

# **The International MotherBaby Childbirth Initiative (IMBCI): Working to Create Optimal Maternity Care Worldwide\***

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## **Introduction**

This article tells the story of the creation of an international initiative designed to improve childbirth care and childbirth and breastfeeding outcomes for all women and, most specifically, of the organization and the individuals behind it. This initiative arose from a dream and is well on its way to becoming a reality grounded in a strong evidence basis and in a clear human rights framework. The specifics of this initiative and the process of its creation form the subject matter of this article. In telling this story, we hope to offer a template for positive change—a template that builds on the prior work of many others, created by and for the birth-giving women of the world.

## **History of the International MotherBaby Childbirth Organization (IMBCO)**

### **The Role of CIMS**

The Coalition for Improving Maternity Services (CIMS) was founded in 1996 in the U.S. and today incorporates in its membership 50 childbirth-related organizations representing over 90,000 members. Its mission was then and continues to be to promote a wellness model of maternity care that will improve birth outcomes and substantially reduce costs. During its inceptional meeting at Mt. Madonna (an apt site) in California, the founders of CIMS (including two of us, Robbie and Mayri) began work on creating the *Mother-Friendly Childbirth Initiative (MFCI): 10 Steps to Mother-Friendly*

*Hospitals, Birth Centers, and Home Birth Services* for the U.S. (For the history and full text of the MFCI, go to [www.motherfriendly.org](http://www.motherfriendly.org).) The MFCI was modeled, in part, after the Baby-Friendly Hospital Initiative (BFHI). Individuals who had participated in the development of the original WHO/UNICEF BFHI initiative were invited to meetings during the creation of the BFHI. Much dialogue and discussion ensued about ways to integrate the MFCI and the BFHI, therefore ensuring that ‘mother-friendly care’ supported ‘baby-friendly’ care. As a result, the tenth step of the MFCI specifies that a mother-friendly service “strives to achieve the WHO-UNICEF ‘Ten Steps of the Baby-Friendly Hospital Initiative’ to promote successful breastfeeding,”—a strategy that was later replicated in the International MotherBaby Childbirth Initiative (IMBCI).

After the MFCI was released in 1996, it went global via the Internet, was translated into multiple languages and put to work in many countries, most often by consumer organizations. In subsequent years, CIMS received many requests from organizations and advocacy groups both large and small in many countries to help them create their own initiatives. To these requests, CIMS consistently responded with the message that its U.S.-based initiative, the MFCI, was freely available and could be adapted by any country to meet its own needs. We did not want to seem in any way to be “American imperialists,” so we kept repeating that message.

CIMS did hold an internationally-oriented meeting in 2002 in response to requests from international organizations to take the MFCI around the world, with midwives Mary Kroeger and Jan Tritten as co-chairs. Mary Kroeger’s vision had long been to create an international document that addressed the mother and baby as one unit. This informal 2002 meeting and a series of others solidified the idea in the minds of those who attended, and over time, more and more international birth activists and practitioners, including obstetricians, kept showing up at CIMS conferences in the US, and repeating their requests for CIMS to create a global initiative that would work for all countries.

The year 2002 was pivotal for the international birth and breastfeeding communities. CIMS was represented at the special UN General Assembly on Children in New York City; CIMS representatives presented the MFCI at the International Congress of Midwives (ICM) Congress in Vienna, to the Ministry of Health in Brazil, and at many conferences around the world. Mary Kroeger, a certified nurse-midwife and global midwifery activist, was instrumental in the development of the World Alliance for Breastfeeding Action (WABA) Global Forum II with birthing practices as a core theme. In 2003, the World Health Organization embraced “Mother-Friendly” concepts in their publication *Global Strategy for Infant and Young Child Feeding: A tool for assessing national practices, policies, and programs*.

The global stage was set as the demand for CIMS to develop an international version of the MFCI continued to grow. The rationale was that “we had done it once, so we were better equipped to do it again”! Our international representatives consistently repeated that we had the international advantage of creating such an initiative in English, which was increasingly becoming the global *lingua franca*, and that CIMS had more resources for creating this initiative than the nascent country organizations could have.

### **The CIMS International Committee**

Finally, CIMS gave up protesting that each country should create its own initiative, and in 2005 formally created an International Committee with the idea that this Committee would create a global initiative based on the MFCI. It was midwife Mary Kroeger who held the vision for the creation of this committee. She had worked to invite delegates from around the world to the first official CIMS International meeting in Virginia in 2005 and had planned to chair this first meeting. Yet she fell ill, and convinced Debra Pascali Bonaro to chair “just this one meeting!” in her place. Together they had

requested and received funding for scholarships to bring international representatives to this meeting from the New Hampshire Charitable Trust Foundation, as well as support from the Johnson and Johnson Pediatric Institute. Representatives from Europe, Asia and the Americas attended this ground-breaking meeting February 25 and 26 in Arlington, Virginia. Their advocacy for the creation of an international initiative was, to say the least, enthusiastic and convincing, as was—to her astonishment--their advocacy for Debra to become the first Chair of the new CIMS International Committee. This one day meeting ended with a vision and a list of next steps:

1. Develop a global data base of every regional and country-level birth and breastfeeding organization--including NGOs, government, and grassroots organizations--in the world, with the assistance of four regional representatives, and develop country contacts around the world.
2. Create and administer a survey of these organizations on the 10 Steps of the MFCI.
3. Hold a meeting in Geneva with global representation of major organizations within one year.

With survey input, international organizations, and committee input, we envisioned that we would create a global document that would be culturally appropriate and effect change in all regions of the world.

Debra remembers waking the day after she returned home, looking at the list tucked into her pajamas, and feeling overwhelmed with the task of creating a global initiative. Then the phone rang. Jane Arnold, a nurse-midwifery faculty member, had communicated the results of our meeting to her colleagues at the Center for Women's Health Research at the University of North Carolina at Chapel Hill; its Director Katherine Hartmann was willing to lend a hand. Canadian midwife Bridget Lynch, who later became President of the International Confederation of Midwives (ICM), was instrumental in helping us outline the above tasks and helped us to organize a series of calls, create a steering committee and working groups, and guide us to key contacts.

The CIMS International Committee set out on a global search. Via a grant and the support of Childbirth Connection, a U.S. based leader in maternity care quality improvement, we created an international network of regional and country representatives from the four major regions of the world—

Africa, Asia-Pacific, Europe, and the Americas encompassing 163 countries. These regional representatives included Flavia Previtali from Uruguay, regional rep for the Americas; Lucie Ryntova MA and Eliska Kodysova MA from the Czech Republic, regional reps for Europe; Mandisa Singata MBA, RM, RN from South Africa, regional rep for Africa; and Mun Tip Lew from Malaysia, regional rep for Asia. They went to work developing country contacts who could gather information for organizations of pregnancy, birth, and breastfeeding providers, consumers, grassroots consumer groups, advocacy groups, women's health groups, health care professionals, and both governmental and non-governmental organizations, generating the world's largest international database on maternity and breastfeeding organizations.

The Center for Women's Health Research at the University of North Carolina used this database to conduct a global survey of the 10 steps of the CIMS Mother-Friendly Childbirth Initiative (MFCI). This survey did not include Step 9 on circumcision, which is not an issue in most countries (as it is not routinely performed), yet did include an additional question on informed decision making—a point strongly emphasized by the international representatives. Using a Likert scale, the survey (conducted online), requested feedback on the other 9 Steps of the MFCI and included a few open-ended questions about barriers to best practices. The multidisciplinary team at the Cecil G. Sheps Center for Health Services Research evaluated the results, which showed an 80-95% agreement on each of the steps included in the survey.

This survey assured the CIMS International Committee that there was indeed strong international support for the principles and goals of the U.S. Mother-Friendly Childbirth Initiative (MFCI), and that support gave us a sound basis for creating what we eventually called the **International MotherBaby Childbirth Initiative (IMBCI)**. We chose this name because we wanted to draw attention to the mother and baby as one integral unit, a dyad that should not be separated, and because our Initiative places a

great deal of emphasis on the impact of birth practices on breastfeeding, which was fully documented in Mary Kroeger's book, The Impact of Birthing Practices on Breastfeeding: Protecting the Mother and Baby Continuum (2004).

A second CIMS International Committee meeting followed in Boston in March 2006 at the CIMS annual meeting that was attended by 50 international birth advocates and professionals from 22 countries, most of whom represented organizations. The New Hampshire Charitable Foundation and Johnson and Johnson Pediatric Institute again offered scholarships and support that enabled us to bring in representatives from Africa, Israel, the Philippines, South America, and Europe. J. Nikki McKoy, from The Center for Women's Health Research at the University of North Carolina at Chapel Hill, presented our first look at the international survey. Maureen Corry, Executive Director of Childbirth Connection (formerly called the Maternity Center Association), was also present and was recruited to co-chair the newly formed Committee with Debra. Other members of the CIMS International Committee came quickly to include Rae Davies, Mayri Sagady-Leslie, and Robbie Davis-Floyd. As in, we went to a meeting just to be supportive, and came out of it as a fully-formed group! Inspired by the level of international support, Debra and Maureen and the rest of us went to work immediately.

### **Creation of the IMBCI**

In May 2006, the CIMS International Committee held a Steering Committee meeting in Chapel Hill at the University of North Carolina to work on the wording for an initial draft of what at the time we were calling the *Global Mother-Friendly Childbirth Initiative* (because our grounding at the time, our solid basis as confirmed by the survey, was the CIMS Mother-Friendly Childbirth Initiative). This meeting was attended by midwifery instructor Jane Arnold, Maureen Corry, Rae Davies, Rosha Forman (a budding midwifery student, friend and apprentice of Mary Kroeger, she has since attended and graduated from midwifery school), Katherine Hartmann, who was then professor and researcher at the

Center for Women's Health Research at University of Carolina, Miriam Labbok, former director of the BFHI for UNICEF, Nikki McKoy, then project manager at the Center for Women's Health Research (University of Carolina), Debra Pascali-Bonaro, and Robbie Davis-Floyd.

We had in our hands the MFCI, the Better Birth Initiative (which originated in South Africa), and various other related documents. We felt daunted by the task ahead, yet we were not working from scratch! We very much wanted to keep our new international initiative to 10 Steps, following the MFCI and the BFHI, as 10 is a powerful round number that works to “keep it simple” and maintain a strong focus. We also had a very clear mandate from our international survey on what Step 1 should be: All of the international organizations surveyed noted that respect for the woman and her choices, along with full information provided to her, should be the foundation of any and all models of birth care. So, of course, **Step I** reads that “An optimal MotherBaby maternity service has written policies, implemented in education and practice, requiring that its health care providers”:

**Treat every woman with respect and dignity, fully informing and involving her in decision making about care for herself and her baby in language that she understands, and providing her the right to informed consent and refusal.**

Our fearless Chairwomen Debra Pascali Bonaro and Maureen Corry had many international contacts, and helped us realize that any attempt at creating a global initiative would have to have the support of the already-existing global maternal health-related organizations. Yet how to proceed? Bridget Lynch again was instrumental in guiding us. She suggested that we develop a Technical Advisory Group consisting of representatives from all the major international agencies involved with maternity care. She opened many doors for us, one of which led to Maureen and Debra holding several meetings with Nancy Terrari from UNICEF. These and many other discussions led to the creation of the Technical Advisory Group.

As we had predicted earlier, it quickly became obvious that a face-to-face meeting of these representatives would have to be held for rapid progress to be made. Debra and Maureen obtained funding for such a meeting from the New Hampshire Charitable Trust Foundation, from a fund that later came to be known as the Transforming Birth Fund—we are forever grateful to its founders!

Thus the CIMS International Committee, with the direct participation of Childbirth Connection, held a Technical Advisory Group meeting in Geneva, Switzerland in June 2006 to present and refine the initial draft of the Initiative and to gauge the level of interest in supporting and promoting the Initiative. This meeting, for which we all came well-prepared with our ideas and our initial draft of the Initiative from our Chapel Hill meeting, was chaired by Dr. Monir Islam, the current director of Making Pregnancy Safer (WHO). The participants in this Geneva meeting included representatives from WHO, UNICEF, USAID, CIMS, Childbirth Connection, Lamaze International, DONA, La Leche League International, Wellstart International, the World Alliance of Breastfeeding Associations (WABA), the International Lactation Consultant Association (ILCA), the International Confederation of Midwives (ICM), the International Council of Nurses (ICN), the International Pediatric Association (IPA), and JPHIEGO. We recruited these organizations because of our profound respect for the international work they had already done, and because we knew that we could not create such an Initiative in isolation.

There was tremendous support for developing this Initiative from all present, and we spent hours refining the wording of the document in a very rewarding group consensus process—well, it turned out to be very rewarding, yet it was very trying for one of us (Robbie)—as designated editor (she had been the lead editor for the MFCI, along with Roberta Scaer and Henci Goer, back in 1995, so it made sense for her to be lead editor this next time around), she had our preliminary draft from Chapel Hill up on PowerPoint, and for two afternoons straight she took verbal suggestions from the TAG reps, sometimes shouted out with much discussion around every word—a huge challenge to change the wording on the

spot, yet lots of fun—a most creative and exciting process! Each night Robbie sat up late incorporating all the verbal suggestions, to present it all again the next day, while Debra, Maureen, Rae, and the rest of our Committee worked on strategy.

During this most amazing TAG meeting, after Dr. Katherine Hartmann presented the encouraging results of the international survey on the MFCI 10 Steps, we not only worked on the wording of the IMBCI but also on making preliminary plans for pilot testing the IMBCI in various hospitals around the world and conceptualizing its future. We culminated the meeting with a huge round of applause for Debra and Maureen for all their work in bringing us all together to create this global initiative, for which everyone present agreed there was a huge need.

It was most serendipitous that right after this TAG meeting, Robbie, accompanied by Rae Davies (who later became our IMBCO Administrative Director) was headed to give some talks at the Hecvsante Nursing and Midwifery School in Lausanne, Switzerland. Although the IMBCI was not on the schedule, Robbie and Rae convinced the entire faculty of the school to meet with us to review the powerpoint of the IMBCI as it then stood in its initial stage. Many of its major steps regarding humane care had long been implemented in Switzerland, so the faculty went beyond those to encouraging us to include a whole step on collaborative care—a major issue for Swiss midwives, as obstetricians there often took a top-down approach and did not bother to collaborate in an egalitarian way with the professional midwives. Robbie and Rae realized that collaborative care was also a major issue in many other countries. The Swiss midwives' suggestion about collaborative care ultimately became **Step 9: “Provide a continuum of collaborative care with all relevant health care providers, institutions, and organizations.”**

As Editor for the IMBCI, Robbie had the responsibility over the next year of gathering international input on the document. Wishing to be as inclusive as possible, Robbie sent it out far and wide. As a

result, the IMBCI was ultimately reviewed by representatives of all of the organizations listed above and around 100 high-level childbirth experts, midlevel practitioners, and grassroots activists from many countries—the full range from bottom-up to top-down. At first, as previously mentioned, wanting to remain connected to the MFCI, we used the title “Global MotherBaby-Friendly Initiative” and then, wanting also to honor Mary Kroeger’s insistence on the integrity of the motherbaby, “International MotherBaby-Friendly Initiative.”

We were on draft #57 when we were asked by UNICEF and WHO—the creators of the international Baby-Friendly Hospital Initiative (BFHI) (and also by the World Alliance of Breastfeeding Organizations (WABA)) *not* to use the phrase “motherbaby-friendly” because that made it sound as if we were the umbrella organization for the Baby-friendly Hospital Initiative, which had already been in existence for over 20 years and had designated many thousands of hospitals in many countries, whereas we were in our incipient stage. So after much debate, we chose the final name *International MotherBaby Childbirth Initiative (IMBCI): 10 Steps to Optimal MotherBaby Maternity Care*. (See below re the term “MotherBaby.”)

At first, Robbie worked closely on the writing of the IMBCI with the members of the official editorial committee who had volunteered for the job at the TAG meeting, yet it in the end it turned out that the ones who had the most patience for the very stressful and lengthy wording process were our other Board members at that time—Debra Pascali Bonaro, Maureen Corry, Rae Davies, and Mayri Sagady Leslie. The crafting of the IMBCI narrowed down to the five of us—we struggled over and carefully considered every single word. This care was necessary because we were writing an Initiative that we intended to be applicable to the entire world, and the needs and resources of developed and developing countries differ widely. Robbie’s education as an anthropologist and her wide knowledge of these differences helped enormously, as did the international experiences of Debra, Maureen, and Rae,

in particular Maureen's thorough knowledge of the scientific evidence and Maryi's long years in nurse-midwifery clinical experience, plus her strong research and epidemiological background.

Our cumulative awareness of those differences led to many difficult yet rewarding conversations—for example, should we say that an optimal MotherBaby facility should offer both drug- and drug-free pain relief options? Clearly, the epidural is experienced by many women as a humanistic pain-relieving option during labor. Yet it carries risks and complications, especially if given too early in labor. So that issue had to be debated at length. In the end, we came down to reality—to insist in our Initiative that pain-relieving drugs, including the epidural, be included in the IMBCI would be to ask developing countries that cannot afford such drugs to provide them, which would be most unrealistic and unfair. (Again, we were very aware that we were creating this Initiative for all countries and all settings.) On the other hand, drug-free pain-relieving interventions cost almost nothing and can be provided in any setting in any country, and are evidence-based as helping to relieve pain while causing no harm. So **Step 4** reads:

**Provide drug-free comfort and pain-relieving methods during labour [we used the British spelling as it has become the global standard], explaining their benefits for facilitating normal birth and avoiding unnecessary harm, and showing women (and their companions) how to use these methods, including touch, holding, massage, laboring in water, and coping/relaxation techniques. Respect women's preferences and choices.**

After a full year of intensive work, we finalized the wording of the IMBCI in February of 2008, and launched the International MotherBaby Childbirth Initiative at the CIMS Annual Meeting in Florida on International Women's Day in March 2008. Of course we had to launch it at CIMS—its mother organization! It was a marvelous occasion. Debra and Robbie presented the IMBCI step-by-step on powerpoint. The many international representatives present organized themselves into a line, and one-by-one stepped up to the microphone to read the Principles we included in the document to pinpoint the underlying philosophy of the IMBCI. These Principles are too lengthy to include here—please visit our

website [www.imbci.org](http://www.imbci.org) to read the Principles, which are included in the full text of the IMBCI. Here we will simply include the Conclusion to the Principles (see below).

### **The MotherBaby**

An important contribution of the IMBCI is the “MotherBaby” model of care. “MotherBaby” is a term first used by Audrey Naylor, MD, DrPH. Dr. Naylor is CEO of Wellstart International, a pediatrician and a longtime champion of breastfeeding in the international arena. In referring to her use of the term, she said:

I strongly believe that mothers and babies are an interdependent, biologic unit that must stay together for at least six months during the period of exclusive breastfeeding and continue for about nine months after birth during the introduction of nutritious complementary foods. Breastfeeding should continue for 2 or more years while the baby is introduced to nutritious complementary family foods. Words are powerful. If we use a single word for this motherbaby unit it may help. (Audrey Naylor, e-mail message to Mayri Sagady Leslie, August 8, 2010.)

The IMBCI promotes the idea that the MotherBaby is Naylor’s ‘single unit,’ inseparable throughout the continuum of care—thus, its conclusion reads:

The mother and baby constitute an integral unit during pregnancy, birth, and infancy (referred to herein as the “MotherBaby”) and should be treated as such, as the care of one significantly impacts the care of the other... This MotherBaby Model of Care promotes the health and wellbeing of all women and babies during pregnancy, birth, and breastfeeding, setting the gold standard for excellence and superior outcomes in maternity care. All maternity service providers should be educated in, provide, and support this MotherBaby Model of Care. ([www.imbci.org](http://www.imbci.org))

Our launching of the IMBCI in March 2008 turned into a powerful ceremony, complete with tears, whistles, and balloons!

### **Creation of the International MotherBaby Childbirth Organization (IMBCO)**

Before this launching, in 2007, with the full support of CIMS, the CIMS International Committee had become a separate organization, called the International MotherBaby Childbirth Organization (IMBCO). The separation was clearly necessary—we could no longer be the CIMS International

Committee, as CIMS is US-based and US-focused, whereas our agenda is international. The CIMS International Committee members at the time became the new Board members of the IMBCO; again, they included Co-Chairs Debra Pascali-Bonaro and Maureen Corry; Rae Davies, Secretary; Robbie Davis-Floyd, Editor; and Mayri Sagady-Leslie, CIMS Liaison. This small group of middle-class white girls had worked well to create the wording of the IMBCI (remember, we took input from over 100 international experts and grass-roots participants), yet we knew that in order to implement this Initiative, the Board would have to expand considerably.

We achieved a major breakthrough in that endeavor when we were finally able to hire, with support from the Transforming Birth Fund, an Argentinean obstetrician and epidemiologist, Rodolfo Gomez Ponce de Leon, MD, MPH, PhD, to be our Executive Director as a half-time position. “Rodo” had worked as an obstetrician-gynecologist for 15 years in a marvelous public hospital in Tucuman, Argentina—Hospital Avellaneda—where he had been instrumental in maintaining its cesarean rates at below 15% for 10 years in favor of supporting the normal physiology of birth via midwifery care and upright positions for labor and birth. He had gone on to earn a doctorate in Public Health in the US and to work for IPAS. Rae Davies, our Board secretary, went off the Board to accept a part-time position as Administrative Director, so that she could handle the logistics of our operation and leave Rodolfo freer to concentrate on promoting it—which he did at many international conferences—and to work with other members of the IMBCO Board and with “Rodo” on developing guides and evaluation tools for the hospitals and other birth facilities that we hoped would come on board to implement the IMBCI and evaluate the results.

We did not stop with that expansion. We put out an international call for new Board members, and subsequently added Petra ten-Hoope Bender, former Secretary General of the International Confederation of Midwives and former Executive Director of the Partnership for Maternal, Newborn

and Child Health (PMNCH); Daphne Rattner MD, a Brazilian epidemiologist, professor, and former Director of the Women's Health Program for the Brazilian Ministry of Health; H  l  ne Vadeboncoeur, a longtime researcher, birth activist and scholar who authored the first Canadian book on VBAC and helped the Quebec Ministry of Health develop the first birth centers in Quebec; and Debrah Lewis, the Director and a practicing midwife at Mamatoto Resource & Birth Centre in Trinidad, who then served as the Americas Regional Board Member of the International Confederation of Midwives (ICM). We also created an Advisory Council, the members of which represent various international organizations. (See [www.imbci.org](http://www.imbci.org) for full bios of all of the above.)

Now fully-fledged and formed as an organization, we needed a logo. We envisioned a mother and baby with the world around them, embodying our global outreach and the connection of MotherBaby to Mother Earth. Board member Mayri's daughter Crystal Sagady was a graphic artist—using our vision, she created this logo for us:



This beautiful logo now graces all our documents. And thanks to the tireless efforts of our Administrative Director Rae Davies, we have become a 501c3 in the U.S, so that we can officially accept tax-free donations for our ongoing work.

### **Maternity Rights as Human Rights**

Another critical component of the IMBCI is that it highlights the fact that “women’s and children’s rights are human rights” and that “access to humane and effective health care is a basic human right.” In June 2009, the United Nations Human Rights Council passed a landmark resolution that recognizes “preventable maternal mortality and morbidity as a pressing human-rights issue that violates a woman’s rights to health, life, education, dignity

and information.” In 2010, Amnesty International released Deadly Delivery: The Maternal Health Care Crisis in the U.S., which frames the issue of maternal health care as a human rights issue.<sup>i</sup> While a public health focus on maternal mortality is not new in the global arena, this focus has been virtually invisible in the U.S. International activist Jill Sheffield convened the Women Deliver conferences in 2007 and 2010, bringing together thousands of maternal child health collaborators from government, private, academic and advocacy sectors across the globe with human rights as a particular focus. One marked difference between the two conferences included an increased presence of focus on maternal morbidity and the violation of maternal rights in the U.S. as well as abroad.

To support that effort, IMBCO undertook the task of extrapolating the MotherBaby rights inherent in the IMBCI. These MotherBaby Rights can be found at [www.imbci.org](http://www.imbci.org).

### **IMBCO’s Ongoing Work: The Pilot/Demonstration Site Project**

Once the IMBCI logo was completed and beautifully formatted by Crystal Sagady, we immediately posted it on our newly created website [www.imbci.org](http://www.imbci.org) and sent it out to all our international representatives. They went to work on translation—the IMBCI has now been translated into 16 languages—and on putting it to work in their countries and regions. A number of NGOs have taken the IMBCI as their chartering document, and are working to implement it in their countries.

A common course for international initiatives is to seek to have them ratified in a formal process by all major and relevant organizations. CIMS did pass through that process, from 1995-1996, with all major US-based childbirth reform organizations, all of which did eventually ratify the CIMS Mother-Friendly Childbirth Initiative (MFCI). IMBCO did not choose that course, recognizing that international formal ratification by all of our TAG participants could have held dissemination of the document up for

years! We understood that the first step should instead be pilot/demonstration-site testing of the efficacy of the IMBCI 10 Steps.

So we put out an international call, and have received and, after careful review, accepted applications from pilot/demonstration sites in seven countries—Canada, Austria, Brazil, the Philippines, India, South Africa, and Mozambique (2 sites) ; to date we have accepted the eight following sites—we list them here along brief descriptions of the sites and the reasons why they are choosing to work to implement the IMBCI 10 Steps. All information provided below comes from the application forms submitted to IMBCO by these pioneering sites. (And one more site application is on its way, from the CASA Hospital and the CASA School for Professional Midwives, in San Miguel de Allende, state of Guanajuato, Mexico.)

**Pavillon des Naissances, Hôpital Brome Missisquoi Perkins, Cowansville, Centre de Santé et Services Sociaux La Pommeraie, in Quebec, Canada.**

This publically-funded health and social services center provides services to a population of 52,000. This hospital was the first facility in Canada to become Baby-Friendly, in the 1990s.

At the hospital, maternity services are provided in a natal care pavilion housing 10 private labor-delivery-postpartum rooms. The mother remains in this room with her baby until her release. Each room includes: a bathroom, a hide-a-bed for the person who accompanies the mother, and a lunch corner for the family. There is no nursery because the parents room-in with their baby 24/7. If a newborn requires special care, he/she is transferred with his/her mother to a hospital with tertiary care. This happens rarely.

Around 950 births per year are attended. Family physicians attend 100% of normal births; there are no midwives on staff, yet in the effort to implement the IMBCI 10 Steps, midwives will be incorporated in the facility and employed to do the necessary training. Obstetricians attend the 21% of births that take place by cesarean.

Since the 1990s, this hospital is recognized in the province of Quebec as a leader in progressive birth practices. In 2010, it won a mention for a public health prize. It is participating in the MOREob program (of the Society of Obstetricians and Gynecologists of Canada), and takes part in a multi-centre randomized controlled study – QUARISMA – on lowering cesarean rates.

**Statistics show the following:**

Normal spontaneous births: 79% of cases

Labour induction: 12%. Little oxytocin augmentation.

Forceps and vacuum rates 13%

Cesarean section: 21%

Elective CS 11% (49% of total caesareans)  
VBAC after 1 caesarean 16%  
Epidural 39%  
Episiotomy 10%

Routine procedures used include freedom of position, skin-to-skin contact, breastfeeding support, no separation of mother and baby.

**“Implementing the 10 Steps of the IMBCI will stimulate the facility to make constant efforts to improve quality of obstetrical clinical work and ensure ongoing improvement of therapeutic standards to meet maternal and neonatal needs and wishes, including lowering our caesarean and episiotomy rates.”**

### **Community Hospital Feldbach, Feldbach, Austria, Department of Obstetrics and Gynaecology**

This recently built obstetric department (1991) is designed to include all alternative obstetric and delivery possibilities (e.g. waterbirth, vertex positions, Römer wheel, homeopathy, acupuncture, Bach flowers, rooming-in, baby massage, breast feeding (rate 90%) and has a long history of individualized, supportive structures in compliance with personal parental needs. Maternal and paternal wishes are fully implemented in diagnostic, therapeutic pre-/ peri- and postpartal decision making in inpatient and outpatient settings.

The facility comprises: 10 senior physicians, 16 midwives, 8 physicians in training, associated other specialities. 3 ambulatory counselling rooms with CTG, ultrasound and special equipment. 5 delivery rooms, recreation area within delivery station, 1 enclosed operating theatre, 56 beds in general and 256 beds in the hospital.

Clients include rural population and citizens of the county capital nearby of all social layers. The facility also provides backup for homebirth providers. Continuing education is provided for collaborating providers/associated midwives.

Midwives attend 100% of births, with obstetricians also in attendance at 95% of births. Around 1800 births per year are attended and the number is growing.

#### **Statistics show the following:**

Normal spontaneous births 71.8%.  
Labour induction 13%.  
Oxytocin augmentation 1.6%.  
Forceps and vacuum 2.9%.  
Caesareans: 27.5%.  
Elective caesarean 14.5% (almost half of the CS rate).  
VBAC after 1 CS: 17%.  
Epidural 8.6%.  
Episiotomy: 34% of vaginal deliveries.

Routine procedures include choice of position during childbirth, skin-to-skin motherbaby contact, warming and drying the baby, clean cord care, delayed cord clamping, early initiation of breastfeeding, and after caesarean, skin-to-skin contact with father until the mother is ready.

**“Implementing the 10 Steps of the IMBCI will stimulate the facility to make constant efforts to improve quality of obstetrical clinical work and ensure ongoing improvement of therapeutic standards to meet maternal and neonatal needs and wishes, including lowering our caesarean and episiotomy rates.”**

## **Hospital Sofia Feldman, Belo Horizonte, Brazil**

This hospital has been working under a MotherBaby philosophy since its maternity ward foundation in 1982. Since that time they have abolished some routine procedures commonly used in other maternity wards in Brazil such as enemas and pubic shaving, and allowed a companion of the mother's choice during her labour and birth. The first childbirth ever in this facility was assisted by a nurse-midwife. Some other practices such as supine position for labour and birth, withholding food and water, routine artificial rupture of membranes, etc. have subsequently been abolished.

In 1995 Hospital Sofia Feldman was awarded the UNICEF Baby-Friendly Hospital designation, the first hospital in the state of Minas Gerais and the eighth in Brazil. In 1998 it was awarded the first Galba de Araujo prize given by the Ministry of Health in Brazil to hospitals that achieve goals related to humanization of childbirth care. And it is currently involved in a Japan International Cooperation Agency (JICA) international training program.

Sofia Feldman Hospital serves a population of approximately 400,000 people in the northern and northeast of Belo Horizonte, Minas Gerais state's capital. It is also a secondary level referral facility for the state of Minas Gerais in high risk obstetric care and a tertiary referral for neonatal care. The population is mainly low-income level, with a low and medium degree of education.

This hospital holds a birthing center staffed by midwives on its premises. It also has interesting features like two houses nearby for babies who need to stay longer (with their mothers), and for pregnant women who need closer surveillance during part of their pregnancy.

Number of births attended per year:

2008: 9,762                      2009: 10,483                      2010: 9086

Nurse-midwives attend 70% of births; obstetricians attend around 30% and a team of community volunteer doulas works 24/7. The facility has UNICEF Baby Friendly designation and fully supports breastfeeding and skin-to-skin.

### **Statistics show the following (2010):**

Normal spontaneous births 77.4%

Labour induction 15%

Oxytocin augmentation 22.3%

Forceps and vacuum: 1.4%

Cesarean section 20.5%

Elective CS 10% of the above

VBAC after 1 caesarean 40% (approximately)

Epidural 40%

Episiotomy 11%

Routine procedures include choice of position, skin to skin, delayed cord clamping (by companion), early initiation of breastfeeding.

The facility provides backup for the nurse-midwives who assist homebirth in Belo Horizonte, some of whom work in the hospital.

**“The facility wishes to fully implement the 10 Steps of the IMBCI because it is the busiest maternity ward in the state of Minas Gerais, and *if Sofia Feldman can do it, any other hospital can.* In addition, there is a strong desire to set an example for others, for which the facility is well-placed as a teaching hospital.”**

These hospitals are paving the way for demonstrating how maternity care services can offer women optimal MotherBaby maternity care. IMCO board members have visited these sites and worked directly with their key staff members. IMBCO has developed guides and evaluation tools for these and future sites to utilize. For example, the demo sites will be regularly measuring 30 variables operationalized from the 10 Steps, using various methods, depending on the variables: a questionnaire addressed to women who just gave birth in these sites, self-assessment by the caregivers, and standard statistical measuring for interventions such as cesarean or induction rates, etc.

We are currently seeking funding for the research components of the implementation of the IMBCI—all funds obtained will be granted by IMBCO to the demonstration sites for IMBCO trainings and site visits and statistical documentation of the results of implementation of the IMBCI 10 Steps.

**IMBCO would also welcome any researchers who care to study the process of implementation and document both the barriers these sites may face and the outcomes we hope they achieve.** Each site will also determine its most pressing needs in terms of implementing this Step or that Step, and IMBCO will help in identifying local, regional or international resources to support them. Again, in 2011, these sites will be organized in a communication network so that they can learn from each other around the IMBCI implementation process.

### **MotherBaby Networks (MBnets)**

In addition, seeking to aid the many independent sites that want to implement the IMBCI on their own, we have created what we are calling MotherBaby networks (MBnets):

MotherBaby Networks are a result of increased interest throughout the world in supporting the International MotherBaby Childbirth Initiative (IMBCI) and promoting the 10 Steps to Optimal MotherBaby Maternity Services. MBnets consist of individuals such as midwives and physicians; or a collaboration of individuals, community grassroots advocates and organizations, and careproviders; or a facility such as a birth center, clinic or hospital where women give birth.

MBnets are an unlimited number of sites throughout the world which, by their own initiative, are using the International MotherBaby Childbirth Initiative (IMBCI) to promote the 10 Steps to Optimal MotherBaby Maternity Services in their own contextual surroundings. These sites have contacted the International MotherBaby Childbirth Organization (IMBCO) to inform us of their work, completed our online questionnaire, and confirmed their support of the IMBCI. As such, they are recognized by IMBCO as being part of the MotherBaby Network of sites engaged in the promotion of the IMBCI. As a result, they have access to IMBCO resources and will have the opportunity to share their victories and/or challenges through the IMBCO website. (quoted from [www.imbci.org](http://www.imbci.org))

Some of our Board members—Debra Pascali Bonaro, Robbie Davis-Floyd, Daphne Rattner, and Helene Vadeboncoeur-- attended the III International Congress on the Humanization of Childbirth, held in Brasilia, Brazil in late November and early December 2010. Robbie presented the IMBCI in a huge general session attended by over 2000 people, and received an enormously positive response. Representatives from the Brazilian Ministry of Health are working on a plan to implement the IMBCI throughout Brazil.

Four Latin American MBnets joined us at this conference; they are representative of many others so we describe them here, to concretize for our readers our concept of MBnets:

- Clinica La Primavera, in Quito, Ecuador—a small private hospital run by obstetrician Diego Alarcon and his wife Lili, a midwife, with other obs on staff, entirely under a midwifery model of care offering all birth options, including water birth in their two beautiful tub suites. They are currently attending 30 births per month. Their cesarean rate is 18% as they attend births of all risk levels and offer women fully informed choice for breech and twin births—they attend them as vaginal births when the mother chooses, but usually women choose cesareans for these types of births. This clinic has cesarean facilities on site. As an MBnet, they will review all their protocols and procedures to be sure they are fully implementing the 10 Steps. [www.clinicalprimavera.org](http://www.clinicalprimavera.org)
- AuroraMadre, a non profit organization and private practice run by obstetrician Beltran Lares and his wife Isabella Polito, a doula, offering a full spectrum of humanistic birth services in Caracas, Venezuela, with other doulas also incorporated in the practice. It was founded in 2007 by this couple after 20 years of working in different private practice scenarios doing water birth and home birth. Today, attending around 15 births per month in home and hospital, they have a

cesarean rate of 25 %, episiotomies 6%, waterbirth 2%, homebirth 4-5 per year and exclusive breastfeeding rates of 75% at six month. They attribute their relatively high cesarean rate to extreme pressure from the medical community, which has them under constant scrutiny. And they notice that the couples who attend their prenatal workshops have much lower rates—15%-20%. They also organize workshops and conference on humanized childbirth and doula training. As an MBnet, they will be working on lowering their cesarean rate. [www.auroramadre.com](http://www.auroramadre.com)

- El Grupo Hanami, a recently founded (2010) private birth service in Florianopolis, Brazil staffed by a team of nurse-midwives and obstetricians, including the well-known Brazilian obstetrician Marcos Leite, attending an average of 5 births a month in home or hospital. (All staff have other jobs, and spell each other when a homebirth comes up, providing caseload care.) Nurse-midwife Vânia Sorgatto began attending home births in 2002, with Marcos as backup. In 2005, she went to Japan on a grant from JICA to take a three-month course on homebirth. In 2006, another nurse-midwife, Joyce Green Koettker, also went to Japan to take the course; upon her return, she and Vania founded El Grupo Hanami (the name means “cherry blossom” in Japanese, and was intended as a tribute to JICA), which came to include 5 other nurse-midwives. Marcos Leite continued to provide backup, then in 2009 (after years of insisting he never would), he too began to attend homebirths with group members. In 2010, Dr. Roxana Knobel joined Hanami and began homebirth practice. To date, the staff of Hanami have attended 143 births, with a cesarean rate of 8.8% and a 10% transfer rate. The client decides her place of birth, with the help and advice of the team. [www.partodomiciliar.com](http://www.partodomiciliar.com)
- The private practice of obstetrician Ricardo Jones and his wife Zeza, a nurse-midwife, and various doulas, attending home and hospital births, around 7 per month, with a cesarean rate of around 5%, in Porto Alegre, Rio Grande do Sul, Brazil. The team goes to the mother’s home during labor, and either attends her there or transports according to need, with Ricardo performing any truly necessary cesarean—giving a whole new meaning to “continuity of care”. [rhjones@ig.com.br](mailto:rhjones@ig.com.br). For more information, see Ricardo’s chapter in *Birth Models That Work* (2009).

Many more MBnets have already joined us or are on the way, from countries all over the world! Ric Jones has become our International Coordinator for the IMBCI MBnets—he is in the process of developing a website on which MBnets can share their statistics and help each other with the challenges—if your practice wishes to become an MBnet, please contact Ric at [rhjones@ig.com.br](mailto:rhjones@ig.com.br).

## **In Conclusion:**

The purpose of the **IMBCI 10 Steps** is to improve care throughout the childbearing continuum, in order to save lives, prevent illness and harm from the overuse of obstetric technologies, and promote health for mothers and babies. Rising cesarean rates around the world, the increasing overuse of

obstetric technologies, and failure to implement the scientific evidence in favor of normal, physiological birth have created the need for clear guidelines for providing optimal maternity care.

This Initiative addresses the needs of all nations and birthing women for evidence-based and humanistic improvements in the quality of maternity care. The IMBCI is both educational and instrumental in purpose. Its educational purpose is to call global attention to the importance of the quality of the mother's birth experience and its impact on the outcome, the risks to mother and baby from inappropriate medical interventions, and the scientific evidence showing the benefits of MotherBaby-centered care based on the normal physiology of pregnancy, birth, and breastfeeding and on attention to women's individual needs. The instrumental purpose of the IMBCI 10 Steps is to put into worldwide awareness and practice the MotherBaby Model of Care--a woman-centered, non-interventive approach that promotes the health and wellbeing of all women and babies during pregnancy, birth, and breastfeeding, setting the gold standard for excellence and superior outcomes in maternity care.

The mission of the International MotherBaby Childbirth Organization (IMBCO), in collaboration with other organizations, is to develop, regularly update, and promulgate the International MotherBaby Childbirth Initiative worldwide to improve care throughout the childbearing continuum, in order to save lives, prevent illness and harm, and promote health for mothers and babies around the world.

The full text of the IMBCI is available at [www.imbci.org](http://www.imbci.org) for anyone in any country to download and work with in their area. Individuals and organizations can sign on as supporters of the IMBCI, adopt it as a focal point for their work, and use it as an educational instrument and guide to help hospitals improve their maternity care. Hospitals and other practices and facilities can work to achieve the 10 Steps as a means to providing optimal MotherBaby care. Again, we believe that *the IMBCI sets the global gold standard for optimal maternity care*, and that those who truly wish to achieve that kind of

care for mothers and babies will utilize the IMBCI in every way possible to meet that goal. Ultimately, our vision is that every birth facility will operate according to the IMBCI 10 Steps, resulting in vastly improved and evidence-based care that will dramatically reduce mortality and morbidity and enhance birth outcomes, including breastfeeding, for the mothers and babies of the world. We welcome your support!

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\*Endnote: Portions of this article are excerpted in Davis-Floyd, Robbie, Debra Pascali Bonaro, Mayri Sagady Leslie, Rae Davies, Helene Vadeboncoeur, and Rodolfo Gómez Ponce de León, "The International MotherBaby Childbirth Organization: Working to Create Optimal Maternity Care Worldwide". Andrea O'Reilly ed., The 21<sup>st</sup> Century Motherhood Movement: Mothers Speak Out on Why We Need to Change the World and How to Do It, forthcoming 2011.

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