DOI: 10.1002/ijgo.12844

FIGO STATEMENT

WILEY International Journal of GYNECOLOGY OBSTETRICS FIGO

The International Childbirth Initiative: 12 steps to safe and respectful MotherBaby–Family maternity care

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1 | BACKGROUND

The International MotherBaby Childbirth Organization (IMBCO) and the International Federation of Gynecology and Obstetrics (FIGO) joined forces, developing a single global initiative to provide guidance and support for safe and respectful maternity care. This work built upon their previous initiatives—the IMBCO '10 Steps to Optimal MotherBaby Maternity Services'[1] and the FIGO 'Guidelines to Mother-Baby Friendly Birthing Facilities'[2]—and incorporates the most recent evidence and insights relating to quality maternal, newborn and child health provision. It also reflects much of the work being carried out by organizations involved in maternal and newborn health throughout the world.

This initiative, 'The International Childbirth Initiative (ICI): 12 Steps to Safe and Respectful MotherBaby–Family Maternity Care' was launched in October 2018 during the FIGO World Congress in Brazil in a special side event with presentations from key partner organizations. ICI provides clear steps for the implementation of evidence-based maternity care worldwide, acknowledging the interaction between the MotherBaby dyad and the family environment as well as their interactions with health providers and systems. The term 'maternity care' refers to the entire scope of care provided by healthcare providers to women and babies during pregnancy, birth and the postnatal period.

2 | 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 user, in which the health needs and expectations of the care recipient, as well as the desired health outcomes, are the driving forces behind decision-making and quality measurements.[3–5] 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 healthcare providers.[6–8]

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 healthcare professional organizations, including the international organizations representing midwives,[9] obstetricians,[10] pediatricians,[11] and family doctors.[12]

The ICI has chosen to place the MotherBaby–Family unit as the care recipient in the centre of care provision. '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

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significantly impacts on the other. 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.[13]

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

- *Family-centred 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 aims to improve the health and wellbeing of individuals and families and empower 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.[14] 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 healthcare quality improvement. This model calls for reproductive healthcare 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.[15]
- *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 physiological processes that carry significant meaning to the woman, her family, and her community.[16]
- *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 physiological processes of reproduction and early life, and for strengthening women's capabilities to care for themselves and their families.[17]

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 healthcare 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.[18] 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 well-being to last a lifetime and to positively affect future generations.
- Pregnancy, labor, and birth are healthy and life-changing physiological processes for most women and their families that benefit from the midwifery scope of practice and philosophy.
- Multidisciplinary 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 unit.
- Each healthcare provider a woman sees during the childbirth continuum should listen to what women 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*.

3 | 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 they are aligned with relevant international recommendations and current evidence.

3.1 | 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 well-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.

3.2 | 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 unit should be protected from disrespectful or violent practices of any kind, as well as from infringements of their right to privacy.

3.3 | 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 unit should be actively engaged in care provision, aspiring to shared decision-making, with the woman ultimately being the decision-maker.

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

- Pregnancy, labor, birth, and breastfeeding are most often normal and healthy physiological 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.

3.5 | 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 about 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.

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

- Pregnancy, birth, and postpartum practices affect the MotherBaby–Family unit 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 healthcare system for the quality of care provision. The needs of the MotherBaby–Family must take precedence over the needs of caregivers and institutions.
- Healthcare 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 with a sufficient infrastructure that includes adequate supplies, equipment, and staff, without mistreatment or abuse by superiors and with their encouragement and support.

3.7 | Using an evidence-based approach to maternal health services based on the MotherBaby–Family model of care

- Maternal and newborn health benefit 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 lies in a combination of value-based care models that are driven by health needs and expectations, based on partnership with women, and contribute to optimizing the normal bio-psychosocial 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 obstetric and neonatal complications and emergencies.

4 | THE 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 labor 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.

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, to be followed by maternal and newborn health services and health care providers.

4.1 | 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.

4.1.1 | Indicators

1. Feedback mechanisms are provided for addressing complaints (such as a complaints 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.

4.2 | 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 cesarean 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 owing to lack of payment.

4.2.1 | Indicators

1. There are no cases in which women, newborns or infants are refused care or detained after care owing 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 displaying all relevant costs in ways comprehensible to families are visibly posted on entrance to the labor 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.

4.3 | 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-psychosocial processes of childbirth by promoting the midwifery philosophy and scope of practice for most women, within a system that ensures multidisciplinary 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.

4.3.1 | Indicators

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.

4.4 | 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 may include the father, partner, family member, doula (a birth companion trained and certified in the provision of continuous labour support), traditional birth attendant (when acknowledged, recognized and/or integrated into maternal health service provision), or others. Continuous support during labor improves outcomes for women and newborns, including: a more positive birthing experience; an increase in spontaneous vaginal birth; a shorter duration of labor; a decrease in the number of cesarean 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, is not a member of the woman's own network, is experienced in providing labor support, and has at least a modest amount of training, such as a doula.[19]

4.4.1 | Indicators

1. Clear policies stating both verbally and graphically that (birth) companions are welcome into the facility to accompany women in labor 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.

4.5 | 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 wellbeing.[20]

4.5.1 | Indicators

1. Written protocols about comfort measures and pain relief, including the need for increased monitoring of the MotherBaby unit 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.

4.6 | Step 6: Provide evidence-based practice

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

- Allowing labor to unfold at its own pace, while refraining from interventions based on fixed time limits.[21]
- When possible, refraining from admitting laboring women into labor wards and/or birthing units until they are in active labor, while ensuring that women in early labor have access to the 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 mobilize and rest).
- Offering the mother access to food and drink as she wishes during labor.[21]
- Supporting the laboring 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.[21,22]
- Providing all mothers with privacy during labor and birth, as evidenced by privacy walls or curtains, or separate/individual labor 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 the MotherBaby unit stays together.
- Delaying cord clamping to facilitate the transfer of nutrients to the newborn.[21]
- 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 (skin to skin) care, and supporting the mother to provide her own milk (or other human milk) to her baby when breastfeeding is not possible.[23]

4.6.1 | Indicators

1. Posters showing women eating, drinking, walking, and moving about during labor are prominently displayed, as are posters illustrating upright and other physiological 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 labor 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 providing kangaroo care to her newborn.

4.7 | 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, labor, birth and the postpartum and neonatal period (see Table 1). 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. They should be fully discussed with the mother to ensure her informed consent.[24]

4.7.1 | 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.

4.8 | 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.

TABLE 1 Avoiding potentially harmful procedures.

Routine practices that should be avoided	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
Enema	Medical induction or augmentation of labour
Sweeping of the membranes	Intravenous fluids (IV)
Artificial rupture of membranes	Continuous electronic fetal monitoring
Episiotomy	Insertion of a bladder catheter
Frequent or repetitive vaginal exams	Forceps and vacuum extraction
Withholding food and water	Manual exploration of the uterus
Keeping the mother in bed or immobilized	Suctioning of the newborn
Supine or lithotomy position	Caesarean section
Numerous caregivers constantly going in and out	
Caregiver-directed pushing	
Fundal pressure (Kristeller)	
Immediate cord clamping	
Separation of mother and baby	

- 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[25] 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.

4.8.1 | Indicators

1. Pre- and postnatal 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.

4.9 | 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 hemorrhage, hypovolemic shock, breathing difficulties, and sepsis.

4.9.1 | 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.

4.10 | Step 10: Have a supportive human resource policy

The should be 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. It should include an exemption policy that protects the retention and continuity of dedicated, experienced, and skilled maternal healthcare providers (especially midwives and nurses) in all units and facilities where births take place.

4.10.1 | 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 confirm that it addresses the above issues; staff can also provide information on work safety conditions and general work environment issues.

4.11 | Step 11: Provide a care continuum

Provide a continuum of collaborative maternal and newborn care with all relevant healthcare educators, providers, institutions, and organizations. Include traditional birth attendants 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 labor 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.

4.11.1 | 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.

4.12 | Step 12: Promote breastfeeding and skin-to-skin contact

Achieve the 10 Steps of the revised Baby-Friendly Hospital Initiative (2018): *Protecting, Promoting and Supporting Breastfeeding in Facilities Providing Maternity and Newborn Services*[26]:

1. Comply with the *International Code of Marketing of Breast-Milk Substitutes*[27] 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.
2. Ensure that staff have sufficient knowledge, competence, and skills to support breastfeeding.
3. Discuss the importance of management of breastfeeding with pregnant women and their families.
4. Facilitate immediate and uninterrupted skin-to-skin contact and support mothers to initiate breastfeeding as soon as possible after birth.
5. Support mothers to initiate and maintain breastfeeding and manage common difficulties.
6. Do not provide breastfed newborns with any food or fluids other than breastmilk, unless medically indicated.
7. Enable mothers and their infants to remain together and to practice rooming-in 24 hours a day.
8. Support mothers to recognize and respond to their infants' cues for feeding.
9. Counsel mothers on the use and risks of feeding bottles, teats, and pacifiers.
10. Coordinate discharge so that parents and their infants have timely access to ongoing support and care.

4.12.1 | Indicators

1. Staff can be observed encouraging skin-to-skin contact and mothers are kept together with their newborns, establishing breastfeeding as soon as possible.
2. The facility provides combined care and sufficient space for the MotherBaby unit 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 Baby-Friendly Hospital Initiative 10 Steps.

5 | CONCLUSION

The International Childbirth Initiative provides a clear and unifying template for optimal care around which all relevant organizations should rally to promote quality maternity care in a comprehensive manner. ICI also envisions that successful implementation of the 12 Steps can be measured and monitored using the basic performance indicators combined with a minimum data collection package (currently in development) in a practical, reflective, and low-cost quality improvement cycle, using local assessors, with community involvement and with a global platform for training, sharing, and learning that will include data collection and webinars.

The International Childbirth Initiative was developed by IMBCO and FIGO (Appendix A) in a consultative consensus process with partner organizations. It has been endorsed by health professionals' organizations, advocacy groups, childbirth education organizations, educational institutions and facilities providing maternal, newborn, and child health services, and support is growing.

The full ICI launch document, a summary document of the 12 Steps and a list of ICI-endorsing partners is available on the ICI website (in development): www.internationalchildbirth.com.

AUTHOR CONTRIBUTIONS

The document was developed in collaboration with FIGO and IMBCO writing groups, and further refined by all authors. This policy statement was approved in 2018 by the FIGO Executive Board and Safe Motherhood and Newborn Health Committee.

ACKNOWLEDGMENTS

This article is based on an initiative first documented on the International Childbirth Initiative website.[28]

CONFLICTS OF INTEREST

The authors have no conflicts of interest.

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