standards. Therefore, just as there are global criteria for hospitals, it is critical that we enable common and achievable standards for midwifery centres in any setting (Table 1).

Our process

Evidenced-based standards for midwifery centres were developed in high resource countries such as the United States' American Association of Birth Centres (AABC) (American Association of Birth Centers 2018) and the European Midwifery Unit Network (Rayment et al., 2020, Rocca-Ihenacho et al., 2018). These midwifery centre standards were gathered with the "Standards for Improving Quality of Maternal and Newborn Care n Health Facilities" from the World Health Organization, (World Health Organization 2018) White Ribbon Alliance's "Rights of Childbearing Women", (White Ribbon Alliance 2018) and the International Childbirth Initiative (ICI)'s "12 steps to Safe and Respectful Mother-baby-family Maternity Care" (Lalonde et al., 2019). All of the documents reinforced human rights, midwifery care and the woman's experience as integral for quality health care.

Beginning in 2017 we compared the above sets of standards and guidelines and identified common themes. Redundancies and country specific language were removed to create the initial draft of operational

Table 1
Operation Standards

No.	Dignity: WOMAN focused Standards (13)
1	There is an **expressed institutional commitment** that: every woman and newborn will be treated with respect and dignity, no woman or newborn is subjected to mistreatment; including physical abuse, sexual abuse, verbal abuse, discrimination, neglect, detainment, extortion, denial of services, and no care or procedures done without informed consent.
2	Every woman has **access to her health information** and receives information about her care, the reasons for interventions and outcomes are clearly explained, so the woman is able to make informed choices about the services she receives.
3	**Communication** with users is respectful. For example, mothers are addressed by name, unknown staff members identify themselves, the roles of various staff members are clearly communicated.
4	There is **shared decision making** for all services related to pregnancy, birth and newborn care
5	Every mother is offered an **orientation** to the birth center's model of care and a tour of the facility
6	There is a mechanism for **home visits**, either routinely or as needed.
7	User **confidentiality** is respected
8	The environment offers adequate **privacy** based on user preferences
9	The midwifery center participates in interactive **community activities**
10	Every mother is informed about the benefits of **supporting physiological processes** such as drug-free comfort and pain relief methods to support normal labor
11	Every mother is informed of the benefits and encouraged to have **continuous physical support,** by someone of her choosing- including family and traditional healers- to accompany her during labor and delivery.
12	Each mother is asked about in her **cultural traditions and spiritual expectations** pertaining to her pregnancy, delivery, and postpartum care for herself and her newborn and if safe, supported.
13	Every woman receives **support** to strengthen her capability during childbirth including childbirth education, and comfort measures.
No.	**Quality: PROVIDER focused Standards (13)**
1	The midwifery center clearly defines its **scope of practice** including support for normal birth and prohibition of potentially harmful interventions and referral mechanism.
2	The midwifery center strives to achieve the **Baby Friendly Health Initiative** 10 Steps to Successful Breast feeding.
3	Every woman and newborn receives routine, **evidence-based care** with **written guidelines** for major areas of care (i.e. SOP, CPG) that are periodically reviewed to keep practices up to date with professional guidelines and identify practices that may be unnecessary or harmful.
4	The midwifery center has a mechanism for local and national (if available) **data collection**, analysis and feedback as part of its activities for monitoring and improving performance and makes these results public to the community.
5	Every woman and newborn has a complete, accurate, standardized **medical record** for all care provide that includes **continual risk assessment** to determine whether referral is required. .
6	Women's health is addressed in a **holistic framework**, both during individual encounters and with community engagement.
7	Birth services are provided within the **life course** context of sexual and reproductive health.
8	Women with complications (i.e.: pre-eclampsia, eclampsia, postpartum hemorrhage, obstructed labor) and newborns with complications (i.e.: premature or low birth weight, failure to breathe, risk or suspicion of infection) receive **immediate stabilizing interventions** then referred (see below) if necessary.
9	Every woman and newborn that cannot be managed with the currently available resources is appropriately referred according to a **pre-determined emergency plan** with **appropriate information exchange** between health facilities and accompanied by a qualified staff member.
10	The staff possess and routinely apply **midwifery knowledge and skills** that optimize the normal physiology of birth
11	At every birth, there are at least **two staff currently trained for emergency management** of common birth complications. (i.e.: PPH, PEE, NBR, breech, shoulder dystocia)
12	The midwifery center staff collectively has the skills and competencies to meet the needs of women and newborns during labor, childbirth and in the early postnatal period, **meeting ICM standards and trained on BEmONC functions**.
13	The midwifery center conducts **regular professional development programs** including: routine, periodic maternal and newborn emergency drills, and in-service education on evidence-based midwifery care.
No.	**Community-Administrative focus (17)**
1	The midwifery center functions as **part of a larger health care system**. (i.e.: participating in data collection, accreditation and licensure if available, education of health work force and utilizing referral pathways).
2	The population and community served is defined.
3	There is a process in place for **informing the community** of the services of the midwifery center.
4	The midwifery center seeks to **comply with applicable local and national regulations** and where applicable, the midwifery center seeks status as a legally constituted organization.
5	The facility has **functioning, reliable, safe, and sufficient systems** for each of the following: clean water, dependable energy, facility sanitation, hand hygiene, general waste disposal, and medical waste disposal.
6	There are systems in place for the **management of required medical supplies and hazardous disposal** of waste (i.e.: medication inventory, sharps management, expired medications)
7	There are **protocols for maintenance** of equipment, building and grounds, as well as control of the use of the facility.
8	The midwifery center facility provides **adequate security** measures for staff and families and has appropriate disaster plans.
9	The facility establishes and maintains a **safe, relaxing home like environment** for healthy women, newborns and staff. (including office, cooking facilities, classroom, relaxation space, washrooms, and private birth areas)
10	There is a plan to ensure **fiscal sustainability**. (if not publicly funded)
11	There is a **plan for the operation** of the center in the absence of the administrator and/or clinical director.
12	There is an established **mechanism for staff and clients to provide input** to the midwifery center leadership on care.
13	The midwifery center maintains **written personnel policies**, available to all staff, that address conditions of employment, respective obligations, staff benefits, grievance procedures, and protections from sexual harassment and workplace violence.
14	The midwifery center has a **system for staff competency** that includes hiring, training, performance evaluation, continuing education, and support.
15	The midwifery center has leadership programs for **continuous quality improvement**.
16	At least one skilled birth attendant and support **staff are immediately available at all times**.
17	Any research activities and protocols for conducting **research are approved by the governing body** of the midwifery center.

process standards for midwifery centres in global settings. In 2027 and 2018 the standards were reviewed by a consortium of over 150 midwifery centre experts and researchers, in addition to midwifery centre administrators and staff from low and middle-income countries, in online meetings and in focus groups with over 50 participants in Haiti and Mexico and at the International Confederation of Midwives meeting in Toronto, Canada.

By 2019 the final draft list of 52 process standards was organized into 3 domains: Dignity- woman focused standards, Quality- provider/care focused standards and Community-facility/administration focused stan-

dards. These were then piloted at 8 midwifery centres in 8 countries (Sierra Leone, Cambodia, Bangladesh, Mexico, Haiti, Peru, Uganda and Trinidad). Through emails, online meetings, and face to face focus group discussions, feedback on language and usability in these lower resource settings was incorporated into the standards. After consensus discussions and pilot testing a final list of 43 process standards were identified. (Goodbirth Network Accessed Jan 2020)

A final focus group with midwives in Bangladesh was done in early 2020 to review the implementation process for the standards. This group focused on how the local context could be captured and identifying examples of how to document standard Implementation.

The 43 process standards remained organized into three domains, Dignity, Quality and Community. The 13 Dignity domain standards focus on processes that directly impact women and their experience of care. The 13 Quality domain standards focus on processes that impact the quality of care provided by the midwives. Finally, the 17 Community domain standards focus on processes supporting the center as part of the larger health system and community. The standards were crafted in such a way to allow for country contextualization that is necessary for full ownership.

Limitations and opportunities

Working across countries, languages, economic divides, and cultures provided the challenge of cultural translation. Although the standards have been translated into Spanish, French, and Bangla, the work always included local providers. It was the cultural translation of ideas around communication, shared decision making, consent, and continuous quality improvement that proved the greatest challenge. Time was needed to talk out ideas and concepts, and how they were shared or experienced differently in cultures. These concepts are particularly complex in post-colonial settings where midwifery education is often based on algorithmic models that reinforce hierarchies and patriarchy. In these settings, practicing midwifery through the lens of gender equity and critical decision making are often absent from education curricula and clinical practice.

Future development includes the finalization of a self-assessment tool based on the operational standards. This is seen as the first step for a midwifery centre interested in creating processes for consistent quality of care. Additionally, it opens an opportunity for licensure in countries where there is none, and to develop national accreditation pathways for midwifery centres.

The current COVID-19 epidemic has brought healthcare inequities to the forefront. The lack of standardized processes for quality of care centred around the needs and realities of pregnant women has never been more salient than during this time. Maternal health researchers have signalled the need to maintain human rights even during this crisis (Jolivet et al., 2020). Midwifery centres during COVID-19 may provide a strategic response to keeping healthy pregnant and labouring women away from high risk ill patients in hospital settings. They enable decentralizing services, keeping them in the community and at lower costs which are key factors in COVID-19 response, particularly in precarious settings (Rocca-Ihenacho and Alonso, 2020 Jun).

Conclusion

Our goal was to enable a consistent application of the midwifery centre model of care, through creating common operating standards and processes to ensure that high quality of care can be measured and provided at a global level. These process standards can now be utilized at midwifery centres globally to standardize governance and programs of care, for continuous quality improvement. The definition and process standards serve as a framework for national and local governments to create regulatory frameworks and integrate midwifery centres into the healthcare setting where these are absent. In settings where midwifery centres serve as ad hoc primary care centres, the standards can enable elevating clarity on what are basic operating standards to ensure safety and quality. In addition, we predict that the more midwifery centres are implemented in these settings, the more midwives will improve their capacity for critical thinking through a gendered lens practicing an autonomous model of midwifery that truly puts women at the centre of care. Midwifery centres have the potential to be the enabling environment for midwifery to be fully expressed.

Finally, global standardization maintains cultural nuance and sensitivity while allowing for research to be conducted at centres utilizing the same standards. As with all health care facilities within a system, midwifery centres need standards for operation with a mechanism for licensure and accreditation, at the country level. With consensus on minimum global standards for midwifery centres, research could now move forward to improve quality and impact on women's experiences of care, as well as their potential impact on health systems.

Acknowledgements

A special thank you to the participating midwifery centres:

Victoria-Taiama Partnership Birth Center, Sierra Leone www.taiama.org

Thmar Krae & Sandan Community Birth Centers Samaritan Purse Cambodia https://www.samaritanspurse.org/article/giving-mothers-hope-in-cambodia/

Bharuakhali, Islampur, Khunia Palong, and Pockhali Birth Centers, Hope Foundation, Bangladesh https://www.hopeforbangladesh.org/hope-birthing-centers

Luna Maya Chiapas and DF, Mexico www.lunamaya.org

Maison De Naissance, Haiti http://globalbirthinghomefoundation.org/

Shanti Uganda, Uganda www.shantiuganda.org

Mamatoto, Trinidad and Tobago www.mamatoto.net

Midwives Exclusive, South Africa https://www.midwives-exclusive.co.za/wp/

Pakarii Casa de Nacimiento, Peru https://pakarii.com/

Credit Author Statement

Jennifer Stevens: Conceptualization, methodology, validation, writing, project administration.

Cristina Alonso: Methodology, validation, writing, project administration

Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.midw.2020.102882.

References

Kirkham, M., 2003. A "cycle of empowerment": The enabling culture of birth centres. Modern Midwife 6 (11), 12–15.

Stevens, J.R, Alonso, C., 2020. Commentary: Creating a definition for global midwifery centers. Midwifery 85, 102684.

Stevens, J.R, Alonso, C., 2020. Commentary: Creating a definition for global midwifery centers. Midwifery 85, 102684.

While we acknowledge that more people than women have a uterus and become pregnant, the work done on this project occurred in settings where political and health systems operate from a patriarchal model. In this model the basic rights of women, including positive and empowering childbirth are still absent from most women´s realities. In addition, this article is intended for use in LMICs where the term "pregnant person" would not be understood as including women, trans men and non-binary folks.

United Nations General Assembly (2005) Resolution adopted by the General Assembly on 16 September 2005. UN Doc. A/RES/60/1. New York: United Nations

Stapleton, S.R., Osborne, C., Illuzzi, J., 2013. Outcomes of care in birth centers: Demonstration of a durable model. J of Midwifery and Women's Health. Jan 30, 2013 58, 1. Available at: https://onlinelibrary-wiley-com.ezproxy.bu.edu/doi/pdf/10.1111/jmwh.12003.

Christensen, L, Overgaard, C, 2017. Are freestanding midwifery units a safe alternative to obstetric units for low risk, primiparous childbirth? An analysis of effect differences by parity in a matched cohort study. BMC Pregnancy and Childbirth 17, 14.

Scarf, Vanessa L, et al., July 1, 2018. Maternal and Perinatal Outcomes by Planned Place of Birth among Women with Low-Risk Pregnancies in High-Income Countries: A Systematic Review and Meta-Analysis. Midwifery 62, 240–255. https://doi.org/10.1016/j.midw.2018.03.024.

Goodbirth map available at: https://www.goodbirth.net/map/

Tunçalp, Ö., et al. (2015). Quality of care for pregnancy women and newborns–the WHO vision. BJOG 2015;122:1045 1049. Available at: http://www.who.int/maternal_child_adolescent/topics/quality-of-care/who-vision-quality-care-for-pregnant-women-and-newborns.pdf?ua=1

World Health Organization. (2018). WHO Recommendations Intrapartum care for a positive childbirth experience Geneva: World Health Organization, 2018 [Available from: http://www.who.int/reproductivehealth/publications/intrapartum-care-guidelines/en/

Lilford, R, Brown, CA, Nicholl, J, 2007. Use of process measures to monitor the quality of clinical practice. BMJ Sept 2007 335, 648–650.

Government of Canada. (2017) Family-Centred Maternity and Newborn Care: National Guidelines 2017 Available from: https://www.canada.ca/en/public-health/services/maternity-newborn-care-guidelines/preface.html.

Rayment, Dr Juliet, et al., February 20, 2020. The Development of Midwifery Unit Standards for Europe. Midwifery 0 (0). https://doi.org/10.1016/j.midw.2020.102661.

Bohren, MA, Hofmeyr, GJ, Sakala, C, Fukuzawa, RK, Cuthbert, A, 2017. Continuous support for women during childbirth. Cochrane Database of Systematic Reviews doi:10.1002/14651858.CD003766.pub6, 2017;7:Art. No.: CD003766.

World Health Organization. (2016). WHO recommendations on antenatal care for a positive pregnancy experience 2016 Available from: http://apps.who.int/iris/bitstream/10665/250796/1/9789241549912-eng.pdf?ua=1.

World Health Organization. (2018). WHO Recommendations Intrapartum care for a positive childbirth experience Geneva: World Health Organization, 2018 [Available from: http://www.who.int/reproductivehealth/publications/intrapartum-care-guidelines/en/

American Association of Birth Centers. National Standards for Birth Centers. American Association of Birth Centers. March 1985. Revised 2017. Perkiomenville PA. Accessed June 30 2018. Available from: https://cdn.ymaws.com/www.birthcenters.org/resource/resmgr/AABC-STANDARDS-RV2017.pdf

Rayment, J, et al., 2020. The Development of Midwifery Unit Standards for Europe. Midwifery 20.

Rocca-Ihenacho, L, et al., 2018. Midwifery unit standards. Midwifery Unit Network. http://www.midwiferyunitnetwork.org/mu-standards/.

World Health Organization. Standards for improving quality maternal and newborn care in health facilities. WHO, 2016 Geneva. Accessed June 30, 2018. Available from: http://www.who.int/maternal_child_adolescent/documents/improving-maternal-newborn-care-quality/en/

White Ribbon Alliance. The universal rights of childbearing women. October 2011 WRA Washington DC. Accessed: June 30, 2018. Available from: https://www.whiteribbonalliance.org/wp-content/uploads/2017/11/Final_RMC_Charter.pdf

Lalonde, A, Herschderfer, K, Pascali-Bonaro, D, et al., 2019. The international childbirth initiative: 12 steps to respectful motherbaby-family maternity care. Int J Gynecol Obstet 146, 65–73. https://www.internationalchildbirth.com/uploads/8/0/2/6/8026178/ici_initiative_bw.pdf.

Goodbirth Network. Operational standards for midwifery centers. Accessed Jan 2020. Available at: https://goodbirth.net/operational-standards-for-midwifery-centers/

Jolivet, R.R., Warren, C.E, Sripad, P, Ateva, E, Gausman, J, Mitchell, K, … Langer, A., 2020. Upholding Rights Under COVID-19. Health and Human Rights 22 (1), 391–394.

Rocca-Ihenacho, L, Alonso, C., 2020 Jun. Where do women birth during a pandemic? Changing perspectives on Safe Motherhood during the COVID-19 pandemic. J Glob Health Sci 2 (1), e4.