

Humanization of birth, women's empowerment, and midwives' actions and knowledge: experiences from Quebec and Chile

A humanização do nascimento, o empoderamento das mulheres e a reapropriação de ações e conhecimentos das parteiras: experiências do Québec e do Chile

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ABSTRACT Whether in pre-pregnancy, pregnancy, birth and/or the postnatal and neonatal periods, midwives' practices are underpinned by humanism. However, in this era of postmodernity, there is an ever-growing need for rehumanization. This article adopts an auto-ethnographic approach in order to undertake a reflective analysis on the humanization of birth based on the practice of midwifery in two different contexts, namely Quebec (Canada) and Chile. In light of the evolution of the profession in these two countries, and the influence of health policies and social movements, there are factors such as the systematic use of technology and the hypermedicalization of reproductive processes which are maintaining women's ignorance and keeping them from being able to participate in their maternity process. Women's autonomy and empowerment become a key element for their participation in decisions regarding their maternity, assistance methods, or type of care. Concurrently, midwives' autonomy is a prerequisite for fully exercising their role in supporting and assisting women in this re-appropriation of their power by means of a comprehensive approach that takes into account psychological and social aspects as well as biomedical ones.

KEYWORDS Humanizing childbirth. Midwife. Empowerment. Medicalization. Quebec. Chile.

RESUMO *Seja na pré-gravidez, na gravidez, no nascimento, seja nos períodos pós-natal e neonatal, as práticas das parteiras são sustentadas pelo humanismo. Entretanto, na atual era de pós-modernidade, há uma necessidade cada vez maior de reumanização. Este artigo adota uma abordagem autoetnográfica, a fim de realizar análise reflexiva sobre a humanização do nascimento baseada na prática da obstetrícia em dois contextos diferentes: Quebec (Canadá) e Chile. À luz da evolução da profissão nestes dois países e da influência das políticas de saúde e dos movimentos sociais, existem fatores, como o uso sistemático da tecnologia e a hipermedicalização dos processos reprodutivos, que estão mantendo as mulheres desinformadas e impedindo-as de participar de seu processo de maternidade. A autonomia e o empoderamento das mulheres tornam-se um elemento-chave para sua participação nas decisões relativas à sua maternidade, métodos de assistência ou tipo de cuidado. Ao mesmo tempo, a autonomia das parteiras é um requisito para o pleno exercício de seu papel de apoio e assistência às mulheres nesta reapropriação de seu poder, por meio de uma abordagem abrangente, que leve em conta tanto aspectos psicológicos e sociais quanto biomédicos.*

PALAVRAS-CHAVE Humanização do parto. Parteira. Empoderamento. Medicalização. Quebec. Chile.

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Introduction

The humanization of birth is a concept that became widespread in the early 2000s following an international conference on the subject held in Brazil and bringing together 26 countries. The concept of humanization refers to a process of communication and caring between people that leads to personal transformation, an understanding of the fundamental meaning of life, a feeling of compassion and oneness with the universe, spirit, nature, as well as with others in our families, communities, countries and the larger human family in continuity with past and future generations¹. It applies to all aspects of health care and especially to childbirth, since it has an influence on life and is a key to sustainable social development. Humanization is an important means of supporting and strengthening individuals and groups in order to have a fulfilling life. Humanizing birth involves, among other things, giving support and comfort to women, and has been seen as a way to help eliminate the fear of pregnancy and childbirth that has developed in the postmodern world^{2,3}.

Twenty years later, there continues to be a need to re-humanize. This need concerns obstetric and perinatal practice in all its facets, whether during pre-pregnancy, pregnancy, birth or care for mothers and newborns. Women's fears are growing^{4,5}, and to varying degrees, studies are highlighting pervasive obstetric violence in care during the maternity process^{6,7}. Around the world, many women experience disrespectful treatment and abuse during birth in health facilities⁸. According to the World Health Organization (WHO), the humanization of birth remains an important concern. The WHO promotes this concept as a guiding value that all countries should uphold and apply, recognizing that a positive childbirth experience is important for all women. The WHO⁹ defines a positive childbirth experience as:

one that fulfils or exceeds a woman's prior personal and sociocultural beliefs and expectations, including giving birth to a healthy baby

in a clinically and psychologically safe environment with continuity of practical and emotional support from a birth companion(s) and kind, technically competent clinical staff. It is based on the premise that most women want a physiological labour and birth, and to have a sense of personal achievement and control through involvement in decision-making, even when medical interventions are needed or wanted.

Midwives unquestionably have an important role to play in the humanization of these events. Evidence and reports from international forums in favour of midwives have only proliferated over the past decade. Midwives' assistance facilitates positive birth experiences for mothers and improved health outcomes^{10,11}. However, a challenge for the humanization of childbirth is hypermedicalization, which remains a significant barrier as it increases in pace with the growing pervasiveness of technology and interferes with representations of the processes surrounding birth, both for caregivers and women, and with the relationships they form¹².

An analysis of the different practice contexts should shed light on the main challenges that midwives face in providing quality support in order to enable women to have a positive experience of maternity.

The purpose of this article is to bring to light the evolution of the profession of midwife in Quebec and Chile in order to identify proposals that might enable them to fully exercise their role in a context where a return to humanism and respect for women is becoming a global need.

Methodology

The critical analysis presented here is mainly based on the experiential knowledge of the authors, who are midwives themselves and have held various professional positions and worked in organizations aimed at improving care for women and their families in their respective countries. The auto-ethnographic

approach is a recognized method that allows for combining theoretical analysis and empirical research by focusing on the experiences of people directly involved in phenomena in order to better grasp the social practices associated with them in society¹³. From the perspective of a pragmatic constructivist paradigm, research legitimizes knowledge through reflective work¹⁴. This approach, drawing on knowledge arising from experience in a professional setting, focuses on understanding cultural experience¹⁵ and reporting on the experience of one's own group¹⁶. The comparative ethnographic approach helps illuminate contextual dimensions and better understand how they contribute to shaping a professional identity as it appears to us. The present reflection is based on publications on this topic and on the authors' research in the field of midwifery, and suggests areas of convergence and divergence across the two contexts.

History and evolution of the midwifery profession in Chile and Quebec

Chile is one of the very first countries where midwifery has been professionally established in America, while Canada, including Quebec, has only recently legally recognized the profession.

The university training of midwives in Chile developed under the influence of public policies. The first midwifery school in Chile was inaugurated in 1834 at the University of Chile Faculty of Medicine with the aim of reducing maternal and infant mortality. Later, in 1913, with the recognition of newborn care up to 28 days of life, these schools were named Schools of Obstetrics and Child Care. As the profession spread to rural areas, the Chilean government prohibited the practice of empirical midwives. It is estimated that this practice died out in the first half of the 20th century¹⁷.

Since its inception, the profession has served the health goals of the country and, as a result, it is the state that has provided training and employment for Chilean midwives. Until the 1970s, the scope of practice of Chilean midwives was limited to the health of the mother-child pair. However, major socio-demographic and socio-cultural changes have contributed to expanding this professional role through universal access to sexual and reproductive health programs, at all stages of women's reproductive cycle. Nevertheless, since the 1980s, the privatization of the health sector has restricted the full exercise of their competencies. Thus, in private clinics, deliveries are performed by doctors. In parallel with the hyper-medicalization of obstetric practice, the community sector has gradually been reduced and liberal practice remains limited. Since 2006, ministerial standards have tended to strengthen the humanization of birth and to restore a more active role for midwives in hospitals. This trend should also encourage greater independent private practice, including home birth.

In Chile, the Sanitary Code regulates the practice of midwifery while the Order of Midwives (created in 1962) is primarily mandated with guaranteeing the proper practice of the profession, but also defending it. Importantly, under the military dictatorship (1973–1989), all professional orders lost the powers to guarantee professional ethics, and being on the roll was no longer a requirement in order to practice. They have still not recovered these powers – a fact that has considerably weakened the bond between midwives and the advocacy efforts of the professional order. Today, according to the records of the National Order, 8,000 out of the country's 14,500 midwives belong to the order.

As Chile is a highly centralized country, the practice of midwifery spread homogeneously. Currently, midwives are distributed across all 16 regions of the country and are responsible for normal deliveries in all public maternity services. Despite this, Chilean

midwives' participation in assisted birth has only dropped, from 75.5% in 1991 to 48.4% in 2017, while medical intervention during pregnancy, labour and birth has only increased¹⁸.

In Quebec (Canada), at the beginning of the colony, in the 1600s, midwives from France came to practice in what was then called New France. With the creation of the Corporation des médecins in 1847 and rising numbers of doctors, midwives were first controlled and then excluded, and almost disappeared altogether¹⁹. In the late 1970s there emerged a social movement criticizing the medicalization surrounding birth. Groups strongly called for the humanization of birth, women's empowerment, and the reappropriation of related actions and knowledge. It was in this context that the practice of midwives resurfaced, initially in the form of pilot projects in 1990²⁰. Following the success of this experiment, the Government of Québec legalized the profession in 1999 by creating a professional order of midwives, and integrated them into the public health network, as front-line professionals²¹. A university training program was also launched in 1999.

Quebec is one of Canada's 10 provinces, from which it differs in important respects: It is the only French-speaking province, and has its own distinct culture. The laws governing professional orders and state jurisdiction over health services also differ. The scope of practice is determined by the Midwives Act, which covers pregnancy, birth and normal postnatal care up to six weeks of life. Situations involving consultation and transfer of care to a doctor are governed by a specific regulation²². Otherwise, the woman and the newborn remain under the sole care of the midwife. Each midwife must be a member of the Ordre des sages-femmes in order to practice. The mandate of the order is to protect the public and to promote the development of the profession. The order regulates practice through admission, professional inspection, disciplinary measures in the event of breaches of the code of conduct, continuing education, and

control of illegal practice²³. The Midwives Act has thus enabled real professional autonomy.

The province currently has 262 active midwives. Midwives have also formed an association with the mandate of upholding the professional, economic and social interests of its members²⁴.

All midwives work under contract in public health centers. A council of midwives established in each of these centers is responsible for generally monitoring and assessing the quality and relevance of the acts performed, while ensuring an appropriate distribution of services²⁵.

Any woman with a midwife can choose the place of birth, namely a birth center (chosen by 80–85% of women), a hospital (chosen by 2–3%) or at home (chosen by 15–20%). The services are covered by the Quebec public health insurance plan²⁶.

In Quebec, of the 85,000 births that take place each year, only 4.5% are currently performed with midwives. To reduce this gap, a government development plan has been established to expand the proportion of midwifery services to at least 10% of women for all regions of Quebec^{24,26}.

Midwifery practice and its relationship to the humanization of birth

The humanization of birth is a central concern for midwifery in Quebec. This concern was a result of the *Accoucher ou se faire accoucher* symposia organized in 1980 by the Association de santé publique du Québec, in all regions of Quebec, which allowed women and families to make their voices heard and to demand the humanization of birth, the creation of birth centers, and the legalization of the profession of midwife²⁰. Thus, the practice was able to develop under a different paradigm in response to women's demand to humanize birth and to reappropriate their experience of maternity.

As Chile is a highly centralized country, the practice of midwifery spread homogenously and in accordance with protocols in medical teams, especially for childbirth assistance and newborn care.

The risk approach introduced in obstetric and perinatal standards has gradually translated into 'zero tolerance' toward risk. Obstetricians have been given a very prominent role in procedures such as caesarean sections, and therefore childbirth inductions have, in some cases, become systematic. In this context, midwives have gradually faded from the scene and been estranged from their professional role as supportive figures who protect and ensure their natural physiological processes during childbirth and birth. Today, some growing feminist movements associate the image of the midwife with the violence exerted by obstetric teams. In light of these movements, the debate is progressing and one bill against obstetric violence considers that each woman should be accompanied by a midwife during labour and childbirth.

It is worth noting that, apart from hospitals and private clinics, midwives in community clinics with a more preventive role, applying the principles of monitoring and continuity of care even at home and having an educational role in the school community, are less exposed to criticism from the female population.

Women's empowerment and professional autonomy

Analysis of our experience reveals that in order to promote autonomy in maternity, midwives must have a woman-centered practice guided by a comprehensive approach that takes into account psychological and social aspects as well as biomedical ones. This can only be achieved by establishing a genuine professional relationship characterized by active listening and respect toward women.

In Quebec, this means a relationship of mutual trust where each woman and midwife can trust the other. The midwife brings her professional

knowledge and skills to the relationship, while the woman contributes her knowledge of herself and her feelings. Support holds a key place in follow-ups. "Recognizing women's autonomy entails having a dialogue with them, which changes the relationship to risk because it becomes discussed and shared"²⁷⁽¹⁴⁵⁾. This means a non-hierarchical relationship, with the full recognition that it is the woman who wields the power to make the decisions. To this end, midwives must provide parents with information so that they can make informed choices. This approach also involves taking an interest in the views and values of parents, whether in prenatal screening, diagnostic examinations, care, their expectations relating to birth, etc. From the point of view of Quebec parents, a non-hierarchical relationship demands reciprocity and collaboration²⁷. The environment is also an important element in facilitating and humanizing birth and carrying out the birth plan as desired by the parents.

More broadly speaking, popular education allows women and families to demystify the birth and likely be less afraid of it. In a society marked by risk, it becomes essential to reinforce the fact that the birth experience could take place without intervention most of the time. Accurate information can give power back to women and families in the birth of a child, i.e., a transformative and highly significant event in their lives.

Moreover, "professional autonomy is the backbone that allows the profession to stand up, to realize itself, and to uphold its social mission"²⁷⁽¹⁴⁷⁾. Without professional autonomy, midwives cannot fully perform their job of providing comprehensive support in a spirit of respect for individual differences.

Barriers to women's autonomy and the humanization of care

According to our analyses, the medicalization of practices around birth, the rise of technology, the directive approach, and the sometimes

blind or non-consensual systematization of care offered to women constitute barriers to developing women's autonomy and the humanization of care.

Accompanying women throughout their reproductive life, in the care of a new child and the development of their families, means being there with women and families during profoundly meaningful life events that are not fundamentally linked to illness. This requires a holistic approach centered on all the needs attendant to this life transition. Yet scientific knowledge and medical research have developed in relation to pathology²⁸.

Since the 1980s, Chilean midwives have participated in the risk-based biomedical model, applying the ministerial protocols and standards that guide obstetric practice. These documents are drawn up by expert committees with a strong medical presence. The predominance of the medical approach and the socio-political context linked in particular to the privatization of health care has resulted in midwives' loss of autonomy in private clinics where deliveries are performed by doctors. In general, the midwife's role in normalizing the process of pregnancy and childbirth is limited. The rise of the private sector in Chile and the associated increase in interventions, including caesarean sections, shows that excessive medicalization of pregnancy and birth leads to a gradual loss of midwives' presence and role²⁹. This is concurrent with the spread of a certain culture of risk and fear among women. Women are less and less confident in their ability to be protagonists in an area as essential to their lives as maternity.

Chile has recently adopted a policy on the practice of humanized childbirth, and although the scientific community seemed to be aligned with the ministerial recommendations for a more respectful childbirth, the proposed changes are progressing slowly. Moreover, complaints about obstetric violence have been noted in addition to the public's demand for quality care³⁰.

In Quebec, the scope of practice allows midwives to focus more on normality and affords them some protection from growing medicalization. However, they are not immune to the ever-growing numbers of tests and examinations, the influence of clinical medical guidelines (e.g., inducing labour at an advanced maternal age), or the technological values that pervade society and influence women or midwives themselves.

Since midwives are still few and far between and can assist only about 4% of births, they remain marginal, even if they are integrated into the health system. Their vision of birth as falling under a holistic paradigm continues to lie on the fringes of the dominant medical paradigm. They must fight constantly to hold on to certain gains. For example, according to the legislative regulations, women who have had a caesarean section may be cared for by a midwife during a subsequent pregnancy. However, even if midwives carefully measure the risks (e.g., type of caesarean section, thickness of the scar, etc.), they come up against a powerful medical lobby in favour of withdrawing these rights or preventing agreements between institutions to provide the medical support required when new midwifery services are established. There is inequality in the balance of power. In some settings, out-of-hospital birth also remains contested, despite the evidence of its safety for healthy women under the care of skilled professionals^{31,32}. Physicians also question midwives' conduct (clinical behaviours), which creates tension during consultations and transfers, for both women and midwives. Some doctors sometimes assume the right to keep women under their care following a consultation, or to collaborate only on the condition that they impose their own rules. Over time, the community engagement of midwives, too, has eroded. They devote themselves to the families they meet, but no longer participate or participate very little in the community life that allowed them to remain close to women and families and their concerns, and to play a

more prominent social role. User committees, which had a strong presence in the early 2000s, have found themselves threatened under certain health center administrations. All of these factors are contributing to creating environments that are less conducive to normal life events and to the recognition of women's abilities.

In both countries, the medical influence is still present in clinical practice and in certain continuing education programs. Development of the profession is also limited by competition with other health professions, such as nurses in Quebec who continue to occupy the field of obstetrics as well as nurses in Chile, where, with the cross-cutting skills of the health professions, nursing practice is gradually gaining ground where midwives would benefit from exercising their full role for the well-being of women, newborns and families. Additionally, with the rise of technology, the role of midwife is also poised to change profoundly considering that with the increasing rates of caesarean sections (about 30% in Quebec and 50% in Chile), birth is more and more an act that falls under the field of medicine. Moreover, the dominant paradigms of risk and medicalization open the door for and are already profoundly transforming birth, related events, and the experience of women and newborns.

For example, the institutions where midwives practice play a significant role. When midwives must comply with institutions to the detriment of their relationships with women, this results in a mode of practice contrary to professional ethics³³. In addition, the very hierarchical structures of some health facilities prevent visibility and recognition within the obstetric and perinatal team of midwives' contributions and leadership in the areas of low-risk pregnancies, normal deliveries and child care. Maternity services would benefit from fostering a model of care focused on relational continuity that is personalized in accordance with the one midwife/one woman principle, as also recommended by the WHO³⁴.

Obstacles can also arise from midwives themselves. Indeed, the work of midwives has been bureaucratized by new requirements which

have not been challenged or assessed for their impacts, through the delegation of duties specific to the profession to other junior subordinates on a team (e.g., welcoming a woman in labour) or through midwives' consent to take on more and more administrative tasks (e.g., digitizing clinical records) to the detriment of the quality time highly valued by women.

Focusing solely on measurable clinical parameters and moving away from support goes against the movement of humanizing births and recognizing women's autonomy in their maternity.

In addition, when a woman wants to exercise a choice that the midwife does not approve of, the midwife may tend to convince the woman to agree to the recommended care and then to use 'increasing intrusion' strategies associated with domination and the patriarchal institution³⁵.

Moreover, professionals are often slow to change their practices despite scientific evidence and continue to use strategies that are not guaranteed to be effective. "There is, therefore, a long way to humanize the care provided during childbirth"³⁶⁽⁵⁹⁾.

Proposals for a humanizing practice

A woman-centered humanizing practice involves developing or maintaining ties with different groups of women. It is a challenge that requires a strong professional identity.

Woman-centered care entails clinical practice that emphasizes the woman/midwife relationship and women's choice, control and empowerment in their experience. To this end, caregivers must develop a meaningful relationship with women and create an environment that respects their choices and decisions³⁷.

Autonomy in the processes surrounding motherhood is strongly linked to the context of women's lives and is associated with socio-cultural, economic and political dimensions. In order to achieve full autonomy, women need to be freed from all domination.

To this end, it is important to convey a different vision of birth and childcare. In today's society, the overvaluing of technical knowledge and the hypermedicalization of reproductive processes maintain women's ignorance and inability to participate in their physiological birth process⁷. Power and knowledge are inseparable, because one strengthens the other³⁸. Thus, greater sharing of midwives' knowledge about pregnancy, childbirth and everything surrounding motherhood, including rights such as the refusal of interventions or care, helps to further women's power and autonomy³⁹.

Maintaining a specific, solid and independent professional practice requires appropriating the midwife identity, focusing on it in alignment with professional values, and developing leadership adapted to technological and socio-cultural changes. Reclaiming the meaning of the midwifery profession and its social role becomes imperative in our societies in order to rediscover support for women and to celebrate birth⁴⁰.

As we have seen, the social role of midwife is an important part of the profession and involves a partnership with women, families and the community in order to provide well-adapted support.

Midwives' expertise includes the application of popular education principles connected to health promotion and protection. Indeed, the behavioural changes that are so sought-after in health promotion are built upon the foundation of empowering individuals and communities⁴¹⁻⁴⁴.

The profession of midwife, in its essence, personifies the protective figure of the physiological processes of pregnancy and childbirth⁴². This can generate 'shockwaves' in the world of obstetrics, owing to the difference in models of care, i.e., centered on principles of humanization versus derived from the biomedical technocratic model^{43,44}.

The growing medicalization of obstetrics in conjunction with the restriction of the role of midwives becomes an important issue that calls for reclaiming the founding pillars of the profession. To be able to provide holistic and personalized care, midwives need to be autonomous and to distance themselves from the patriarchal

biomedical model. There is a need to respond with a proactive stance and without submitting to the hypermedicalization in obstetrics and perinatology. Midwives' autonomy can ensure women's autonomy in a world where many elements contribute to restrict it²⁷.

Professional ethics have played an important role in the practice of midwives since the earliest times. The professional order, whose mission is to protect the rights of users, is an essential means of upholding ethical principles and the quality of services. As such, it is important that it bring all professionals together. Our experiences confirm that professional orders, professional associations and universities are key pillars for ensuring professional quality as promoted by the International Confederation of Midwives⁴⁵. It is also important to ensure peer training, which makes it possible to offer a practice that is relevant to women and adapted on an ongoing basis. In addition, there is a need to defend the profession against initiatives to restrict it or alter the professional profile of midwives, and to participate in professional bodies and make this visible in the community.

To address many of the challenges mentioned above, research by midwives is a very powerful tool. This research includes documenting practices, increasing and disseminating knowledge, innovating, and improving actions and outcomes. Research highlights the impact of midwifery which is not measured only in terms of epidemiological or demographic statistics, but also in terms of psychological and social outcomes.

Finally, another challenge is to ensure the presence of midwives in decision-making bodies for public policy, i.e., not only healthy policies, but also social policies concerning women and children's health. It is important to advocate for access to public health services. As Murray's studies in Chile have shown, it is clear that in addition to exacerbating social inequality, private services strongly contribute to the medicalization of health^{29,46}.

Table 1 summarizes the main proposals arising from our reflexive analysis.

Table 1. Proposals for developing an autonomous and humanizing practice of midwifery

Developing a meaningful relationship with women and creating an environment that respects their choices and wishes.
Sharing of midwives' knowledge about pregnancy, childbirth and everything surrounding motherhood, including rights to participate in their physiological process.
Appropriating the identity of midwife and developing leadership with respect to the physiological process of pregnancy, and childbirth.
Strengthening the social role of the profession in partnership with women, families and the community in order to be at the forefront and to provide comprehensive practice adapted to contexts.
Responding to hypermedicalization by adopting a proactive as opposed to submissive stance, and mobilizing the knowledge of midwives as well as that of women with respect to their own process.
Protecting women's rights and defending the profession and its ethical principles, which is essential in order to guarantee the quality of services.
Participating in bodies for the development of the profession, such as professional orders, professional associations, universities and continuing education institutions.
Carrying out applied research to highlight practice outcomes and demonstrate impacts.
Participating in power-wielding and decision-making bodies in all areas concerned by the profession.

Source: Own elaboration.

Conclusions

Critical analysis of the history and evolution of midwifery in Chile and Quebec shows that the differences between the two countries are mainly attributable to the socio-political context surrounding the profession's development. In Chile, midwifery first developed under the auspices of social and health policies. Subsequently, the neoliberal model favored the private sector, which controlled obstetrical and perinatal processes and restricted the autonomy of midwives' professional practice. In Quebec, women's demands put pressure on the government to legalize the profession i.e., demands for care based on their needs as defined by them. The respective postures of serving health policy and serving the needs of users shape the goals and means of midwifery; these two determinants should not be in opposition.

The experiences of Chile and Quebec show that at least two conditions are required in order to fully exercise the role of

midwife. The first is state support via public policies to achieve broad coverage of care, as in the case of Chile where midwives' work has translated into improved indicators of maternal, perinatal and child health nationwide. The second is professional autonomy, which is more developed in Quebec. This is a prerequisite for meeting women's needs and guaranteeing the essential role of midwife, which is to protect the normal course of pregnancy, delivery and birth, as well as contribute to individual, family and social well-being throughout these processes.

These aspects are essential if the voices of women and their families are to be heard. Only in this way will midwives be able to assert the profession in all its uniqueness and fully exercise their social role. Their practice has a significant impact on the health care system when they contribute to promoting health, reducing unnecessary interventions, and furthering the well-being of the families they serve. In the future, midwives will be called upon to work more extensively in the community and to exercise leadership

within civil society to promote awareness of the mechanisms that diminish the decision-making power of women and families.

Whether in North America, South America or elsewhere, faced with common issues such as hypermedicalization, midwives stand to benefit from strengthening their identity by applying the founding principles of their role while preserving their professional autonomy in order to safeguard a humanized practice.

Collaborators

Gagnon R (0000-0002-2899-7303)* contributed to data collection for Quebec, critical analysis, design and writing of the manuscript, review of the article at all stages, and supervision of the production of the article. Orellana PL (0000-0003-2139-518X)* contributed to the collection of data for Chile, critical analysis, participated in the drafting of the manuscript, and revision of the article at all stages.■

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