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## FIGO GUIDELINES

### Mother–baby friendly birthing facilities<sup>☆</sup>



International Federation of Gynecology and Obstetrics<sup>1,2</sup>, International Confederation of Midwives, White Ribbon Alliance, International Pediatric Association, World Health Organization

#### 1. Introduction

Although the global maternal mortality ratio (MMR) is declining, few low- and middle-income countries (LMICs) are on track to meet Millennium Development Goal 5 by 2015. An unacceptable inequity exists for birthing women related to where they give birth, with women in LMICs dying at far higher rates than women in more developed settings.

The majority of maternal mortality reduction programs encourage facility birth with skilled providers [1], including conditional cash transfers and other methods/strategies to improve facility-based delivery rates [2]. However, many facilities, particularly in LMICs are overcrowded, understaffed, and have few resources. Women often choose to avoid facilities because of abuse, coercion, or neglect [3]. Recently there has been increasing focus among international and national organizations on examining the quality of care, abuse/neglect of women in facilities during childbirth, and the lack of professional and social accountability among facility-based providers of care [4–8]. Evidence collected in a variety of settings has documented that the quality of care is related to the quality of maternal and newborn health outcomes, including mortality [4,9,10]. Miller et al. [11] noted that paradoxically high rates of maternal mortality persisted in the Dominican Republic, despite 98% facility delivery by skilled attendants. The results of the study demonstrated that the lack of quality care and accountability was at the root of unnecessary maternal deaths [11]. A recent review series on quality of maternal and newborn care found that improving access to facilities did not guarantee improved maternal outcomes, and posited that poor quality of care was the most likely explanatory factor [12].

A 2013 publication explored a study protocol to promote respectful maternity care and reduce disrespect and abuse [13], while Althabe et al. [14] demonstrated, in a systematic review, strategies for improving quality of care in maternal and child health. International agencies such as the World Health Organization (WHO), White Ribbon Alliance (WRA), and the International MotherBaby Childbirth Initiative

(IMBCI) have developed statements on respectful birthing and the rights of childbearing women [15–17].

FIGO believes that every woman has the right to a positive birth experience and to compassionate care from knowledgeable, skilled providers who recognize that each woman, family, and newborn is unique and deserving of individualized dignified care. The published evidence of violations of women's human rights during childbirth is shocking and distressing, but can also serve as an impetus for action. Professional associations and facilities should provide not only the best evidence-based quality of care, but attend to each woman's inviolable right to dignity, privacy, information, supportive care, pharmacological or nonpharmacological pain relief, and choice of birthing companion(s), without abuse, financial extortion, or differential care based on age, marital status, HIV status, financial status, ethnicity, or other factors.

In response to rising rates of abuse/neglect/extortion, evidence of lack of quality care, and lack of evidence of declining maternal mortality despite increasing deliveries in facilities around the globe, FIGO's Safe Motherhood and Newborn Health (SMNH) committee examined ways to improve the quality of facility-based care. The Committee began a process to develop criteria by which a facility could be certified as "mother friendly," similar to the WHO/UNICEF Baby Friendly Initiative [18] (See Appendix A). In collaboration with the International Pediatric Association (IPA), International Confederation of Midwives (ICM), WRA, and WHO, a working group developed criteria for certifying a facility as "Mother and Baby Friendly," focusing on labor, delivery, and peripartum practices (Table 1). Methodologies for assessing adherence to the criteria will be by assessors using checklists for observation of written policies; observation of information, education, and communication materials (wall charts, posters, pamphlets) for presence, location, content, and comprehensibility; interviews with staff; and direct observation of care delivery.

#### 2. Foundation of FIGO, ICM, WRA, IPA and WHO mother–baby friendly birthing facilities initiative

All rights are grounded in established international human rights instruments, including the Universal Declaration of Human Rights; the Universal Declaration on Bioethics and Human Rights [19]; the International Covenant on Economic, Social and Cultural Rights [20]; the International Covenant on Civil and Political Rights [21]; the Convention on the Elimination of All Forms of Discrimination Against Women [22]; the Declaration of the Elimination of Violence Against Women [23]; the Report of the Office of the United Nations High Commissioner for Human Rights on preventable maternal mortality and morbidity and human rights [24]; and the United Nations Fourth

<sup>☆</sup> These guidelines were approved by the FIGO Executive Board in July 2014.

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**Table 1**  
Summary of criteria and indicators for qualifying a facility as mother and newborn friendly.

Criteria	Indicators
Adopt preferred positions for women in labor and provide food and beverages	Written policy and implementation as observed during care
Nondiscriminatory policy for HIV-positive women, family planning, youth services, ethnic minorities, etc.	Implementation of guidelines for HIV-positive women, family planning, and youth services
Privacy in labor/delivery	Curtains, walls, etc observed
Choice of birthing partner	Accommodation of partners, including traditional birth attendant observed
Culturally competent care	Trainings, posters, policies, direct observations of care
No physical, verbal, emotional, or financial abuse	Written policy, display Charter of Human Rights, no abuse observed, exit questionnaires for mothers/families/partners
Affordable or free maternity care	Costs clearly posted and in line with national guidelines
No routine practice	Evidence-based interventions in protocols and seen in direct observation
Nonpharmacological and pharmacological pain relief	Training on pain relief, direct observation of relief methods
Skin-to-skin mother–baby care and breastfeeding	Protocols/policies on combined care of mother and baby, immediate breastfeeding, observations of care

World Conference on Women, Beijing [25], all of which make specific reference to birthing women's rights.

All of the above rights documents are critical to understanding that negligent, nonevidence-based, abusive, or extortive care in facilities are violations of women's human rights and evidence of gender inequities. However, the document that provides the strongest support for humanistic, humane, quality care is the Charter on the Universal Rights of Childbearing Women [17]. This document has served not only to raise awareness of childbearing women's rights, but also to clarify the connection between human rights and quality maternity care. It can further support maternal health advocates to hold health systems, communities, and governments accountable.

### FIGO, ICM, WRA, IPA, WHO mother–baby friendly birthing facilities

Whereas:

- Every woman has the right to be treated with dignity and respect by facility staff regardless of background, health, or social status, this includes, but is not limited to, women who are young, older, single, poor, uneducated, HIV positive, or a minority in her community.
- The gap between rates of maternal and newborn mortality of women with access to quality care and those without access to quality care is unacceptable.
- Every woman has the right to a positive birth experience and to dignified, compassionate care during childbirth, even in the event of complications.
- Every woman and every newly born baby should be protected from unnecessary interventions, practices, and procedures that are not evidence-based, and any practices that are not respectful of their culture, bodily integrity, and dignity.
- A woman's ability to have a health delivery outcome and to care for her newborn is significantly influenced by a positive birthing environment.

The Charter on the Universal Rights of Childbearing Women [17] aims to promote respectful and dignified care during labor in line with best clinical practices, to address the issue of disrespect and abuse among women seeking maternity care, and to provide a platform for improvement by:

- Raising awareness of childbearing women's inclusion in the guarantees of human rights recognized in internationally adopted United Nations and other multinational declarations, conventions, and covenants;

- Highlighting the connection between human rights language and key program issues relevant to maternity care;
- Increasing the capacity of maternal and newborn health advocates to participate in human rights processes;
- Aligning childbearing women's sense of entitlement to high-quality maternity and newborn care with international human rights community standards; and
- Providing a basis for holding the maternal and newborn care system and communities accountable to these rights.

### 3. Criteria

WHO, FIGO, WRA, ICM, IPA, and partner organizations have signed the Charter on the Universal Rights of Childbearing Women [17]. Under that framework we have proposed the following criteria for establishing mother–baby friendly birthing facilities:

A FIGO, ICM, WRA, IPA, WHO mother–baby friendly birthing facility:

1. Offers all birthing women the opportunity to eat, drink, walk, stand, and move about during the first stage of labor and to assume the position of her choice/comfort during the second and third stages, unless medically contraindicated.
2. Has clear, nondiscriminatory policies and guidelines for the treatment and care of HIV-positive mothers and their newborns, as well as policies for counseling and provision of postpartum family planning, and youth-friendly services.
3. Provides all mothers with privacy during labor and birth.
4. Allows all birthing women the comfort of at least one person of her choice (e.g. father, partner, family member, friend, and traditional birth attendant as culturally appropriate) to be with her throughout labor and birth.
5. Provides culturally competent care that respects the individual's customs, nonharmful practices, and values around birth, including those women who experience perinatal loss.
6. Does not allow physical, verbal, emotional, or financial abuse of laboring, birthing, and postpartum women and their families.
7. Provides care at affordable costs in line with national guidelines and assures financial accountability and transparency. Families will be informed about what charges can be anticipated and how they might plan to pay for services. Families must be informed if any additional charges apply for complications. Health facilities should have a process for payment that does not include detention of the woman or baby. Refusal of care for the mother or the baby because of inability to pay should not be permitted.
8. Does not routinely employ practices or procedures that are not evidence-based, such as routine episiotomy, induction of labor, or separating mother and baby care etc, consistent with international guidelines and action plans. Each birthing facility should have the capacity, staff, policy, and equipment to provide neonatal and maternal resuscitation, minimize the risk of infection, provide prompt recognition and prevention/treatment of emergent maternal and neonatal needs, have established links for consultation and prospectively planned arrangements for stabilization and/or transport sick mothers or sick/premature infants.
9. Educates, counsels, and encourages staff to provide both non-pharmacological and pharmacological pain relief as necessary.
10. Promotes immediate skin-to-skin mother/baby contact and actively support all mothers to hold and exclusively breastfeed their babies as often as possible and provides combined care for mother and baby as appropriate. (See Appendix A).

Facilities that adhere to these criteria, as evidenced by meeting the indicators listed, will be awarded a FIGO, ICM, WRA, IPA, WHO Mother and Newborn Friendly Birthing Facility certificate. The certificate will be posted on the organizations' web sites and the web sites of other organizations who support this project.

#### 4. Process

International and national agencies should work together to develop a cadre of individuals to conduct site visits to certify and monitor this process. ICM, FIGO, IPA with the collaboration of WHO at the country level are willing to work with governments to spearhead the process. Indicators and methods of documenting adherence to these guidelines will be developed.

Certification could be considered if the hospital adheres to the suggested criteria. A certificate should be produced and made available for birthing centers that fulfill the suggested criteria. Provisional certification (1 year) can be given when the facility has reached most of the goals and agrees to implement the recommendations of the assessment team during the year. Re-evaluation is made after the 1-year period.

#### 5. Indicators for FIGO, ICM, WRA, IPA, WHO mother–baby friendly birthing facilities

Facilities will demonstrate their adherence to the criteria given above by demonstrating to the assessors via these methodologies (observation of written policies, interviews with staff, direct observation of care delivery) the following indicators:

##### Indicator 1

The health facility has a written policy in place allowing free movement and eating/drinking in the first stage of labor and free choice of position during labor. This policy will be available for review by the assessors. Women and families are informed about this policy by posters, information material, community engagement, etc. The materials should be visible to the assessors who should be able to confirm that these policies are in practice during observational assessments of labor/delivery.

##### Indicator 2

Hospital or birthing units follow national guidelines on prevention and treatment of HIV in pregnancy, including prevention of transmission and early treatment of HIV-positive newborns. The facility has clear written policies in place that ensure respectful treatment of all women, regardless of HIV status. All testing of women/newborns for HIV status must be voluntary. These policies are available for review by the assessors. Women and their families will be informed about these policies via posters with information that graphically depicts these policies, which should be posted where women and their families can see them.

Likewise, written policies are available that show evidence that postpartum family planning and youth-friendly services are offered by the facility.

##### Indicator 3

The facility provides privacy during childbirth, as evidenced by privacy walls or curtains, if not separate/individual labor and birthing rooms, and all efforts are made to keep newborns and mothers together at all times.

##### Indicator 4

The health facility has a written policy in place that encourages women to have at least one person of their choice, as culturally appropriate, with them during labor. This policy will be available for review

by the assessors and women are informed about this right by posters, information material, community engagement, etc. It should be clearly written and posted that TBAs are welcome into the facility to accompany women in labor.

##### Indicator 5

The birth facility should have a written policy in place to assure the incorporation of social and cultural values and a rights-based approach, preventing exclusion of the marginalized and socioeconomically disadvantaged, including a protection of HIV-positive women and women who experience perinatal loss. The facility can demonstrate the policy that covers these topics. The policy should be available for review by the assessors. Women are informed about the policy by posters, information material, community engagement, etc. The information/education posters should have culturally appropriate graphics, illustrating mother and newborn care, and assessors should be able to make direct observations of care, which adhere to the rights-based approach.

##### Indicator 6

The facility has a written policy in place guaranteeing that women will be treated with dignity and respect without physical, verbal, emotional, or financial abuse. Women are informed of the policy by posters, information materials, community engagement, and mechanisms of handling complaints are in place (complaint box, etc). The Charter on the Universal Rights of Childbearing Women should be on display, and the facility should have client information visible for grievance process.

##### Indicator 7

Costs for delivery and care of the newborn, which are in line with national guidelines, are made visible and transparent, and include risk pooling for complications (no additional charge for cesarean delivery or other complications). Under-the-table payments are forbidden and the application of this is routinely enforced. Informational posters or signs must be visible and comprehensible to families in the labor and delivery area, on entrance to the units, and, perhaps, at discharge/cashier, about what the costs for delivery services are. Signs must also include how patients/families can report nonadherence to the policies and/or requests for bribes.

##### Indicator 8

All obstetric and newborn interventions are evidence-based and essential. Written policies are available for review and are current with FIGO, ICM, WRA, IPA recommendations for maternal care and newborn care are consistent with international guidelines. Policies for the newborn include having at least one person trained in neonatal resuscitation present at all times, having the capacity, staff, and equipment to stabilize sick and premature infants by providing warmth and oxygen, etc. If unable to provide ongoing care, the ability to transport the infant to another facility safely should be available at all times.

Rates of procedures are within acceptable national and international ranges. Facility-based procedure rates must be made available to the assessors. Rates could be compared to the district or state level; different levels will be expected for referral and referring facilities.

##### Indicator 9

Staff are trained on nonpharmacological and pharmacological pain relief. Written protocols about pain relief, including the need for increased monitoring of mother and newborn if pharmacological pain relief is used, are in place and made available to the assessors. Questions can be asked of staff on location about the existence of the protocols, content of protocols, and time of last training in pain relief methods. Direct observations can also be made if pain relief is being offered and if monitoring is being done. Random record review may be a possibility in some facilities.

## Indicator 10

Staff encourage skin-to-skin contact, mothers should be able to hold newborns immediately after birth and breastfeed their babies as soon as possible after birth. The facility provides combined care for mother and baby and space should accommodate mother/newborn pairs after delivery. All staff are trained regularly on newborn resuscitation. Posters/signs for mothers/newborns are in local languages and heavily graphic. Observers will be able to directly assess delivery, postpartum care, and newborn care to validate that skin-to-skin contact and early initiation of breastfeeding occurs.

## 6. Enabling measures

The following enabling measures are needed to implement this strategy:

- The facility has a supportive human resource policy in place for recruitment and retention of all staff, and ensures that staff are safe and secure and are enabled to provide quality of care. This includes an exemption policy that protects dedicated and experienced labor ward staff (midwives, nurses, and doctors) from being transferred to other departments. Evidence of the policy is that it is available on request; further, staff can be questioned about length of time on the labor ward and timing of most recent transfers.
- Women are supported and encouraged to have as normal a pregnancy and birth as possible, with evidence-based interventions recommended to them only if they benefit the woman or her baby and, midwifery and/or obstetric care are based on providing good clinical and physiological outcomes.
- The following basic changes are fundamental to ensuring the environment and facilities are mother and baby friendly. Care is provided in a comfortable, clean, safe setting that promotes the well-being of women, newborns, families, and facility staff; respecting women's needs, preferences, and privacy; with a physical environment (including safe water and clean sanitation) that supports normal birth outcomes for the woman and baby.
- Support and endorsement of this initiative are also enabling; therefore support and endorsement are sought from all organizations working to improve the care of mothers and newborns.

## 7. Implications and conclusions

In a recent review of literature on quality of maternal and newborn health care, strategies to improve professional practice were reported to significantly affect desired practices [12]. The organizations behind this mother-baby friendly initiative likewise support the concept that our efforts at certification of facilities as mother/newborn friendly will, with proper implementation, supportive supervision, and ongoing accountability, effect significant changes in the quality of care at maternity facilities.

Improving attitudes and behaviors of individual providers, provider associations, and international organizations is not enough however; much more is needed at many levels, not least of which would be facilities and health systems providing adequate resources and means by which healthcare professionals can provide evidence-based, respectful care. The implementation of the mother-baby friendly birthing facilities initiative must be accompanied by advocacy by FIGO and others for social accountability by ministries of health and donors to enhance the birthing environments, improve the staffing, and increase resources available that will enable quality care by staff sensitized by the initiative. No one organization or even coalition of organizations can improve quality of care provided by skilled attendants in facilities. However, as the global maternal health community works to increase women's use of facilities, it is imperative that all professional associations, governmental and nongovernmental and grassroots organizations, as well as

community and family members, work together to provide and demand mother and baby friendly facilities providing the highest quality, evidence-based care.

Implementation of this initiative will require collaboration and mobilizing of resources. Professional organizations in close collaboration with UN agencies and other committed groups are pivotal to ensuring the success of this initiative. The national organizations need to work in partnership with national and local governments to make this initiative a reality. The partners will engage funding agencies toward securing funds to pilot this initiative in three LMICs prior to a scale-up for all FIGO countries. FIGO will work with high-resource countries to seek early adoption and implementation.

FIGO, ICM, WRA, IPA and WHO need to engage national governments to endorse and support the deployment of this initiative that will reduce inequalities of care across countries and regions worldwide. With this policy implemented and in place, sustained improvement in quality of care could lead to reduction in maternal and newborn morbidity and mortality.

This policy can be implemented in a step-wise process, thus allowing for quick gains while working on more difficult and challenging areas. These policies and proposed changes are imminently doable, low cost, and can be implemented in low- and high-resource countries alike.

## Appendix A

The WHO/UNICEF ten steps of the baby-friendly hospital initiative to promote successful breastfeeding.<sup>a</sup>

Every facility providing maternity services and care for newborn infants should:

1. Have a written breastfeeding policy that is routinely communicated to all healthcare staff.
2. Train all healthcare staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within a half-hour of birth.
5. Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants.
6. Give newborn infants no food or drink other than breast milk, unless medically indicated.
7. Practice rooming in: allow mothers and infants to remain together 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospitals or clinic.

<sup>a</sup> Reproduced with permission granted by WHO from: World Health Organization, UNICEF. Promoting, protecting and supporting breast-feeding: the special role of maternity services. A joint WHO/UNICEF statement. Geneva: WHO; 1989. <http://whqlibdoc.who.int/publications/9241561300.pdf?ua=1>

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