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The International MotherBaby Childbirth Initiative: A Human Rights Approach to Optimal Maternity Care

by Robbie Davis-Floyd, Debra Pascali-Bonaro, Rae Davies and Rodolfo Gomez Ponce de Leon

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Is birth a human right? Clearly not, as millions of women around the world are infertile or have other conditions and complications that prevent them from giving birth, even if they wish to do so. There is no guaranteed right to be able to get pregnant and give birth. So why are we discussing birth as a human rights issue? Because we deeply believe that women who do get pregnant should have what we consider to be the basic human right of humane and evidence-based maternity care. It's not about the right to give birth—there is no such right—it's about the right to receive appropriate care when you do.

That right should be obvious and a given everywhere, yet any global glance will tell the observer that millions of women, in both developed and underdeveloped countries, are not receiving appropriate maternity care. Recent anthropological ethnographies describe women in India, Mexico, Tanzania, Papua New Guinea, Croatia, Canada and elsewhere saying the same thing about the care they receive in biomedical clinics and hospitals: "They expose you, they shave you, they cut you, they leave you alone and don't come when you call, and they won't allow your relatives to be with you." Here is a highly representative quote from anthropologist Pauline Kolenda, describing birth in a hospital near a small village in India:

"Before entering the hospital we have first to decide how much money we have to give. We are not admitted unless we first give them money. When the woman enters into the hospital, the doctor behaves rudely with her. Sometimes nurses beat her. They do not let close and affectionate relatives, who came from home with us, stand at our side. They themselves do not stay near us. We wish that somebody [would] hold us by the waist when pains come, but they do not do it. We have not even to moan, lest they talk sarcastically, make fun of us,

which is very [hurtful] still we have to bear. If we moan too much, they may sometimes slap us. If we happen to say something, they retort by asking us whether they had invited us to come. 'Why have you come then? You may go back home!' In hospital, we have to lie down on the bed to get delivered. In the hospital they excise the vaginal wall with a blade for enlarging it. The body gets damaged unnecessarily. After delivery we feel terribly hungry, but we consider ourselves lucky if we get a cup of tea."(1)

Consider the following description of a hospital birth in rural Papua New Guinea

What exactly are the rights of the birthing mother? Visit www.imbci.org to read the entire 10 Steps of the IMBCL and see if your care—or the care your provider offers—follows the optimal motherbaby model.

from the doctoral dissertation of Julia Byford, an Australian nurse-midwife who also became an anthropologist:

"Mispa, a young woman of 20, was admitted to the hospital this morning. She is seen by the Health Examination Officer, who does a vaginal exam and tells me that she is 4–5 cm dilated...and that she may commence a Syntocinon infusion.... The labour room is small.... There is a sink but no plumbing to allow it to be operational. There is no water at the hospital today anyway.... Mispa asks to sit on the floor and is given permission to do this, but as her labour progresses the nurse says she

must stay on the bed so the staff can do their observations. Most of the time she is left alone. She has not eaten all day and only drunk a small amount of water. Her lips are dry and swollen. The staff do numerous vaginal examinations but none of them are recorded [so when a shift changes, another exam is performed]....

During the second stage of labour, every time Mispa has a contraction, the Health Examination Officer [HEO] inserts a few fingers into Mispa's vagina between the perineum and the baby's head in order to stretch the perineum. Mispa finds this excruciating and tightens her grip on my arm.... [After the birth] I am dismayed although not surprised to see that the baby is flat and pale and requires resuscitation. The HEO delivers the placenta by placing one hand on Mispa's abdomen and pulling on the umbilical cord with the other hand...as soon as the placenta is out, Mispa has a large postpartum hemorrhage. The HEO asks me to increase the intravenous infusion rate and then inserts her hand high up into Mispa's vagina and manually removes some retained placental pieces. This is done without explanation or anesthetic. ... Perhaps the hardest thing for me to come to terms with is the lack of care offered to Mispa simply on a human level. She was never consulted, only told what to do and what not to do. ... No one tended to her basic needs for food or fluids or inquired if she needed to go to the toilet. It was as if Mispa, the embodied person, did not exist."(2)

In other words, Mispa's basic human right to humane health care was utterly violated; she and her baby survived in spite of,

not because of, their biomedical care. That care was not based on consideration of the mother's needs or on scientific evidence, but rather on Western biomedical models of labor and birth "management"—a traditional, not evidence-based, system that defines the doctor as the expert, the midwives and nurses as his or her expert support team, and the mother as an inexperienced patient reliant on authoritative others to generate the successful birth of the baby. This globally dominant model ensures that its practitioners will generally be trained only in the biomedical management of birth and untrained in how to support the normal physiological and psychological process of birth.

In her ethnography of birth in a Canadian hospital, H el ene Vadeboncoeur concluded, "Whilst women are treated kindly and attention is paid to them in this hospital, there is very little respect for the birth process and the physiological nature of this event."⁽³⁾ Her study is in line with many others demonstrating the extreme biomedical lack of understanding of how to properly facilitate normal birth in both the developed and developing worlds. The global biomedical lack of awareness about normal birth generates faulty, overly interventive care that violates women's basic human right to appropriate care during labor and birth.

What constitutes appropriate care? From our perspective as long-time students of the subject, we can say with some authority that appropriate maternity care should first and foremost address the psychology of the mother—she should always be treated

by her caregivers with respect and compassion and with efforts to instill confidence in herself and in her ability to give birth. And secondly, appropriate maternity care should be soundly based on the scientific evidence

birth practices that promote optimal birth, such as those put forth in the International MotherBaby Childbirth Initiative (www.imbci.org).

Resources

- International MotherBaby Childbirth Initiative: www.imbci.org
- International Initiative on Maternal Mortality and Human Rights: [www.righttomaternalhealth.org](http://righttomaternalhealth.org); <http://righttomaternalhealth.org/resource/beijingplus15> (This Beijing Platform for Action acknowledges a woman's right to reproductive healthcare services to ensure safe pregnancy and childbirth.)
- International Planned Parenthood Federation: www.ippf.org/en/Resources/Statements/The+Right+to+Information+and+Education.htm; www.ippf.org/en/Resources/Statements/The+Right+to+Health+Care+and+Health+Protection.htm; www.ippf.org/en/Resources/Statements/The+Right+to+Freedom+of+Assembly+and+Political+Participation.htm
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- World Alliance for Breastfeeding Action (WABA): www.waba.org/my/Baby-Friendly-Hospital-Initiative; www.unicef.org/programme/breastfeeding/baby.htm
- Universal Declaration of Human Rights: www.un.org/en/documents/udhr/
United Nations Human Rights Council: www2.ohchr.org/english/bodies/hrcouncil/
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- For a full description of the midwifery model of care, see *Birth Models That Work*, eds. Robbie Davis-Floyd, Lesley Barclay, Betty-Anne Daviss and Jan Tritten. 2009. Berkley: University of California Press, pp. 441–62.

about the normal physiology of pregnancy, labor, birth and breastfeeding, which means that whether or not midwives themselves are the primary practitioners for labor and birth, what is internationally known as the midwifery model of care should always be the basic underlying ideology of birth practice. We need to shift the global paradigm to

benefits of motherbaby-centered care based on the normal physiology of pregnancy, birth and breastfeeding and attention to women's individual needs. The instrumental purpose of the IMBCI 10 Steps is to put into worldwide awareness and practice the motherbaby (midwifery) model of

The International MotherBaby Childbirth Initiative

The International MotherBaby Childbirth Initiative (IMBCI): 10 Steps to Optimal Maternity Care was created and developed in 2008 by the International MotherBaby Childbirth Organization (IMBCO), a non-profit NGO that grew out of the US-based Coalition for Improving Maternity Services (CIMS) to focus on the international arena. 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 promote health for mothers and babies around the world. The IMBCI is a testament to and an affirmation of women's fundamental rights during childbirth. Its educational purpose is to call global attention to: the importance of the quality of the mother's birth experience and its impact on the outcome; the risks to mother and baby from inappropriate medical interventions; and the scientific evidence showing the ben-

MotherBaby Rights

(Derived from the International MotherBaby Childbirth Initiative)

1. You and your baby have the right to be treated with respect and dignity.
2. You have the right to be involved in and fully informed about care for yourself and your baby.
3. You have the right to be communicated with in a language and in terminology that you understand.
4. You have the right to informed consent and to informed refusal for any treatment, procedure or other aspect of care for yourself and your baby.
5. You and your baby have the right to receive care that enhances and optimizes the normal processes of pregnancy, birth and postpartum under a model known as the midwifery (or motherbaby) model of care.
6. You and your baby have the right to receive continuous support during labor and birth from those you choose.
7. You have the right to be offered drug-free comfort and pain-relief measures during labor and to have the benefits of these measures and the means of their use explained to you and to your companions.
8. You and your baby have the right to receive care consisting of evidence-based practices proven to be beneficial in supporting the normal physiology of labor, birth and postpartum.
9. You and your baby have the right to receive care that seeks to avoid potentially harmful procedures and practices.
10. You have the right to receive education concerning a healthy environment and disease prevention.
11. You have the right to receive education regarding responsible sexuality, family planning and women's reproductive rights, as well as access to family planning options.
12. You have the right to receive supportive prenatal, intrapartum, postpartum and newborn care that addresses your physical and emotional health within the context of family relationships and your community environment.
13. You and your baby have the right to evidenced-based emergency treatment for life-threatening complications.
14. You and your baby have the right to be cared for by a small number of caregivers who collaborate across disciplinary, cultural and institutional boundaries and who provide consultations and facilitate transfers of care when necessary to appropriate institutions and specialists.
15. You have the right to be made aware of and to be shown how to access available community services for yourself and your baby.
16. You and your baby have the right to be cared for by practitioners with knowledge of and the skills to support breastfeeding.
17. You have the right to be educated concerning the benefits and the management of breastfeeding and to be shown how to breastfeed and how to maintain lactation, even if you and your baby must be separated for medical reasons.
18. You and your baby have the right to initiate breastfeeding within the first 30 minutes after birth, to remain together skin-to-skin for at least the first hour, to stay together 24 hours a day and to breastfeed on demand.
19. Your baby has the right to be given no artificial teats or pacifiers and to receive no food or drink other than breast milk, unless medically indicated.
20. You have the right to be referred to a breastfeeding support group, if available, upon discharge from the birthing facility.

Our thanks to Marcia Westmoreland for her work on extrapolating these Mother-Baby Rights from the text of the IMBCI.

care—a woman-centered, non-interventive approach that promotes the health and well-being of all women and babies during pregnancy, birth and breastfeeding, setting the gold standard for excellence and superior outcomes in maternity care.

The IMBCI acknowledges that women's rights are human rights and that women have a right to informed decision-making and to receive care that is evidence-based for themselves and their babies. The IMBCI recognizes the effects of birth practices on maternal self-confidence and on breastfeeding, and the importance of cultural sensitivity and continuity of care. These core principles, along with the IMBCI 10 Steps, have the ability to transform birth and breastfeeding practices around the world. With infant and maternal mortality and morbidity at distressing rates, the IMBCI is a call to action that will help achieve the United Nations' Millennium Development Goals (MDG) to improve the quality of care for mothers and babies of the world (www.un.org/millenniumgoals). The IMBCI provides the structure and framework for achieving not only the MDG goals but also for respecting and supporting women's human rights during the childbearing continuum.

In addition to assuring optimal care during labor and birth, the IMBCI recognizes motherbaby as one unit, a dyad, not to be separated. The World Alliance for Breastfeeding Action (WABA), which constitutes part of the IMBCI Technical Advisory Group, issued the following statement at the Second WABA Global Forum in Arusha, Tanzania, in September 2002:

“Breastfeeding is a basic human right and it is agreed that the protection of women's right to breastfeed is a shared position of the women's movement and breastfeeding movement. Women can fully exercise this right only where there exists a gender-equal social and political environment, whereby women's contribution to productive and reproductive work, including nurturing, is recognized, and where all forms of breastfeeding support can be made available. Gender equity is therefore basic to the breastfeeding movement.”

Step 1 of the IMBCI 10 Steps crystallizes the essence of these issues. It states that

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Birth in 2050

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Canada, Brazil and France and other countries—and all say how awful and mostly dangerous hospital practices are in their part of the world. These are horrendous birth stories, but often the same writer learned and followed up with a great birth—most after they found a caring midwife. Many of these writers became midwives or doulas themselves to change birth or at least to make it better for one motherbaby, one birth at a time.

These issues remind me of the story of the little girl and the starfish: The little girl was walking along a beach strewn with thousands of starfish. She was throwing starfish that had washed ashore back into the ocean, saving their lives. A man came along and asked her, “What does it matter? You cannot save all of these starfish.” The little girl held up a starfish, said, “It matters for this one,” and threw it back into the ocean. With all of us working, one motherbaby at a time, we can do it. Birth in 2050 will be a miraculous passage—just as it was meant to be!



Jan Tritten is the founder, editor-in-chief and mother of *Midwifery Today* magazine. She became a midwife in 1977 after the amazing homebirth of her second daughter. Her mission is to make loving midwifery care the norm for birthing women and their babies throughout the world. Meet Jan at our conferences around the world, or join her online, as she works to transform birth practices.

Networking

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mentality early on, which means learning to say no when my calendar is already filled with the small number of clients I have chosen to serve; disappointing other people because I cannot help them does not make me less valuable as a person or as a midwife.

I have been accused of “just playing midwife” instead of truly being called, and while I have never been sure of the reasons for this observation, after five years of attending birth I can honestly say there is no such thing as “playing” midwife. It is work—emotional, spiritual, physical work—that along with motherhood itself, is the most challenging and rewarding job there

is. I would never want to jeopardize it by allowing myself to become black toast.

Anita Woods, CPM

www.nekansashomebirth.com

A Hidden Tragedy

Continued from page 10

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The International MotherBaby Childbirth Initiative

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an optimal maternity care service should “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.” Recently, IMBCI Executive Administrator Rae Davies undertook a survey of IMBCI country representatives. Respondents included representatives from Argentina, Brazil, Peru, Belize, Haiti, Hungary, Holland, Switzerland, Slovenia, the Czech Republic, India, Israel, Bangladesh, New Zealand and Canada. These representatives vary in profession among midwives, obstetricians, pediatricians, doulas, childbirth educators, lactation consultants, researchers, sociologists, presidents of organizations, writers, lobbyists and founders of NGOs. They are all supporters of the IMBCI.

The survey asked them which of the IMBCI 10 Steps were most relevant and most important for their countries. The overall consensus was that Step 1 is the most important. In responding, the Bangladeshi representative stated, “It is alarming to note

that 14% of maternal death in Bangladesh is due to violence or injury inflicted on pregnant women. ... Caring behavior is essentially needed to meet the crisis prevailing in the Bangladeshi community.” The Czech representative, Eliska Kodysova, noted that in her country, “Maternity care providers just don’t seem to know how sensitive a birthing woman is and often try to shut her up if she’s too loud (now more often by offering an epidural, I admit) or criticize her deficient ‘performance.’ Hospitals are very focused on giving women a ‘safe’ childbirth by providing all technology and interventions possible. Midwives are becoming ‘medwives.’”

Our Brazilian representative, Daphne Rattner, pointed out that in her country, “Most women are disrespected during childbirth in a shameful manner ... they are treated as patients and asked to hurry up with [a] lot of screaming, so their experience is traumatic rather than pleasurable.” This general country consensus on the importance of Step 1 clearly illustrates the importance of calling attention to birth as a human rights issue.

According to the survey respondents, the next most important of the IMBCI 10 Steps are Step 2: “Possess and routinely apply midwifery knowledge and skills that enhance and optimize the normal physiology of pregnancy, labour, birth, breastfeeding and the postpartum period”; Step 5: “Provide evidence-based practices proven to be beneficial”; and Step 6: “Avoid potentially harmful procedures and practices.”

The Brazilian representative noted that, “As we don’t have midwives, only obstetric nurses, the midwifery knowledge will have to be reconstructed in our country,” while our New Zealand representative stated, “I and others here hope that IMBCI Steps 5 and 6 [will] help re-educate the health bureaucrats, doctors and midwives of New Zealand to promote, protect and encourage physiological childbirth! ... Step 2 is also significant in New Zealand for, sadly, there also needs to be a re-birth or ascendancy of midwifery knowledge and skills that enhance and optimize the normal physiology of pregnancy, labour, birth, breastfeeding and the postpartum period.”

Most of us hold the New Zealand midwifery-based system in high esteem, making her comment that even New Zealand midwives must work to maintain

adherence to the midwifery model of care all the more significant. The same sort of acknowledgement comes from a northern Europe representative, who stated,

“It’s at a different level in countries like Holland and Switzerland. In principle, all the Steps are followed, so it’s hard to say which one is lacking in implementation. If anything, it would be to maintain the midwifery model of care in the secondary and tertiary levels of care and to provide drug-free pain relief (epidurals are increasing), and finally, probably to support and promote breastfeeding. So Steps 2, 4 and 10. But they all have to do with the amount of time staff have to invest, rather than with the actual knowledge and implementation of these Steps. All facilities have to be efficient and make the best possible use of resources (human and other), so a lot of the one-on-one care is gone....”

It is for such reasons as these that the IMBCI 10 Steps were carefully designed during two years of work with experts around the world to be equally applicable to countries and birth facilities in both the developed and the developing world. The hegemony of the biomedical model is strong in most countries, thus every effort to replace that model with a midwifery ideology and motherbaby-centered practice must be made.

Mortality and Morbidity

It is a well-known fact that more than 500,000 women die around the world due to maternity-related issues each year. The immediate, emergent causes of maternal death during birth include hemorrhage, eclampsia, sepsis and obstructed labor. Thus, Step 8 of the IMBCI calls for emergency obstetric care to be available and accessible. Yet the IMBCI acknowledges that this is not the sole solution to reducing maternal and neonatal morbidity and mortality. The deeper underlying causes of such conditions include poverty, malnutrition, overwork, underpay and the general cultural devaluation of women—especially in developing countries with high maternal mortality rates. Step 7 notes that these problems must also be addressed at their sources through measures designed to prevent illness and promote wellness, and to empower women.

Mortality is not the only issue here. Morbidity—unnecessary injury to mother and child—is also a serious concern. A major strength of the IMBCI is its focus on avoiding practices that have been scientifically shown to do harm. For example: Hospital policies that restrict the mother’s ability to eat or drink at-will can lead to weakness from hunger that complicates labor and birth; over-performance of vaginal exams can lead to infection; Pitocin induction can lead to dysfunctional labor and premature birth; Pitocin augmentation shuts down a mother’s own oxytocin production and interferes with her ability to breastfeed; and epidurals can increase the length of the first and second stages of labor and lead to increased use of forceps and vacuum extraction, and possibly cesarean section.(4)

The Cesarean Epidemic

The World Health Organization’s (WHO) 1985 statement that “There is no justification for any region to have caesarean section rates higher than 10–15%,” has been largely ignored, as evidenced by the increase in c-section rates around the globe. (**Editor’s note:** In 2009, the WHO updated its stance on cesarean rates, stating that there is no optimum range and recommending that world regions may want to “use a range of 5–15%, or set their own standards.”)

In 2007, a group of WHO researchers and affiliates studied the underuse of cesareans in low-resource countries and overuse in high-resource countries(5), correlating cesarean rates with maternal, infant and neonatal mortality. Below 15%, higher c-section rates were unambiguously correlated with lower maternal mortality. Above this range, however, higher c-section rates were predominantly correlated with higher maternal mortality. A similar pattern was found for infant and neonatal mortality.(6) The often-ignored, negative, long-term consequences of cesareans include infection; chronic pain; difficulty with bonding and breastfeeding; maternal and neonatal injury and death; newborn respiratory problems; problems during future pregnancies, including higher risk of uterine rupture, ectopic pregnancy, preterm delivery, placenta previa, placenta accreta, and placental abruption that may necessitate

hysterectomies; and increased incidence of postnatal depression.

The cesarean epidemic is transforming the nature of childbirth worldwide. The overuse of this operation that was designed to save lives is now costing them. Such evidence makes it crystal clear that the overuse of c-sections and other routine obstetric interventions constitutes a major violation of women’s rights to appropriate care.

Birth and Breastfeeding

As the WABA statement quoted above mentioned, breastfeeding is also a basic human right. The IMBCI fully acknowledges that obstetrical practices can negatively impact a woman’s ability to breastfeed. Birth and breastfeeding cannot be separated—they are part of the motherbaby continuum—and the way birth proceeds can have a major impact on the way breastfeeding will proceed. Any procedure that interrupts the mother’s physiological systems or interferes with her self-esteem can be highly detrimental to breastfeeding, including separation of motherbaby after birth and the use of bottles or pacifiers in the hospital. For these reasons, Step 10 of the IMBCI includes all 10 steps of the WHO/UNICEF Baby-Friendly Hospital Initiative (BFHI). Interference with the breastfeeding process can endanger babies’ health and chances of survival. For example, in developing countries where nutrition is poor, the water is not clean, and rates of infectious diseases are high, babies die at a significantly higher rate when they are not breastfed. Babies whose mothers are willing and able to breastfeed have a right to be breastfed for their health and survival, mothers have the right to be fully enabled to breastfeed, and health care practitioners must work to facilitate breastfeeding practices.

IMBCI Demonstration Sites

With the strength and power of the above statements and the political will to change, the International MotherBaby Childbirth Initiative (IMBCI) offers an evidence-based approach with 10 steps to achieve optimal motherbaby maternity care and consequently has launched a demonstration project that will put this model to work. Two hospitals—Brome-Missisquoi-Perkins Hospital in Cow-

ansville, Quebec, Canada, and Hospital Regional de Tacuarembó in Tacuarembó, Uruguay—are paving the way for demonstrating how maternity care services can comply with the human rights agenda and offer women optimal motherbaby maternity care. They are beginning the process of implementing the IMBCI 10 Steps in their respective institutions and will be carefully documenting and evaluating the effects. In addition to these two sites, IMBCO is making plans to include four additional demonstration sites in other areas of the world.

The full text of the IMBCI is available at www.imbci.org for you to download and work with in your area. Individuals and organizations can visit our Web site to support it, adopt it as a focal point for their work and use it as an educationaw instrument and guide to help hospitals and other birth facilities in their areas improve their maternity care. Hospitals can work to achieve the 10 Steps as a means to providing optimal motherbaby care.

Conclusion

For more than 30 years, a significant part of the women's health movement has repeatedly asked for a re-appropriation of women's bodies while birthing, coupled with a request for the de-medicalization of this important event for women. More recently, women's rights have been emphasized in the domain of sexuality and reproduction—for instance, the right to decide, to be adequately informed and to have bodily integrity. In June 2009, the UN Human Rights Council passed a landmark resolution(7) 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.”(8) More recently, Amnesty International released a report entitled “Deadly Delivery: The Maternal Child Health Crisis in the USA” demonstrating that even resource-rich countries have not put practices in place that treat women with dignity, respect and appropriate care.(9)

To recap, birth itself is not a human right, but humane and evidence-based care during birth is a human right, just as humane and evidence-based care is a human right for every person who seeks

health care. It's time for all women, men, midwives, nurses, doulas and care providers to see birth as a human rights issue.



Robbie Davis-Floyd, PhD, Senior Research Fellow, Department of Anthropology, University of Texas, Austin, and Fellow of the Society for Applied Anthropology, is a medical anthropologist specializing in the anthropology of reproduction. An international speaker and researcher, she is author of more than 80 articles and of *Birth as an American Rite of Passage* (1992, 2004); coauthor of *From Doctor to Healer: The Transformative Journey* (1998); and coeditor of 10 collections, including *Childbirth and Authoritative Knowledge* (1997); *Mainstreaming Midwives* (2006); and *Birth Models That Work*, (2009), an edited collection that highlights excellent models of birth care around the world. Her research on global trends and transformations in childbirth, obstetrics and midwifery is ongoing. Robbie speaks regularly at national and international childbirth, obstetric and midwifery conferences. She currently serves as program chair for the Society of Medical Anthropology, senior advisor to the Council on Anthropology and Reproduction and editor for the International Mother Baby Childbirth Initiative (IMBCI): 10 Steps to Optimal Maternity Care.

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Editor's note: At Midwifery Today's upcoming conference in Strasbourg, France, which is the seat of the European Court of Human Rights as well as the European Parliament, we plan to thoroughly examine these issues and to make plans for replacing current, harmful birth practices with supportive, evidence-based care. Our conference theme is “Birth Is a Human Rights Issue.” Let us commit to an optimal birth for every mother and baby. We hope to report back to you about this event. Please consider joining or sponsoring us in our continuing efforts to create change and educate the world about these ongoing human rights violations. Please share this information with your network and colleagues, and help us to spread this important movement around the world. For more information about this event, please visit our Web site at www.midwiferytoday.com/conferences/Strasbourg2010/.

From Hospital to Home
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Not realizing how close I was to birthing my baby, I told her I was doing well and that she could go back to bed for a while. Minutes later, my membranes released and Alan summoned my midwife, as well as her apprentice, Erin, and my best friend, Alisha.

The water break put me into transition. Between pushes, I was in ecstasy. I felt soft and fresh, like the calm after a storm. I was able to laugh and talk. I felt so much love for Alan and kept kissing him and telling him how much I loved him. Although I had no sense of time, I later learned that this pushing phase lasted only 15 minutes.

Anna slipped into the water. The midwives gently floated Anna to the surface and placed her on my chest. I looked at my baby in astonishment, then looked up at Alisha and said “I can't believe it! I did it!” Alan, who had been holding me from outside the pool, told me (in his most sincere statement to me ever), “I am so proud of you! You did it!”

Anna was peaceful and alert. She gazed at me for minutes after her birth. She was so pink and healthy looking. I was the first to hold her, and I was the only one to hold her for her first hour outside the womb.