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Creating the International MotherBaby Childbirth Initiative (IMBCI): Anthropologically Informed Activism[1]

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Abstract: This article tells the story of the creation of an international initiative designed to improve childbirth care and childbirth and breastfeeding outcomes for all women and my role in that process—a role that I felt very privileged to play and that was specifically informed by my anthropological perspective.

Keywords: childbirth, breastfeeding, maternity care, birth outcomes, motherbaby initiative, activism, anthropology

The Role of CIMS and the Creation of the IMBCI

The Coalition for Improving Maternity Services (CIMS) was founded in 1996 in the U.S. with a mission to promote a wellness model of maternity care to improve birth outcomes. The founders of CIMS (including myself) created the *Mother-Friendly Childbirth Initiative (MFCI): 10 Steps to Mother-Friendly Hospitals, Birth Centers, and Home Birth Services* for the U.S. In 2005, in response to multiple requests from around the world to create a global initiative that would work for all countries, CIMS created an International Committee. It later evolved into the International MotherBaby Childbirth Organization (IMBCO), with the internationally renowned childbirth educator, doula trainer, and film producer Debra

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Pascali-Bonaro as chair and myself and five other birth activist leaders as members. We created an international network of regional and country representatives and, with help from the Center for Women's Health Research at the University of North Carolina, conducted a global survey of the MFCI 10 Steps. This survey assured us that there was indeed strong international support for the MFCI 10 Steps, which gave us a sound basis for creating what we eventually called the *International MotherBaby Childbirth Initiative* (IMBCI).

The survey also gave us a clear mandate on what Step 1 of the IMBCI should be: **Treat every woman with respect and dignity, fully informing and involving her in decision-making about care for herself and her baby in language that she understands, and providing her the right to informed consent and refusal.**

Our next steps were to create a Technical Advisory Group consisting of representatives from all the major international agencies involved with maternity care, to obtain funding, and to hold a meeting in Geneva in June 2006 to develop the initial draft of the Initiative. We spent hours refining the wording of the document in an exhausting yet rewarding group consensus process. As designated editor (I had been the lead editor for the MFCI back in 1995, so it made sense for me to be lead editor this next time around), I had a preliminary draft up on PowerPoint, and for two afternoons I took verbal suggestions from the TAG representatives, sometimes shouted out with much discussion around every word. Each night I sat up late incorporating all the verbal suggestions, to present it all again the next day, while the rest of our committee worked on strategy.

Serendipitously, right after this TAG meeting, I was headed to give some talks at the Hecvsante Nursing and Midwifery School in Switzerland. My IMBCO colleague, Rae Davies, and I convinced the entire faculty of the school to review the just-created IMBCI, which we had up on PowerPoint. Many of its steps regarding humane care had long been implemented in Switzerland, so the faculty went beyond those to encourage us to include a whole step on collaborative care—a major issue for Swiss midwives, as obstetricians there, as in many other countries, often took a top-down approach and did not bother to collaborate with the professional midwives. The Swiss midwives' suggestion became **Step 9: Provide a continuum of collaborative care with all relevant healthcare providers, institutions, and organizations.**

In my role as lead editor, over the next year I gathered international input on the IMBCI 10 Steps, Philosophy, and Principles from representatives of all the relevant international organizations and around 100 childbirth experts, practitioners, and grassroots activists from many countries. I cannot begin to describe the intensity of this process! In the

end, the final crafting of the IMBCI narrowed down to our five IMBCO Board members at the time: Debra Pascali-Bonaro, Maureen Corry, Rae Davies, Mayri Sagady Leslie, and myself. We struggled over every single word because we were writing an Initiative intended to be applicable to the entire world, and we were just "five white girls" keenly aware that the needs and resources of developed and developing countries differ widely. Our awareness of those differences led to many difficult yet rewarding conversations—for example, should we say that an optimal MotherBaby facility should offer both drug and drug-free pain relief options? Clearly, the epidural is experienced by many women as a humanistic pain-relieving option during labor. Yet it carries risks and complications, especially if given too early in labor. Anthropology helped us realize that to insist on pain-relieving drugs would be to ask developing countries that cannot afford such drugs to provide them, which would be most unrealistic and unfair. On the other hand, drug-free pain-relieving interventions cost almost nothing and can be provided in any setting in any country, and are evidence-based as helping to relieve pain while causing no harm. Step 4 originally read:

> Provide drug-free comfort and pain-relieving methods during labour, explaining their benefits for facilitating normal birth and avoiding unnecessary harm, and showing women (and their companions) how to use these methods, including touch, holding, massage, laboring in water, and coping/relaxation techniques. Respect women's preferences and choices.

In later years, FIGO and other organizations critiqued the wording of this step as it did not include any mention of pharmacologic pain relief options, and it is a fact that many women around the world want those options, especially the epidural. Yet we strongly disagree with "pushing drugs" on women, as many practitioners do. So, in late 2016, we altered the wording of Step 4 to be more inclusive of all options without actively promoting drugs; the new wording is as follows:

> Offer drug-free comfort and pain relief measures as safe first options, explaining their benefits for facilitating normal birth and avoiding unnecessary harm. Educate women (and their companions) about how to use these methods, including touch, holding, massage, relaxation techniques, and laboring in water (when available). Provide pharmacological pain relief in labour when requested and available. Explain benefits and risks of all pain relief options. Respect women's preferences and choices.

We finalized the wording of the IMBCI and launched it at the CIMS Annual Meeting in Florida on International Women's Day in March 2008 to much celebration and acclaim!

The IMBCO Board and some of our regional representatives collectively launching the IMBCI at a CIMS conference in Florida, March 2008.
Photo by Jay Hathaway

The MotherBaby and Women's Rights as Human Rights

An important contribution of the IMBCI is the "MotherBaby" model of care. "MotherBaby" is a term first used by Audrey Naylor MD, DrPH, a pediatrician and CEO of Wellstart International, who sees mothers and babies as a single, interdependent unit, inseparable throughout the continuum of care. Another critical component of the IMBCI is its insistence that "women's and children's rights are human rights" and that "access to humane and effective health care is a basic human right." This assertion is consonant with several recent initiatives. In June 2009, the United Nations Human Rights Council passed a landmark resolution that recognizes "preventable maternal mortality and morbidity as a pressing human-rights issue that violates a woman's rights to health, life, education, dignity and information." In 2010, Amnesty International released *Deadly Delivery: The Maternal Health Care Crisis* in the U.S., which frames the issue of maternal healthcare as a human rights issue. While a public health focus on maternal mortality is not new in the global arena, this focus has been virtually invisible in the U.S. The Women

Deliver conferences of 2007, 2010, and 2013, which we attended and which brought together thousands of experts and advocates from around the world, also focused on human rights. To support these efforts, we at IMBCO extrapolated the MotherBaby rights inherent in the IMBCI (found at www.imbci.org).

IMBCO's Ongoing Work

Seeking to document the results of implementation of the IMBCI 10 Steps, our Board is working with three pilot/demonstration sites: Hôpital Brome Missisquoi Perkins in Quebec; Community Hospital Feldbach, Austria; and Hospital Sofia Feldman, Belo Horizonte, Brazil. We are still seeking funding for the research components—all funds obtained will be granted to the demonstration sites for trainings and statistical documentation of the results. *IMBCO would also welcome researchers to study the process of implementation and document both the barriers these sites may face and the outcomes we hope they achieve.*

The IMBCI has now been translated into over 20 languages; a number of independent practices have taken it as their chartering document and are working to implement it in their countries on their own. We call them MotherBaby Networks (MBnets), and are always open to receiving applications from more (see www.imbci.org). One of our MBNets is Mercy in Action, whose staff members undertook disaster relief efforts after Super-Typhoon Haiyan, which struck the Philippines in November of 2013. In a tent, with no running water and no electricity, they attended 165 births with successful outcomes, and provided pre- and postnatal care to thousands of women, managing to implement all of the IMBCI 10 Steps (which they had translated into the local dialect and posted everywhere) in every case of care.

Conclusion

Rising cesarean rates around the world, the increasing overuse of obstetric technologies, and failure to implement the scientific evidence in favor of normal, physiological birth have created the need for clear guidelines for providing optimal maternity care. The purpose of the IMBCI 10 Steps is to improve care throughout the childbearing continuum in order to save lives, prevent illness and harm from the overuse of obstetric technologies, and to promote health for mothers and babies. This Initiative addresses the needs of all nations and birthing women for evidence-based and humanistic improvements in the quality of maternity care. The educational purpose of the IMBCI is to call global attention to

the importance of the quality of the mother's birth experience and its impact on the outcome, the risks to mother and baby from inappropriate medical interventions, and the scientific evidence showing the benefits of MotherBaby-centered care based on the normal physiology of pregnancy, birth, and breastfeeding and on attention to women's individual needs. The instrumental purpose of the IMBCI is to put into worldwide awareness and practice the MotherBaby model of care: a woman-centered, non-interventionist approach that promotes the health and wellbeing of all women and babies, setting the gold standard for excellence and superior outcomes in maternity care. The full text of the IMBCI is available at www.imbci.org. Individuals and organizations can sign on as supporters of the IMBCI, adopt it as a focal point for their work, and use it as an educational instrument and guide to help hospitals and other practices to improve their maternity care. We welcome your support!