Chapter 10
The International Childbirth Initiative: An Applied Anthropologist's Account of Developing Global Guidelines

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Introduction: A Focus on Process

As Jordan and Davis-Floyd have written, birth is everywhere socially marked and shaped, and *local realities necessitate adjusting maternity care to fit local contexts* (Jordan & Davis-Floyd, 1993). To date, much of the anthropology of policy in health has been concerned with how policies are localized and has underlined the importance of considering the economic, political, and social contexts when developing and implementing health interventions (see for instance Whiteford & Manderson, 2000). In this chapter, I draw on my personal experience as an applied anthropologist to reflect on the development of global guidelines in maternal and child health – the *International Childbirth Initiative (ICI): 12 Steps to Safe and Respectful MotherBaby-Family Maternity Care* (2018), for which I served as lead editor and wordsmith. This experience sheds light on how guidelines, at the global level, can be successfully developed and implemented with attention to local context, with the efforts of what McDougall (2016), building on the work of Sabatier and Jenkins-Smith (1993) and Keck and Sikkink (1998, 1999), terms "global advocacy coalitions."

The chapter focuses on what my colleagues and I learned from our processes: First, in addition to being guided by evidence, the guidelines grew out of earlier initiatives, described below, that cohered around shared ideas and values of the women's health and midwifery movements, including woman-centered care, a recognition of the interconnectedness of mother, baby, and family, and the understanding that women's rights are human rights. Second, the *process* of making guidelines heavily influences the final *product*, so the process must be honored, not rushed, and undertaken with commitment to see it through. Multi-level collaboration and

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networking around a clear and shared vision, garnering input from many people with diverse voices and perspectives, and discussion and debate were essential parts of the creation of the ICI. I will elaborate further on these key lessons and others in my Conclusion. How we learned these key lessons will be clearly illustrated in what follows. In order to understand the creation of the ICI, it is first necessary to briefly acknowledge the histories of birth activism and global movements to improve the quality of maternal health within which the ICI is embedded.

Birth Activism

The creation of the ICI and its three closely related predecessors—the *Mother-Friendly Childbirth Initiative* (MFCI) (1995), the *International MotherBaby Childbirth Initiative* (IMBCI) (2008), and the *FIGO Guidelines to Mother-Baby-Friendly Birthing Facilities* (2015) – are continuous with the deep history of activism around childbirth that has been diligently recorded and brought to light by scholars in the anthropology of reproduction, including Brigitte Jordan (1978), Emily Martin (1987), Adrienne Rich (1977), Diana Scully (1980), Nancy Stoller Shaw (1974), Sheila Kitzinger (1972, 1979, 1980), Ann Oakley (1979, 1980, 1984), Barbara Katz Rothman (1982, 1989), and others. The feminist revision of birth as presented in these early works still retains immense power and value, exposing the intense patriarchal bias in what I have long called the *technocratic* (Davis-Floyd, 1992, 2001, 2018a, b) treatment of women and their bodies throughout labor and birth. In addition to exposing the unnecessary medicalization of birth, these writers conducted research that revealed and defended the important social and cultural nature of midwifery and childbirth. Their work provided much of the inspiration for my own insights and birth activist work (see, for example, Davis-Floyd, 2018c, d), including my rather thrilling involvement with the ICI.

The Larger Context: A Need for a Quality-of-Care-Based Initiative

The ICI guidelines are embedded within larger global movements to improve the quality of maternal care. Significant progress has been made in maternal and infant health over recent decades, yet major problems remain in both developed and developing countries. Nearly 300,000 women die each year from issues related to pregnancy and childbirth, mostly in developing regions, and many more suffer from complications of pregnancy and childbirth. The leading individual causes of maternal mortality include haemorrhage, sepsis, eclampsia, obstructed labor, unsafe abortion, and infectious diseases such as HIV/AIDS and malaria during pregnancy (Nour, 2008; Say et al., 2014). All these are socio-structurally "stratified" (Ginsburg

& Rapp, 1995) to affect the poor far more than the well-off, as their underlying causes include structural violences such as poverty, lack of access to education, malnutrition, and the lower status of women (Davis-Floyd, 2018f; Farmer, 2004). The global infant mortality rate stands at around 29/1000 (WHO, 2018a). Leading individual causes of neonatal and infant mortality include prematurity, low birth weight, birth asphyxia and injuries, infection, congenital birth defects, sudden infant death, respiratory distress, and gastro-intestinal diseases—most of which also stem from the underlying causes listed above (WHO, 2018b). Yet despite their stratified embeddedness in these larger problems, *most maternal and infant deaths are preventable* through a combination of strategies including skilled attendance during childbirth from caregivers trained in facilitating the normal physiology of birth and breastfeeding, and access to emergency obstetric care (Cheyney & Davis-Floyd, 2019).

Although a global increase has been seen in skilled birth attendance, mainly due to an increase in facility-based birth, still many women, fetuses, and babies die or develop lifelong disabilities due to poor quality of care, despite having reached a facility (see Bhutta et al., 2014; Miller et al., 2003). The use of medical interventions in pregnancy, labor, and birth can be lifesaving, but their overuse leads to avoidable complications, and causes harm and even death. Unnecessary overuse has resulted in a massive increase in health care costs, straining resources without improving birth outcomes (see Anderson et al., 2020). For example, caesarean rates in many countries far surpass the recommended upper limit of 15–20% (Miller et al., 2016; WHO Statement on Caesarean Rates, 2015). Lack of availability of caesarean section when needed costs lives, but its overuse carries serious potential short- and long-term harms, especially for mothers, including infection, blood loss, blood clots, and problems in future pregnancies. Care providers trained in intervention use are rarely also trained in the skills and knowledge required to support the normal physiology of labor and birth (Miller et al., 2016).

Ministries of Health and national governments in general see facility birth as an essential part of their overall push toward "development" and "modernization" (Cheyney & Davis-Floyd, 2019). Yet many birth facilities, particularly in low- and middle-income countries (LMICs), are overcrowded, understaffed, and have few resources. Women often choose to avoid such facilities because of abuse, coercion, and/or neglect (Sadler et al., 2016; Savage & Castro, 2017; UN, 2006). Recently there has been increasing focus among international and national organizations on examining the quality of care and highlighting the abuse/neglect of women in facilities during childbirth and the lack of professional and social accountability among facility-based care providers (Assembly UNG, 1993; UN, 1966; UN Entity for Gender Equality and the Empowerment of Women, 2009; UN High Commissioner, 2010). Evidence collected in a variety of settings has documented that the *quality of care is directly related to maternal and newborn health outcomes*, including mortality (UN, 1996, 2009; White Ribbon Alliance 2011). Therefore, many saw a need for a global initiative focused on improving quality of care, and that understanding led to the development of the IMBCI, the FIGO Guidelines, and finally the ICI—a progression that I will describe in the next section.

Creating the International MotherBaby Childbirth Initiative (IMBCI): 10 Steps to Optimal MotherBaby Maternity Services

The Coalition for Improving Maternity Services (CIMS), founded in the United States in 1996, for a time incorporated in its membership 50 childbirth-related organizations representing over 90,000 members. Its mission was to promote a wellness model of maternity care that would improve birth outcomes and substantially reduce costs. This mission was ultimately realized as the *Mother-Friendly Childbirth Initiative (MFCI): 10 Steps to Mother-Friendly Hospitals, Birth Centers, and Home Birth Services.* I served as lead editor and wordsmith for the MFCI, with Henci Goer and Roberta Scaer as co-editors. The MFCI was modeled, in part, after the long extant (1991) WHO-UNICEF *Baby-friendly Hospital Initiative* (BFHI), and the BFHI 10 Steps to successful breastfeeding were incorporated as the final Step of the MFCI and the other three initiatives that followed it.

The MFCI was released in 1996, went global via the internet, was translated into multiple languages, and was 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 around the world to help them create their own initiatives. To these requests, CIMS consistently responded with the message that 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. Yet over time, more and more international birth activists and practitioners, including obstetricians, kept showing up at CIMS conferences in the United States and repeating their requests for CIMS to create a global initiative that would work for all countries, insisting that they did not have the resources nor experience to create such an initiative, whereas we—supposedly—did.

Finally, in 2005, CIMS gave up protesting that each country should create its own initiative, and formally created the CIMS International Committee, which eventually morphed into the International MotherBaby Childbirth Organization (IMBCO), with Debra Pascali Bonaro (world-renowned birth activist, doula trainer, and producer of the film *Orgasmic Birth*) as its Chair, and Maureen Corry (then-Director of Childbirth Connection), Rae Davies (a doula trainer and administrator who later became IMBCO's Administrative Director), Mayri Sagady-Leslie (nurse-midwifery practitioner, researcher, and professor), and myself (an applied reproductive anthropologist) as the five original IMBCO Board members. Our initial goal would be to create a global initiative based on a worldwide survey of birth and breastfeeding organizations to assess levels of agreement with the 10 Steps of the MFCI. The survey results showed that agreement was high, so we felt we had a working mandate to create what became the IMBCI—an initiative based on a process of *extensive collaboration and networking*, which we knew were essential in order to ensure strong international support.

To jump-start our process, we obtained funding to hold a meeting in Geneva of what we called our Technical Advisory Group (TAG), which was attended by representatives from the following organizations: WHO, UNICEF, USAID, CIMS, Childbirth Connection, Lamaze International, DONA, La Leche League International, Wellstart International, the World Alliance of Breastfeeding Associations (WABA), the International Lactation Consultant Association (ILCA), the International Confederation of Midwives (ICM), the International Council of Nurses (ICN), the International Pediatric Association (IPA), and JPHIEGO. We recruited these organizations because of our profound respect for the international work they had already done, and left that 2-day meeting with an initial draft of the IMBCI. The process of finalizing the IMBCI then took a full year, during which I, as lead editor, garnered feedback from over 100 childbirth experts, practitioners, grassroots activists, and some interested lay women from many countries, and of course, from the original members of the IMBCO Board. *Gathering this broad range of feedback was essential to the IMBCI's success* and its eventual ability to serve as a template for the ICI (see below). Every individual who received a draft was able to make some kind of contribution toward its betterment, demonstrating the values of collaboration and of patience.

An important and lasting contribution of the IMBCI is the term "MotherBaby" – first used by Audrey Naylor, MD, DrPH, who was then CEO of Wellstart International. A pediatrician and longtime champion of breastfeeding in the international arena, Naylor believed that "mothers and babies are an interdependent, biologic unit…inseparable throughout the continuum of care" (Naylor, e-mail message to Mayri Sagady Leslie, August 8, 2010). Once the IMBCI was completed, we posted it on our newly created website www.imbci.org and sent it out to our IMBCO regional and country representatives. They translated the IMBCI into 27 languages and put it to work in their countries and regions. A number of smaller birthing facilities and NGOs took the IMBCI as their chartering document and implemented it in their practices and countries. (The full story of the IMBCI is told in Davis-Floyd et al., 2011.)

IMBCO's Pilot Project: Disappointment and Setback

A common course for international initiatives is to seek to have them ratified in a formal process by all major and relevant organizations. IMBCO did not choose that course, since we recognized that international formal ratification could hold dissemination of the document up for a year or more. Instead, we chose to pilot the IMBCI at demonstration sites to test its efficacy in decreasing unnecessary interventions and improving outcomes via high quality of care. We felt that once contextually relevant evidence was available, we would have a far better chance of receiving international endorsements and funding.

We put out an international call, and received and, after careful review, accepted applications from eight hospital pilot/demonstration sites in seven countries.

However, we needed funding for practitioner training in how to implement the 10 Steps, and for statistical documentation of the results of implementation so that we could prove efficacy. Then, suddenly, the Transforming Birth Fund, our former staunch supporter, indicated that they had shifted focus to the United States and would no longer be able to fund us. Although we were devastated, three of our pilot sites in Canada, Austria, and Brazil were high-resource enough to implement on their own: the Pavillon des Naissances, Hôpital Brome Missisquoi Perkins, Cowansville, Centre de Santé et Services Sociaux La Pommeraie, in Quebec, Canada; Community Hospital Feldbach, Feldbach, Austria, Department of Obstetrics and Gynaecology; and Hospital Sofia Feldman, Belo Horizonte, Brazil. (Sofia Feldman is described in Davis-Floyd & Georges, 2018; see also Davis-Floyd et al., 2011).[1] These highly humanistic hospitals are demonstrating in practice how maternity care services can offer women optimal MotherBaby care. IMBCO also developed evaluation tools for these and future sites to utilize, including questionnaires addressed to women who had just given birth, self-assessment by caregivers, and standard statistical measurements for interventions such as cesarean or induction rates.

MotherBaby Networks (MBnets)

As word about the IMBCI spread, many smaller independent facilities and practices began to contact us, asking how they could participate. We responded that they were perfectly free to implement the IMBCI 10 Steps on their own, yet we wanted to be connected, as by now we fully understood the importance of networking and "global advocacy coalitions." Our then-Administrative and Executive Directors Rae Davies and Rodolfo Gomez came up with the idea of linking these sites in an international network and calling them "MotherBaby networks"—"MBnets" for short. "Mbnets consist of individuals such as midwives and physicians; or a collaboration of individuals, community grassroots advocates and organisations, and careproviders; or a facility such as a birth center, clinic or hospital where women give birth... that are using the IMBCI to promote the 10 Steps in their own contextual surroundings" (IMBCO, 2020).

Two of these MBnets—the Bumi Sehat Foundation, founded by midwife Robin Lim, and Mercy in Action, founded by midwife Vicki Penwell—successfully implemented all 10 Steps of the IMBCI for years in their birth centers in Indonesia and the Philippines. They have also done so during their maternity care relief work in major disaster zones in the Philippines after Hurricane Hayan; in Aceh, Indonesia after the tsunami; and in Nepal and Haiti after major earthquakes, providing prenatal and postpartum care and assisting births in tents, with no electricity or running water! (For full descriptions, see Davis-Floyd et al., 2021; Penwell, 2018, and Lim

[1] See http://imbco.weebly.com/demonstration-sites.html

& Davis-Floyd, 2021). Their work demonstrates that *full IMBCI or ICI implementation is not dependent on the availability of high technologies*. We believe that this flexibility and non-reliance on high technology during labor and birth are two of the greatest strengths of these initiatives.

The FIGO Initiative

From its launch in 2008 until 2015, the IMBCI was the only global initiative of its kind. Then in 2015, FIGO published its own international initiative—the *FIGO Guidelines to Mother-Baby Friendly Birthing Facilities*—in the *International Journal of Gynecology and Obstetrics*. These guidelines were developed by the members of the FIGO Safe Motherhood and Newborn Health (SMNH) Committee in collaboration with the International Confederation of Midwives (ICM), IPA, WRA (White Ribbon Alliance), and WHO. I vividly recall my reaction upon first reading them—that they contained many similarities to the IMBCI, that they were evidence-based and extremely well intentioned, and that some of their 10 Steps were a mélange of too many different things crowded together in each Step, resulting in a lack of clarity. I longed to dig my editorial fingers into these *FIGO Guidelines*—and 3 years later, to my everlasting delight, I got the chance.

Creating the International Childbirth Initiative: 12 Steps to Safe and Respectful MotherBaby-Family Maternity Care

After launching the IMBCI in 2008, we expanded our IMBCO Board considerably to be more global and diverse. It currently consists of Debra Pascali Bonaro still as Chair; Rae Davies as Administrative Director; myself; 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 VBAC and helped the Quebec Ministry of Health develop the first birth centers in Quebec; Amali Lokugamage, an obstetrician and researcher from Sri Lanka who works in London; Soo Downe, a UK midwifery professor and researcher; and Kathy Herschderfer, a Dutch midwife and former CEO of the International Confederation of Midwives. It was this IMBCO Board that participated in creating the ICI.

In the fall of 2016, Board member Daphne Rattner organized a conference in Brasilia in which she took care to create a session in which both the IMBCI and the *FIGO Guidelines* would be presented. The similarities between the two were obvious to all attending, and two of our IMBCO Board members, Kathy Herschderfer and Helene Vadeboncoeur, had already begun comparing their principles and Steps. That night, FIGO SMNH representative Andre Lalonde, Debra Pascali Bonaro, and

I had dinner together in the conference hotel and followed through on the idea of formally merging them—and that job was assigned to me.

Since this was now my third initiative to serve as lead editor for (after the MFCI and the IMBCI), I had a pretty good idea of how to proceed: I immediately began to painstakingly integrate the two sets of guidelines, sentence by sentence and phrase by phrase. Early in the process, I realized that this new initiative, which we had decided to call the *International Childbirth Initiative* (ICI), was going to have to contain 12 Steps instead of 10, as the FIGO SMNH Committee members had thought of two important Steps that the IMBCI did not contain. One was staff safety and protection. It was surprising that we at IMBCO had not thought about including this issue, given that many birth ethnographers, including myself, had documented the challenges of being a compassionate caregiver when you yourself are being abused by others higher up in the system (Beck & Gable, 2012; Olza, 2013; Leinweber et al., 2017; Davis-Floyd, 2018e). The other was full financial disclosure of all hospital costs and charges in advance of a birth—we should have thought of that too, as it can be common in some LMICs to refuse to release babies until the parents have paid the hospital bill in full, even when care is supposed to be free. Lim and Legget (2021) also realized the wisdom of including Indicators for measuring the implementation of each Step – something that *FIGO Guideline*s contained but the IMBCI did not. (The lesson here: *learn from others*.)

Resolving Disagreements in the Creation of the ICI

FIGO SMNH Coordinator Andre Lalonde informed us that one of the reasons FIGO had not just adopted the IMBCI wholesale, but created its own Guidelines instead, was the issue of pain relief. In the FIGO *Guidelines*, Step 9 said that a mother–baby-friendly birthing facility: "Educates, counsels, and encourages staff to provide both non-pharmacological and pharmacological pain relief as necessary." While creating the IMBCI, we had debated whether or not an optimal MotherBaby facility should offer both drug and drug-free pain relief options. 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. In addition, the IMBCO Board felt that including pain-relieving drugs, most especially the epidural, would be to ask developing countries that cannot afford such drugs to provide them, which would be unrealistic and unfair. Thus the IMBCI suggests only non-pharmacologic pain relief options. FIGO was not comfortable with leaving out drug-induced pain relief, whereas we at IMBCO were not willing to "push epidurals." However, we could all agree that *use of pain relief measures must be the mother's choice*, and that non-drug pain relief options should be offered first. Therefore, after various drafts, that ICI Step and its associated Indicators ended up reading:

> **Step 5 PROVIDE PAIN RELIEF MEASURES. Offer drug-free 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 laboring 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 preferences and informed choices to maximize their confidence and well-being.

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.

This wording worked for FIGO, and it worked for us, as it does not *require* facilities to have the resources to provide epidurals, etc., nor does it advocate for pharmacological pain relief, but rather leaves that entirely up to the birthing person as part of the principle of informed choice. Thus, in addition to being guided by evidence, the IMBCO and FIGO cohered around shared ideas and values of the women's health and midwifery movements, including: woman-centered high quality care; recognition of the interconnectedness of mother, baby, and family; and the understanding that women's rights are human rights. This coherence also demonstrates my point that the *process* of consensus building in the development of these guidelines heavily influenced the final *product*, so the process must be honored, not rushed, and undertaken with commitment to see it through.

Another tense issue was whether or not (and how) to refer to traditional midwives. Anthropologists tend to prefer the terms "traditional," "Indigenous," or "empirical" midwives in order to fully acknowledge their important roles in their communities as *midwives*. Yet the International Confederation of Midwives defines a "midwife" as one who has graduated from a government-approved midwifery training program, seeking to reserve that appellation for professional midwives only (ICM, 2017). Thus, ICM, WHO, UNICEF, and others refer to these practitioners as "traditional birth attendants" (TBAs), and we understood that we could not garner their support if we used the term "traditional midwife." In fact, the FIGO Guidelines made no mention at all of traditional midwives/TBAs, while the IMBCI Step 9 called for a "continuum of collaborative maternal and newborn care with all relevant health care providers, institutions and organizations" including TBAs. The carefully negotiated inclusion of the TBA in two steps of the ICI would eventually read:

Step 4 OFFER CONTINUOUS SUPPORT. Inform the mother of the benefits of continuous support during labor and birth, and affirm her right to receive such support from companion(s) of her choice. These include father, partner, family member, doula, TBA, or others. [Bold in original]

Step 11 PROVIDE A CARE CONTINUUM. Provide a continuum of collaborative maternal and newborn care with all relevant health care educators, providers, institu-

> **tions, 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. [Bold in original]

I put the "and/or" in there very much on purpose, wishing to be careful not to require that TBAs had to be "integrated"—as so often they are not, hampering their ability to ensure quick access to emergency care when needed (see Roy et al., 2021). And originally, the ICI Executive Group and the various partner organizations had put "trained" in front of "TBA." We were determined to avoid wording that insisted that TBAs had to be officially trained to provide labor support, attend births, and/or accompany women to clinical facilities, and we also argued that TBA "trainings" had been shown by ethnographers to frequently be pedagogically ineffective and culturally inappropriate (Jordan & Davis-Floyd, 1993; Pigg, 1997) and that TBAs had been shown by health researchers to often be helpful adjuncts to quality maternity care (Sibley et al., 2004). I was told that in discussions among FIGO SNMH reps and representatives from WHO that WHO had not wanted TBAs to be mentioned at all. This compromise in wording is one of many examples of how anthropological knowledge and perspectives on reproduction, along with knowledge of scientific evidence, careful wording, and consensus on key principles, contributed to the successful development of global guidelines in the form of the ICI.

Another issue to negotiate was perineal shaving. In the IMBCI, it was part of **Step 6: Avoid potentially harmful procedures and practices that have no scientific support for *routine or frequent use* in normal labor and birth**. But it got left out of the ICI because, I was told, women in many countries now shave themselves—either in preparation for birth or for personal or cultural reasons. Shaving can lead to tiny abrasions where bacteria can grow, but IMBCO and FIGO collectively felt that we should pick our battles carefully and that the risks of shaving were not significant enough to include in the list of routine procedures to avoid. Much more important were the procedures that *were* included in this list in ICI Step 7 of procedures to avoid unless strongly medically indicated. They include, among others:

- Medical induction or augmentation of labor.
- Intravenous fluids.
- Withholding food and water.
- Continuous electronic fetal monitoring.
- Frequent vaginal exams.
- Supine or lithotomy position.
- Episiotomy.
- Forceps and vacuum extraction.
- Immediate cord clamping.
- Cesarean section.
- Suctioning of the newborn.
- Separation of mother and baby.

Since almost all of these procedures are absolutely routine and culturally entrenched in hospitals all over the world, it is going to take a paradigm shift of epic

proportions to get practitioners to stop performing them. Yet the scientific evidence against their routine use is solid, and in some settings, the rates of these unnecessary procedures are beginning to fall. For instance, episiotomy rates in the United States fell from 25% in 2004 to 14% in 2014 (Friedman et al., 2015), as is the case in many European countries (Graham et al., 2005),

After numerous and mostly harmonious email and phone conversations between Andre and myself, I finished my tasks of wordsmithing the 12 Steps and their Indicators and merging the IMBCI and the FIGO Foundational Principles, first begun by Kathy and Helene. These principles give the ICI a solid human-rights-based, woman-and-family-centered, and midwifery model of care foundation, which we decided to rename ***The MotherBaby-Family Maternity Care Model*** (Fig. 10.1). The ICI principles include:

- Advocating rights and access to care.
- Ensuring respectful maternity care.
- Protecting the MotherBaby–Family triad.
- Promoting wellness, preventing illness and complications, and ensuring timely emergency referral and care.
- Supporting women's autonomy and choices to facilitate a positive birthing experience.
- Providing a healthy and positive birthing environment: The responsibilities of caregivers and health systems.
- Using an evidence-based approach to maternal health services based on the MotherBaby-Family Model of Care.

Fig. 10.1 ICI logo created by graphic designer Suzie Vitez (Permission for the use of the ICI logo in this publication has been granted by the ICI Executive Committee. Logo not to be replicated without express permission from the ICI Executive Committee.)

Endorsement and Implementation

Unlike with the IMBCI, which we wanted to put into immediate action, with the ICI we sought endorsements from professional associations, NGOs, and university-based research institutes concerned with maternal and newborn health. We quickly received endorsements from FIGO, IMBCO, the White Ribbon Alliance, the International Confederation of Midwives, the International Council of Nurses, the International Pediatric Association, Lamaze International, DONA International, the Harvard T. Chan School of Public Health, and others (for the full list, go to www.ICIchildbirth.org). These endorsements will matter as plans for implementation proceed and funding for implementation trainings and results documentation is sought—a process already underway. We are seeking active participation from endorsing partners to move the initiative forward.

Any practice or facility can implement the ICI Philosophy and 12 Steps on its own and join our MotherBaby networks; the ICI Executive Committee created an application process for sites that would like to become "early adopters" and the applications are flowing in. To quote directly from the ICI (p. 19):

> 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…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 professionals' organisations 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.

The key feature here is the *ICI's emphasis on the involvement of local groups and organizations*. We unanimously agreed that local grassroots community groups are the most ideally positioned to collaborate with caregivers and facilities to monitor and encourage a facility's progress toward implementation, in combination with international trainers to be sent in as needed. This approach is not only money-saving – sending international trainers is expensive – but also has the great advantage of engaging communities with the facilities that serve them, which will also enable these community representatives to ensure that implementation is contextually appropriate and culturally safe. At present, the IMBCO is developing, with the FIGO SNMH Committee, updated versions of our IMBCO Women's Questionnaires and tools for monitoring progress and self-initiated quality assurance mechanisms. The ICI Executive Committee also envisions a system of recognition for those who successfully implement the 12 Steps in any setting.

The latest update (May 2021), which I received from Debra Pascali Bonaro, IMBCO Chair and member of the ICI Executive Committee, includes the information that 61 hospitals and health centers in 19 countries are in the process of ICI implementation; three midwifery programs are engaging in curriculum development based on the ICI in the US, Kenya, and Sweden; the ICI 12 Steps were included in the *German Guidelines for Vaginal Birth at Term* in December 2020: these guidelines are for use in Germany, Austria, and Switzerland; and the ICI core documents have been translated into 23 languages, including Turkish, Croatian, Tagalog, Waray Waray, Dutch, French, Spanish, Chinese, and Mongolian. In addition, Moi University in Kenya received a UNFPA grant to develop and teach a training curriculum based on the ICI; the curriculum was prepared and taught during a 3-day training for public facility staff in October 2020. In addition, the students of the Mercy in Action College of Midwifery have developed training modules based on the ICI to teach to their partner health centers in the Philippines in 2021. The IMBCO Board has finalized ICI implementation guidance and tools for monitoring, evaluation, and learning. According to IMBCO Board and ICI Executive Committee member Kathy Herschderfer:

> We at IMBCO have created a series of webinars addressing each Step; these have been very well received. The FIGO ICI Working Group will start with a project funded by the New South Wales Government in Australia. This will involve ICI implementation in Fiji, the Solomon Islands and Papua New Guinea. A regional support team has been established in Australia and contacts have been made with key persons in the islands who will be responsible for the project. It is expected that the implementation will take place in 1-3 settings in each island and this project has been met with great enthusiasm. Because of the coronavirus pandemic, the start of the project has been postponed until (hopefully) in the fall. Preliminary preparations are being worked on with virtual communication. We are continuing to be a presence in various global communities who deal with respectful care.

Conclusion

The ICI addresses the needs of all nations and birthing women for evidence-based and humanistic improvements in the quality of maternity care, and is both educational and instrumental in purpose. The ICI's *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-Family-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 ICI 12 Steps is to put into worldwide awareness and practice the MotherBaby-Family Model of Care – a woman-centered, non-interventive approach that promotes the health and well-being of all women and babies during pregnancy, birth, and breastfeeding in a human rights and midwifery model of care framework, with care and compassion for MotherBaby within their family context.

To recap, my account of the development of the ICI highlights two important reflections about the development of global guidelines. First, just as the quality of care influences birth outcomes, *the process of making guidelines heavily influences the final product.* Attention to process was essential, including collaboration and networking around a clear vision and respectful and fruitful dialogue and discussion. Second, attention to key values of the women's health and midwifery movements, such as the importance of woman-centered care and women's rights as human rights, were important shared ideas and values upon which consensus could be negotiated when disagreements arose.

These findings align with McDougall's account of the work of global advocacy coalitions in maternal health. According to McDougall, advocacy coalitions are "formal or informal networks through which actors build resources and strategies to influence policy." McDougall (2016, pp. 310–311) argues that in the global case, "coalitions are understood less as geographically bounded and operating with formal political systems, but rather as loose collections of alliances made up of committed individual and institutional policy actors with dense inter-organisational and interpersonal ties working across borders to influence policy." McDougall shows that advocacy coalitions are important in facilitating cooperation among stakeholders, and can create a common platform on which many different institutions and types of stakeholders can engage. This insight applies to the creation of the ICI, as we included many different organizations and individuals in our process, and their participation did create a "common platform" for endorsement by diverse maternity-related organizations.

As McDougall (2016) emphasizes, advocacy coalitions can also compete against one another for political attention. As a result, certain "camps" and actors, values, and forms of evidence may come to dominate policy processes. Yet in FIGO's and IMBCO's process of creating the ICI, no individual nor "camp" dominated. We worked relatively harmoniously, despite the fact that FIGO is a much larger and more globally powerful organization than IMBCO, a small NGO. Our efforts

resulted in the successful development of both a global advocacy coalition and a set of global guidelines in the form of the ICI.

I reiterate that this chapter describes my own experience and thus can be only partial. Others in our advocacy coalition would no doubt tell these creation stories differently. In an effort to ensure that their voices would not contrast too severely from my own, I sent this chapter to all the members of the IMBCO Board and of the ICI Executive Committee for their review; they all approved it. Of course, it remains to be seen whether or not this new global policy initiative will be successful at effecting real change on a large scale. Global guidelines, such as the Baby-friendly Hospital Initiative, have been thinly implemented in some contexts, failing to improve quality of care, owing to various challenges (see for instance UNICEF and WHO, 2017; Wieczorek et al., 2015). Researchers will be needed to study the implementation process, help to identify barriers, and document outcomes.

Our Ultimate Vision: Setting the Gold Standard for Optimal Maternity Care

The full text of the ICI is available at www.ICIchildbirth.org for anyone in any country to download and work with in their area. Individuals, practices, facilities, and organizations can join our mailing list to stay informed and become involved in supporting and implementing the ICI 12 Steps as a template for their work, and use the ICI as an educational instrument and guide. Ultimately, our vision is that every birth facility and practice will operate according to the ICI 12 Steps, resulting in high quality, evidence-based, and respectful care that will dramatically reduce mortality, morbidity, and financial costs, and will physically and psychologically enhance both birth and breastfeeding outcomes for mothers, babies, and families.

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