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The International MotherBaby Childbirth Initiative: Working to Create Optimal Maternity Care Worldwide

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This article tells the story of the creation of the *International MotherBaby Childbirth Initiative (IMBCI): 10 Steps to Optimal MotherBaby Maternity Services*, a global initiative designed to improve childbirth care and birth and breastfeeding outcomes for all women, and 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.

KEYWORDS: childbirth; breastfeeding; international initiative; normal birth; improved outcomes; quality of care; human rights

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 Coalition for Improving Maternity Services

The Coalition for Improving Maternity Services (CIMS) was founded in 1996 in the United States, and today incorporates in its membership 50 childbirth-related organizations representing more than 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)

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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 United States (For the history and full text of the MFCI, go to 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 World Health Organization (WHO) and United Nations Children's Fund (UNICEF) BFHI initiative were invited to meetings during the creation of the MFCI. 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 10th step of the MFCI specifies that a mother-friendly service "strives to achieve the WHO-UNICEF '10 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 cochairs. 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 United States, 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 United Nations (UN) General Assembly on Children in New York City; CIMS representatives presented the MFCI at the International Congress of Midwives (ICM) Congress in Vienna, Austria 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 WHO embraced "Mother-Friendly" concepts in their publication *Global Strategy for Infant and Young Child Feeding: A tool for assessing national practices, policies and programmes*.

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!" (IMBCI, p. 3). 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 Coalition for Improving Maternity Services 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 Foundation, as well as support from the Johnson & Johnson Pediatric Institute. Representatives from Europe, Asia, and the Americas attended this groundbreaking meeting on 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 nongovernment organizations (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 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 representative for the Americas; Lucie Ryntova, MA, and Eliska Kodysova, MA, from the Czech Republic, regional representatives for Europe; Mandisa Singata, MBA, RM, RN, from South Africa, regional representative for Africa; and Mun Tip Lew from Malaysia, regional representative 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 government and nongoverment 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 MFCI. This survey did not include Step 9 on circumcision, which is not an issue in most countries (because 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. MFCI, and that support gave us a sound basis for creating what we eventually called the *International MotherBaby Childbirth Initiative*. 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* (Kroeger & Smith, 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 & 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 cochair 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, Maureen, and the rest of us went to work immediately.

Creation of the International MotherBaby Childbirth Initiative

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 MFCI). 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 a 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 because 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 1 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. (IMBCI, p. 3)

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 (TAG) 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 TAG.

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 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 TAG 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 (MPS). The participants in this Geneva meeting included representatives from WHO, UNICEF, United States Agency for International Development (USAID), CIMS, Childbirth Connection, Lamaze International, DONA International, La Leche League International, Wellstart International, WABA, the International Lactation Consultant Association (ILCA), ICM, the International Council of Nurses (ICN), the International Pediatric Association (IPA), and JHPIEGO. 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

representatives, 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 because 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 maternal and newborn 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 previously 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 BFHI (and also by WABA) *not* to use the phrase MotherBaby-friendly because that made it sound as if we were the umbrella organization for the BFHI, which had already been in existence for more than 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 subsequent text regarding 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 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, labouring in water, and coping/relaxation techniques. Respect women's preferences and choices. (IMBCI, p. 3)

After a full year of intensive work, we finalized the wording of the IMBCI in February of 2008 and launched the IMBCI 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 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 subsequent text).

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 6 months during the period of exclusive breastfeeding and continue for about 9 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. (A. Naylor, personal communication to M. 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 Mother Baby 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)

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

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 because CIMS is U.S.-based and U.S.-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 cochairs 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 more than 100 international experts and grassroots participants), yet we knew that 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 "Rodo" Gómez Ponce de León, 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 United States 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 Rodo freer to concentrate on promoting our initiative—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 ICM 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; Hélène Vadeboncoeur, a longtime researcher, birth activist, and scholar who authored the first Canadian book on vaginal birth after cesarean (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 representative of the ICM. We also created an advisory council, the members of which represent various international organizations. (See http://www.imbci.org for full bios of all mentioned.)

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 a logo for us (see Figure 1). 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 United States, so that we can officially accept tax-free donations for our ongoing work.

FIGURE 1 International MotherBaby Childbirth Organization (IMBCO) logo.

Maternity Rights as Human Rights

Another critical component of the IMBCI is that it highlights that "women's and children's rights are human rights" and that "access to humane and effective health care is a basic human right." (p. 2) 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 woman's rights to health, life, education, dignity, and information." In 2010, Amnesty International released *Deadly Delivery: The Maternal Health Care Crisis* in the United States, which frames the issue of maternal health care as a human rights issue. Although a public health focus on maternal mortality is not new in the global arena, this focus has been virtually invisible in the United States. 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 United States 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 http://www.imbci.org.

INTERNATIONAL MOTHERBABY CHILDBIRTH ORGANIZATION'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 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. Several 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 to 1996, with all major U.S.-based childbirth reform organizations, all of which did eventually ratify the CIMS 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 (two 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 as follows 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 people. 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 or she is transferred with his or 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 Managing Obstetrical Risk Efficiently (MOREob) program (of the Society of Obstetricians and Gynecologists of Canada) and takes part in a multicenter randomized controlled study—QUARISMA—on lowering cesarean rates.

Statistics show the following:

- Normal spontaneous births: 79% of cases
- Labor induction: 12%. Little oxytocin augmentation.
- Forceps and vacuum rates: 13%
- Cesarean section (CS): 21%
- Elective CS: 11% (49% of total cesareans)
- VBAC after 1 cesarean: 16%
- Epidural: 39%
- Episiotomy: 10%

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

> Why we wish to implement the IMBCI in our facility:
>
> **Mother, newborn and family:** We believe that each pregnancy is unique in itself and that birth is a normal occurrence of life that does not necessitate an intervention unless it is clinically determined to be beneficial for the health of mother and baby. We believe that preparation to give birth and emotional support during labour optimize the chance of a normal delivery. We also believe that the mother…has the competence to make a clear decision if she has all the required information. [Implenting the]

IMBCI can improve morbidity and mortality for both mother and child.

We wish to improve our support to mothers before, during and after childbirth to thereby decrease the interventions that could be harmful or that do not provide any advantage to mothers or babies. We wish to decrease the number of cesareans performed for reasons that are not based on conclusive data. We can learn from other places all over the world and be inspired by the latest research based on proven facts.

The staff working in obstetrics would have more satisfaction supporting a woman through a life experience that is positive and enriching. This incites pride and increases employee retention. In addition, the IMBCI brings a decrease of tasks—interventions--leaving place for support and a shared responsibility with the mother and the person who accompanies her. We also believe that pressure on the medical staff would be lessened.

The health care system would benefit from the better health of mothers and babies, which in the long run decreases the need for care associated with maternal and infant morbidity. It has been proven that a positive childbirth experience for a woman brings benefits far beyond childbirth itself. This has an impact on self-esteem, couple relationships and on the development and attachment to the child. All in all, this has a huge impact on health in general (mental and physical).

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, breastfeeding [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 prepartal/peripartal 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 cardiotocography (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 home birth 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 1,800 births per year are attended and the number is growing.

Statistics show the following:

- Normal spontaneous births: 71.8%
- Labor induction: 13%
- Oxytocin augmentation: 1.6%
- Forceps and vacuum: 2.9%
- CS: 27.5%
- Elective CS: 14.5% (almost half of the CS rate)
- VBAC after 1 cesarean: 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 cesarean, 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 cesarean 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 then, 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 labor and birth. The first childbirth ever in this facility was assisted by a nurse-midwife.

Some other practices such as supine position for labor and birth, withholding food and water, routine artificial rupture of membranes, and so forth 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.

Hospital Sofia Feldman 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: 9,086

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 Hospital designation and fully supports breastfeeding and skin-to-skin contact.

Statistics show the following (2010):

- Normal spontaneous births: 77.4%
- Labor induction: 15%
- Oxytocin augmentation: 22.3%
- Forceps and vacuum: 1.4%
- CS: 20.5%
- Elective CS: 10% of total cesareans
- VBAC after 1 cesarean: 40% (approximately)
- Epidural: 40%
- Episiotomy: 11%

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

The facility provides backup for the nurse-midwives who assist home birth 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 Hospital 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.

Kwazakhele Unit, Port Elizabeth, South Africa

The midwife-managed Kwazakhele Unit is a newly opened unit, functional since August 2009. The motivation for opening the unit was to provide women with quality care in comfortable surroundings. Some principles are not to separate mother and baby after birth and to limit interventions.

The Nelson Mandela Bay District Office (Health) is the management unit overseeing primary health care services in the Port Elizabeth area. A total of five midwife obstetric units are under the management of the district office.

The total population for the Metro is 1.2 million. The catchment population for Kwazakhele Midwife Obstetric Unit (MOU) is ± 300,000 and represents the low-income (unemployed) community, densely populated in an urban area, with a large section of informal settlements.

Kwazakhele MOU is managed completely by midwives caring for low-risk women giving birth and the immediate postnatal period. Midwives attend 100% of the births in this unit, providing full prenatal care and referring women with identified risks to the local hospital.

They do record their data but do not have computer facilities.

Their projected number of births per year is around 1,000.

Statistics show the following: The first 651 births to take place in the unit were all normal spontaneous labors with almost no interventions and almost no episiotomies. (However, data is missing on the outcomes of hospital transfers.) Most women deliver in lying down positions; as they begin to implement the IMBCI, they are working on encouraging women to be in vertical

positions for labor and birth. They do not delay cord clamping and state that they need to work on that.

Skin-to-skin MotherBaby contact after birth is the norm, so is breastfeeding, with the complication that a large percentage of their patients are HIV positive.

They will be able to provide 5 hours of dedicated staff time per week to recording their statistical results but have no other funding sources for this project.

> The principles and 10 Steps of the IMBCI project will support and assist staff in the unit to further implement and document changes to overall improve quality of care to mom and baby pairs, including delaying cord clamping and reducing other interventions.

Banashankari Maternity Hospital, Bengaluru, Karnataka, India

Banashankari Maternity Hospital is located in South Bangalore on the edge of a large series of slums. Slum residents are the main recipients of care from the hospital. Typical occupations of women living in the slums include domestic work, and work in the garment industry and in incense factories. It is a 30-bed referral hospital. Cases are referred there from government antenatal clinics, dispensaries, and other less advanced maternity homes. The facility provides 24-hour care and has an operation theatre where cesarean sections are performed. There is no blood bank facility, so family members often supply blood for a patient when needed. On staff are seven nurses who perform most of the deliveries, one obstetrician, one general practice physician, one pediatrician, and one anesthesiologist. Nurses attend all of the normal births. Doctors are called in for complicated cases or to perform CS.

Obstetricians attend 10% of the births, and general practitioners attend another 10%. Nurses attend 80% of births. In general, the hospital practitioners attend around 2,600 births per year.

Most people who frequent the hospital live below the poverty line and carry a government welfare card allowing them services for free or a reduced fee. The general public is charged regular fees. Even with the promise of receiving free care or care at reduced cost, families will often incur cumbersome hidden costs such as the cost of essential medicines that are not available at the center, cost of transport, missed work days, and so forth. In this population, most women instinctively and traditionally believe their right is to professional, high touch/low technology care that is delivered with respect and with only medical interventions that are necessary. However, this type of care is not available.

Bangalore Birth Network (BBN) is a local advocacy and education group promoting evidence-based care and IMBCI's *10 Steps to Optimal MotherBaby-Friendly Maternity Services*. Researchers and midwives from the BBN will be responsible for all aspects of project coordination and oversight, data collection and quality.

At present, data is collected in clinical records, logbooks, and a referral book at the hospital. A basic clinical record is entered into a computer by a data entry operator on location at the hospital. Hospital staff will work with the site data entry operators for more comprehensive entry, including variables of interest for the 10 Steps.

Statistics show the following:

- Normal spontaneous births: 70%
- Induction and augmentation: 18%
- Operational vaginal deliveries: 5%
- CS: 30%
- Elective CS: 0%
- VBAC: 0.5%
- Epidural: 0%
- Episiotomy: 50%, only for nulliparous women

Routine procedures include IVs, systematic rupture of membranes, restriction of maternal movement during labor, immediate cord clamping, skin-to-skin contact, and early initiation of breastfeeding.

This hospital does not have internal financial support to contribute to the project. They can provide 5 hours of staff time per week to document results. Nurses/doctors who attend deliveries will fill out the questionnaires. Data entry operators hired by the project will enter data for the project. They hope to obtain a grant to establish the demonstration site. Bruhat Bangalore Mahanagara Palike (BBMP) will be able to make some in-kind contributions, although of a limited nature such as meeting space because the municipal corporation is currently operating under financial losses.

Funding potential at this point exists with USAID through the assistance of IMBCO and possibly through a local institute in Bangalore. They will actively search for additional potential donors and feel optimistic of donor interest, given the current international and national recognition that quality of care improvements are critical.

This hospital desires to be an IMBCI demonstration site:

1. To promote evidence-based maternal health care in an urban Indian environment where intervention and medicalized birth are the norm and go unquestioned, especially because of the current government of India's policy to achieve 100% institutional deliveries to improve maternal and newborn outcomes.
2. To lower their cesarean and episiotomy rates and improve their VBAC rates, and institute delayed cord clamping and other beneficial procedures such as freedom of movement for laboring mothers.
3. To train government clinical staff who do not have other opportunities to learn MotherBaby-friendly care and support them in sustaining MotherBaby-friendly practices and use the work of the demonstration site in quality of care advocacy.
4. To provide women of lower socio-economic status with a community-based center of excellence in MotherBaby-friendly evidence-based care.

Dr. Jose Fabella Memorial Hospital, Manila, Philippines

A specialty tertiary hospital directly under the nation's Department of Health, this is the largest maternity hospital in the Philippines in terms of patient load and number of deliveries, attending approximately 22,000 births per year. As such, it was designated in 1991 as the National Maternity Hospital. In addition to midwifery/obstetric and neonatal care, the hospital also provides other pediatric and gynecologic services because it offers residency training programs in these specialties. It also has a school of midwifery that offers undergraduate midwifery education.

Most of this hospital's clientele are residents of the metropolitan Manila area, consisting of 12 cities and 1 municipality; some patients arrive from adjacent and even distant provinces. About two thirds of these patients belong to the low-income category or the urban poor where in most cases only one partner in a couple (usually the husband) is employed. Most patients are high school graduates without college degrees.

The main service offered by this hospital is maternal and newborn care. As such, most of it is a birthing facility—70% of their admissions are parturients and their babies. The rest are early pregnancy losses (miscarriages and ectopics), gynecologic, and other pediatric cases. They have only 10 delivery beds and 4 operating rooms that can barely accommodate all of their admissions—birthing women sometimes have to share beds. They have four huge postpartum wards that can accommodate 60–100 patients each.

The home-setting unit is run by their school of midwifery. Care of patients admitted in this unit is handled by midwives from prenatal until the end of puerperium. Referrals or transfers of care are made to obstetric residents on duty as needed. Hospital practitioners want to expand this unit to accommodate most, if not all, of their low-risk admissions but are limited by space constraints. They have expectations that the government will transfer the hospital and the home-setting unit to a bigger, more spacious site.

Some of the midwives trained or educated in the hospital-attached school of midwifery are eventually employed as home birth providers. The thrust in maternal care now is the importance of the presence of a skilled birth attendant during delivery because childbirth complications cannot always be predicted. The government has stopped training traditional birth attendants (TBAs). Instead, a team of doctor, nurse, and midwife who work in rural areas are trained in Basic Emergency Obstetric and Newborn Care (BEmONC). For this, this institution has once again been designated as one of the three regional training centers in the country mainly because of its setup, resources, and high patient load.

This institution has always pioneered innovative obstetric and neonatal practices in the country as evidenced by the following milestones:

1. It was the first hospital in the country to set up a home-setting unit, where deliveries are conducted in a room in the hospital that simulates a typical Filipino home and assisted by midwives using traditional protocol that requires very minimal intervention. This unit serves as a laboratory for domiciliary care training of their midwifery students.
2. It was one of the first certified Baby-Friendly hospitals in the country. It received initial certification in 1992 and has, since then, been designated as the National Lactation Management Training Center. Trained staff go around the country to train other health care providers on the 10 Steps to successful breastfeeding and how to address common breastfeeding problems.

3. It was the first and, at present, one of the only two institutions in the country that is offering and actively promoting Kangaroo Mother Care (KMC). It has a 30-bed KMC ward that has been in place for 10 years now.
4. For about three decades now, there has been no central nursery for well babies. All babies delivered in this institution (except those who are sick and need special/intensive care) are roomed-in with their mothers immediately after birth. At present, these hospital practitioners are in the process of implementing the WHO Essential Newborn Care program that entails nonseparation and continuous skin-to-skin contact of the mother and baby from the moment of birth. They have removed their former "holding area" for recently delivered babies.
5. They have a very strict breastfeeding policy such that they do not allow formula, bottles, and other feeding paraphernalia inside the hospital. Even sick babies are fed with their own mother's breast milk either by cup or tube. They maintain a milk bank for babies in the NICU.
6. In 2008, they opened the country's first commercial human milk bank and since then have been supplying human breast milk to other hospitals in the country.

Midwives and midwifery students attend 20%–25% of births. Obstetric residents attend 40%–50% of births. (These include senior medical student affiliates who are under the supervision of obstetric residents.) Obstetrician-consultants attend about 10% of births (usually the more complicated ones). Nurses and student nurse affiliates attend 20%–25% of births.

Partner and family support is available only in the home-setting unit (300 births per year). Hospital staff wish to extend this practice to the larger facility.

Data collection is done on paper. They still do not have a dependable system for data integration and analysis. They have a simple database called *HADIS* (*Hospital Admissions and Discharges Information System*) which they started in 2009. It contains only the most important and most sought after information on patients. However, this database is not always updated—they always have a problem with availability of encoders and also because of the bulk of data (patients) that need to be entered. They have no resources to implement a computer based data collection system and will look to IMBCO to provide funding for that.

Statistics show the following (see also Table 1):

- Normal spontaneous birth rate: 70%
- Cesarean rate: 25%
- Epidurals are not readily available and are used in around 5% of births.
- Induction and augmentation occur in around 35% of births.
- Episiotomies are performed in approximately 30% of births, mostly for primiparas.

Women can choose their positions for labor, but almost all births are in the lithotomy position. They do delay cord clamping and provide skin-to-skin contact and breastfeeding encouragement and support.

This hospital wishes to become an IMBCI demonstration site:

- To improve further the quality of maternal and newborn services that they offer.
- To inculcate to all staff the importance and benefits of implementing evidence-based, less interventionist, more patient-friendly practices. (It has been their experience that "it is often difficult to change the way things are being done.")
- To have an organized, fast, and accurate system of documenting, integrating, and analyzing the quality of these services which will serve as basis for further improvements in care.

TABLE 1 Outcome Statistics for Dr. Jose Fabella Memorial Hospital

	2006	2007	2008	2009	2010
Stillbirth rate (per 1,000 total births)	20.94	20.27	17.04	17.18	19.27
Neonatal death rate (per 1,000 livebirths)	52.76	49.46	50.49	32.75	38.20
Perinatal death rate (per 1,000 total births)	72.60	68.72	66.67	49.36	56.73
Maternal mortality rate (per 100,000 livebirths)	92	93	76	48	106

Note. Implementation of the International MotherBaby Childbirth Initiative (IMBCI) is expected to bring about a reduction in these numbers. The other seven sites are expected to send us their mortality figures soon. For now, these figures from the Philippines can serve as indication of the mortality problem—we can expect equally high or higher figures from our sites in India and Mozambique.

Hospital Central de Maputo, Maputo, Provincia de Maputo, Mozambique

Maputo General Hospital is a large referral hospital in the capital, Maputo, with a high and increasing volume of deliveries. The group of obstetricians consists of 12 specialists and 8 who are doing their postgraduate work. They attend 25% of deliveries, and work closely with the midwives, who attend 55%; general practitioners attend 15%; and nurses 5%.

9,049 births were attended in 2010.

Normal procedures for vaginal deliveries include choice of position for birth, routine cord clamping, skin-to-skin contact, and immediate initiation of breastfeeding. Women are counseled on immediate and exclusive breastfeeding. Women room-in with their babies and stay 24 hours postpartum.

Data are tallied on paper forms and analyzed by the hospital's statistics department. Current statistics show that 50% are normal, spontaneous births without technological intervention (but no data is collected on induction, augmentation, vaginal operative deliveries, or episiotomy), and 50% of births are by cesarean. There are no VBACs. Epidurals are not available.

They state that they need to work on their extremely high cesarean rate, on making VBAC available, and eliminate routine cord clamping, among other things.

This hospital wants to be an IMBCI demonstration site because

- We are a reference hospital not only for the city of Maputo but also for the province as well as some cases of national scale. In this way, we set a standard and example for the rest of the country.
- We are a training site for doctors and nurses so that any improvements we make in this initiative will be multiplied in effect as these trainees graduate and practice elsewhere.
- We would like to have an increased chance to integrate services and continue the process of the humanization of childbirth, begun under the Model Maternities Initiative (MMI).

Beira Central Hospital, Beira, Sofala, Mozambique

Beira Central Hospital is the second largest hospital in Mozambique. It is a regional hospital with about 700 beds. It is located in the city of Beira in Sofala Province. Beira has a population of 1,715,557 people. They also attend patients referred from the provinces of Manica, Tete, and Zambezia.

Hospital staff attended 4,308 deliveries in 2010, 1,269 of which were cesarean sections. The normal spontaneous delivery rate is 70.5%; the cesarean rate is 29.5%; VBAC rate is 5%. Epidural use is minimal.

Routine procedures include choice of position, skin-to-skin contact, immediate cord clamping, and immediate breastfeeding.

The staff of the maternity consists of seven obstetricians, four general physicians in postgraduate education, and 10 midwives. They have all been trained to develop and implement plans to improve the quality and humanization of services. Midwives attend around 80% of the births, whereas the doctors attend around 20%.

Data is collected on paper forms and reviewed monthly by the hospital's statistics department. They will need IMBCO support to establish a computer based data collection and review system.

The Ministry of Health fully supports Beira Central Hospital's proposal to be an IMBCI demonstration site

If chosen, the Ministry of Health plans to integrate our participation in this initiative to our ongoing participation in the MMI (see as follows).

This hospital wishes to become an IMBCI demonstration site because

- First and foremost, we believe this will help us accelerate progress in reducing maternal and perinatal morbidity and mortality.
- We want to improve the process of guaranteeing sexual and reproductive rights and humanization of care for prenatal, and labor and delivery care for mothers as well as postpartum care to mothers and their newborns.
- We want to improve the supportive supervision process and the process of recognition of success in attaining the goals of humanized care.

THE MODEL MATERNITIES INITIATIVE

The MMI, which begun in 2009, led by the Ministry of Health, and funded by various agencies including USAID and JHPIEGO, has as its purpose to create facilities that are models not only for quality patient care but also to serve as top of the line clinical training sites for improving health care worker education. The 34 model maternities cover 21% of institutional births and about 12% of all births nationwide.

The MMI and the IMBCI have much in common, including the promotion of normal physiologic birth and humanistic care both to improve quality of care and to reduce maternal and perinatal mortality. MMI leaders in Mozambique are eager to implement the IMBCI 10 Steps in the two proposed hospitals "so that they can become 'centers of excellence' who can show to the rest what the whole package would look like: humanization of care and full implementation of evidence-based practice—and thus, help to motivate them more. Being recognized through this initiative and the added attention that would bring would be a very exciting way to hasten this process" (Jim Ricca, a personal communication to Helene Vadeboncouer, March 15, 2011).

As should be clear from the above site descriptions, full implementation of the IMBCI 10 Steps will be much more difficult in our developing country sites than in those in the developed world (with the exception of the site in Brazil, which is already well on its way). IMBCO will establish a network for all eight demonstration sites to help each other during the process of implementation.

These hospitals are paving the way for demonstrating how maternity care services can offer women optimal MotherBaby maternity care. IMBCO board members have by now visited most of these sites and worked directly with their key staff members. They are beginning the process of implementing the IMBCI 10 Steps in their respective institutions, and, pending funding, we will be carefully documenting and evaluating the effects. IMBCO has developed guides and evaluation tools for these and future sites to use. 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, and so forth.

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. (http://www.imbci.org)

Some of our board members—Debra Pascali-Bonaro, Robbie Davis-Floyd, Daphne Rattner, and Helene Vadeboncoeur—attended the III International Conference 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 more than 2,000 people, and received an enormously positive response. Representatives from the Brazilian Ministry of Health stated that they would work on a plan to implement the IMBCI throughout Brazil.

Four Latin American MBnets joined us at this conference; they are representatives of many others so we describe them in this article 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 obstetricians 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 (http://www.clinicalaprimavera.org).
- AuroraMadre, a nonprofit 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%, water birth 2%, home birth 4–5 per year and exclusive breastfeeding rates of 75% at 6 months. 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 conferences on humanized childbirth and doula training. As an MBnet, they will be working on lowering their cesarean rate (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 five births a month in home or hospital. (All staff have other jobs, and spell each other when a home birth 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 3-month course on home birth. 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 five other nurse-midwives. Marcos Leite continued to provide backup; then in 2009 (after years of insisting he never would), he too began to attend home births with group members. In 2010, Dr. Roxana Knobel joined Hanami and began home birth 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 (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 seven 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). For more information, see Ricardo's chapter in *Birth Models That Work* (Jones, 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.

IN CONCLUSION

The purpose of the IMBCI 10 Steps is to improve care throughout the childbearing continuum, 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, noninterventive approach that promotes the health and well-being 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 IMBCO, in collaboration with other organizations, is to develop, regularly update, and promulgate the IMBCI worldwide to improve care throughout the childbearing continuum, to save lives, to prevent illness and harm, and to promote health for mothers and babies around the world.

The full text of the IMBCI is available at 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 use 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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