The International Childbirth Initiative (ICI)

12 Steps to Safe and Respectful MotherBaby-Family Maternity Care

FIGO International Federation of Gynecology and Obstetrics

International Confederation of Midwives

International Motherbaby Childbirth Organization

IPA International Pediatric Association
Every Child · Every Age · Everywhere

The White Ribbon Alliance
Healthy Mothers Healthy World

American College of Nurse-Midwives
With women, for a lifetime®

Bixby Center for Global Reproductive Health

UCSF University of California San Francisco

bumi sehat Foundation

Commonsense Childbirth
National Perinatal Task Force

COINN
Council of International Neonatal Nurses

DONA International

Every Mother Counts

Harvard T.H. Chan School of Public Health
Department of Global Health and Population

ICEA
International Childbirth Education Association

International Council of Nurses
The global voice of nursing

İstanbul Doğum Akademisi

Lamaze International

Midwifery Today
The heart and science of birth

Midwives Alliance North America

Mercy In Action

The Sanctuary
Natural Birth Center

The International Childbirth Initiative (ICI) was developed in 2018 in a consultative consensus process with partner organizations and is currently endorsed by the following organizations as of December 2020.

International Federation of Gynaecology and Obstetrics (FIGO)

International Confederation of Midwives (ICM)

International Pediatrics Association (IPA)

International MotherBaby Childbirth Organization (IMBCO)

White Ribbon Alliance for Safe Motherhood (WRA)

American College of Nurse-Midwives

Bixby Center for Global Reproductive Health, UCSF

Bumi Sehat Foundation

China Midwives Alliance

Commonsense Childbirth National Perinatal Task Force

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Istanbul Birth Academy

Lamaze International

Mercy in Action

Midwifery Today

Midwives Alliance

The Sanctum Natural Birth Center

FIGO ICI Working Group

We are the current members of the ICI FIGO Working Group and FIGO has agreed to manage the finances of the Working Group. Dr Carlos Fuchtner, FIGO president, has made ICI a major presidential initiative for the next 3 years.

Members of FIGO ICI Working Group

Carlos Fuchtner, MD, Obs/Gyn, Bolivia, President FIGO 2018-2021

André Lalonde, MD, Obs/Gyn , Chair, FIGO ICI Working Group, Canada

Kathy Herschderfer, RM, Netherlands, executive director

Debra Pascali-Bonaro, LCCE, USA, co-chair

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Claudia Hanson, MD, PhD, Obs/gyn, Sweden, member

Doug McMillan, MD, Pediatrician, International Pediatric Association (IPA) representative, Canada, member

William Keenan, MD, Pediatrician, IPA representative, USA, member

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The International Childbirth Initiative (ICI)

12 Steps to Safe and Respectful MotherBaby-Family Maternity Care[1]

Introduction

Background

In 2008, the International MotherBaby Childbirth Organization (IMBCO) launched the *International MotherBaby Childbirth Initiative (IMBCI): 10 Steps to Optimal MotherBaby Maternity Services.* The IMBCI embodied the Principles and Steps of the US-based *Mother-Friendly Childbirth Initiative* (MFCI), adapting it for use at the global level (1). In 2014, the International Federation of Gynecology and Obstetrics (FIGO), collaborating with the World Health Organization (WHO), the International Confederation of Midwives (ICM), the International Pediatrics Association (IPA) and the White Ribbon Alliance (WRA), launched the *FIGO Guidelines to Mother-Baby Friendly Birthing Facilities,* (2) inspired by the WHO/UNICEF *Baby-Friendly Hospital Initiative* (BFHI), and grounded philosophically and ethically in the White Ribbon Alliance charter on *Respectful Maternity Care: The Universal Rights of Childbearing Women.* In 2018, IMBCO and FIGO joined forces to merge their initiatives. An analysis revealed a strong overlap among the Principles, Criteria and Steps, identifying common denominators that formed the foundation for the Principles and Steps in this document. In addition, a quick scan was carried out to identify and integrate the newest evidence and insights into what constitutes optimal maternal and newborn health care. In comparison with the founding initiatives, the ICI contains more Steps, has a broader emphasis on rights and quality of care, and responds to the call to more explicitly include the newborn.

A Human Rights Focus for Women and Infants

A number of established international human rights documents and instruments make specific reference to the rights of birthing women (3-9). In particular, the WRA charter on *Respectful Maternity Care: The Universal Rights of Childbearing Women* demonstrates the legitimate place of maternal health rights within the broader context of human rights, focussing on the interpersonal aspects of care received by women seeking maternity services and alerting to the growing evidence of disrespect and abuse in these service. (10). There has also been more attention paid towards identifying and defining disrespect and abuse of newborns, with evidence showing that mistreatment of babies exists both in the immediate and later postnatal periods (11). The ICI also recognizes the rights of newborns and infants as formulated in the *Position*

1 The term *maternity care* refers to the entire scope of care provided by health care providers to woman and babies during pregnancy, birth and the postnatal period.

Paper on Infant Rights (12), which affirms the specific rights of infants beyond those already mentioned in previous UN conventions and subsequent UN *General Comment on the Human Rights of Children* (13, 14). This declaration draws attention to the particular needs and rights of the child in the first years of life in order to build a lifetime of mental and physical health.

The ICI's Vision on Quality of Maternity Care

The ICI has integrated current thinking regarding quality in health care, aligning with a shift in how quality of care is defined and how it can best be delivered in health care systems. Universal health coverage (UHC), aiming for the provision of health security and universal access, is an important global objective embedded in the *Sustainable Development Goals* (SDGs). The perspective of three global institutions (WHO, the Organization for Economic Co-operation and Development (OECD), and the World Bank Group) proposed in *Delivering Quality Health Services: A Global Imperative for Universal Health Coverage*s that quality of care underpins and is fundamental to universal health coverage, and defines quality health care as effective, safe, and in keeping with the preferences and needs of the people and communities being served (15).

The same is true for quality of maternity care. Although a global increase has been seen in skilled birth attendance, mainly due to an increase in facility-based birth, still many women, foetuses and babies—despite having reached a facility—die or develop lifelong disabilities due to poor quality of care. The *Global Strategy for Women's, Children's and Adolescent Health* envisions that maternity services need to undergo transformation in order to assure quality care ensuring that women, babies and families thrive as well as survive following childbirth (16).

The ICI is aligned with three important publications addressing the quality of maternity care as a health system and facility issue. The *Blueprint for Advancing High-Value Maternity Care through Physiologic Childbearing* draws upon evidence showing the short and long-term benefits to the mother and newborn achieved by supporting the hormonally driven physiologic perinatal processes (17). This *Blueprint* charts an efficient pathway for promoting healthy physiologic processes, whenever possible, as a preventive approach to health and safety for childbearing women and their newborns, focusing on a health systems shift to the provision of high-value care and on improving health outcomes and experiences with wiser spending (18). The WHO document *Standards for Improving Quality of Maternal and Newborn Care in Health Facilities* recognizes that such improvement is an important focus in ending preventable maternal and newborn mortality and morbidity. These *Standards* present a definition of quality of care with two inter-linked dimensions—care provision and experience of care—within a framework designed to improve the quality of care for mothers and newborns around childbirth (19). A modification of this framework, in the WHO *Standards for Improving the Quality of Care for Children and Young Adolescents in Health Facilities,* addresses the quality of pediatric care, recognizing that the health, physical, psychosocial, developmental, communication and cultural needs of children differ from those of adults (20).

A number of important published guidelines embrace this broader concept of what constitutes good quality maternity care. The ICI is aligned with the WHO recommendations in *Antenatal Care for a Positive Pregnancy Experience* (21) and in *Intrapartum Care for a Positive Childbirth Experience* (22), both of which underline the importance of meeting the needs of mothers, babies and families (23). The intersection between maternal and newborn health is clearly evident in changing insights into early childhood development (ECD). In all settings, maternity services can support ECD because of their extensive contact with pregnant women and young children and their families, enabling the implementation of interventions that promote family bonding and physical and cognitive development before conception and during the first 1000 days of a child's life (24-26). The framework *Nurturing Care for Early Childhood Development* sets out a roadmap for

action referring to the role of maternity care services during pre-pregnancy through postnatal periods (27).

The ICI is grounded in the concepts of culturally sensitive and culturally safe maternity services, incorporating the WHO recommendation supporting culturally-appropriate maternity care services to improve maternal and newborn health (28). It also addresses the four key themes that were prominent in subsequent research into the implementation of culturally-appropriate maternity services: accessibility, community participation, person-centered respectful care, and cohesiveness among maternity services along the continuum of care (29). In addition, the ICI has integrated the concept of *cultural safety* as a key philosophical shift from providing care regardless of difference, to care that takes account of persons' unique needs. It requires health care providers to undertake an ongoing process of self-reflection and cultural self-awareness, and an acknowledgement of how their personal culture impacts on their individual care provision (30).

The ICI also recognizes the potential of *self-care* as described in *Self Care: A Cost Effective Solution for Maternal, Newborn and Child Health for All* as a means of improving maternal, newborn and child health, and supports the promotion of self-care into maternity services (31). This approach is aligned with the ICI Steps that promote women not being passive recipients of care but active participants, empowered with knowledge, skills and confidence to maintain healthy pregnancies, prevent complications, identify emergencies, and defend their rights and the rights of their children.

The MotherBaby-Family Maternity Care Model

The ICI acknowledges and welcomes the ongoing development of care models that have shifted the traditional medical model of care to a value-based model grounded in partnership between provider and use, and in which health needs and expectations of the care recipient, as well as the desired health outcomes, are the driving force behind decision making and quality measurements (32-34). This is especially applicable to maternal and newborn care in the context of woman-centred care, where there is a natural link to the full scope of care provided by midwives and other maternal and newborn health care providers (35-37).

These models overlap in principles and aims and mainly differ in their emphasis on the type of recipient of care: woman, newborn, child, person, client, patient, family, etc. Embodiment of this concept of *recipient-centred* care is found in the core statements from a large number of maternity health care professionals' organizations, including the international organizations representing midwives (38), obstetricians (39), pediatricians (40) and family doctors (41).

The ICI has chosen to place the MotherBaby-Family unit as the care recipient in the centre of care provision[2]. This model was inspired by and adapted from the Canadian *Family-Centred Maternity and Newborn Care: National Guidelines,* which state that this model of care is a complex, multidimensional, dynamic process of providing safe, skilled and individualized care, responsive to the physical, emotional, psychosocial and spiritual needs of the women, the newborn and the family (42).

In addition, the MotherBaby-Family model of care presented here reflects the definitions and principles of a number of other relevant care models, including:

2 MotherBaby-Family refers to an integral unit during pre-conception, pregnancy, birth, and infancy influencing the health of one another. Within this triad, the MotherBaby dyad remains central in importance, as the care of one significantly impacts on the other.

- *Family Centered Care*: The Institute for Patient-and Family-Centered Care promotes an approach to planning, delivery and evaluation of health care grounded in mutually beneficial partnerships among providers, patients and families, and aimed towards improving the health and well-being of individuals and families and empowering them to maintain control over decision making in their health care. Moreover, this approach recognizes that patients and families are essential allies for quality and safety in direct care interactions as well as in quality improvement, health professionals' education, facility design, and policy development (43). The international organizations representing obstetricians and pediatricians have endorsed this model of care.

- *Person-Centered Care Framework for Reproductive Health Equity:* This framework was developed in response to the issue of global maternal, newborn, and reproductive health inequities, recognizing that people's rights to and expectations for equitable, safe and respectful care should be a global health priority at the heart of maternal and newborn health care quality improvement. This model calls for reproductive health care provision that is respectful and responsive to individual women and their families' preferences, needs and values, and to ensuring that their values guide all clinical decisions (44).

- *Philosophy and Model of Midwifery Care:* Developed by the International Confederation of Midwives, this philosophy and model is rooted in partnership with women, recognizing their rights to self-determination and to caregiving that is respectful and personalized. Care is holistic and grounded in an understanding of the social, emotional, cultural, spiritual, psychological and physical experiences of women. The ICM model recognizes pregnancy and childbearing as usually normal physiologic processes that carry significant meaning to the woman, her family and her community (45).

- *Scope of Midwifery Practice and Quality Maternal and Newborn Health (QMNH) Framework:* The Lancet Series on Midwifery developed a framework for quality maternal and newborn care that was subsequently used to structure analyses of evidence and to identify the scope of midwifery practice. Results showed that outcomes including survival, health and wellbeing of women and infants can be improved by practices that lie within the scope of midwifery practice. This study also showed the importance of the midwifery scope of practice for optimizing normal physiologic processes of reproduction and early life and for strengthening women's capabilities to care for themselves and their families. (46)

There is a growing pool of evidence revealing that the MotherBaby-Family care model, with integration of a midwifery scope of practice, is the strong foundation on which safe and respectful maternity care resides. The midwifery scope of practice is derived from provision of care from midwife maternity care professionals, and recognizes that an educated, trained, certified, licensed and regulated midwife workforce integrated into the health system is the best option for most women during their childbearing continuum. Yet, even in the absence of midwives, this scope of practice can be partially or fully provided by other maternity health care professionals. Obstetricians, pediatricians and nurses can provide uninterrupted quality care as maternal newborn health professionals with identified competencies, or as part of a team that collectively spans the same set of competencies (47). The MotherBaby-Family maternity care model can be provided in any birth setting—home, birth centre, clinic, and hospital, as well as throughout the entire continuum of maternity care, including obstetric or neonatal emergency situations.

The MotherBaby-Family maternity care model is based on the following characteristics:

- The period from conception until age 2 is a window of opportunity for parents and caregivers to lay the foundation of health and wellbeing to last a lifetime and to positively affect future generations.
- Pregnancy, labour and birth are healthy and life-changing physiologic processes for most women and their families that benefit from the midwifery scope of practice and philosophy.
- Multi-disciplinary education and teamwork—including communication, collaboration, consultation and referral—are essential to ensuring optimal care for women and babies, especially those with obstetric-neonatal risk or when obstetric-neonatal complications occur.
- Maternity care must be supportive, individualized and value-based as a partnership model between maternity health professionals and the MotherBaby-Family.
- Each health care provider a woman sees during the childbirth continuum should listen to what woman and their families say, and should communicate health knowledge and information in a culturally safe and sensitive manner and in a language that the woman and her family understand.
- Decision-making should be a collaborative effort between the pregnant woman, her family and her healthcare providers; in most circumstances, the final decision-maker should be the woman.
- Policy, education and practice should reflect current, evidence-based knowledge.
- Mothers and babies should stay together after birth whenever possible.

This MotherBaby-Family maternity care model is fully integrated into the *ICI Principles* and *12 Steps to Safe and Respectful Maternity Care.*

ICI-The Future

The founding organizations, together with the endorsing partner organizations, believe that this initiative provides clear Steps that collectively form a template for implementing safe and respectful maternal health care in any practice setting, and encourage other organizations and initiatives to join in, creating a broad global collaboration for implementation of maternity care that benefits the MotherBaby-Family unit. The *ICI 12 Steps to Safe and Respectful Maternity Care* will inspire maternal health systems, decision-makers, managers and care providers to review, adapt and evaluate maternity care provision to women, mothers, babies and families worldwide.

ICI Foundational Principles

The following Principles are the foundation of the *International Childbirth Initiative (ICI): 12 Steps to Safe and Respectful MotherBaby-Family Maternity Care*. They reflect the merging of the visions and principles from the founding initiatives, integrating the characteristics of the MotherBaby-Family care model and are aligned with relevant international recommendations and current evidence.

Advocating rights and access to care

- Women's and children's rights are human rights and must be ensured in all settings and circumstances, including humanitarian and conflict settings. Every woman and newborn, regardless of background, social and educational status, citizenship, age, and health status has the right to access well-staffed and equipped and free or fairly-priced maternal and newborn health services that provide quality care from skilled attendants. Higher rates of maternal and newborn mortality and morbidity resulting from inadequate access to essential care services and poor quality of care are unacceptable.

Ensuring respectful maternity care

- Consideration, respect and compassion for every woman and newborn should be the foundation of all maternity care, even in the event of complications.

- Every MotherBaby should be protected from disrespectful or violent practices of any kind, as well as from infringements on their right to privacy.

Protecting the MotherBaby-Family triad

- The *MotherBaby-Family* refers to an integral unit during pre-conception, pregnancy, birth and infancy influencing the health of one another. Within this triad, the MotherBaby dyad remains recognized as one unit, as the care of one significantly impacts the other. The addition of *Family* to this unit conveys the importance of husbands, partners and the social and/or community family structure in which a child in conceived, born and raised, and emphasizes that maternal care activities and systems need to fulfil the needs of the MotherBaby-Family triad in order to achieve the full potential of safe and respectful maternity care.

- Throughout the entire continuum of maternity care, the MotherBaby-Family should be actively engaged in care provision, aspiring for shared decision making, with the woman ultimately being the decision maker.

Promoting wellness, preventing illness and complications, and ensuring timely emergency referral and care

- Pregnancy, labour, birth and breastfeeding are most often normal and healthy physiologic processes that require supportive care and skilled attention.

- Many pregnancy-related and newborn complications can be prevented or attenuated by primary maternity care and public health measures designed to prevent illness and promote wellness.

- Accessible, appropriate and effective maternal and newborn emergency care is essential for the reduction of maternal and neonatal morbidity and mortality.

Supporting women's autonomy and choices to facilitate a positive birthing experience

- Continuity of supportive care and sensitivity to the mother's cultural, religious, and individual beliefs and values reduce the risk of psychological trauma and enhance women's trust in their caregivers, their experiences of childbearing, and their willingness to accept care and to seek it in the future.

- All women, including those with complications, should receive full, accurate and unbiased information based on best evidence on potential harms and benefits of obstetric and neonatal procedures and alternatives, so that they can make informed decisions about their care and their babies' care. Access to evidence-based prenatal education to prepare women and their partners strongly contributes to this decision making ability.

- Women should have a full range of choices throughout their maternity care experiences, including risk appropriate choices for the place of birth.

- Women with normal, low-risk pregnancies can safely give birth outside of medical facilities in clinics, birth centres, and homes when skilled care and effective referral are available.

Providing a healthy and positive birthing environment: The responsibilities of caregivers and health systems

- Pregnancy, birth, and postpartum practices affect the MotherBaby-Family physiologically and psychologically. A woman's confidence and ability to have a healthy pregnancy and birth and to breastfeed and care for her newborn are significantly influenced by her birthing environment and can be enhanced or diminished by every caregiver she encounters.
- Establishing a caring and supportive atmosphere, listening to the mother, encouraging her self-expression and ensuring an equal communication interchange in language a woman understands, in order to achieve individualized care, are essential aspects of culturally safe and respectful maternity care.
- Caregivers are individually and collectively responsible to the mother, baby, family, community, and health care system for the quality of care provision. The needs of the MotherBaby-Family must take precedence over the needs of caregivers and institutions.
- Health care systems are equally responsible for providing safe environments that also take the needs of the providers into account. Skilled providers should be supported to provide optimal care by a sufficient infrastructure that includes adequate supplies, equipment, and staff, without mistreatment or abuse by superiors and with their encouragement and support.

Using an evidence-based approach to maternal health services based on the MotherBaby-Family Model of Care

- Maternal and newborn health benefits from an evidence-based approach to care. Every MotherBaby should be protected from unnecessary and potentially harmful interventions, practices, and procedures and from both overuse and underuse of medical technology.
- The foundation of safe and respectful MotherBaby-Family maternity care is lies in a combination of value-based care models that are driven by health needs and expectations, are based on partnership with women, and contribute to optimizing the normal bio-psycho-social processes of childbirth as well as health outcomes.
- The MotherBaby-Family care model can be practiced by all maternal and newborn health professionals in any setting, in every level of care provision and during obstetrical and neonatal complications and emergencies.

The ICI 12 Steps to Safe and Respectful MotherBaby-Family Maternity Care

The 12 Steps of the ICI are based on the Principles listed above and on best available evidence about the safety and effectiveness of maternity care provision. *Safe maternity care* refers to ensuring that the care women receive helps them to feel physically and psychologically secure, enabling a positive birth experience. *Safe maternity care* also includes evidence-based practices that minimize the risk of error and harm and support the normal physiology of labour and birth. *Safe maternity care* contributes to achieving expected benefits and is appropriate to the needs of the MotherBaby-Family. *Respectful maternity care* refers to inclusive, non-discriminatory, accessible, affordable and acceptable care that ensures dignity, compassion and privacy for the MotherBaby-Family unit.

Safe and respectful MotherBaby-Family Maternity Care is measurable. For each of the 12 Steps, a number of basic performance indicators have been developed that can be used in all settings to monitor and evaluate ICI implementation. It is expected that these may be further developed with relevant and measurable targets and tailored to local needs.

In the following section, the full 12 steps (unabridged version) are listed with their corresponding indicators.

The 12 Steps to Safe and Respectful MotherBaby-Family Maternity Care

with corresponding performance indicators

Safe and Respectful MotherBaby-Family Maternity Services **display the ICI 12 Steps to Safe and Respectful MotherBaby-Family Maternity Care** and in addition, have written policies, implemented in education and practice and available for review, requiring that maternal and newborn health services and health care providers:

Step 1 Provide Respect, Dignity and Informed Choice

Treat every woman and newborn with respect and dignity, fully informing and communicating with the woman and her family in decision making about care for herself and her baby in a culturally safe and sensitive manner ensuring her the right to informed consent and refusal. Incorporate a rights-based approach, preventing exclusion and maltreatment of the marginalized and socioeconomically disadvantaged, and including protection of HIV-positive women and women who experience perinatal loss. Under no circumstances is physical, verbal or emotional abuse of women, their newborns and their families ever allowed.

Indicators

1. *Feedback mechanisms are provided for addressing complaints (such as a complaint box).*
2. *A grievance process is defined and available to mothers and their families.*
3. *The charter on Respectful Maternity Care: The Universal Rights of Childbearing Women is displayed.*
4. *Local observers witness respectful treatment.*
5. *Women's questionnaires and/or interviews show compliance with this Step.*

Step 2 Provide Free or Affordable Care with Cost Transparency.

Respect every woman's right to access and receive non-discriminatory and free or affordable care throughout the continuum of childbearing. Inform families about what charges can be anticipated, if any, and how they might plan to pay for services. Make costs for prenatal education and antenatal, intrapartum and postpartum care visible, transparent and in line with national guidelines. Include risk pooling for complications (no additional charge for caesarean delivery or other complications). Forbid under-the-table payments and routinely enforce this rule. Under no circumstances should a woman or baby be refused care or detained after birth for lack of payment.

Indicators

1. *There are no cases in which women, newborns or infants are refused care or detained after care due to inability to pay.*
2. *Survey and interview responses from women indicate that the fees they were asked to pay meet the advertised rates, and they were not asked/required to provide any extra fees or in-kind payments.*
3. *Informational posters or signs showing all relevant costs in ways comprehensible to families are visibly posted on entrance to the labour and delivery units, and at discharge/cashier. These include information on how patients/families can report non-adherence to the policies and/or requests for bribes.*

Step 3 Routinely Provide MotherBaby-Family Maternity Care.

Incorporate value- and partnership-based care grounded in evidence-based practice and driven by health needs and expectations as well as by health outcomes and cost effectiveness. Base care provision on what women want for their newborns and families during the childbirth continuum. Optimize the normal bio-psycho-social processes of childbirth by promoting the midwifery philosophy and scope of practice for most women, within a system that ensures multi-disciplinary collaboration, communication and care for women and newborns, including those with obstetric-neonatal risk and/or complications. Ensure that this MotherBaby-Family care model is available at all levels of care and in any setting and is provided by individual skilled health workers with the full scope of competencies, or within a team with combined competencies.

Indicator

1. *Knowledge about this model can be assessed through questionnaires and interviews with providers and management.*
2. *The presence of this care model and its associated practices are observed by accessors.*
3. *Women's questionnaires and interviews indicate that this model is being practiced.*

Step 4 Offer Continuous Support.

Inform the mother of the benefits of continuous support during labour and birth, and affirm her right to receive such support from companion(s) of her choice. These include father, partner, family member, doula[3], TBA[4], or others. Continuous support during labour improves outcomes for women and newborns including: a more positive birthing experience, an increase in spontaneous vaginal birth, a shorter duration of labour, a decrease in the number of caesarean and instrumental vaginal births, less need for analgesics and a low 5-minute Apgar score. Such care appears to be most beneficial when given by a person who is present solely to provide support and is not a member of the woman's own network, is experienced in providing labour support, and has at least a modest amount of training (such as a doula) (48).

Indicators

1. *Clear policies stating both verbally and graphically that (birth) companions are welcome into the facility to accompany women in labour are visibly posted and explained in prenatal visits.*
2. *Observers witness that every woman has the option of continuous support.*
3. *Women and families state in interviews and/or questionnaires that accompaniment was encouraged and supported, and that space was made for their chosen companions.*

Step 5 Provide Pain Relief Measures.

Offer non-pharmacological comfort and pain relief measures as safe first options, explaining their benefits for facilitating normal birth. Educate women (and their companions) about how to use these methods, including breathing, touch, holding, massage, relaxation techniques, and labouring in water (when available). If pharmacological pain relief options are available and requested, explain their benefits and risks. Train staff in all comfort measures and pain relief options and to respect women's

3 Doulas are birth companions trained and certified in the provision of continuous labour support.

4 Traditional Birth Attendants when acknowledged, recognized and/or integrated into maternal health service provision.

preferences and informed choices to maximize their confidence and wellbeing . (49)

Indicators

1. *Written protocols about comfort measures and pain relief, including the need for increased monitoring of MotherBaby if pharmacological pain relief is used, are in place and made available to assessors.*
2. *In interviews and/or surveys, staff confirm their knowledge of these protocols and report being trained in all methods of comfort measures and pain relief.*
3. *Direct observations can be made as to whether comfort measures and pain relief are being offered and appropriate monitoring is being done.*
4. *Random record review for documenting compliance may be a possibility in some facilities/practices. New mothers can be queried about the availability of pain relief measures via questionnaires and interviews.*

Step 6 **Provide Evidence-Based Practice.**

Provide and promote specific evidence-based practices proven to be beneficial in supporting the normal physiology of labour, birth, and the postpartum and neonatal periods. These include but are not limited to:

- Allowing labour to unfold at its own pace, while refraining from interventions based on fixed time limits (22).
- When possible, refraining from admitting labouring women into labour wards and/or birthing units until they are in active labour, while ensuring that women in early labour have access to staff and facilities necessary to optimize their wellbeing and that of their baby and attending family (including supportive care, maternal comfort measures, food and fluids, and space to mobilise and rest).
- Offering the mother access to food and drink as she wishes during labour (22).
- Supporting the labouring woman to walk and move about freely and assisting her to assume the positions of her choice, including squatting, sitting, and hands-and-knees, and providing tools supportive of upright positions (22, 50).
- Providing all mothers with privacy during labour and birth, as evidenced by privacy walls or curtains, or separate/individual labour and birthing rooms where possible.
- Training staff to utilize techniques for turning the baby in utero from breech to cephalic lie, and to safely conduct vaginal breech deliveries.
- Facilitating immediate and sustained skin-to-skin MotherBaby contact for warmth, attachment, breastfeeding initiation, and developmental stimulation, and ensuring that MotherBaby stay together.
- Delaying cord clamping to facilitate the transfer of nutrients to the newborn (22).
- Reliably carrying out all elements considered part of Essential Newborn Care including: ensuring the mother's full access to her ill or premature infant, kangaroo care, and supporting the mother to provide her own milk (or other human milk) to her baby when breastfeeding is not possible (51).

Indicators

1. *Posters showing women eating, drinking, walking, and moving about during labour are prominently displayed, as are posters illustrating upright and other physiologic birth positions that include the woman being supported by a companion.*
2. *Tools for facilitating such positions, such as birthing balls, chairs and stools, floor mattresses or pads, and wall ladders and ropes, are clearly visible and easily accessible in labour and birthing spaces.*
3. *Privacy walls or curtains are visible.*
4. *Evidence of staff training in external version and vaginal breech delivery is shown to assessors.*
5. *Observations by assessors and women's interviews and questionnaires indicate immediate and prolonged skin-to-skin contact, rooming-in, delayed cord clamping, the mother's full access to the neonatal intensive care unit (NICU), and to providing kangaroo (skin-to-skin) care to her newborn.*

Step 7 Avoid Harmful Practices

Avoid potentially harmful procedures that have insufficient evidence of benefit outweighing risk for routine or frequent use in normal pregnancy, labour, birth and the postpartum and neonatal period. When considered for a specific situation, their use should be supported by best available evidence that the benefits are likely to outweigh the potential harms and are consistent with national and/or international guidelines and recommendations, and should be fully discussed with the mother to ensure her informed consent (52).

Routine practices that should be avoided include:

- *enema*
- *sweeping of the membranes*
- *artificial rupture of membranes*
- *episiotomy*
- *frequent or repetitive vaginal exams*
- *withholding food and water*
- *keeping the mother in bed or immobilized*
- *supine or lithotomy position*
- *numerous caregivers constantly going in and out*
- *caregiver-directed pushing*
- *fundal pressure (Kristeller)*
- *immediate cord clamping*
- *separation of mother and baby*

Practices that can be harmful for low-risk women yet helpful or essential in emergency situations or certain high-risk cases, and thus should only be used when medically indicated, include:

- *medical induction or augmentation of labour*
- *intravenous fluids (IV)*
- *continuous electronic fetal monitoring*
- *insertion of a bladder catheter*
- *forceps and vacuum extraction*
- *manual exploration of the uterus*
- *suctioning of the newborn*
- *caesarean section*

Indicators

1. *Facility or practice rates of procedures are within acceptable international ranges and are made available to the assessors. Different ranges will be expected for referral practices and referring facilities.*
2. *Benchmarking with other services is available.*
3. *Women's interviews and questionnaires show that they are informed about the reasons for suggested interventions or procedures and their consent is sought.*

Step 8 Enhance Wellness and Prevent Illness

Promotion of wellness and prevention of illness are the foundations of improving maternal and newborn health. **Implement educational and public health measures that enhance wellness and prevent illness and complications for the MotherBaby:**

- Provide education about and foster access to good nutrition, clean water, and a clean and safe environment.
- Make water, sanitation and hygiene (WASH) measures part of maternity services. Ensure promotion and provision of clean or boiled water, clean toilet facilities and a clean environment in all birth settings.
- Provide education in and access to methods of disease prevention and treatment for mother and baby, including for malaria, syphilis, hepatitis B, toxoplasmosis, HIV/AIDS, and tetanus toxoid immunization.
- Have clear, non-discriminatory policies and guidelines for the treatment and care of HIV-positive women and their newborns. Follow national guidelines on prevention and treatment of HIV in pregnancy, including prevention of transmission and early treatment of HIV-positive newborns.
- Provide education in responsible sexuality, family planning, and women's reproductive rights, as well as access to family planning options and youth-friendly services.
- Provide supportive and culturally competent prenatal education based on evidence (53) and antepartum, intrapartum, postpartum, and newborn care that addresses the physical and emotional health of the mother and baby within the context of family relationships and community environment, including those women who experience perinatal loss.
- Discharge preparation and planning should include adequate knowledge of postnatal and neonatal care by the mother and family including appropriate immunizations, scheduled follow-up care, understanding of maternal and neonatal danger signs and access to emergency care.

Indicators

1. *Pre- and post-natal education, materials and displays exist that address the criteria described above.*
2. *Staff and providers report being kept up-to-date via ongoing training in these measures for enhancing maternal and newborn wellness and preventing illness, including addressing hygiene and sanitation measures and providing family planning options.*
3. *Women's questionnaires and interviews indicate that the above criteria are included in their care. Observational data confirm that the infrastructure requirements are met to enable the facility or practice to provide these criteria.*
4. *Documentation of family education and preparation for ongoing neonatal care is made available.*

Step 9 Provide Emergency Care and Transport

Provide access to skilled emergency treatment for life-threatening complications. Ensure that staff are trained in timely recognition of potentially dangerous conditions and complications and in providing effective treatment or stabilization, and have established links for consultation and an accessible and reliable system of transport:

- Ensure birth preparedness and emergency readiness during pregnancy through health promotion activities and organized community and health services mechanisms.
- Provide planning and arrangements for situations in which the mother or the baby need care beyond the capacity of available resources. Include remote consultation, an effective communication system, and timely and safe transport of the mother and/or infant to a referral facility.
- Ensure that all maternal and newborn healthcare providers have adequate and ongoing training in emergency skills for appropriate and timely stabilization and treatment of mothers and their newborns, including the provision of neonatal and maternal resuscitation.
- Have available drugs, devices and equipment to stabilize and treat mothers and their newborns when complications occur, such as severe hypertensive disorders, severe postpartum haemorrhage, hypovolemic shock, breathing difficulties, and sepsis.

Indicators

1. *Emergency treatment drugs, devices and equipment, including magnesium sulphate, uterotonics, balloon tamponade kits, LifeWrap NASGs, resuscitation equipment, oxygen tanks, and transport incubators for sick newborns are visible to observers, as is evidence of ongoing staff training in emergency care and referral.*
2. *Written policies and guidelines for transport and information transfer for referrals are in place.*
3. *In the case of referral from home, clinic, birthing centre etc. to a medical facility, women's questionnaires and interviews show that all referrals and those referring are welcomed at the facility and treated with respect and without blame.*
4. *Proof of ongoing education and practice for all emergency procedures is shown to assessors.*

Step 10 Have a Supportive Human Resource Policy

in place for recruitment and retention of all staff, and to ensure that staff are safe, secure, and encouraged and enabled to provide quality care in a respectful and positive work environment. Include an exemption policy that protects the retention and continuity of dedicated, experienced, and skilled maternal health care providers (midwives, nurses) in all units and facilities where births take place.

Indicators

1. *The policy is available on request and addresses staff safety, security, and exemptions from transfer or rotation policies.*
2. *Surveys or interviews of the staff demonstrate understanding of the policy and can confirm that it addresses the above issues; staff can also provide information on work safety conditions and general work environment issues.*

Step 11 Provide a Care Continuum

Provide a continuum of collaborative maternal and newborn care with all relevant health care educators, providers, institutions and organizations. Include traditional birth attendants (TBAs) and others attending at births who have been acknowledged, recognized, and/or integrated into the health services in this continuum of collaboration. Specifically, individuals within institutions, agencies and organizations offering maternity-related services should:

- Collaborate across disciplinary, educational, cultural, and institutional boundaries to provide the MotherBaby with the best possible care within a functioning team, recognizing each other's specific competencies and respecting each other's knowledge and experience.
- Foster continuity of care during labour and birth for the MotherBaby from a small number of caregivers.
- Have established links with frontline health providers working in primary care and the community to support stabilization, consultations and transfers of care in a timely manner to appropriate institutions and specialists for sick mothers and sick/premature infants.
- Ensure that the mother is aware of and can access available community services specific to her needs and those of her newborn.

Indicators

1. *Written policies for collaboration and care transfers are available for inspection.*
2. *Surveys or interviews show that there are established and working mechanisms for periodic communication and fostering good relationships between facility and community health providers.*
3. *Surveys or interviews of outside practitioners demonstrate their knowledge of facility/practice policies and provide descriptions of their experiences working with the facility/practice.*
4. *Staff and women's interviews and questionnaires indicate recognition of collaboration and the presence of continuous care from a small number of providers.*

Step 12 Promote Breastfeeding and Skin-to-Skin Contact

Refer to the following 10 Steps of the revised Baby-Friendly Hospital Initiative (2018)—Protecting, promoting and supporting breastfeeding in facilities providing maternity services through practice, training and policies (54):

- Comply with *the International Code of Marketing of Breast-milk Substitutes* and relevant World Health Assembly Resolutions; have a written infant feeding policy that is routinely communicated to staff and parents; establish ongoing monitoring and data-management systems.
- Ensure that staff have sufficient knowledge, competence and skills to support breastfeeding.
- Discuss the importance of management of breastfeeding with pregnant women and their families.
- Facilitate immediate and uninterrupted skin-to-skin contact and support mothers to initiate breastfeeding as soon as possible after birth. Skin-to-skin contact is the practice where a baby is dried and laid directly on the mother's bare chest immediately after birth, both of them covered by a warm blanket and left for at least one hour or until the start of breastfeeding.
- Support mothers to initiate and maintain breastfeeding and manage common difficulties.

- Do not provide breastfed newborns with any food or fluids other than breast milk, unless medically indicated.
- Enable mothers and their infants to remain together and to practice rooming-in 24 hours a day.
- Support mothers to recognize and respond to their infants' cues for feeding.
- Counsel mothers on the use and risks of feeding bottles, teats and pacifiers.
- Coordinate discharge so that parents and their infants have timely access to ongoing support and care.

Indicators

1. *Staff can be observed encouraging skin-to-skin contact and mothers kept together with their newborns, establishing breastfeeding as soon as possible.*
2. *The facility provides combined care and sufficient space for the MotherBaby in beds large enough for both with bassinets at hand (when available).*
3. *No pharmaceutical posters advertising infant formula are displayed and no infant formula is provided as a parting gift.*
4. *Culturally appropriate and heavily graphic posters in local languages depicting skin-to-skin contact and breastfeeding, along with explanations of their benefits, are prominently placed.*
5. *Women's questionnaires and interviews indicate the facility's or practice's compliance with these revised BFHI 10 Steps.*

Implementation and Evaluation

ICI Implementation

The ICI envisions that the actual implementation of the 12 Steps will vary between settings based on an assessment of current services, available resources and perceived needs. Whether or not the 12 Steps are implemented as a whole or in phases can be determined locally. The ICI Coordination Group will continually gather information on the process of implementation as it is being done in real-time, collate this information, analyze it, and feed it back to assist on-going implementation and new implementation processes. In doing so, a learning cycle will be created and maintained that will benefit implementation of the ICI Steps in all settings.

Implementation can be small- or large-scale and both top-down and bottom-up. Individual facilities may be motivated and have resources to start on ICI implementation themselves, while in other situations, health managers and planners may initiate a process of implementation for a specific district or region. The ICI acknowledges and welcomes both scenarios. In general, the ICI offers the following implementation recommendations:

- Work with local community groups to ensure relevance, engagement and acceptance by the end users;
- Ensure the involvement of local and/or national health professional's organizations to support the valued care providers on the work floor;
- Whenever possible, include the knowledge, skills and evidence contained in the ICI 12 Steps in continuing educational programmes and trainings to help with efficient implementation in practice.

The ICI envisions that the 12 Steps will be implemented in partnerships among local and national health planners and managers, maternity care providers and communities. Ideally the ICI 12 Steps will be embedded in local and national guidelines and recommendations and supported by governments, UN agencies, and health funding mechanisms. The ICI endorsing partners can provide continuing support through their networks.

ICI assessment and Quality improvement mechanisms

The ICI recognizes that implementation of its 12 Steps, although important, is not enough in itself. Implementation of this initiative needs to be accompanied by assessment processes and quality improvement mechanisms that are culturally sensitive and fit to local needs. **The ICI vision for quality improvement is locally led assessment with community engagement, based on easy-to-access education and training packages, and (when needed) supported by (inter)**

national and/or regional experts in verification. The results of these processes can lead to a recognition[5] status for facilities and practices as part of an ongoing quality assurance cycle. Furthermore, the information provided locally will contribute to the ICI as an international learning initiative that adapts based on lessons from the field, and thereby continues to grow in its ability to benefit mothers, babies, families, and providers throughout the world.

The generic criteria and process indicators developed for each of the 12 Steps can be utilized as a minimum assessment package to monitor and evaluate ICI implementation locally. This package includes a set of Women's Questionnaires developed by the IMBCO for both internal and external assessment. There are three questionnaires, with a common base, that have been adapted to type of birth: one questionnaire for women who gave birth vaginally, one for women who had a caesarean delivery following some labour, and one for women who had a planned caesarean delivery. The questionnaires are based on a set of variables related to the criteria for the ICI 12 Steps. The global standards described in the 2018 implementation guidance for the *Revised Baby-Friendly Hospital Initiative* (54) can be adapted and used by practices and facilities for measuring implementation of Step 12. Evaluation of care provision relating to the recipient-based MotherBaby-Family care model will require measurement of non-clinical aspects of care, incorporating human rights dimensions of respectful maternity services with domains of knowledge exchange and experiences of care (55). The development and validation of a tool to measure person-centered maternity care in low-resource settings has been shown useful and could also be adapted for evaluation (56), along with other relevant tools developed to measure women's experiences with childbearing (57). In addition, assessors can use existing locally developed assessment tools or develop new ones that provide relevant information and outcomes that relate to the ICI. These can include checklists for proof of written policies and visibility of information, education, and communication materials (wall charts, posters, pamphlets) for presence, location, content, and clarity; and direct observation of care delivery that should evidence integration of some or all of the ICI 12 Steps into maternity services.

Facility/practice staff should be trained in reflective practice and assessment. Methodologies for assessing adherence to the ICI Principles and 12 Steps will vary—for example, women's self-reports, based on questionnaire responses, and private in-person, individual interviews with staff and with women. Anonymity should be maintained at all times. Data collection should be supported with information technologies (IT) wherever possible.

The ICI envisions that district and local health authorities working collectively with providers and communities should be the primary promoters of the ICI, and that National Health Ministries should be strong supporters. The ICI endorsing partner organizations are willing to work with governments and local groups to spearhead the evaluation process, relying heavily on individuals from the community and the facility/practice to ensure local engagement and self-assessment (including local women's and public health organizations). The assessment will need to be thorough, but not burdensome. It should be conducted positively, with the intention of supporting improvement, and not as a blaming and shaming process.

5 The ICI acknowledges that certification cycles are not feasible or desired in all settings and therefore suggests the concept of *recognition* as a valid method of indicating that a facility or practice is engaged in ICI implementation and to evaluate its results, based on a minimum package of process and outcome indicators.

ICI Call to Action

The *International Childbirth Initiative* (ICI) acknowledges the great inequity in resources for and access to quality maternity care around the world. The challenge for the 21st century is to increase access to skilled caregivers and emergency care where these are lacking, while decreasing the overuse and underuse of medical interventions, increasing the understanding of the normal physiology of birth and breastfeeding, and improving the quality of maternal and newborn care provided in all countries of the world.

The ICI provides a template for maternity services to take action in promoting and providing safe and respectful maternity care, providing clear Steps for implementing evidence-based maternity services worldwide, and acknowledging the interaction between the MotherBaby dyad and their family and social environment, as well as their interactions with health providers and systems. The ICI has been endorsed by health professionals' organizations, advocacy groups and childbirth education organizations, and support is growing.

The ICI 12 Steps include promoting compassion and dignity in care provision, ensuring access to affordable care, and adopting a MotherBaby-Family maternity care model. Other Steps include provision of continuous support during labour and birth, appropriate use of non-pharmacologic pain relief and evidence-based practice, including avoidance of unnecessary and potentially harmful routine procedures. The Steps address measures to enhance health and wellness and appropriate emergency care with collaboration and communication between types of providers and levels of care. The ICI promotes a supportive human resource policy, and fully incorporates the revised Baby-Friendly Hospital Initiative. The ICI also supports the implementation of its 12 Steps and self-initiated quality improvement mechanisms that can be used to monitor process, effects, and engagement in safe and respectful maternity services.

Support for and endorsement of the *International Childbirth Initiative* is sought from individuals and organizations—including local and national governments, health funding agencies, UN and (inter)national NGO health promotion and education groups, and local community groups working to improve the health and wellbeing of mothers and newborns worldwide.

The International Childbirth Initiative (ICI)

The 12 Steps (summary version) to Safe and Respectful MotherBaby-Family Maternity Care

Step 1 **Treat every woman and newborn with compassion, respect and dignity,** without physical, verbal or emotional abuse, providing culturally safe and culturally sensitive care that respects the individual's customs, values, and rights to self-expression, informed choice and privacy.

Step 2 **Respect every woman's right to access and receive non-discriminatory and free or at least affordable care** throughout the continuum of childbearing, with the understanding that under no circumstances can a woman or baby be refused care or detained after birth for lack of payment.

Step 3 **Routinely provide MotherBaby-Family maternity care.** Incorporate value- and partnership-based care grounded in evidence-based practice and driven by health needs and expectations as well as by health outcomes and cost effectiveness.

Step 4 **Acknowledge the mother's right to continuous support during labour and birth** and inform her of its benefits, and ensure that she receives such support from providers and companions of her choice.

Step 5 **Offer non-pharmacological comfort and pain relief measures during labour** as safe first options. If pharmacological pain relief options are available and requested, explain their benefits and risks.

Step 6 **Provide evidence-based practices beneficial for the MotherBaby-Family** throughout the entire childbearing continuum.

Step 7 **Avoid potentially harmful procedures and practices that have insufficient evidence of benefit outweighing risk for routine or frequent use** in normal pregnancy, labour, birth, and the post-partum and neonatal period.

Step 8 **Implement measures that enhance wellness and prevent illness** for the MotherBaby-Family, including good nutrition, clean water, sanitation, hygiene, family planning, disease and complications prevention and pre-and-post natal education.

Step 9 **Provide appropriate obstetric, neonatal, and emergency treatment** when needed. Ensure that staff are trained in recognizing (potentially) dangerous conditions and complications and in providing effective treatment or stabilization, and have established links for consultation and a safe and effective referral system.

Step 10 **Have a supportive human resource policy** in place for recruitment and retention of dedicated staff, and ensure that staff are safe, secure, respected and enabled to provide good quality, collaborative, personalized care to women and newborns in a positive working environment.

Step 11 **Provide a continuum of collaborative care** with all relevant health care providers, institutions, and organizations with established plans and logistics for communication, consultation and referral between all levels of care.

Step 12 **Promote breastfeeding and skin-to-skin contact,** refer to the 10 Steps of the revised Baby-Friendly Hospital Initiative and integrate into practice, training, and policies.

Please access the full ICI at **www.icichildbirth.org** to read the full 12 steps and to learn more about the background, principles and aims of the initiative.

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