TELECONFERENCE MEETING
Of The
CERTIFIED NURSE MIDWIFE COUNCIL
Of The
KANSAS STATE BOARD OF HEALING ARTS
Wednesday, June 29, 2016

FORMAT OF MINUTES – Prior to each motion there appears the names of two Committee members in parenthesis. The first made the motion, the latter seconded the motion. Ayes, nays, abstentions and recusals are recorded when requested.

I. CALL TO ORDER - ROLL CALL

The Certified Nurse Midwife Council of the Kansas State Board of Healing Arts met via teleconference on Wednesday, June 29, 2016. The meeting was called to order at 12:00 noon by Kathleen Selzler Lippert, Executive Director, KSBHA. The following members attended by teleconference.

Kent Bradley, M.D.	present
Cara Busenhart, PhD, CNM, APRN	present
Cathy Gordon, RN, MSN, FNP-BC, CNM	present
Joel Hutchins, M.D.	present
Chad Johanning, M.D.	present
Manya Schmidt, CNM, APRN	present
Tarena Sisk, CNM	present

Staff members present were Kathleen Selzler Lippert, Executive Director; Kelli Stevens, General Counsel; Stacy Bond, Assistant General Counsel; Dan Riley, Disciplinary Counsel; Joshana Offenbach, Associate Disciplinary Counsel; and Jennifer Cook, Legal Assistant to General Counsel.

II. NEW BUSINESS

Staff provided an overview of the timeline involved with developing Certified Nurse Midwife (CNM) regulations and with coordinating around dates for Board of Nursing board meetings.

Council members reviewed their calendars so that future CNM meetings could be scheduled. CNM Council meetings were scheduled for 2:00 p.m. on the following dates: July 14, 2016, August 4, 2016 and August 18, 2016. These meetings will be held at the offices of the Kansas State Board of Healing Arts, 800 SW Jackson, Lower Level Suite A, Topeka, Kansas.

III. ADJOURNMENT

The meeting adjourned at 2:30 p.m.

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Kathleen Selzler Lippert
Executive Director

MEETING
of The
CERTIFIED NURSE-MIDWIFE COUNCIL
of The
KANSAS STATE BOARD OF HEALING ARTS
Wednesday, July 14, 2016

I. CALL TO ORDER - ROLL CALL

II. The Certified Nurse-Midwife Council of the Kansas State Board of Healing Arts (KSBHA) met on Thursday, July 14, 2016, at the KSBHA offices. The meeting was called to order at 2:00 p.m. by Kelli Stevens, General Counsel, KSBHA. The following Council members attended in person:

Kent Bradley, M.D.	present	
Cara Busenhart, PhD, CNM, APRN	present	
Cathy Gordon, RN, MSN, FNP-BC, CNM	present	
Joel Hutchins, M.D.	present	
Chad Johanning, M.D.	present	
Manya Schmidt, CNM, APRN		absent
Tarena Sisk, CNM	present	

Staff members present were Kelli Stevens, General Counsel; Stacy Bond, Assistant General Counsel; Dan Riley, Disciplinary Counsel; Joshana Offenbach, Associate Disciplinary Counsel; John Nichols, Licensing Administrator, Jennifer Cook, Legal Assistant to General Counsel and Ryan Hamilton, Law Clerk. Also present were Jerry Slaughter and Rachelle Columbo from KMS, Bob Williams from KAOM, Mary Blubaugh and Diane Glynn from KSBN, Dodie Wellshear, KAFP and Kendra Wyatt, NBC.

III. OLD BUSINESS

None- Minutes from 6/29/16 meeting were not available for review.

IV. NEW BUSINESS

a. Council members, staff and other individuals present introduced themselves to one another. Ms. Stevens reviewed open meeting (KOMA) rules with the Council members with respect to conducting Council business and email communications.

b. Ms. Stevens gave an overview of the new Independent Practice of Midwifery Act, which will become law on January 1, 2017. The Council discussed the Board of Healing Arts' (KSBHA) and Board of Nursing's (KSBN) roles with respect to developing regulations for the new license of independent certified nurse midwife.

Scope of practice and other substantive regulations must have consultation and concurrence by both boards prior to adoption by the KSBHA. The KSBHA is solely tasked with developing regulations for the administrative provisions, such as renewal of licensure. The regulations must be adopted by January 1, 2017. The short timeframe will require the KSBHA to pursue adoption of temporary regulations to meet the deadline. The Council members reviewed the materials sent to them by KSBHA staff. Not all members had time to review all the materials before the meeting due to their late transmission. For future meetings, staff will send out materials to the Council members much sooner to allow adequate time for review.

c. The Council discussed several areas which might need implementing regulations, including prescriptive authority, diagnostic authority, defining "normal newborn" care, further delineation of scope of practice; criteria for referral and transfer of OB patients; and what factors determine what is an uncomplicated vs. a complicated pregnancy.

During discussion, it was noted that there is little consistency between the various types of practice settings where CNMs work, that being home births, birth centers and hospitals. Even though 95% of midwife births are done in a hospital setting, that is very different than a home setting. The Council expressed concern about tailoring the regulations to the specific practice setting. It shouldn't matter where the delivery occurs, because the scope of practice and standard of care should be the same. The Council felt it was best to start the regulation development process by setting minimal requirements for practice in all settings. The goal is not to micromanage the standard of care but to state overall parameters.

The Council felt it was appropriate to use the lowest care level, which is home birth, and start there. The regulations should require independent CNMs to stratify risk and have a plan in place for each possible situation. Risk can be defined based on both pregnancy and delivery setting. The KDHE birth center regulations set out risk factors for determining maternal risk. The Council felt that one requirement to put in regulation would be that VBACs, multiple gestations, and breach deliveries only occur in an accredited, licensed birth center or a hospital, and not in a home birth.

With respect to prescription authority, a list of prescription medications could be set forth by class, and exclusions or limitations might be based, in part, on the setting of delivery. Certain medications, such as cardiac drugs, can be excluded. Staff will provide the Council members with some examples.

The new law requires that independent CNMs first be licensed by the KSBN. Currently both the KSBN and KSBHA certify and approve schools and programs for their professions. The KSBHA would likely adopt the schools approved by KSBN for independently practicing CNMs. Conceivably, a CNM holding dual

licensure could practice under a collaborative agreement and also have an independent practice.

d. Cathy Gordon, Cara Busenhart and Tarena Sisk were designated to individually review draft language of the regulations with staff, if needed in between Council meetings.

e. The agenda for the next meeting, August 4, 2016, will include drug classification lists, background information on accreditation of schools, information about the nurse-midwife certification examination, additional information from the Accreditation Commission for Midwifery Education (ACME) and the American Congress of Obstetricians and Gynecologists (ACOG). Staff will begin drafting outlines of regulations and provide these to the Council.

V. ADJOURNMENT

The meeting adjourned at 3:36 p.m.

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Kelli Stevens, General Counsel

Kansas State Board of Healing Arts

CNM Advisory Council Memo

To: Certified Nurse Midwife Advisory Council

From: Kelli Stevens, General Counsel
Stacy Bond, Assistant General Counsel

Date: August 4, 2016

Re: Materials and Issues for Discussion at Council Meeting on August 4, 2016

The materials for this meeting are bookmarked and include very rough drafts of proposed regulations and resource materials provided by various Council members and staff. Please carefully review the draft regulations for discussion at the meeting. In reviewing the drafts, please keep in mind the statutory scope of practice for this license is:

> *. . . clinical services . . . limited those associated with a normal, uncomplicated pregnancy and delivery, including:*
>
> *(1) The prescription of drugs and diagnostic tests;*
> *(2) The performance of episiotomy or repair of minor vaginal laceration;*
> *(3) The initial care of the normal newborn; and*
> *(4) family planning services, including treatment or referral of male partners for sexually-transmitted infections.*

The list of services above is not exclusive. The regulations may further delineate other services that may be provided. However, those services must still be "limited to those associated with a normal, uncomplicated pregnancy and delivery." Of note, even though family planning services are specifically listed, they would not necessarily be restricted to the statutory scope of practice.

Based on the recommendations of the Council received at this meeting, we will continue drafting the regulations and seek input from the full Board of Healing Arts at their meeting on August 12th. We will bring their comments back to the Council at our meeting on August 18th to assist in further refinement of the draft regulations. We anticipate requesting a special board meeting for the full Board to review the final drafts before sending them to the Board of Nursing during their Board meeting on September 12th-14th. If the Board of Nursing concurs with the substance of the regulation drafts, we will then begin the process of having them reviewed by the Department of Administration for form and language, and then sending them for a legal review by the Attorney General's Office.

Below are a few issues where Stacy and I require Council input for further drafting:

1) The new Independent Practice of Midwifery Act does not appear to preclude continued practice through collaboration under a CNM's APRN license. Can an independent CNM use their APRN license, with its broader scope of practice, to provide services to a patient that is not authorized under their independent CNM license?

2) Is delivery of a stillbirth (in limited circumstances) within the scope of the independent CNM license? If it is, does the definition of "uncomplicated labor and delivery" in the Definitions regulation need to be changed?

3) Does the Council wish to address VBACs, multiple births, etc. in the regulations?

4) With respect to the Referral and Transfer draft regulation, does "written agreement" need to be defined? (does it encompass hospital privileges, transfer agreements, co-management agreements?)

5) Are the use of anesthesia and the induction or augmentation of labor prohibited by the scope of practice for an independent CNM? Would they be within the scope of practice if only performed at a hospital?

6) Do the regulations need to specifically prohibit any services which are not completely clear when reading the scope of practice? Do any services need to be specifically authorized?

100-74-1. Definitions. As used in this article, each of the following terms shall have the meaning specified in this regulation:

(a) “Abortion” has the meaning specified in K.S.A. 65-6701, and amendments thereto.

(b) “Birthing center” means a facility which provides delivery services for normal, uncomplicated pregnancies but does not include a medical care facility as defined by K.S.A. 65-425, and amendments thereto.

(c) “Family planning services” means the provision of contraceptive methods, preconception health services, and sexually transmitted infection screening and treatment to patients.

(d) “Home birth” means an attended birth in a private residence or location other than a birth center or hospital.

(e) “Hospital” has the meaning specified in K.S.A. 65-425, and amendments thereto.

(f) “Initial care of the normal newborn” means care of the normal newborn during the first 28 days of life. (would include circumcision)

(g) “Normal newborn” means a newborn infant that has been determined to be at low risk of developing complications.

(h) “Normal, uncomplicated delivery” means a delivery that results in a singleton cephalic vaginal birth and that does not require the use of general, spinal, or epidural anesthesia.

(i) “Normal, uncomplicated pregnancy” means a pregnancy that is initially determined to be at a low risk for a poor pregnancy outcome and that remains at a low risk throughout the pregnancy.

(j) “Poor pregnancy outcome” means any outcome other than a live, healthy patient and newborn.

(Authorized by K.S.A._____; implementing K.S.A.; effective, T-_____, _____; effective P-_____.)

K.A.R. 100-74-7. Prohibited acts; act not to include certain persons; penalty for violations.

(a) It shall be unlawful for any person who is not licensed under the independent practice of midwifery act or whose license has been revoked or suspended to engage in the practice as an independent certified nurse-midwife as defined by this act.

(b) It shall be unlawful for any person who is not licensed under the independent practice of midwifery act, and amendments thereto, as an independent certified nurse-midwife or whose license has been suspended or revoked in any manner to represent oneself as an independent certified nurse-midwife or to use in connection with such person's name the words independent certified nurse-midwife or use the abbreviation CNM-I, or any other letters, words, abbreviations or insignia, indicating or implying that such person is an independent certified nurse-midwife.

(c) The provisions of the independent practice of midwifery act shall not be construed to include the following persons:

(1) Persons rendering gratuitous services in the case of an emergency.

(2) Persons gratuitously administering ordinary household remedies.

(3) Individuals practicing religious beliefs which provide for reliance on spiritual means alone for healing.

(4) Persons whose professional services are performed through a collaborative agreement or by order of a practitioner who is licensed under the healing arts act.

(5) Other health care providers licensed, registered, certified or otherwise credentialed by agencies of the state of Kansas when practicing within the scope of XXXXXX.

(e) Nothing in this act shall be construed to permit the practice of medicine and surgery. No statute granting authority to licensees of the state board of healing arts shall be construed to

confer authority upon independent certified nurse-midwife to engage in any activity not conferred by article XX of chapter XX of the Kansas Statutes Annotated, and amendments thereto. (Authorized by K.S.A._____; implementing K.S.A.; effective, T-_____, _____; effective P-_____.)

100-74-XX. Professional liability insurance coverage required as condition to practice independent certified nurse-midwife.

Professional liability insurance coverage shall be maintained in effect by each licensed independent certified nurse-midwife actively practicing in this state as a condition to rendering professional services as an independent certified nurse-midwife in this state. The board shall fix by rules and regulations the minimum level of coverage for such professional liability insurance. (Authorized by K.S.A._____; implementing K.S.A.; effective, T-_____, _____; effective P-_____.)

100-CNM-8. Scope of Practice. A certified nurse-midwife may perform clinical services within the scope of practice set forth in Sec. 89(c), and amendments thereto, that include:

(a) ordering and interpreting laboratory and diagnostic tests;

(b) prescribing and administering prescription-only medications, including controlled substances;

(c) prescribing the use of medical devices; and

(d) insertion and placement of contraceptive devices.

(Authorized by K.S.A._____; implementing K.S.A; effective, T-_____, _____; effective P-_____.)

K.A.R. 100-74-9. Licensees who direct, supervise, order, refer, accept responsibility for, or delegate acts which constitute practice of independent certified nurse-midwife to others; requirements and limitations. (a) The services of an independent certified nurse-midwife may be supplemented by the assignment of tasks to an individual licensed by the Kansas Nursing Board or by the delegation of selected nursing tasks or procedures to unlicensed personnel under supervision by the independent certified nurse-midwife.

(b) Every supervising or responsible licensee who directs, supervises, orders, refers, accepts responsibility for, or who delegates acts which constitute the practice of the independent certified nurse-midwife to other persons shall:

(1) Be actively engaged in the practice of independent certified nurse-midwife in Kansas;

(2) direct, supervise, order, refer, or delegate to such persons only those acts and functions which the supervising or responsible licensee knows or has reason to believe can be competently performed by such person and is not in violation of any other statute or regulation;

(3) direct, supervise, order, refer, or delegate to other persons only those acts and functions which are within the normal and customary specialty, competence and lawful practice of the supervising or responsible licensee;

(4) provide for a qualified, substitute licensee who accepts responsibility for the direction, supervision, delegation and written agreements or practice protocols with such persons when the supervising or responsible licensee is temporarily absent; and

(5) comply with all rules and regulations of the board establishing limits and conditions on the delegation and supervision of services constituting the practice of independent certified nurse-midwife.

(c) ‘‘Responsible licensee’’ means a person licensed by the state board of healing arts to practice independent certified nurse-midwife who has accepted responsibility for the actions of persons who perform acts at the order, referral, direction, supervision or delegation from such responsible licensee.

Failure to meet the requirements of this regulation shall constitute unprofessional conduct.

(Authorized by K.S.A._____; implementing K.S.A.; effective, T-_____, _____; effective P-_____.)

100-74-10. Duty of Referral and Transfer of Patient.

Transfers.

(a) Each licensee shall develop and implement policies, procedures, and clinical protocols for the transfer of patients and newborns. Each licensee shall ensure that these policies, procedures, and clinical protocols are readily accessible and followed.

(b) The policies, procedures, and clinical protocols shall include a written plan on file designating who will be responsible for the transfer of a patient or newborn. The plan shall include the following:

(1) A written agreement with an obstetrician and a pediatrician or with a group of practitioners that includes at least one obstetrician and at least one pediatrician; or

(2) a written agreement with a medical care facility providing obstetrical and neonatal services; and

(3) a plan for transporting a patient or a newborn by emergency medical services (EMS) entity.

(c) Each licensee shall ensure that all employees attending labor and delivery have immediate access to a working telephone or another communication device and to contact information for transferring a patient or a newborn in case of an emergency.

100-74-XXX. Referral and Transfer of Care of Patient

(a) A licensed independent certified nurse midwife must facilitate the immediate transfer of a client to a hospital for emergency care if the client has any of the following disorders, diagnoses, conditions or symptoms:

(1) Maternal fever in labor of more than 100.4 degrees Fahrenheit, in the absence of environmental factors;

(2) Suggestion of fetal jeopardy, such as frank bleeding before delivery, any abnormal bleeding (with or without abdominal pain), evidence of placental abruption, meconium with non-reassuring fetal heart tone patterns where birth is not imminent, or abnormal fetal heart tones with non-reassuring patterns where birth is not imminent;

(3) Non-cephalic presentation at the onset of labor or rupture of membranes, whichever occurs first, unless imminent delivery is safer than transfer;

(4) Current spontaneous premature labor;

(5) Current pre-term premature rupture of membranes;

(6) Current pre-eclampsia;

(7) Current hypertensive disease of pregnancy;

(8) Continuous uncontrolled bleeding;

(9) Bleeding that necessitates the administration of more than two (2) doses of oxytocin or other anti-hemorrhagic agent;

(10) Delivery injuries to the bladder or bowel;

(11) Grand mal seizure;

(12) Uncontrolled vomiting;

(13) Coughing or vomiting of blood;

(14) Severe chest pain; or

(15). Sudden onset of shortness of breath and associated labored breathing.

(b) Plan for Emergency Transfer and Transport. When facilitating a transfer under this subsection, the licensed midwife must notify the hospital when the transfer is initiated, accompany the client to the hospital, if feasible, or communicate by telephone with the hospital if the licensed midwife is unable to be present personally. The licensed midwife must also ensure that the transfer of care is accompanied by the client's medical record, which must include:

(1) The client's name, address, and next of kin contact information;

(2) A list of diagnosed medical conditions;

(3) A list of prescription or over the counter medications regularly taken;

(4) A history of previous allergic reactions to medications; and

(5) If feasible, the licensed midwife's assessment of the client's current medical condition and description of the care provided by the licensed midwife before transfer.

(c)Transfer or Termination of Care. A midwife who deems it necessary to transfer or terminate care pursuant to the rules and regulations of the Board or for any other reason shall transfer or terminate care and shall not be regarded as having abandoned care or wrongfully terminated services. Before non-emergent discontinuing of services, the midwife shall notify the client in writing, provide the client with names of licensed physicians and contact information for the nearest hospital emergency room and offer to provide copies of medical records regardless of whether copying costs have been paid by the client.

100-74-XXXX. Transfer of Care of Newborn.

(a) Conditions for which a licensed midwife must facilitate the immediate transfer of a newborn to a hospital for emergency care:

(1) Respiratory distress defined as respiratory rate greater than eighty (80) or grunting, flaring, or retracting for more than one (1) hour.

(2) Any respiratory distress following delivery with meconium stained fluid.

(3) Central cyanosis or pallor for more than ten (10) minutes.

(4) Apgar score of six (6) or less at five (5) minutes of age.

(5) Abnormal bleeding.

(6) Any condition requiring more than eight (8) hours of continuous postpartum evaluation.

(7) Any vesicular skin lesions.

(8) Seizure-like activity.

(9) Any green emesis.

(10) Poor feeding effort due to lethargy or disinterest in nursing for more than two (2) hours immediately following birth.

(b) Newborn Consultation Required. Conditions for which a licensed midwife must consult a Pediatric Provider (Neonatologist, Pediatrician, Family Practice Physician):

(1) Temperature instability, defined as a temperature less than ninety-six point eight (96.8) degrees Fahrenheit or greater than one hundred point four (100.4) degrees Fahrenheit documented two (2) times more than fifteen (15) minutes apart.

(2) Murmur lasting more than twenty-four (24) hours immediately following birth.

(3) Cardiac arrhythmia.

(4) Congenital anomalies.

(5) Birth injury.

(6) Clinical evidence of prematurity, including but not limited to, low birth weight of less than two thousand five hundred (2,500) grams, smooth soles of feet, or immature genitalia.

(7) Any jaundice in the first twenty-four (24) hours after birth or significant jaundice at any time.

(8) No stool for more than twenty-four (24) hours immediately following birth.

(9) No urine output for more than twenty-four (24) hours.

(10) Development of persistent poor feeding effort at any time.

(Authorized by K.S.A._____; implementing K.S.A.; effective, T-_____, _____; effective P-_____.)

100-CNM-11. Patient Records (a) Each licensee of the board shall maintain an adequate record for each patient for whom the licensee performs a professional service.

(b) Each patient record shall meet these requirements:

(1) Be legible;

(2) contain only those terms and abbreviations that are or should be comprehensible to similar licensees;

(3) a signed and dated informed consent form;

(4) identifying information, including the patient's name, address and telephone number;

(5) indicate the dates any professional service was provided;

(6) documentation of the initial history and physical examination, including laboratory findings and dates;

(7) contain pertinent and significant information concerning the patient's condition;

(8) all obstetrical risk assessments, including the dates of the assessments;

(9) reflect what examinations, vital signs, and tests were obtained, performed, or ordered and the findings and results of each;

(10) indicate the initial diagnosis and the patient's initial reason for seeking the licensee's services;

(11) indicate the medications prescribed, dispensed, or administered and the quantity and strength of each;

(12) reflect the treatment performed or recommended;

(13) document the patient's progress during the course of treatment provided by the licensee;

(14) documentation of instruction and education related to the childbearing process;

(15) the date and time of the onset of labor;

(16) the course of labor, including all pertinent examinations and findings;

(17) and the exact date and time of birth, the presenting part of the newborn's body, the sex of the newborn, and the Apgar scores;

(18) the time of expulsion and the condition of the placenta;

(19) all treatments rendered to the patient and newborn, including prescribing medications and the time, type and dose of eye prophylaxis;

(20) documentation of metabolic and any other screening tests completed;

(21) the condition of the patient and newborn, including any complications and action taken;

(22) all medical consultations concerning the patient and the newborn;

(23) all referrals for medical care and transfers to medical care facilities, including the reasons for each referral and transfer;

(24) the results of all examinations of the newborn and of the postpartum patient;

(25) the written instructions given to the patient regarding postpartum care, family planning, care of the newborn, arrangements for metabolic testing, immunizations, and follow-up pediatric care; and

(26) include all patient records received from other health care providers, if those records formed the basis for a treatment decision by the licensee.

(c) Each entry shall be authenticated by the person making the entry unless the entire patient record is maintained in the licensee's own handwriting.

(d) Each patient record shall include any writing intended to be a final record, but shall not require the maintenance of rough drafts, notes, other writings, or recordings once this information is converted to final form. The final form shall accurately reflect the care and services rendered to the patient.

(e) For purposes of implementing the healing arts act and this regulation, an electronic patient record shall be deemed a written patient record if the electronic record cannot be altered and if each entry in the electronic record is authenticated by the licensee.

(f) Each licensee shall maintain the patient record for a minimum of 10 years from the date the licensee provided the professional service recorded. Any licensee may designate an entity, another licensee, or health care facility to maintain the record if the licensee requires the designee to store the record in a manner that allows lawful access and that maintains confidentiality.

(g) Patient records may be stored by an electronic data system, microfilm, or similar photographic means. A licensee may destroy original paper records stored in this manner if the stored record can be reproduced without alteration from the original.

(h) Each electronically stored record shall identify existing original documents or information not included in that electronically stored record.

(i)Each licensee of the board who terminates the active practice of the healing arts within this state shall, within 30 days after terminating the active practice, provide to the board the following information:

(1) The location where patient records are stored;

(2) if the licensee designates an agent to maintain the records, the name, telephone number, and mailing address of the agent;

(3) the date on which the patient records are scheduled to be destroyed, as allowed by K.A.R. 100-24-2. (Authorized by K.S.A._____; implementing K.S.A.; effective, T-_____, _____; effective P-_____.)

4 regulations need to be drafted

1. **Definitions**
2. **Ordering of tests/ Diagnostics**
3. **Prescribing of medications**
4. **Referral or Transfer of care in the event of complications**

1. Definitions.

(a) "Normal, uncomplicated delivery" means a delivery that results in a singleton cephalic vaginal birth. (KDHE BIRTH CENTER)

(b) "Normal, uncomplicated pregnancy" means a pregnancy that is determined to be at a low risk for a poor pregnancy outcome. (KDHE BIRTH CENTER)

(c) "Patient" means a women, focusing on gynecological needs, pregnancy, childbirth, the postpartum period, care of the newborn, and family planning, including indicated partner evaluation, treatment, and referral for infertility and sexually transmitted diseases; See nursing KSA 60-11-105(d)

(d) "Poor pregnancy outcome" means any outcome other than a live, healthy patient and newborn that may require referral, consult or transfer of care.(KDHE BIRTH CENTER)

(e) "Home "- Location, other than a hospital or other facility, where the patient receives care in a private residence (CMS location of service code)

(f) "Birth Center" -A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of new born infants. (CMS location of service code)

(g) "Hospital" -A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions. (CMS location of service code)

2. Ordering of Tests and Diagnostic Service. - order and interpret laboratory and diagnostic tests and order the use of medical devices.(ACNM Scope of Midwifery)

3. Prescribing of Medications- Prescribe medications including controlled substances , with DEA certification, and contraceptive methods (ACNM scope of midwifery –CABC)

4. Referral or Transfers in the event of complications or emergencies.

A plan that includes at least one obstetrician and at least one pediatrician for referral or transfer of care and/or a written agreement with a medical care facility providing obstetrical and neonatal services. (KDHE BIRTH CENTER REGS)

OTHER ITEMS TO TALK ABOUT

Clinical services and patient care. (EVALUATING RISK)

Each CNM shall limit patients to those women who are initially determined to be at low maternity risk and who are evaluated regularly throughout the pregnancy to ensure that each patient continues to be at low risk for a poor pregnancy outcome.

When conducting the maternity risk assessment, each CNM shall assess the health status and maternity risk factors of each patient after obtaining a detailed medical history, performing a physical examination, and taking into account family circumstances and psychological factors. Add exclusion criteria. (KDHE BIRTH CENTER REGS)

Initial care of newborn include -care of the normal newborn during the first 28 days of life (ACNM scope of midwifery& 60-11-105.)

Family planning services. - provide family planning, including indicated partner evaluation, treatment, and referral for infertility and sexually transmitted diseases(60-11-105(d).

Abortion- not to include natural causes, fetal demise or still birth.

Category: Antepartum Care
Title: Evaluation of Antepartum Risk Status

Policy: New Birth Company desire for all clients to be assessed during Antepartum visits and upon admission in labor, to determine whether she continues to meet birth center risk criteria. Criteria for immediate exclusion for birth center delivery include: Clients recommended for hospital delivery by Maternal Fetal Medicine or our collaborating physicians. Other risks factors that exclude birth center delivery include, multiple gestation, Uncontrolled Chronic Hypertension, Pulmonary embolus, moderate to severe nephritis, 2 or more prior cesarean sections, required use of anticonvulsant drug, current drug addiction (heroin, barbiturates, alcohol), Diabetes mellitus requiring insulin for control.

Problems identified for RISK Assessment purposes includes the following:
Previous history of: Cesarean section or uterine wall surgery; placenta previa &/or abruption; previous preterm birth; grand multi-parity >7, Rh-sensitization

Major Medical Problems: Chronic HTN; Pulmonary emboli; CAD; congenital heart defects; severe renal disease, substance abuse addiction, anticonvulsant medication, uncontrolled diabetes or insulin dependent, infectious disease, uncontrolled thyroid disease, hemolytic disease.

Symptoms of: PIH, poly or oligohydramnios, placental abruption, chorioamnionitis, has known fetal anomaly, multiple gestations, IUGR, pyelonephritis, thrombophlebitis, non-reassuring fetal status, alcoholism or drug addition.

Procedure

1. Provider will assess risks status of prenatal clients at every Antepartum visit. Determination of the risk assessment will include current assessment and data obtained during the prenatal course.
2. Risk status is defined as follows
    a. 0-1 = no problems identified; meets risk criteria
    b. 2 = has identified (1-2) problem(s) requiring follow-up and/or consultation but still meets risk criteria.
    c. 3 = has identified (3-4) problems requiring follow-up, consultation and probably co-management with physicians or transfer of care.
    d. 4 = has identified (>5) problems requiring consultation and probable transfer to physician care and not eligible for birth center care.
3. Risk status will be recorded on the prenatal flow sheet at the end of each visit.
4. Clients with known risk factors may be ruled no longer at risk through education and discovery. Determination may also occur through collaboration, consults and discussions with physicians and comfort level of the New Birth Company midwives.

Kansas Department of Health & Environment Maternity Center Regulations
http://www.kdheks.gov/bcclr/regs/birth_centers/Birth_Center_regulations.pdf page.36-37

	NONE Within **Class**	ALL Within **Class**	ALL Except Specify Below
Analgesics (non-narcotic)	☐	☐	☐
Anthelminthics	☐	☐	☐
Antibiotics	☐	☐	☐
Antifungals	☐	☐	☐
Antihistamines	☐	☐	☐
Antihypertensives	☐	☐	☐
Antinauseants	☐	☐	☐
Antispasmodics	☐	☐	☐
Bronchodilators	☐	☐	☐
Contraceptives	☐	☐	☐
Cough Suppressants	☐	☐	☐
Cardiac Drugs	☐	☐	☐
Decongestants	☐	☐	☐
Diuretics	☐	☐	☐
Expectorants	☐	☐	☐
Estrogens	☐	☐	☐
Progesterone Preparations	☐	☐	☐
Hemorrhoidal Preparations	☐	☐	☐
Injectables	☐	☐	☐
Skeletal Muscle Relaxants	☐	☐	☐
Topical Ophthalmic Preparations, Except Steroids	☐	☐	☐
Otic Preparations	☐	☐	☐
Vaginitis Preparations	☐	☐	☐
Vitamins and Minerals	☐	☐	☐
Topical Preparations	☐	☐	☐
Steroids	☐	☐	☐
Anti-Anxiety and Anti-Depressants	☐	☐	☐
Other (SPECIFY BELOW)	☐	☐	☐

College Statement of Policy

As issued by the College Executive Board

MIDWIFERY EDUCATION AND CERTIFICATION

The American College of Obstetricians and Gynecologists (the College) is the representative organization of physicians who are qualified specialists in providing health services to women. The College is committed to facilitating access to women's health care that is both safe and high quality. One method of attaining this goal is to assure that providers of care meet educational and professional standards of a certification process. The College has long recognized the educational and professional standards currently used by the American Midwifery Certification Board (AMCB)* to evaluate and certify midwives. The College now also recognizes and accepts the International Confederation of Midwives (ICM)** Global Standards as the common worldwide education, licensure, regulatory and practice standards for midwifery and expresses support for ACNM's endorsement of the ICM standards. ACOG supports the development of legislation and regulations that utilize the ICM educational standards as the baseline for midwifery education and training here in the United States and the rest of the world.

The College supports women having a choice in determining their providers of care. The College specifically supports the provision of care by midwives who are certified by AMCB (or its predecessor organizations) or whose education and licensure meet the ICM Global Standards. The College does not support provision of care by midwives who do not meet these standards.

*The American Midwifery Certification Board (AMCB), formerly known as the ACNM Certification Council (ACC), was incorporated in 1991. The AMCB develops and administers the national certification examination for Certified Nurse-Midwives (CNMs) and Certified Midwives (CMs). CNMs are registered nurses who have graduated from a midwifery education program accredited by the Accreditation Commission on Midwifery Education (ACME) and have passed a national certification examination administered by AMCB. Certified midwives also have graduated from a midwifery education program accredited by the Accreditation Commission on Midwifery Education, have successfully completed the same requirements, have passed the same AMCB national certification examination as certified nurse-midwives and adhere to the same professional standards as certified nurse-midwives.

**International Confederation of Midwives. Essential Competencies for Basic Midwifery Practice (2010). Global Standards for Midwifery Education (2010). Many nations and global health organizations have endorsed the ICM standards and support bringing national health care systems and institutions in alignment with these standards.

Approved by the Executive Board February 2006
Amended: February 2007
Reaffirmed: July 2011
Amended and Reaffirmed: July 2014

The American College of Obstetricians and Gynecologists
409 12th Street, SW, PO Box 96920 • Washington, DC 20090-6920 Telephone 202 638 5577

ACOG Endorses the International Confederation of Midwives Standards for Midwifery Education, Training, Licensure And Regulation*

April 20, 2015

Washington, DC — Since 2010, the International Confederation of Midwives (ICM, www.internationalmidwives.org) has called for minimum education and training standards for midwives in all countries including the United States. ICM also recommends uniformity in how governments license and regulate midwives, robust and transparent government oversight, as well as use of a single midwife credential. Universal implementation of the ICM standards will help ensure women everywhere receive safe and high quality care.

The American College of Obstetricians and Gynecologists (ACOG) endorses the ICM education and training standards and strongly advocates the ICM criteria as a baseline for midwife licensure in the United States, through legislation and regulation. Women in every state should be guaranteed care that meets these important minimum standards.

A March 2015 consensus document, *Levels of Maternal Care,* developed jointly by ACOG and the Society for Maternal-Fetal Medicine, calls for systems-level improvements, including implementation of a new uniform classification system for how maternal care is delivered across the US, and specifies new regional criteria for facilities including birth centers. While *Levels of Maternal Care* references certified professional midwives, ACOG holds firm that all midwife providers must meet or exceed the ICM education and training standards.

Here in the US, midwifery groups have no agreed-upon definition of a midwife. There are three separate midwifery credentials — certified nurse midwives (CNMs), certified midwives (CMs), and certified professional midwives (CPMs) — with differing levels of education and training. CNMs and CMs meet and exceed ICM's minimum education standards. However, possibly as many as two-thirds of CPMs do not meet the ICM standards.

It's time for the US to uphold the standards for midwifery care expected by women in other nations around the world. Today, US state laws and regulations governing midwifery vary widely; few states require a common, minimum requirement for education and accredited training that every midwife must meet to practice legally.

Our health care partners and state lawmakers must work with us to ensure that no woman in the US receives midwifery care that wouldn't meet the standards received by women in other, even less developed, nations. ACOG advocates for implementation of the ICM standards in every state to assure all women access to safe, qualified, highly skilled providers.

All midwives — whatever their title or professional designation and regardless of where they practice — should meet the ICM standards, to ensure access to safe, qualified, highly skilled midwives in all settings including birth centers.

**This policy statement is a companion document to the ACOG Policy Statement on Midwifery Education and Certification and the Obstetric Care Consensus document, Levels of Maternal Care, developed jointly by ACOG and the Society for Maternal-Fetal Medicine.*

AMERICAN COLLEGE of NURSE-MIDWIVES
With women, for a lifetime®

DEFINITION OF MIDWIFERY AND SCOPE OF PRACTICE OF CERTIFIED NURSE-MIDWIVES AND CERTIFIED MIDWIVES

Midwifery as practiced by certified nurse-midwives (CNMs®) and certified midwives (CMs®) encompasses a full range of primary health care services for women from adolescence beyond menopause. These services include primary care, gynecologic and family planning services, preconception care, care during pregnancy, childbirth and the postpartum period, care of the normal newborn during the first 28 days of life, and treatment of male partners for sexually transmitted infections. Midwives provide initial and ongoing comprehensive assessment, diagnosis and treatment. They conduct physical examinations; prescribe medications including controlled substances and contraceptive methods; admit, manage and discharge patients; order and interpret laboratory and diagnostic tests and order the use of medical devices. Midwifery care also includes health promotion, disease prevention, and individualized wellness education and counseling. These services are provided in partnership with women and families in diverse settings such as ambulatory care clinics, private offices, community and public health systems, homes, hospitals and birth centers.

CNMs are educated in two disciplines: midwifery and nursing. They earn graduate degrees, complete a midwifery education program accredited by the Accreditation Commission for Midwifery Education (ACME), and pass a national certification examination administered by the American Midwifery Certification Board (AMCB) to receive the professional designation of CNM. CMs are educated in the discipline of midwifery. They earn graduate degrees, meet health and science education requirements, complete a midwifery education program accredited by ACME, and pass the same national certification examination as CNMs to receive the professional designation of CM.

CNMs and CMs must demonstrate that they meet the *Core Competencies for Basic Midwifery Practice* of the American College of Nurse-Midwives (ACNM) upon completion of their midwifery education programs and must practice in accordance with ACNM *Standards for the Practice of Midwifery*. ACNM competencies and standards are consistent with or exceed the global competencies and standards for the practice of midwifery as defined by the International Confederation of Midwives.[1] To maintain the designation of CNM or CM, midwives must be recertified every 5 years through AMCB and must meet specific continuing education requirements.

REFERENCES

1. International Confederation of Midwives. Essential competencies for basic midwifery practice 2010. http://www.unfpa.org/sowmy/resources/docs/standards/en/R430_ICM_2011_Essential_Competencies_2010_ENG.pdf. Published 2011. Accessed October 10, 2011.

Source: Division of Standards and Practice

Approved: ACNM Board of Directors, Dec. 2011

Replaces: Definition of Midwifery Position Statement, developed 1992, last revised 2004

APPENDIX A: Comparison of Certified Nurse-Midwives, Certified Midwives, and Certified Professional Midwives

Clarifying the distinctions among professional midwifery credentials in the U.S. (Continued)*

	CERTIFIED NURSE-MIDWIFE (CNM®)	CERTIFIED MIDWIFE (CM®)	CERTIFIED PROFESSIONAL MIDWIFE (CPM)®
EDUCATION (continued)			
Clinical Experience Requirement	Attainment of clinical skills must meet Core Competencies for Basic Midwifery Education (ACNM 2008). Clinical education must occur under the supervision of an AMCB-certified CNM/CM or Advanced Practice RN (APRN) who holds a graduate degree and has clinical expertise and didactic knowledge commensurate with the content taught. Clinical skills include management of primary care for women throughout the lifespan, including reproductive health care, pregnancy, and birth; care of the normal newborn; and management of sexually transmitted infections in male partners.		Attainment of clinical skills must meet the Core Competencies developed by the Midwives Alliance of North America. Clinical education must occur under the supervision of a midwife who must be nationally certified, legally recognized and who has practiced for at least three years and attended 50 out-of-hospital births. Clinical skills include management of prenatal, birth and postpartum care for women and newborns.
Degree Granted	Master's or doctoral degree; a master's degree is the minimum requirement for the AMCB certification exam	Master's degree; a master's degree is the minimum requirement for the AMCB certification exam	No degree is granted through the PEP pathway. MEAC-accredited programs vary and may grant a certificate or an associate's, bachelor's, master's, or doctoral degree. Most graduates attain a certificate or associate degree; there is no minimum degree requirement for the CPM certification exam.
ACCREDITING ORGANIZATION			
	The Accreditation Commission for Midwifery Education (ACME) is authorized by the US Department of Education to accredit midwifery education programs and institutions.		The PEP pathway is not eligible for accreditation. The Midwifery Education Accreditation Council (MEAC) is authorized by the US Department of Education to accredit midwifery education programs and institutions.
LICENSURE			
Legal Status	Licensed in all 50 states plus the District of Columbia and US territories	Licensed in New Jersey, New York, and Rhode Island. Authorized by permit to practice in Delaware. Authorized to practice in Missouri.	Regulated in 26 states (variously by licensure, certification, registration, voluntary licensure, or permit)
Licensure Agency	Boards of Nursing, Boards of Medicine, Boards of Midwifery/Nurse-Midwifery, Departments of Health	Board of Midwifery, Board of Medicine, Department of Health	Departments of Health, Boards of Medicine, Boards of Midwifery

Continued...

APPENDIX A: Comparison of Certified Nurse-Midwives, Certified Midwives, and Certified Professional Midwives

Clarifying the distinctions among professional midwifery credentials in the U.S. (Continued)*

	CERTIFIED NURSE-MIDWIFE (CNM™)	CERTIFIED MIDWIFE (CM™)	CERTIFIED PROFESSIONAL MIDWIFE (CPM)™
SCOPE OF PRACTICE			
Range of Care Provided	Independent management of women's health care throughout the lifespan, from adolescence through menopause. Comprehensive scope of practice including primary care and gynecologic care, family planning, annual exams (including breast and PAP screening), pregnancy, birth in all settings, and postpartum care. Care of the normal newborn. Management of sexually transmitted infections in male partners.		Independent management of care for women and newborns during pregnancy, birth, and postpartum. Birth in homes and birth centers. Care of the normal newborn.
Prescriptive Authority	All US jurisdictions	New York	None. However, may obtain and administer certain medications in some states.
Practice Settings	All settings — hospitals, birth centers, homes, and offices. The majority of CNMs and CMs attend births in hospitals.		Homes, birth centers, and offices. The majority of CPMs attend out-of-hospital births.
THIRD-PARTY REIMBURSEMENT			
	Most private insurances; Medicaid coverage mandated in all states; Medicare; Champus	New York, New Jersey, Rhode Island—most private insurance; Medicaid	Private insurance in some states; Medicaid in 10 states for home birth, additional states if birth occurs in birth center.

** This document does not address individuals who are not certified and who may practice midwifery with or without legal recognition.*

*** AMCB and NARM are accredited by the National Commission for Certifying Agencies, which "was created in 1987 ... to help ensure the health, welfare, and safety of the public through the accreditation of a variety of certification programs/organizations...Certification organizations ... are evaluated based on the process and products, not the content, and are therefore applicable to all professions and industries." (http://www.credentialingexcellence.org/ProgramsandEvents/NCCAAccreditation/tabid/82/Default.aspx)*

Reviewed ACNM-MANA Liaison Committee February, 2011

Approved by ACNM Board of Directors March, 2011

Last updated August, 2011

International Confederation of Midwives

Global Standards for Midwifery Education (2010) Amended 2013

Introduction

The ICM *Global Standards for Midwifery Education (2010)* are one of the essential pillars of ICM's efforts to strengthen midwifery worldwide by preparing fully qualified[1] midwives to provide high quality, evidence-based health services for women, newborns, and childbearing families. ICM's pillars include updated core competencies for basic midwifery practise, midwifery education, midwifery regulation and strong midwifery associations. The education standards were developed in tandem with the update of the *Essential Competencies for Basic Midwifery Practice (2010)* as these competencies define the core content of any midwifery education programme. The education standards were also completed in harmony with midwifery standards of practise and regulation (See web links to these other documents). The Education standards are founded upon the guiding principles and core documents of the ICM that are listed in Key References at the end of this document.

The midwifery education standards* were developed globally using a modified Delphi survey process during 2009-2010 and represent the **minimum** expected for a quality midwifery programme, with emphasis on competency-based education rather than academic degrees. Companion Guidelines were also developed to address the following questions: "What is needed to implement each standard (suggested guidelines)?" and "How does one determine whether the standard has been met (evidence needed)?" A glossary of key terms used throughout the Standards is offered to assist in understanding.

*[The definition of **standard** used in this document is "a norm/uniform reference point that describes the required level of achievement (performance) for quality midwifery education"]

Preface to the Standards

Purposes of Midwifery Education Standards

Having global standards for midwifery education available to countries and regions, most especially those without such standards currently, will help to set benchmarks for the preparation of a midwife based on global norms. Standards also help to define the expectations for performance (competencies) and scope of midwifery practise for a given country or region needed to promote the health of women and childbearing families. These minimal education standards can be expanded to include higher expectations and to reflect country specific needs for curriculum content and cultural appropriateness.

[1] The use of "fully qualified' as a modifier for the words "midwife" or "midwives" in this standards document refers to the midwife who is educated and trained to competency in all the ICM basic competencies. Throughout this document, the term "midwife" applies to those individuals who are fully-qualified, whatever the routes of entry into a midwifery education programme.

Specifically, the purposes of midwifery education standards are to:

- Hold the midwifery programme accountable to the public – the profession, consumers, employers, students – and to one another by ensuring that midwifery programmes have philosophy statements, goals and outcomes that prepare individuals as fully qualified midwives;
- Provide the framework for designing, implementing and evaluating the ongoing quality of a midwifery education programme;
- Promote an education process to prepare midwives who have all the essential ICM competencies for basic midwifery practise as well as additional competencies based on individual country needs;
- Promote safe midwifery practise and quality midwifery care for women and their families;
- Reinforce the autonomy of the profession of midwifery and midwives as autonomous practitioners; and
- Foster continuing improvement in midwifery programmes and thereby, in practise.

ICM Education Standards: A Value-Based Initiative

The founding values and principles upon which these standards have been developed are as follows.

The founding values include:

- Fostering ***trust*** in the midwifery education processes through the global development of midwifery education standards by midwives and a select panel of experts
- Stimulating and supporting ***continuous quality improvement*** in midwifery programmes and their outcomes
- Maintaining ***integrity*** through a consistent, fair and honest education process
- Fostering an education climate that supports students, graduates and faculty in their pursuit of ***life-long learning***
- Promoting ***autonomy*** of the profession of midwifery, midwives, and midwifery programmes

The founding principles include agreement that there is:

- Congruence with current core ICM documents, and position statements relating to the preparation of a fully qualified, competent midwife and midwifery teachers
- Commitment to engagement in self-evaluation of personnel, procedures and services to maintain quality and 'fit-for-purpose' programmes in a given country

Intended Use of the Standards

ICM developed the *Global Standards for Midwifery Education* to assist primarily three groups of users: 1) countries who do not yet have basic midwifery education but are wanting to establish such programmes to meet country needs for qualified health personnel, 2) countries with basic midwifery education programmes that vary in content and quality who wish to improve and/or standardize the quality of their midwifery programme(s), and 3) countries with existing standards for midwifery education who may wish to compare the quality of their programme to these **minimum** standards. ICM expects that those countries whose current standards exceed these

minimum standards will continue to offer the higher level of preparation for midwives in their region.

It is anticipated that these global standards for midwifery education will be used by governments, policy-makers, ministries of health and education, and health care systems as well as midwives and midwifery associations. The shared goal is that competent midwives will be prepared and available to meet the health needs of the population, particularly women and childbearing families.

It is understood that some countries wishing to start and/or upgrade their preparation of midwives who are educated and trained to proficiency in the ICM *Essential Competencies for Basic Midwifery Practice (2010)* may not be able to attain every one of the minimum standards initially – especially in areas where sufficient qualified midwife teachers or learning resources are not yet available. It is expected that such countries will work collaboratively with government agencies, education institutions, donors and midwifery consultants to develop a plan for attaining or exceeding all the education standards. Midwives will work with policy-makers in each country to determine the time frame for implementation of these global standards.

Contact and Support

The ICM Education Standing Committee (ESC) is the primary resource group for these standards and guidelines, and can be contacted through ICM Headquarters or under Standing Committees section of this website: www.internationalmidwives.org/who-we-are/standing-committees/standing-committee/education/

Summary

The *Global Standards for Midwifery Education (2010)* and *Companion Guidelines* are living documents. They will undergo continual evaluation and amendment as the evidence concerning midwifery education and the health care needs of childbearing women and families change. The *Glossary of Terms* for the standards were agreed globally and in collaboration with the essential competency and regulation task forces. It is vital to use the three documents together for maximum understanding, beginning with the *Glossary*, then the *Global Standards for Midwifery Education,* followed by a review of the *Companion Guidelines.*

Strengthening Midwifery Globally

International Confederation of Midwives

Global Standards for Midwifery Regulation (2011)

Background

The International Confederation of Midwives (ICM) has developed the ICM *Global Standards for Midwifery Regulation (2011)* in response to requests from midwives, midwifery associations, governments, UN Agencies and other stakeholders. The goal of these standards is to promote regulatory mechanisms that protect the public (women and families) by ensuring that safe and competent midwives provide high standards of midwifery care to every woman and baby. The aim of regulation is to support midwives to work autonomously within their full scope of practice. By raising the status of midwives through regulation the standard of maternity care and the health of mothers and babies will be improved.

These standards were developed during 2010 in tandem with the development of global standards for midwifery education and the revision of the ICM essential competencies for basic midwifery practice. Together, the ICM essential competencies and the global standards for regulation and education provide a professional framework that can be used by midwifery associations, midwifery regulators, midwifery educators and governments to strengthen the midwifery profession and raise the standard of midwifery practice in their jurisdiction.

When midwives work within such a professional framework they are supported and enabled to fulfil their role and contribute fully to the delivery of maternal and newborn care in their country.

Development of the standards

Background

In 2002 ICM adopted a position statement titled *"Framework for midwifery legislation and regulation"*. This position statement defined midwifery legislation and regulation as follows:

> *Midwifery regulation is the set of criteria and processes arising from the legislation that identifies who is a midwife and who is not, and describes the scope of midwifery practice. The scope of practice is those activities which midwives are educated, competent and authorised to perform. Registration, sometimes called licensure, is the legal right to practise and to use the title of midwife. It also acts as a means of entry to the profession. The primary reason for legislation and regulation is to protect the public from those who attempt to provide midwifery services inappropriately. In some countries midwifery practice is regulated through midwifery legislation whilst in others regulation is through nursing legislation. It has become increasingly apparent that nursing legislation is inadequate to regulate midwifery practice.*

With adoption of the 2002 position statement ICM identified the need to:

> *Establish guidelines for the development of regulatory standards to further enable member associations to achieve regulatory processes appropriate for the practice of midwifery in their country.*

In 2005 ICM adopted a further position statement titled *"Legislation to govern midwifery practice"*. This position statement provided a set of statements about what midwifery regulatory legislation should provide. These statements are as follows:

- *Enable midwives to practise freely in any setting.*
- *Ensure the profession is governed by midwives.*
- *Support the midwife in the use of life-saving knowledge and skills in a variety of settings in countries where there is no ready access to medical support.*
- *Enable midwives to have access to ongoing education.*
- *Require regular renewal of right to practise.*
- *Adopt a 'Definition of the Midwife' appropriate to the country within the legislation.*
- *Provide for consumer representation on the regulatory body.*
- *Recognise that all women have a right to be attended by a competent midwife.*
- *Allow for the midwife to practise in her own right.*
- *Recognise the importance of separate midwifery regulation and legislation which supports and enhances the work of midwives in improving maternal, child and public health.*
- *Provide for entry to the profession that is based on competencies and standards and which makes no distinction on routes of entry.*
- *Provide the mechanism for a regulatory body that is governed by midwives with the aim of protecting the public.*
- *Provide for regular review of the legislation to ensure it remains appropriate and not outdated, as midwifery education and practice and the health services advance.*
- *Encourage the use of peer review and analysis of perinatal, maternal and newborn outcomes in the legislative review process.*
- *Provide for transition education programmes in the adoption of new legislation requiring increased levels of competency of the midwife.*

These statements in effect provide a set of criteria against which midwifery regulatory legislation can be measured. However, member associations are seeking more detail and guidance to enact these statements and to assist development of midwifery regulation in various countries. To this end the ICM Council in 2008, decided to develop global standards for midwifery regulation and appointed a Taskforce to carry out the work. The co-chairs and members of the ICM Regulatory Standing Committee and the ICM Board member responsible for liaison with the regulatory committee formed the Taskforce and managed the project on behalf of ICM.[1]

Process of development

The standards for midwifery regulation were initially drafted by a sub-group of the Taskforce[2] during a meeting in Hong Kong in April 2010. In drafting the standards this group drew on information obtained through regulation workshops held at the ICM Asia-Pacific region conference in India in November 2009 and at the ICM/UNFPA South Asia midwifery meeting in Bangladesh in March 2010. The group also drew on a literature review undertaken to identify the purpose, types, and functions of health regulation and midwifery regulation in particular. It was evident that there is an urgent need for midwifery regulation in many countries and that such regulation needs to support midwifery autonomy within the full scope of midwifery practice as defined by the ICM, protect the title 'midwife', support standardised midwifery education and ensure continuing competence of midwives.

The draft standards were endorsed by the full Taskforce, translated into English, French and Spanish, and disseminated for feedback. The consultation process comprised both written feedback and focus group discussion. Questionnaires were sent to every ICM member association which were also asked to send the questionnaires on to the relevant regulatory authority or agency responsible for regulation in the particular country. Questionnaires were circulated twice during 2010 and responses were received from 33 member associations (33% of total membership) representing all four of the ICM regions. In addition there were 21 further individual and group responses from regulators, educators, ICM Taskforce chairs and others. Taskforce members also facilitated focus group discussions on the draft standards with groups of regulators from Europe, Canada, South East Asia and the Western Pacific. All feedback was considered by the Taskforce.

It was apparent that the concurrent consultations on the ICM *Global Standards for Midwifery Education (2011)* and the *Essential Competencies for Basic Midwifery Practice (2011)* caused some confusion amongst ICM member associations as to which questionnaire and which round of consultation they were responding to. Nevertheless, the response rate on the regulation standards was satisfactory. The final report will provide more detail on the consultation process and responses.

The Taskforce amended the standards in response to feedback and the final standards were approved by the ICM Board in February 2011. The approved standards will be presented to the ICM Council in Durban, South Africa, in June 2011.

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[1] ICM Regulation Taskforce members: Sally Pairman (Co Chair), New Zealand; Louise Silverton (Co Chair), United Kingdom; Karen Guilliland (ICM Board liaison), New Zealand; Kris Robinson (Canada: Americas); Judy Nga Wai Ying (Hong Kong: Asia Pacific); Ursula Byrne (Ireland: Europe); Malfa Kalliope (Greece: Europe); Marianne Benoit Truon Canh (France: Europe); Anne Morrison (Australia: Asia Pacific), Yolande Johnson (Africa - Francophone), Veronica Darko (Africa – Anglophone), Margaret Phiri (WHO).

[2] Marianne Benoit Truon Canh, Karen Guilliland, Anne Morrison, Sally Pairman, Kris Robinson, Judy Nga Wai Ying

This document includes the purpose of regulation, founding values and principles, principles of good regulation, a glossary of terms, the intended use of the standards and the global standards for midwifery regulation with an accompanying explanation for each standard.

Purpose of Regulation

Regulatory mechanisms, whether through legislation, employment or other regulation, aim to ensure the safety of the public. This is achieved through the following six main functions of:

1. Setting the scope of practice
2. Pre-registration education;
3. Registration;
4. Relicensing and continuing competence;
5. Complaints and discipline; and
6. Codes of conduct and ethics.

The purpose of these standards[3] is to describe the regulatory framework necessary for effective midwifery regulation. The framework defines the elements of regulation in order to:

- Determine who may use the title of midwife;
- Describe the scope of practice of a midwife consistent with the ICM definition of a midwife;
- Ensure that midwives enter the register following education consistent with the *ICM Global Standards for Midwifery Education (2011)*;
- Ensure that midwives enter the register able to demonstrate the *ICM Essential Competencies for Basic Midwifery Practice (2011)*;
- Ensure that midwives are able to practise autonomously within their prescribed scope of practice;
- Ensure that midwives demonstrate continuing competence to practise;
- Ensure that midwives and women (as users of midwifery services) are part of the governance of midwifery regulatory bodies; and.
- Ensure public safety through the provision of a competent and autonomous midwifery workforce.

[3] The definition of **standard** used in this document is "a norm/uniform reference point that describes the required level of achievement (performance)'.

Founding Values and principles

The founding values and principles upon which these standards have been developed were derived from the following ICM core documents (www.internationalmidwives.org):

- ICM *Definition of the Midwife,*
- ICM *Position Statement on Regulation 2002*
- ICM *Position Statement on Legislation to Govern Midwifery Practice 2005*
- ICM *Draft Global Standards for Midwifery Education 2010*
- ICM *Essential Competencies for Basic Midwifery Practice – revised 2010*
- ICM *International Code of Ethics,*
- ICM *Midwifery Philosophy and Model of Care,* and
- Selected ICM position statements.

These founding values and principles include:

- Recognition that regulation is a mechanism by which the social contract between the midwifery profession and society is expressed. Society grants the midwifery profession authority and autonomy to regulate itself. In return society expects the midwifery profession to act responsibly, ensure high standards of midwifery care and maintain the trust of the public[4].
- Recognition that each woman has the right to receive care in childbirth from an educated and competent midwife authorised to practise midwifery.
- Recognition that midwives are autonomous practitioners; that is they practise in their own right and are responsible and accountable for their own clinical decision making.
- Recognition that the midwife's scope of practice describes the circumstances in which the midwife may make autonomous clinical decisions and in what circumstances the midwife must practise in collaboration with other health professionals such as doctors.
- Recognition that midwifery is a profession that is autonomous, separate and distinct from nursing and medicine. What sets midwives apart from nurses and doctors is that only midwives can exercise the full scope of midwifery practice and provide all the competencies within this scope.
- Recognition that wherever a registered/qualified midwife with a midwifery practising certificate works with pregnant women during the childbearing continuum, no matter what the setting, she[5] is practising midwifery. Therefore when a midwife holds dual registration/qualification as a nurse she cannot practise simultaneously as a midwife and a nurse[6]. In a maternity setting a registered/qualified midwife always practises midwifery.

[4] Donabedian (1976) cited in Ralph, 1993, p.60.

[5] In this document use of the feminine gender includes the masculine

[6] It is acknowledged that midwives share some skills with other health professionals but it is the entire suite of skills focused around the needs of childbearing women that define midwives and midwifery.

Principles of Good Regulation

The ICM identifies the following principles of good regulation[7] and intends that these principles provide a benchmark against which regulatory processes can be assessed.

- NECESSITY – is the regulation necessary? Are current rules and structures that govern this area still valid? Is the legislation purposeful?
- EFFECTIVENESS – is the regulation properly targeted? Can it be properly enforced and complied with? Is it flexible and enabling?
- FLEXIBILITY – is the legislation sufficiently flexible to be enabling rather than too prescriptive?
- PROPORTIONALITY – do the advantages outweigh the disadvantages? Can the same goal be achieved better in another way?
- TRANSPARENCY – is the regulation clear and accessible to all? Have stakeholders been involved in development?
- ACCOUNTABILITY – is it clear who is responsible to whom and for what? Is there an effective appeals process?
- CONSISTENCY – will the regulation give rise to anomalies and inconsistencies given the other regulations already in place for this area? Are best practice principles being applied?

[7] Based on 'Regulating Better', a government White paper, Department of Taoiseach, Government of Ireland, 2004.

Intended use of Standards

The *Global Standards for Midwifery Regulation (2011)* are deliberately generic and take a principle rather than a detailed approach to midwifery regulation. These standards provide a benchmark for global standardisation of midwifery regulation. They have two purposes. Firstly, they provide the basis for review of existing regulatory frameworks. Secondly, they provide guidance and direction to countries seeking to establish regulatory frameworks for midwifery where none currently exist.

Because the ICM is the only international organisation that represents midwives it is important that the ICM sets standards that support midwives to practise within the ICM definition and scope of practice of a midwife and enhance high quality midwifery care. Therefore, the ICM *Global Standards for Midwifery Regulation (2011)* do not merely reflect existing midwifery regulatory frameworks commonly found in many developed countries. Rather these standards are high level standards that set an ideal regulatory direction to underpin and enable autonomous midwifery practice.

It is anticipated that some countries with well-developed specific midwifery regulation frameworks will be able to use these standards as a benchmark. However, it is understood that this will not be the case for many countries. Those countries where existing midwifery regulation is closely linked with nursing or medicine or where regulation is managed by government may identify many differences between these standards and their existing regulatory frameworks and processes. The standards can provide a benchmark against which to assess existing legislation and regulatory processes. Midwives, through their midwifery associations, are encouraged to use the standards as a tool for lobbying for change.

The ICM *Global Standards for Midwifery Regulation (2011)* can guide amendments to existing legislation and promote changes that strengthen regulatory frameworks to support autonomous midwifery practice. For example, where midwives are regulated alongside or together with nurses or other health professionals it is essential that separate and specific regulatory structures and processes are established to enable autonomous midwifery practice and ensure high quality midwifery care for mothers and babies. As a step towards midwifery-specific regulation the separate professional identity of midwives must be recognised in any regulatory processes. Midwives are encouraged to seek opportunities to strengthen midwifery regulation and to work collaboratively with governments, regulators and policy makers to develop a plan and timeframe for implementing these global standards.

In those countries with limited or non-existent regulatory processes these standards can guide the development of new midwifery regulation. Legislation, policies and procedures can be based on these standards to develop regulatory frameworks for midwives. In such countries midwives can work collaboratively with governments, regulators and policy makers to develop a plan and timeframe for implementing these global standards. As a further project the International Confederation of Midwives intends to provide an implementation toolkit to assist in this process.

Glossary of Terminology

A number of key words or terms used throughout the document hold multiple and different meanings. To assist understanding the following definitions are used in this document.

Key words or Terms	ICM Definition
Accountability	Responsibility
Accreditation	A process of review and approval by which an institution, programme or specific service is granted a time-limited recognition of having met certain established standards.
Admitting and discharge rights	Authority granted to a community-based midwife by a hospital/birth centre governing board to provide care to a woman and her baby in the hospital/facility and to access hospital/facility services, including back up emergency services.
Assessment	The systematic procedure for collecting qualitative and quantitative data to assess performance, progress or practice decisions/actions in relation to standards and/or competencies.
Autonomous	Self-governing, self regulating: taking responsibility for one's decisions and actions. The autonomous midwife provides care during the course of pregnancy, labour, birth and the postnatal period and makes decisions in partnership with each woman in her care. The midwife is responsible and accountable for all decisions she makes and the care she provides without delegation from or supervision or direction by any other health care provider.
Autonomy	The condition of being autonomous. Midwife's/woman's autonomy: The freedom of a woman and her midwife to make choices about care and for those choices to be respected. It implies that individuals have competence to make informed decisions and that they should not be coerced or forced during the decision-making process.

Censure	An official rebuke of an individual, a document, or agency Midwifery censure: An official rebuke of a midwife by a Midwifery Regulatory Authority.
Code of Conduct and Ethics	The rules or standards governing the conduct of a person or the conduct of the members of a profession.
Competence	The combination of knowledge, psychomotor, communication and decision-making skills that enable an individual to perform a specific task to a defined level of proficiency.
Conditional	Imposing, depending on, or containing a condition.
Equivalence	A term used to describe and/or determine a relationship of parity between one system, jurisdiction or institution and another with respect to the value and significance of courses, diplomas, certificates, licenses, and/or degrees. Ideally these relationships are mutual so that holders of "equivalent" credentials are treated in the same way by institutions and occupations.
Guideline(s)	A detailed plan or explanation with illustrative examples of actions; a series of steps to implement a standard. By definition, a guideline is never mandatory in contrast to a 'standard' that is expected to be met.
Health professional	An individual who is educated in a health discipline and licensed/regulated to practice that discipline; e.g., midwives, nurses, medically qualified doctors and clinical officers.
Independent	Free from the influence, guidance, or control of another or others; self-reliant and autonomous.
Knowledge	A fund of information that enables an individual to have confident understanding of a subject with the ability to use it for a specific purpose.

Lay member of a midwifery regulatory authority	A person who is not and never has been registered as a midwife and who is not a member of any other regulated health profession.
Legislation	A law or body of laws enacted.
Midwife	A person who meets the ICM *Definition of the Midwife* who has been educated and trained to proficiency in the ICM *Essential Competencies for Basic Midwifery Practice*, demonstrates competency in the practice of midwifery and is legally permitted to use this title.
Midwifery accountability	A midwife must be accountable for her decisions and actions. This accountability is primarily to the woman, but also to the profession and to the public.
Midwifery competence	A combination of knowledge, professional behaviors and specific skills that are demonstrated at a defined level of proficiency in the context of midwifery education and/or practice.
Midwifery continuing competence	The ongoing capacity to demonstrate the knowledge, professional behavior and specific skills necessary to work within the Midwifery Scope of Practice.
Midwifery Continuing Education	Ongoing education undertaken from time of first qualification throughout one's career to enhance or maintain a midwife's level of competence.
Midwifery education	The process of preparing individuals to become competent midwives and to maintain midwifery competence.
Midwifery education institution	The organisation that provides the midwifery education programme. The organisation may include universities, polytechnics, colleges, schools.

Midwifery fitness to practise	Evidence that a midwife has the knowledge, skills, professional behaviours, character and health status necessary to meet the standards or competencies required for entry to the midwifery profession and for the practise of midwifery.
Midwifery governance	The system of management and administration used by the Midwifery Regulatory Authority to exercise its authority to control and guide the profession.
Midwifery partnership	Implies a relationship of trust, reciprocity, and equity between a midwife and a woman. Each midwife strives to ensure that she does not impose her professional and personal power onto women; rather, through negotiation a midwife seeks to establish relationships in which each woman is the primary decision-maker.
Midwifery philosophy	A statement of beliefs about the nature of midwifery practice or midwifery education.
Midwifery education programme	An organised, systematic, defined course of study that includes didactic and practical learning needed to prepare competent midwives.
Midwifery registration/licensure	The legal right to practise and to use the title of midwife. It also acts as a means of entry to the profession within a given jurisdiction.
Midwifery Regulation	The set of criteria and processes arising from the legislation and prescribed by the Midwifery Regulatory Authority that controls the practice of midwifery in a jurisdiction including identifying who can hold the title 'midwife' and practise midwifery. Regulation includes registration/licensure, approval and accreditation of midwifery education programmes, setting standards for practice and conduct and processes for holding midwives to account in relation to professional standards.

Midwifery Scope of Practice	Those activities which midwives are educated, competent and authorised to perform.
Midwifery stakeholder	Any person(s) or organisation that affect(s) or can be affected by the decisions and actions of a midwife, midwifery regulatory authority, a midwifery education programme or the ICM.
Midwifery Standards Review	A systematic process that enables the midwife, whatever her practice setting, to reflect on her midwifery practice in relation to professional standards with midwifery colleagues and consumers of midwifery services.
Midwifery supervision	Overseeing and supporting the practice of one midwife by another in order to ensure the provision of safe and competent midwifery care.
Natural justice	Procedural fairness including principles of good faith and lack of bias.
Pre-registration midwifery education	The process of preparing individuals to become competent midwives and who meet the educational standards for midwifery registration/licensure.
Primary health care	First level health service, community-based and universally accessible with focus on health education and promotion and prevention of individual health problems. Midwives provide primary health care when care is provided in women's homes or community settings and where the focus is on enhancing and supporting pregnancy and childbirth as a normal life process.
Public health	Supporting and improving population health and wellness through health promotion, disease prevention and community-based services.
Professional association	An association of practitioners of a given profession.

Provisional	Temporary; existing only until permanently or properly replaced.
Protection of the public	The key function of a regulatory authority is to ensure the safety of the public through its regulatory mechanisms. The key function of a midwifery regulatory authority is to ensure the safety of mothers and babies (the public) through regulatory mechanisms that ensure safe and competent midwifery care.
Register of midwives	The official list of qualified/licensed/certified midwives as identified by the midwifery regulatory authority in a given jurisdiction; available to the public.
Regulatory Authority/regulator	The organisation that regulates a specific profession and ensures that the public is protected against incompetent or unethical practitioners. An organisation authorised by law or by government to regulate the profession.
Relicensing/ Recertification	To issue a renewed license or certificate within a specified period of time; generally linked to assessment of the practitioner's continuing competence.
Self governing	An individual or profession who is responsible and accountable for making decisions and accepting responsibility for the outcomes of those decisions and actions. In any jurisdiction where a midwifery profession is given a legal and social mandate to regulate itself it is a self-governing profession.
Standard	A norm/uniform reference point that describes the required level of achievement (performance) <u>Practice standard:</u> The desirable and achievable level of achievement (performance) against which actual practice is compared.
Suspend/suspended	To bar a midwife from practice for a period of time.
Temporary	Not permanent; provisional.

Organisation of the standards

The standards are organised under the following four (4) categories:

1. Model of regulation: the type of regulation e.g. via legislation
2. Protection of title: who may use the title 'midwife'
3. Governance: the processes for establishment of a midwifery regulatory authority and the processes by which the regulatory authority carries out its functions
4. Functions: the mechanisms by which a regulatory authority regulates midwives and includes the sub-categories of:
    a. scope of practice,
    b. pre-registration midwifery education,
    c. registration,
    d. continuing competence,
    e. complaints and discipline, and
    f. Code of Conduct and Ethics.

There are several standards in each category or sub-category and an explanation is provided for each standard.

Category	Standard	Explanation
1. Model of regulation	**1.1 Regulation is midwifery specific**	Midwifery requires legislation that establishes a midwifery-specific regulatory authority with adequate statutory powers to effectively regulate midwives, support autonomous midwifery practice and enable the midwifery profession to be recognised as an autonomous profession. Midwifery-specific legislation protects the health of mothers and babies by ensuring safe and competent midwifery practice.
	1.2 Regulation should be at a national level	Where possible regulation should be at a national level. However, if this is not possible there must be a mechanism for collaboration and communication between the midwifery regulatory authorities. National regulation enables uniformity of practice standards and facilitates freedom of movement of midwives between jurisdictions.
2. Protection of title	**2.1 Only those authorised under relevant legislation may use the title 'midwife' endowed by that legislation**	Mothers and their families receiving care from a midwife have a right to know that they are being cared for by a legally qualified practitioner. A legally qualified practitioner is individually responsible and accountable for her actions and is required to adhere to professional codes and standards. Reserving the title 'midwife' for legally qualified midwives identifies legally qualified midwives from others who provide aspects of maternity care. Legislative protection of the title enables the midwifery regulatory authority to prosecute someone who breaches the legislation by holding themselves out to be a midwife when they are not on the register of midwives.
3. Governance	**3.1 The legislation sets a transparent process for nomination, selection and appointment of members to the regulatory authority and identifies roles and terms of appointment.**	Because there is no evidence for any specific model of selection of members for regulatory authorities the ICM recommends a combination of appointment and election for all members of the midwifery regulatory authority. The choice will depend on feasibility and local acceptance. All members of the regulatory authority should demonstrate experience and expertise against pre-determined selection criteria such as broad experience in the midwifery profession; business and finance expertise; education expertise and legal expertise.

	3.2 The majority of members of the midwifery regulatory authority are midwives who reflect the diversity of midwifery practice in the country.	Midwife members should be appointed or elected from nominees put forward by the midwifery profession. The midwife members need to reflect the diversity of midwives and of midwifery practice in the country, have credibility within the profession and be authorised to practise in the jurisdiction. Midwives must make up the majority membership of any regulatory authority to ensure that midwifery standards are utilised in decision-making.
	3.3 There must be provision for lay members	Lay members of the midwifery regulatory authority should reflect the diversity of the country including ethnicity. Ideally lay members will provide perspectives that reflect those of childbearing women.
	3.4 The governance structures of the midwifery regulatory authority should be set out by the legislation.	The midwifery regulatory authority has systems and processes in place to specify roles and responsibilities of board or council members; powers of the council; process of appointment of chairperson. The midwifery regulatory authority determines the processes by which it carries out its functions under the legislation. Such processes must be transparent to the public through publication of an annual report and other mechanisms for publicly reporting on activities and decisions.
	3.5 The chairperson of the midwifery regulatory authority must be a midwife.	The members of the midwifery regulatory authority should select the chairperson from amongst the midwife members.
	3.6 The midwifery regulatory authority is funded by members of the profession	Payment of fees is a professional responsibility that entitles midwives to obtain registration or a license to practise if that midwife meets the required standards. Fees paid by midwives provide politically independent funding of the midwifery regulatory authority. Ideally the midwifery regulatory authority is entirely funded by the profession. However, in countries where the midwifery workforce is small or poorly paid some government support may be required. Government funding has the potential to limit the autonomy of the midwifery regulatory authority and therefore needs to be provided through a mechanism that minimises such a consequence.

	3.7 The midwifery regulatory authority works in collaboration with the midwifery professional association(s).	The midwifery regulatory authority's processes should be based on principles of collaboration and consultation. The midwifery regulatory authority needs to work in partnership[8] with other midwifery organizations that also have a role in public safety and standard setting such as the midwifery association.
	3.8 The midwifery regulatory authority works in collaboration with other regulatory authorities both nationally and internationally.	Collaboration with other regulatory authorities, both nationally and internationally, promotes understanding of the role of regulation and more consistent standards globally. Collaboration can provide economies of scale for developing shared systems and processes that improve quality.
4. Functions		
4.1. Scope of practice	4.1.1. The midwifery regulatory authority defines the scope of practice of the midwife that is consistent with the ICM definition and scope of practice of a midwife.	The midwifery profession determines its own scope of practice rather than employers, government, other health professions, the private health sector or other commercial interests. The scope of practice provides the legal definition of what a midwife may do on her own professional responsibility. The primary focus of the midwifery profession is the provision of normal childbirth and maternity care. Midwives are required to demonstrate the ICM essential competencies for basic midwifery care regardless of setting, whether it be tertiary/acute hospitals or home and community-based services/birthing centres. The scope of practice must support and enable autonomous midwifery practice and should therefore include prescribing rights, access to laboratory/screening services and admitting and discharge rights. As autonomous primary health practitioners midwives must be able to consult with and refer to specialists and have access to back up emergency services in all maternity settings. Associated non-midwifery legislation may need to be amended to give midwives the necessary authorities to practise in their full scope. For example, other legislation that controls the prescription of narcotics/medicines or access to laboratory/diagnostic services may need to be amended.

[8] ICM position statement on partnership between women and midwives, 2005

4.2. Pre-registration midwifery education	4.2.1. The midwifery regulatory authority sets the minimum standards for pre-registration midwifery education and accreditation of midwifery education institutions that are consistent with the ICM education standards.	The midwifery profession defines the minimum standards for education and competence required for midwifery registration. The ICM definition and scope of practice of a midwife, essential competencies for basic midwifery practice and standards for midwifery registration should provide the framework for pre-registration midwifery education programmes. By setting these minimum standards for pre-registration midwifery education the profession (via the midwifery regulatory authority) ensures that midwives are educated to the qualification/standard/level required for midwifery registration and that programmes are consistent. By setting the minimum standards for accreditation of midwifery education institutions the profession (via the midwifery regulatory authority) ensures that the education institution is able to provide quality midwifery education and that there is standardisation across programmes and educational institutions. The midwifery regulatory authority utilises a transparent process of consultation with the wider midwifery profession, maternity consumers and other stakeholders In setting the minimum standards for pre-registration midwifery education and accreditation. It also draws upon the ICM Global Standards for Midwifery Education (2011).
	4.2.2. The midwifery regulatory authority approves pre-registration midwifery education programmes leading to the qualification prescribed for midwifery registration.	The midwifery regulatory authority establishes the processes to approve midwifery education programmes and accredit midwifery education organisations in order to ensure that the programmes and graduates meet the approved education and registration standards and the ICM Global Standards for Midwifery Education. In countries where national accreditation organisations exist the midwifery regulatory authority collaborates in the processes of approval and accreditation. In these situations each organisation may focus on its own specific standards and area of expertise and accept the assessment of the other. For example, a midwifery regulatory authority will need to ensure that the programme leads to the standards for midwifery registration while a specific education accreditation organisation will assess whether the programme or the education institution meets the standards necessary to grant the relevant academic qualification.
	4.2.3. The midwifery regulatory authority accredits the midwifery education institutions providing the approved pre-registration midwifery education programme.	

	4.2.4. The midwifery regulatory authority audits pre-registration midwifery education programmes and midwifery education institutions.	The midwifery regulatory authority establishes the processes for ongoing monitoring and audit mechanisms of pre-registration midwifery education programmes and the midwifery education institutions providing the programmes in order to ensure that appropriate standards are maintained. While it establishes the processes the midwifery regulatory authority may employ external auditors to carry out this work.
4.3. Registration	4.3.1. The legislation sets the criteria for midwifery registration and/or licensure. 4.3.2. The midwifery regulatory authority develops standards and processes for registration and/or licensure	To enter the register of midwives applicants must meet specific standards set by profession (via the midwifery regulatory authority). For example, such standards may include: • demonstration of having met the competencies for entry to the register (refer ICM essential competencies); • successful completion of the approved pre-registration midwifery education programme to the required standard; • successful completion of a national examination; • demonstration of having met standards of fitness for practice including being of good character (possible police check for criminal record), being able to communicate effectively in the professional midwifery role and having no health issues that could prevent safe practice.
	4.3.3. The midwifery regulatory authority develops processes for assessing equivalence of applicants from other countries for entry to the midwifery register/or licensure.	Midwifery registrants from other countries must meet the same registration standards as local midwifery registrants. The assessment process should be comprehensive and may include: • sighting and assessing original qualifications and post-registration midwifery experience of applicants and comparing these with the educational preparation of local new graduate midwives; • asssessing the competence of applicants against the competencies for entry to the register; • obtaining a certificate of good standing from other regulatory authorities with whom the midwife is registered. Assessment methods may include examinations and clinical assessment of competence.

		Midwives from other countries who meet registration standards should be required to complete an adaptation programme to orientate to local society and culture, health system, maternity system and midwifery profession. Midwives can hold provisional registration until these requirements are met within the designated timeframe. Regulatory authorities should cooperate and collaborate to facilitate international mobility of midwives without compromising midwifery standards or public safety or breaching international guidelines on ethical recruitment from other countries.
	4.3.4. Mechanisms exist for a range of registration and/or licensure status.	From time to time midwifery regulatory authorities need flexibility to temporarily limit the practice of a midwife, for example, while a midwife is having her competence reviewed or is undertaking a competence programme or has a serious health issue that may compromise safe practice. Legislation should include categories of registration to provide for particular circumstances. For example provisional, temporary, conditional, suspended and full midwifery registration/licensure. The midwifery regulatory authority develops policy and processes to communicate the registration status of each registered midwife.
	4.3.5. The midwifery regulatory authority maintains a register of midwives and makes it publicly available.	The midwifery regulatory authority demonstrates public accountability and transparency of its registration processes by making the register of midwives available to the public. This may be electronically through a website or by allowing members of the public to examine the register. Women and their families have a right to know that their midwife is registered/licensed and has no conditions on her practice. Therefore this information needs to be accessible to the public.
	4.3.6. The midwifery regulatory authority establishes criteria, pathways and processes leading to registration/licensure for midwives from other countries who do not meet registration requirements.	Where midwives from other countries do not meet the registration standards a range of options can be considered including examination, education programmes, clinical assessment. Some midwives may not be able to meet the registration standards without first completing another pre-registration midwifery education programme.

	4.3.7. The midwifery regulatory authority collects information about midwives and their practice to contribute to workforce planning and research.	The midwifery regulatory authority has a role in supporting workforce planning. Information collected can inform planning for pre-registration and post-registration midwifery education and inform governments about workforce needs and strategies. Some information will be collected from the register of midwives but the midwifery regulatory authority may also collect specific information about midwifery practice through surveys of midwives on the register. The midwifery regulatory authority is an appropriate body to provide a national overview of the midwifery workforce for planning purposes. Midwifery regulatory authorities may be the appropriate body to manage workforce deployment to prevent over or under supply of midwifery workforce numbers. It is an issue of public safety to ensure access to midwives for all women regardless of location.
4.4. Continuing competence	4.4.1. The midwifery regulatory authority implements a mechanism through which midwives regularly demonstrate their continuing competence to practise.	Midwifery competence involves lifelong learning and the demonstration of continuing competence for registration/licensure. Eligibility to continue to hold a licence to practise midwifery is dependent upon the individual midwife's ability to demonstrate continuing competence. Assessment and demonstration of continuing competence is facilitated by a recertification or relicensing policy and process that includes such things as continuing education, minimum practice requirements, competence review (assessment) and professional activities.
	4.4.2. The legislation sets out separate requirements for entry to the midwifery register and/or first license and relicensing on a regular basis.	A requirement for regular relicensing separates the registration/first licensing process from the subsequent application to practise process. Historically in many countries relicensing required only the payment of a fee. Internationally there is an increasing requirement for demonstration of ongoing competence (including updating knowledge) as a requirement for relicensure of health professionals. This is achieved through the issuing of a practising certificate on a regular basis to those who meet the requirements for ongoing competence.

	4.4.3. A mechanism exists for regular relicensing of the midwife's practice.	Midwives may be on the midwifery register for life (unless removed through disciplinary means or by death). However, the establishment of separate processes to approve the ongoing practice of midwives will enable the midwifery regulatory authority to monitor the continuing competence of each midwife. Separation between the processes for registration and approval for ongoing practice also provide a more flexible mechanism for placing conditions and/or restrictions on a midwife's practice if required. The register of midwives must show the practising status of the midwife and must be publicly available.
	4.4.4. Mechanisms exist for return to practice programmes for midwives who have been out of practice for a defined period.	The midwifery regulatory authority is responsible for ensuring that all midwives are competent. As part of a continuing competence framework the midwifery regulatory authority ensures that standards and guidelines are set that identify the timeframes and pathways for midwives returning to practice after a period out of practice.
4.5. Complaints and discipline	4.5.1. The legislation authorises the midwifery regulatory authority to define expected standards of conduct and to define what constitutes unprofessional conduct or professional misconduct.	The midwifery regulatory authority has a public protection role and increasingly there is a public expectation that all professions are transparent and effective in setting standards for practice that protect the public. The midwifery regulatory authority sets the standards of professional conduct and ethics and judges when midwives fall below expected standards.
	4.5.2. The legislation authorises the midwifery regulatory authority to impose, review and remove penalties, sanctions and conditions on practice	The midwifery regulatory authority requires a range of penalties, sanctions and conditions including censure; suspension; midwifery supervision; requirement to undertake an education programme; requirement to undergo medical assessment; restricted practice; conditional practice; and removal from the register. The midwifery regulatory authority utilises due process and a sets a time frame whereby the midwife can apply to have penalties, sanctions or conditions reviewed and or removed.

	4.5.3. The legislation sets out the powers and processes for receipt, investigation, determination and resolution of complaints.	Appropriate mechanisms must be in place to effectively manage issues of competence, health and conduct. The mechanisms must ensure natural justice. The detail in the legislation will depend on the judicial system and cultural context in place in any country. Very prescriptive legislation may restrict the development of a flexible and responsive midwifery workforce.
	4.5.4. The midwifery regulatory body has policy and processes to manage complaints in relation to competence, conduct or health impairment in a timely manner.	Complaint processes enable anyone to make a complaint about a midwife (consumer/service user, other health professional, employer, another midwife, or regulator can initiate a complaint). In addressing competence, health or conduct matters a philosophy of rehabilitation and re-education provides the framework for decision making system in the interests of an effective maternity system.
	4.5.5. The legislation should provide for the separation of powers between the investigation of complaints and the hearing and determining of charges of professional misconduct.	Separation of investigation and hearing and determination allows for fairness to the midwife and transparency to the public. Separation of powers prevents a conflict for the midwifery regulatory authority between protecting the interests of the midwifery profession and ensuring public safety. The decision is made in the public interest, rather than that of the profession.
	4.5.6. Complaints management processes are transparent and afford natural justice to all parties.	A freely available and accessible appeal process should be in place.
4.6. Code of conduct and ethics	4.6.1. The midwifery regulatory authority sets the standards of conduct and ethics.	The codes of conduct and ethics are a baseline for the practice and professional behaviour expected from a midwife and the midwifery profession. The profession sets these standards via the midwifery regulatory authority. Internationally, common elements in codes include rules around personal value systems, professional boundaries, inter-professional respect, collegial relationships, informed consent, advertising, and product endorsement. Codes of ethics should be consistent with the ICM Code of Ethics.

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Strengthening Midwifery Globally

INTERNATIONAL CONFEDERATION OF MIDWIVES

Essential competencies for basic midwifery practice
2010
Revised 2013

PREFACE

The International Confederation of Midwives (ICM) is a federation of midwifery associations representing countries across the globe. The ICM works closely with the World Health Organization, all United Nations agencies, and governments in support of safe motherhood and primary health care strategies for the world's families. ICM takes the leadership role in development of the definition of the midwife, and the delineation of the midwifery scope of practice (the essential competencies). ICM also promotes standards and guidelines that define the expected structure and context of midwifery pre-service education programs; provides guidance for the development of regulations for midwifery practice; and assists countries to strengthen the capacity of midwifery associations and to develop leaders of the midwifery profession worldwide.

Throughout this document the term "competencies" is used to refer to both the broad statement heading each section, as well as the knowledge, skills and behaviours required of the midwife for safe practice in any setting. They answer the questions "What is a midwife expected to know?" and "What does a midwife do?" The competencies are *evidence-based.*

The majority of the competencies are considered to be *basic* or *core*, i.e., those that should be an expected outcome of midwifery pre-service education. Other items are designated as *additional* knowledge or skills. Additional skills are defined as those that could be learned or performed by midwives under either of two circumstances: a) midwives who elect to engage in a broader scope of practice and/or b) midwives who have to implement certain skills to make a difference in maternal or neonatal outcome. This allows for variation in the preparation and practice of midwives throughout the world, depending on the needs of their local community and/or nation.

The competencies are written in recognition that midwives receive their knowledge and skills through several different educational pathways. They can be used by midwives, midwifery associations, and regulatory bodies responsible for the education and practice of midwifery in their country or region. The essential competencies are guidelines for the mandatory content of midwifery pre-service education curricula, and information for governments and other policy bodies that need to understand the contribution that midwives can make to the health care system. The *Essential Competencies for Basic Midwifery Practice* is complemented by ICM standards and guidelines related to midwifery education, regulation and clinical practice.

The *Essential Competencies for Basic Midwifery Practice* is a living document. The competency statements undergo continual evaluation and amendment as the evidence concerning health care and health practices emerges and evolves, and as the health care needs of childbearing women and families change.

KEY MIDWIFERY CONCEPTS

There are a number of key midwifery concepts that define the unique role of midwives in promoting the health of women and childbearing families. These include:

- partnership with women to promote self-care and the health of mothers, infants, and families;
- respect for human dignity and for women as persons with full human rights;
- advocacy for women so that their voices are heard and their health care choices are respected;
- cultural sensitivity, including working with women and health care providers to overcome those cultural practices that harm women and babies;
- a focus on health promotion and disease prevention that views pregnancy as a normal life event; and
- advocacy for normal physiologic labour and birth to enhance best outcomes for mothers and infants.

SCOPE OF MIDWIFERY PRACTICE

The scope of midwifery practice used throughout this document is built upon the ICM international *Definition of the Midwife* which recognises the midwife as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility, and to provide care for the newborn and infant. This care includes preventative measures, the promotion of normal physiologic labour and birth, the detection of complications the accessing of medical care or other appropriate assistance and the carrying out of emergency measures.

The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and child care. A midwife's role as advocate for evidence-based midwifery practices can also be valuable in advancing public health policy regarding women's health and maternal and child health care.

A midwife may practise in any setting including the home, community, hospitals, clinics or health units.

COMPETENCY IN SOCIAL, EPIDEMIOLOGIC AND CULTURAL CONTEXT OF MATERNAL AND NEWBORN CARE

COMPETENCY # 1: Midwives have the requisite knowledge and skills from obstetrics, neonatology, the social sciences, public health and ethics that form the basis of high quality, culturally relevant, appropriate care for women, newborns, and childbearing families.

Knowledge

BASIC

The midwife has the knowledge and/or understanding of...

- the community and social determinants of health (e.g., income, literacy and education, water supply and sanitation, housing, environmental hazards, food security, disease patterns, common threats to health)
- principles of community-based primary care using health promotion and disease prevention and control strategies
- direct and indirect causes of maternal and neonatal mortality and morbidity in the local community and strategies for reducing them
- methodology for conducting maternal death review and near miss audits
- principles of epidemiology, community diagnosis (including water and sanitation), and how to use these in care provision
- methods of infection prevention and control, appropriate to the service being provided
- principles of research, evidenced-based practice, critical interpretation of professional literature, and the interpretation of vital statistics and research findings
- indicators of quality health care services
- principles of health education
- national and local health services and infrastructures supporting the continuum of care (organization and referral systems), how to access needed resources for midwifery care
- relevant national programs (provision of services or knowledge of how to assist community members to access services, such as immunization and prevention or treatment of health conditions prevalent in the country)
- the concept of alarm (preparedness), resources for referral to higher health facility levels, communication and transport [emergency care] mechanisms
- the legal and regulatory framework governing reproductive health for women of all ages, including laws, policies, protocols and professional guidelines
- human rights and their effects on health of individuals (includes issues such as domestic partner violence and female genital mutilation [cutting])
- advocacy and empowerment strategies for women
- local culture and beliefs (including religious beliefs, gender roles)

- traditional and modern health practices (beneficial and harmful)
- benefits and risks of available birth settings (birth planning)
- strategies for advocating with women for a variety of safe birth settings

Professional Behaviours

BASIC

The midwife...

- is responsible and accountable for clinical decisions and actions
- acts consistently in accordance with professional ethics, values and human rights
- acts consistently in accordance with standards of practice
- maintains/updates knowledge and skills, in order to remain current in practice
- uses universal/standard precautions, infection prevention and control strategies, and clean technique
- behaves in a courteous, non-judgmental, non-discriminatory, and culturally appropriate manner with all clients
- is respectful of individuals and of their culture and customs, regardless of status, ethnic origin or religious belief
- maintains the confidentiality of all information shared by the woman; communicates essential information between/among other health providers or family members only with explicit permission from the woman and compelling need
- works in partnership with women and their families, enables and supports them in making informed choices about their health, including the need for referral or transfer to other health care providers or facilities for continued care when health care needs exceed the abilities of the midwife provider, and their right to refuse testing or intervention
- works collaboratively (teamwork) with other health workers to improve the delivery of services to women and families

Skills and/or abilities

BASIC

The midwife has the skill and/or ability to...

- engage in health education discussions with and for women and their families
- use appropriate communication and listening skills across all domains of competency
- assemble, use and maintain equipment and supplies appropriate to setting of practice
- record and interpret relevant findings for services provided across all domains of competency, including what was done and what needs follow-up
- comply with all local reporting regulations for birth and death registration
- take a leadership role in the practice arena based on professional beliefs and values

ADDITIONAL

The midwife has the skill and/or ability to...

- assume administration and management tasks and activities, including quality and human resource management, appropriate for level of health facility and midwifery scope of practice
- take a leadership role in policy arenas

COMPETENCY # 2: Midwives provide high quality, culturally sensitive health education and services to all in the community in order to promote healthy family life, planned pregnancies and positive parenting.

Knowledge

BASIC

The midwife has the knowledge and/or understanding of…

- growth and development related to sexuality, sexual development and sexual activity
- female and male anatomy and physiology related to conception and reproduction
- cultural norms and practices surrounding sexuality, sexual practices, marriage and childbearing
- components of a health history, family history and relevant genetic history
- physical examination content and investigative laboratory studies that evaluate potential for a healthy pregnancy
- health education content targeted to sexual and reproductive health (e.g., sexually transmitted infections, HIV, newborn and child health)
- basic principles of pharmacokinetics of family planning drugs and agents
- culturally acceptable and locally available natural family planning methods
- contemporary family planning methods, including barrier, steroidal, mechanical, chemical and surgical methods of contraception, mode of action, indications for use, benefits and risks; rumours and myths that affect family planning use
- medical eligibility criteria for all methods of family planning, including appropriate timeframes for method use
- methods and strategies for guiding women and/or couples needing to make decisions about methods of family planning
- signs and symptoms of urinary tract infection and sexually transmitted infections commonly occurring in the community/country
- indicators of common acute and chronic disease conditions specific to a geographic area of the world that present risks to a pregnant woman and the foetus (e.g., HIV, TB, malaria) and referral process for further testing and treatment including post-exposure preventive treatment
- indicators and methods for advising and referral of dysfunctional interpersonal relationships, including sexual problems, gender-based violence, emotional abuse and physical neglect
- principles of screening methods for cervical cancer, (e.g., visual inspection with acetic acid [VIA], Pap test, and colposcopy)

Skills and/or abilities

BASIC

The midwife has the skill and/or ability to...

- take a comprehensive health and obstetric, gynaecologic and reproductive health history
- engage the woman and her family in preconception counselling, based on the individual situation, needs and interests
- perform a physical examination, including clinical breast examination, focused on the presenting condition of the woman
- order and/or perform and interpret common laboratory tests (e.g., hematocrit, urinalysis dip-stick for proteinuria)
- request and/or perform and interpret selected screening tests such as screening for TB, HIV, STIs
- provide care, support and referral or treatment for the HIV positive woman and HIV counselling and testing for women who do not know their status
- prescribe, dispense, furnish or administer (however authorized to do so in the jurisdiction of practice) **locally available and culturally acceptable methods of family planning**
- advise women about management of side effects and problems with use of family planning methods
- prescribe, dispense, furnish or administer (however authorized to do so in the jurisdiction of practice) **emergency contraception medications**, in accord with local policies, protocols, law or regulation
- provide commonly available methods of barrier, steroidal, mechanical, and chemical methods of family planning
- take or order cervical cytology(Pap) test

ADDITIONAL

The midwife has the skill and/or ability to...

- use the microscope to perform simple screening tests
- insert and remove intrauterine contraceptive devices
- insert and remove contraceptive implants
- perform acetic acid visualization of the cervix and interpret the need for referral and treatment
- perform colposcopy for cervical cancer screening and interpret the need for referral and treatment

COMPETENCY # 3: Midwives provide high quality antenatal care to maximize health during pregnancy and that includes early detection and treatment or referral of selected complications.

Knowledge

BASIC

The midwife has the knowledge and/or understanding of...

- anatomy and physiology of the human body
- the biology of human reproduction, the menstrual cycle, and the process of conception
- signs and symptoms of pregnancy
- examinations and tests for confirmation of pregnancy
- methods for diagnosis of an ectopic pregnancy
- principles of dating pregnancy by menstrual history, size of uterus, fundal growth patterns and use of ultrasound (if available)
- components of a health history and focused physical examination for antenatal visits
- manifestations of various degrees of female genital mutilation (cutting) and their potential effects on women's health, including the birth process
- normal findings [results] of basic screening laboratory tests defined by need of area of the world, (e.g., iron levels, urine test for sugar, protein, acetone, bacteria)
- normal progression of pregnancy: body changes, common discomforts, expected fundal growth patterns
- implications of deviation from expected fundal growth patterns, including intrauterine growth retardation/restriction, oligo- and polyhydramnios, multiple foetuses
- fetal risk factors requiring transfer of women to higher levels of care prior to labour and birth
- normal psychological changes in pregnancy, indicators of psychosocial stress, and impact of pregnancy on the woman and the family
- safe, locally available non-pharmacological substances for the relief of common discomforts of pregnancy
- how to determine foetal well-being during pregnancy including foetal heart rate and activity patterns
- nutritional requirements of the pregnant woman and foetus
- health education needs in pregnancy (e.g., information about relief of common discomforts, hygiene, sexuality, work inside and outside the home)
- basic principles of pharmacokinetics of drugs prescribed, dispensed or furnished to women during pregnancy
- effects of prescribed medications, street drugs, traditional medicines, and over-the-counter drugs on pregnancy and the foetus
- effects of smoking, alcohol abuse and illicit drug use on the pregnant woman and foetus

- the essential elements of birth planning (preparation for labour and birth, emergency preparedness)
- the components of preparation of the home/family for the newborn
- signs and symptoms of the onset of labour (including women's perceptions and symptoms)
- techniques for increasing relaxation and pain relief measures available for labour
- signs, symptoms and potential effects of conditions that are life-threatening to the pregnant woman and/or her foetus, (e.g., pre-eclampsia/eclampsia, vaginal bleeding, premature labour, severe anaemia, Rh isoimmunisation, syphilis)
- means and methods of advising about care, treatment and support for the HIV positive pregnant woman including measures to prevent maternal-to-child transmission (PMTCT) (including feeding options)
- signs, symptoms and indications for referral of selected complications and conditions of pregnancy that affect either mother or foetus (e.g., asthma, HIV infection, diabetes, cardiac conditions, malpresentations/abnormal lie, placental disorders, pre-term labour, post-dates pregnancy)
- measures for prevention and control of malaria in pregnancy, according to country disease pattern, including intermittent preventive treatment (IPT) and promotion of insecticide treated bed nets (ITN)
- pharmacologic basis of de-worming in pregnancy (if relevant to the country of practice)
- the physiology of lactation and methods to prepare women for breastfeeding

Skills and/or abilities

BASIC

The midwife has the skill and/or ability to…

- take an initial and ongoing history each antenatal visit
- perform a physical examination and explain findings to the woman
- take and assess maternal vital signs including temperature, blood pressure, pulse
- assess maternal nutrition and its relationship to foetal growth; give appropriate advice on nutritional requirements of pregnancy and how to achieve them
- perform a complete abdominal assessment including measuring fundal height, lie, position, and presentation
- assess foetal growth using manual measurements
- evaluate foetal growth, placental location, and amniotic fluid volume, using ultrasound visualization and measurement (if equipment is available for use)
- listen to the foetal heart rate; palpate uterus for foetal activity and interpret findings
- monitor foetal heart rate with Doppler (if available)
- perform a pelvic examination, including sizing the uterus, if indicated and when appropriate during the course of pregnancy
- perform clinical pelvimetry [evaluation of bony pelvis] to determine the adequacy of the bony structures
- calculate the estimated date of birth

- provide health education to adolescents, women and families about normal pregnancy progression, danger signs and symptoms, and when and how to contact the midwife
- teach and/or demonstrate measures to decrease common discomforts of pregnancy
- provide guidance and basic preparation for labour, birth and parenting
- Identify variations from normal during the course of the pregnancy and institute appropriate first-line independent or collaborative management based upon evidence-based guidelines, local standards and available resources for:
    - low and or inadequate maternal nutrition
    - inadequate or excessive uterine growth, including suspected oligo- or polyhydramnios, molar pregnancy
    - elevated blood pressure, proteinuria, presence of significant oedema, severe frontal headaches, visual changes, epigastric pain associated with elevated blood pressure
    - vaginal bleeding
    - multiple gestation, abnormal lie/malpresentation at term
    - intrauterine foetal death
    - rupture of membranes prior to term
    - HIV positive status and/or AIDS
    - hepatitis B and C positive
- prescribe, dispense, furnish or administer (however authorized to do so in the jurisdiction of practice) **selected, life-saving drugs** (e.g., antibiotics, anticonvulsants, antimalarials, antihypertensives, antiretrovirals) to women in need because of a presenting condition
- identify deviations from normal during the course of pregnancy and initiate the referral process for conditions that require higher levels of intervention

COMPETENCY #4: Midwives provide high quality, culturally sensitive care during labour, conduct a clean and safe birth and handle selected emergency situations to maximize the health of women and their newborns.

Knowledge

BASIC

The midwife has the knowledge and/or understanding of...

- physiology of first, second and third stages of labour
- anatomy of foetal skull, critical diameters and landmarks
- psychological and cultural aspects of labour and birth
- indicators of the latent phase and the onset of active labour
- indications for stimulation of the onset of labour, and augmentation of uterine contractility
- normal progression of labour
- how to use the partograph (i.e., complete the record; interpret information to determine timely and appropriate labour management)
- measures to assess foetal well-being in labour
- measures to assess maternal well-being in labour
- process of foetal passage [descent] through the pelvis during labour and birth; mechanisms of labour in various foetal presentations and positions
- comfort measures in first and second stages of labour (e.g., family presence/assistance, positioning for labour and birth, hydration, emotional support, non-pharmacological methods of pain relief)
- pharmacological measures for management and control of labour pain, including the relative risks, disadvantages, safety of specific methods of pain management, and their effect on the normal physiology of labour
- signs and symptoms of complications in labour (e.g. bleeding, labour arrest, malpresentation, eclampsia, maternal distress, foetal distress, infection, prolapsed cord)
- principles of prevention of pelvic floor damage and perineal tears
- indications for performing an episiotomy
- principles of expectant (physiologic) management of the 3rd stage of labour
- principles of active management of 3rd stage of labour
- principles underpinning the technique for repair of perineal tears and episiotomy
- indicators of need for emergency management, referral or transfer for obstetric emergencies (e.g., cord prolapse, shoulder dystocia, uterine bleeding, retained placenta)
- indicators of need for operative deliveries, vacuum extraction, use of forceps or symphisiotomy (e.g., foetal distress, cephalo-pelvic disproportion)

Skills and/or abilities

BASIC

The midwife has the skill and/or ability to...

- take a specific history and maternal vital signs in labour
- perform a focused physical examination in labour
- perform a complete abdominal assessment for foetal position and descent
- time and assess the effectiveness of uterine contractions
- perform a complete and accurate pelvic examination for dilatation, effacement, descent, presenting part, position, status of membranes, and adequacy of pelvis for birth of baby vaginally
- monitor progress of labour using the partograph or similar tool for recording
- provide physical and psychological support for woman and family and promote normal birth
- facilitate the presence of a support person during labour and birth
- provide adequate hydration, nutrition and non-pharmacological comfort measures during labour and birth
- provide pharmacologic therapies for pain relief during labour and birth (in appropriate birth settings)
- provide for bladder care including performance of urinary catheterization when indicated
- promptly identify abnormal labour patterns and initiate appropriate and timely intervention and/or referral
- stimulate or augment uterine contractility, using non-pharmacologic agents
- stimulate or augment uterine contractility, using pharmacologic agents (in appropriate birth settings
- administer local anaesthetic to the perineum when episiotomy is anticipated or perineal repair is required
- perform an episiotomy if needed
- perform appropriate hand manoeuvres for a vertex birth
- perform appropriate hand manoeuvres for face and breech deliveries
- clamp and cut the cord
- institute immediate, life-saving interventions in obstetrical emergencies (e.g., prolapsed cord, malpresentation, shoulder dystocia, and foetal distress) to save the life of the foetus, while requesting medical attention and/or awaiting transfer
- manage a cord around the baby's neck at birth
- support expectant (physiologic) management of the 3rd stage of labour
- conduct active management of the 3rd stage of labour, following most current evidence-based protocol
- inspect the placenta and membranes for completeness
- perform fundal massage to stimulate postpartum uterine contraction and uterine tone
- provide a safe environment for mother and infant to promote attachment (bonding)
- estimate and record maternal blood loss
- inspect the vagina and cervix for lacerations

- repair an episiotomy if needed
- repair 1st and 2nd degree perineal or vaginal lacerations
- manage postpartum bleeding and haemorrhage, using appropriate techniques and uterotonic agents as indicated
- prescribe, dispense, furnish or administer (however authorized to do so in the jurisdiction of practice) **selected, life-saving drugs** (e.g., antibiotics, anticonvulsants, antimalarials, antihypertensives, antiretrovirals) to women in need because of a presenting condition
- perform manual removal of placenta
- perform internal bimanual compression of the uterus to control
- perform aortic compression
- identify and manage shock
- insert intravenous line, draw blood for laboratory testing
- arrange for and undertake timely referral and transfer of women with serious complications to a higher level health facility, taking appropriate drugs and equipment and arranging for a companion care giver on the journey, in order to continue giving emergency care as required
- perform adult cardio-pulmonary resuscitation

ADDITIONAL

The midwife has the skill and/or ability to...

- perform vacuum extraction
- repair 3rd and 4th degree perineal or vaginal lacerations
- identify and repair cervical lacerations

COMPETENCY IN PROVISION OF CARE FOR WOMEN DURING THE POSPARTUM PERIOD

COMPETENCY # 5: Midwives provide comprehensive, high quality, culturally sensitive postpartum care for women.

Knowledge

BASIC

The midwife has the knowledge and/or understanding of...

- physical and emotional changes that occur following childbirth, including the normal process of involution
- physiology and process of lactation and common variations including engorgement, lack of milk supply, etc
- the importance of early breastfeeding for mother and child
- maternal nutrition, rest, activity and physiological needs (e.g., bowel and bladder) in the immediate postpartum period
- principles of parent-infant bonding and attachment (e.g., how to promote positive relationships)
- indicators of subinvolution (e.g., persistent uterine bleeding, infection)
- indicators of maternal breastfeeding problems or complications, including mastitis
- signs and symptoms of life threatening conditions that may first arise during the postpartum period (e.g., persistent vaginal bleeding, embolism, postpartum pre-eclampsia and eclampsia, sepsis, severe mental depression)
- signs and symptoms of selected complications in the postnatal period (e.g., persistent anaemia, haematoma, depression, thrombophlebitis; incontinence of faeces or urine; urinary retention, obstetric fistula)
- principles of interpersonal communication with and support for women and/or their families who are bereaved (maternal death, stillbirth, pregnancy loss, neonatal death, congenital abnormalities)
- approaches and strategies for providing special support for adolescents, victims of gender-based violence (including rape)
- principles of manual vacuum aspiration of the uterine cavity to remove retained products of conception
- principles of prevention of maternal to child transmission of HIV, tuberculosis, hepatitis B and C in the postpartum period
- methods of family planning appropriate for use in the immediate postpartum period (e.g., LAM, progestin-only OCs)
- community-based postpartum services available to the woman and her family, and how they can be accessed

Skills and/or abilities
BASIC

The midwife has the skill and/or ability to...

- take a selective history, including details of pregnancy, labour and birth
- perform a focused physical examination of the mother
- provide information and support for women and/or their families who are bereaved (maternal death, stillbirth, pregnancy loss, neonatal death, congenital abnormalities)
- assess for uterine involution and healing of lacerations and/or repairs
- initiate and support early breastfeeding (within the first hour)
- teach mothers how to express breast milk, and how to handle and store expressed breast milk
- educate mother on care of self and infant after childbirth including signs and symptoms of impending complications, and community-based resources
- educate a woman and her family on sexuality and family planning following childbirth
- provide family planning services concurrently as an integral component of postpartum care
- provide appropriate and timely first-line treatment for any complications detected during the postpartum examination (e.g., anaemia, haematoma maternal infection), and refer for further management as necessary
- provide emergency treatment of late post-partum haemorrhage, and refer if necessary

ADDITIONAL

The midwife has the skill and/or ability to...

- perform manual vacuum aspiration of the uterus for emergency treatment of late post-partum haemorrhage

COMPETENCY# 6: Midwives provide high quality, comprehensive care for the essentially healthy infant from birth to two months of age.

Knowledge

BASIC

The midwife has the knowledge and/or understanding of...

- elements of assessment of the immediate and subsequent condition of newborn (including APGAR scoring system, or other method of assessment of breathing and heart rate)
- principles of newborn adaptation to extrauterine life (e.g., physiologic changes that occur in pulmonary and cardiac systems)
- basic needs of newborn: established breathing, warmth, nutrition, attachment (bonding)
- advantages of various methods of newborn warming, including skin-to-skin contact (Kangaroo mother care)
- methods and means of assessing the gestational age of a newborn
- characteristics of low birth weight infants and their special needs
- characteristics of healthy newborn (appearance and behaviours)
- normal growth and development of the preterm infant
- normal newborn and infant growth and development
- selected variations in the normal newborn (e.g., caput, moulding, mongolian spots)
- elements of health promotion and prevention of disease in newborns and infants (e.g., malaria, TB, HIV), including essential elements of daily care (e.g., cord care, nutritional needs, patterns of elimination)
- immunization needs, risks and benefits from infancy through young childhood
- traditional or cultural practices related to the newborn
- principles of infant nutrition, feeding cues, and infant feeding options for babies (including those born to HIV positive mothers)
- signs, symptoms and indications for referral or transfer for selected newborn complications (e.g., jaundice, haematoma, adverse moulding of the foetal skull, cerebral irritation, non-accidental injuries, haemangioma, hypoglycaemia, hypothermia, dehydration, infection, congenital syphilis)

Skills and/or abilities

BASIC

The midwife has the skill and/or ability to...

- provide immediate care to the newborn, including drying, warming, ensuring that breathing is established, cord clamping and cutting when pulsation ceases
- assess the immediate condition of the newborn (e.g., APGAR scoring or other assessment method of breathing and heart rate)
- promote and maintain normal newborn body temperature through covering (e.g., blanket, cap), environmental control, and promotion of skin-to-skin contact
- begin emergency measures for respiratory distress (newborn resuscitation; suctioning in case of airway obstruction), hypothermia, hypoglycaemia
- give appropriate care including kangaroo mother care to the low birth weight baby, and arrange for referral if potentially serious complications arise, or very low birth weight
- perform a screening physical examination of the newborn for conditions incompatible with life
- perform a gestational age assessment
- provide routine care of the newborn, in accord with local guidelines and protocols (e.g., identification, eye care, screening tests, administration of Vitamin K, birth registration)
- position infant to initiate breast feeding within one hour after birth and support exclusive breastfeeding
- recognize indications of need, stabilize and transfer the at-risk newborn to emergency care facility
- educate parents about danger signs in the newborn and when to bring infant for care
- educate parents about normal growth and development of the infant and young child, and how to provide for day-to-day needs of the normal child
- assist parents to access community resources available to the family
- support parents during grieving process for loss of pregnancy, stillbirth, congenital birth defects or neonatal death
- support parents during transport/transfer of newborn or during times of separation from infant (e.g., NICU admission)
- support and educate parents who have given birth to multiple babies (e.g., twins, triplets) about special needs and community resources
- provide appropriate care for baby born to an HIV positive mother (e.g., administration of ARV and appropriate feeding)

COMPETENCY IN FACILITATION OF ABORTION-RELATED CARE

COMPETENCY #7: Midwives provide a range of individualised, culturally sensitive abortion-related care services for women requiring or experiencing pregnancy termination or loss that are congruent with applicable laws and regulations and in accord with national protocols.

Knowledge

BASIC

The midwife has the knowledge and/or understanding of...

- policies, protocols, laws and regulations related to abortion-care services
- factors involved in decisions relating to unintended or mistimed pregnancies
- family planning methods appropriate for use during the post-abortion period
- medical eligibility criteria for all available abortion methods
- care, information and support that is needed during and after miscarriage or abortion (physical and psychological) and services available in the community
- normal process of involution and physical and emotional healing following miscarriage or abortion
- signs and symptoms of sub-involution and/or incomplete abortion (e.g., persistent uterine bleeding)
- signs and symptoms of abortion complications and life threatening conditions (e.g., persistent vaginal bleeding, infection)
- pharmacotherapeutic basics of drugs recommended for use in medication abortion
- principles of uterine evacuation via manual vacuum aspiration (MVA)

Skills and/or abilities

BASIC

The midwife has the skill and/or ability to...

- assess gestational period through query about LMP, bimanual examination and/or urine pregnancy testing
- inform women who are considering abortion about available services for those keeping the pregnancy and for those proceeding with abortion, methods for obtaining abortion, and to support women in their choice
- take a clinical and social history to identify contraindications to medication or aspiration abortion
- educate and advise women (and family members, where appropriate), on sexuality and family planning post abortion

- provide family planning services concurrently as an integral component of abortion-related services
- assess for uterine involution; treat or refer as appropriate
- educate mother on care of self, including rest and nutrition and on how to identify complications such as haemorrhage
- identify indicators of abortion-related complications (including uterine perforation); treat or refer for treatment as appropriate

ADDITIONAL

The midwife has the skill and/or ability to…

- prescribe, dispense, furnish or administer drugs (however authorized to do so in the jurisdiction of practice) in dosages appropriate to **induce medication abortion**
- perform manual vacuum aspiration of the uterus up to 12 completed weeks of pregnancy

ICM DEFINITIONS

Ability: The quality of being able to perform; a natural or acquired skill or talent
Attitude: A person's views (values and beliefs) about a thing, process or person that often leads to positive or negative reaction
Behaviour: A person's way of relating or responding to the actions of others or to an environmental stimulus
Competence: The combination of knowledge, psychomotor, communication and decision-making skills that enable an individual to perform a specific task to a defined level of proficiency.
Competency (midwifery): A combination of knowledge, professional behaviour and specific skills that are demonstrated at a defined level of proficiency in the context of midwifery education and practice.
Knowledge: A fund of information that enables an individual to have confident understanding of a subject with the ability to use it for a specific purpose
Skill: Ability learned through education and training or acquired by experience, to perform specific actions or tasks to a specified level of measurable performance
Task: A specific component of a larger body of work

ICM Global Standards for Midwifery Education (2010)

I. Organization and Administration

I.1. The host institution/agency/branch of government supports the philosophy, aims and objectives of the midwifery education programme.

I.2. The host institution helps to ensure that financial and public/policy support for the midwifery education programme are sufficient to prepare competent midwives.

I.3. The midwifery school/programme has a designated budget and budget control that meets programme needs.

I.4. The midwifery faculty is self-governing and responsible for developing and leading the policies and curriculum of the midwifery education programme.

I.5. The head of the midwifery programme is a qualified midwife teacher with experience in management/administration.

I.6. The midwifery programme takes into account national and international policies and standards to meet maternity workforce needs.

II. Midwifery Faculty

II.1. The midwifery faculty includes predominantly midwives (teachers and clinical preceptors/clinical teachers) who work with experts from other disciplines as needed.

II.2. The midwife teacher:

II.2.a. has formal preparation in midwifery;

II.2.b. demonstrates competency in midwifery practise, generally accomplished with two (2) years full scope practise;

II.2.c. holds a current license/registration or other form of legal recognition to practise midwifery;

II.2.d. has formal preparation for teaching, or undertakes such preparation as a condition of continuing to hold the position; and

II.2.e. maintains competence in midwifery practise and education.

II.3. The midwife clinical preceptor/clinical teacher:

II.3.a. is qualified according to the ICM *Definition of a midwife*;

II.3.b. demonstrates competency in midwifery practise, generally accomplished with two (2) years full scope practise;

II.3.c. maintains competency in midwifery practise and clinical education;

II.3.d. holds a current license/registration or other form of legal recognition to practise midwifery; and

II.3.e. has formal preparation for clinical teaching or undertakes such preparation.

II.4. Individuals from other disciplines who teach in the midwifery programme are competent in the content they teach.

II.5. Midwife teachers provide education, support and supervision of individuals who teach students in practical learning sites.

II.6. Midwife teachers and midwife clinical preceptors/clinical teachers work together to support (facilitate), directly observe, and evaluate students' practical learning.

II.7. The ratio of students to teachers and clinical preceptors/clinical teachers in classroom and practical sites is determined by the midwifery programme and the requirements of regulatory authorities.

II.8. The effectiveness of midwifery faculty members is assessed on a regular basis following an established process.

III. Student Body

III.1. The midwifery programme has clearly written admission policies that are accessible to potential applicants. These policies include:

III.1.a. entry requirements, including minimum requirement of completion of secondary education;

III.1.b. a transparent recruitment process;

III.1.c. selection process and criteria for acceptance; and

III.1.d. mechanisms for taking account of prior learning.

III.2. Eligible midwifery candidates are admitted without prejudice or discrimination (e.g., gender, age, national origin, religion).

III.3. Eligible midwifery candidates are admitted in keeping with national health care policies and maternity workforce plans.

III.4. The midwifery programme has clearly written student policies that include:

III.4.a. expectations of students in classroom and practical areas;

III.4.b. statements about students' rights and responsibilities and an established process for addressing student appeals and/or grievances;

III.4.c. mechanisms for students to provide feedback and ongoing evaluation of the midwifery curriculum, midwifery faculty, and the midwifery programme; and

III.4.d. requirements for successful completion of the midwifery programme.

III.5. Mechanisms exist for the student's active participation in midwifery programme governance and committees.

III.6. Students have sufficient midwifery practical experience in a variety of settings to attain, at a minimum, the current ICM *Essential competencies for basic midwifery practice.*

III.7. Students provide midwifery care primarily under the supervision of a midwife teacher or midwifery clinical preceptor/clinical teacher.

IV. Curriculum

IV.1. The philosophy of the midwifery education programme is consistent with the ICM *Philosophy and model of care.*

IV.2. The purpose of the midwifery education programme is to produce a competent midwife who:

IV.2.a. has attained/demonstrated, at a minimum, the current ICM *Essential competencies for basic midwifery practice;*

IV.2.b. meets the criteria of the ICM *Definition of a Midwife* and regulatory body standards leading to licensure or registration as a midwife;

IV.2.c. is eligible to apply for advanced education; and

IV.2.d. is a knowledgeable, autonomous practitioner who adheres to the ICM *International Code of Ethics for Midwives,* standards of the profession and established scope of practise within the jurisdiction where legally recognized.

IV.3. The sequence and content of the midwifery curriculum enables the student to acquire essential competencies for midwifery practise in accord with ICM core documents.

IV.4. The midwifery curriculum includes both theory and practise elements with a minimum of 40% theory and a minimum of 50% practise.[2]

[2] The minimum entry level and length of midwifery education programmes were agreed as part of the modified Delphi survey process. ICM understands that time periods are an informed estimate of the time needed to achieve full competency in the practise of midwifery, whatever the route of entry into the education programme. The actual time needed may vary depending on many factors within countries. The important point is education to a predetermined level of competency.

IV 4.a.Minimum length of a direct-entry midwifery education programme is three (3) years
IV4.b. Minimum length of a post-nursing/health care provider (post-registration) midwifery education programme is eighteen (18) months

IV.5. The midwifery programme uses evidence-based approaches to teaching and learning that promote adult learning and competency based education.

IV.6. The midwifery programme offers opportunities for multidisciplinary content and learning experiences that complement the midwifery content.

V. Resources, facilities and services

V.1. The midwifery programme implements written policies that address student and teacher safety and wellbeing in teaching and learning environments.

V.2. The midwifery programme has sufficient teaching and learning resources to meet programme needs.

V.3. The midwifery programme has adequate human resources to support both classroom/theoretical and practical learning.

V.4. The midwfiery programme has access to sufficient midwifery practical experiences in a variety of settings to meet the learning needs of each student.

V.5. Selection criteria for appropriate midwifery practical learning sites are clearly written and implemented.

VI. Assessment Strategies

VI.1. Midwifery faculty uses valid and reliable formative and summative evaluation/assessment methods to measure student performance and progress in learning related to:

VI.1.a. knowledge;

VI.1.b. behaviours;

VI.1.c. practise skills;

VI.1.d. critical thinking and decision-making; and

VI.1.e. interpersonal relationships/communication skills.

VI.2. The means and criteria for assessment/evaluation of midwifery student performance and progression, including identification of learning difficulties, are written and shared with students.

VI.3. Midwifery faculty conducts regular review of the curriculum as a part of quality improvement, including input from students, programme graduates, midwife practitioners, clients of midwives and other stakeholders.

VI.4. Midwifery faculty conducts ongoing review of practical learning sites and their suitability for student learning/experience in relation to expected learning outcomes.

VI.5. Periodic external review of programme effectiveness takes place.

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American College of Nurse-Midwives Clinical Bulletin

Number 61, November 2015 (Replaces ACNM Clinical Bulletin Number 7, March 2003)

Midwifery Provision of Home Birth Services

American College of Nurse-Midwives

The number of women in the United States choosing to give birth at home has risen substantially in the past decade, creating an increased need for understanding of the evidence regarding the provision of midwifery care to women and families considering this option. The safety of home birth has been evaluated in observational studies in several industrialized nations, including the United States. Most studies find that women who are essentially healthy at term with a singleton fetus and give birth at home have positive outcomes and a lower rate of interventions during labor. Although some studies have found increased neonatal morbidity and mortality in newborns born at home when compared to newborns born in a hospital, the absolute numbers reported in both birth sites are very low. The purpose of this clinical bulletin is to review the evidence on provision of care to women and families who plan to give birth at home, including roles and responsibilities, shared decision making, informed consent, and ongoing assessment for birth site selection.

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Keywords: home childbirth, midwifery, shared decision making

The American College of Nurse-Midwives (ACNM) supports the right of every family to experience childbirth in a safe environment where human dignity and self-determination are respected.[1] Every woman has the right to make an informed choice regarding the place of birth that best meets her and her newborn's health needs.[1–3] Midwives provide maternity care in all settings in the United States, including hospitals, birth centers, and homes. ACNM supports the choice of families to give birth at home and the role of certified nurse-midwives (CNMs) and certified midwives (CMs) to provide care in all birth settings.[3] This Clinical Bulletin provides information about factors to be examined when women, families, and midwives consider home as a planned choice for the site of birth.

In the United States, the number of women who had births at home increased by 41% between 2004 and 2012.[4] However, home births (N = 35,184) still accounted for fewer than 1.4% of all births during those years.[4] Access to care for birth at home varies greatly in the United States depending on state and local regulations, availability of qualified health care providers,[5,6] and systems for transport from home to hospital should a transport be needed.[7] Despite the recent increase in the number of women planning to give birth at home, home birth has been controversial in the United States,[2,8,9] and the level of support for planned home birth varies across professional organizations.[2,8,9]

RESEARCH ON MATERNAL AND NEWBORN OUTCOMES FOLLOWING HOME BIRTH

The ultimate goal of all maternity care professionals and parents is a safe birth and healthy outcome for women and their newborns regardless of setting. Increasingly, women choose to give birth at home because they believe a home setting is the safest option.[10] In population-based studies from The Netherlands, Canada, and England, researchers have not found differences in perinatal outcomes between planned home and hospital births.[11–14] However, most of these countries have integrated systems of care, and it is not clear how much the integration of care across different birth settings affects perinatal outcomes.[11–14]

In December 2014 in the United Kingdom, the National Institute for Health and Care Excellence (NICE) issued guidelines entitled *Intrapartum Care: Care for Healthy Women and Their Babies during Childbirth*.[15] These guidelines are based on an extensive review of available scientific evidence regarding maternity care, and one of the key recommendations is that clinicians discuss planned place of birth with all pregnant women. Maternity care providers are advised to inform low-risk multiparous women that midwife-led care at home and in birth centers is recommended because the rate of intervention is less in these settings, and infant outcomes are similar when compared to outcomes of hospital birth. For low-risk nulliparous women, home birth is associated with a small increased risk of adverse neonatal outcomes (9/1000 newborns at home vs 4/1000 newborns in hospital settings). The NICE guidelines recommend that home birth be offered to low-risk nulliparous women as one of the choices for site of birth, after discussing the increased risks, in the context of informed, shared decision making.[15]

In studies of women who had home births in the United States, investigators have primarily used birth certificate data to compare outcomes. In these studies, women who gave birth at home had lower rates of chorioamnionitis,

This Clinical Bulletin was developed under the direction of the Clinical Standards and Documents Section of the Division of Standards and Practice, as an educational aid for midwives. This Clinical Bulletin is not intended to dictate an exclusive course of management or to substitute for individual professional judgment. It presents recognized methods and techniques for clinical practice that midwives may consider incorporating into their practices. The needs of an individual patient or the resources and limitations of an institution or type of practice may appropriately lead to variations in clinical care.

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meconium staining, fetal intolerance to labor, assisted ventilation, and neonatal intensive care unit admission.[16–18] However, women who gave birth at home had a 2-fold to 3-fold increased risk in neonatal morbidity and mortality when compared to women who gave birth in hospitals, although the absolute risk was low.[16–19] Studies based on birth certificate data have limitations that confound the results, such as no differentiation between planned and unplanned home birth or type of provider.[20] Using birth certificate data wherein type of provider was available, investigators who analyzed outcomes of care provided by midwives certified by the American Midwifery Certification Board found either similar outcomes between home and hospital birth or a small variance in neonatal outcomes and/or intrapartum fetal death between home and hospital birth favoring hospital birth.[16,19]

Other US-based studies have small sample sizes for some outcomes, limited ability to conduct intention-to-treat analysis for women who experience transfer of care, inability to control for certification status of the provider, and variable definitions of midwives within a single study.[21–24] In contrast, Cheyney et al conducted an intention-to-treat analysis with a large sample of 16,924 women who gave birth at home between 2004 and 2010.[25] The majority of these births (94%) were attended by certified professional midwives (CPMs), licensed midwives (LMs), licensed direct midwives (LDMs), or CNMs/CMs. Similar to the authors of other studies that analyzed birth certificate data, Cheney et al found that women who plan home births have higher rates of vaginal birth and a lower incidence of several labor complications. With regard to neonatal outcomes, after excluding lethal anomalies, the intrapartum death rate was 1.3 per 1000 births, the early neonatal mortality rate was 0.41 per 1000 births, and the late neonatal mortality rate was 0.35 per 1000 births.[25] In a sub-analysis, the authors analyzed high-risk conditions and found the rates of intrapartum, early neonatal, and late neonatal death in this group were higher than in the overall cohort. In addition, nulliparous women had a higher risk of intrapartum fetal death compared to multiparous women (2.92/1000 vs 0.84/1000) but no increased risk of early or late neonatal death.[25]

PLANNING A HOME BIRTH: INFORMED CHOICE AND SHARED RESPONSIBILITY

The goal in selecting a birth setting is to identify the environment that best meets the health and social needs of the woman and her newborn. A woman with a favorable prognosis for a normal, healthy labor, birth, and postpartum course may desire the documented health benefits associated with a planned home birth attended by a midwife with appropriate education and skills.[10]

Midwives provide care independently in the home for healthy women during pregnancy, labor, and birth within the parameters of setting-specific, clinical practice guidelines. Midwifery care in any setting includes ongoing clinical assessments that inform risk evaluation and clinical decision making throughout pregnancy, labor, birth, and the initial newborn and postpartum period.[26,27] Consistent with the ACNM *Standards for the Practice of Midwifery*,[27] each midwifery practice develops comprehensive clinical guidelines that address access to consultation, collaboration, and referral that includes a process to facilitate transfer of care if necessary.[26]

ACNM recommends the use of the midwife's clinical practice guidelines as a key component of the discussion and shared decision-making process between a woman and the midwife and between the midwife and consultant physician when considering birth setting. The decision to give birth at home is made within the context of the woman's philosophy, culture, and family.[10] The midwife contributes skills, experience, educational preparation, professional accountability, clinical judgment, professional ethics, relationships with other health care professionals, and knowledge of community and professional standards. Clear, transparent, and ongoing shared decision making between the midwife and the woman and her family is an essential component of care throughout the pregnancy, labor, and birth.[28]

The availability of resources for transport and the time and distance to the nearest hospital are factors unique to the home birth setting that must be considered in birth site selection.[29] Planning for a home birth should be done with the understanding that choices and outcomes may depend on the resources available in any birth setting (eg, home, birth center, community hospital, tertiary care hospital)[30] and the proximity to those resources should a transfer of care to hospital-based personnel and equipment become necessary.[7,29]

When meeting with a woman who is exploring the option of a planned home birth, the midwife reviews the midwife's responsibilities and the woman's role in preparing for a birth at home.[31] Responsibilities of the midwife, which are similar in all birth settings, include the following:

- Supporting normal physiologic processes of pregnancy, birth, initial postpartum transition, mother-newborn bonding, and initiation of breastfeeding;
- Supporting a low-intervention model of care;
- Maintaining knowledge of current research and evidence about risk assessment for birth site selection;
- Providing accurate, evidence-based information to support women in making informed decisions about their care options and sites for birth;
- Ongoing monitoring for indications of potential or emergent maternal and/or fetal/neonatal complications;
- Providing necessary equipment and medications[32];
- Offering evidence-based interventions when indicated to maintain the health of the woman or newborn;
- Referring or transferring to in-hospital care when indicated[7,29];
- Ensuring that a minimum of 2 health care professionals, who have current Neonatal Resuscitation Program (NRP) training and cardiopulmonary resuscitation (CPR) certification, are present at birth and have the necessary knowledge and skills to independently make assessments and implement needed interventions as indicated;
- Transmitting readily available, legible, pertinent maternal and newborn care information from home to hospital when a transfer is necessary[7];
- Maintaining current certification by the American Midwifery Certification Board (AMCB) and state licensure;
- Participating in data collection, benchmarking, and peer review;

- Practicing according to the *ACNM Standards for the Practice of Midwifery*[27]; and
- Adhering to the *Best Practice Guidelines: Transfer from Planned Home to Hospital* issued by the Home Birth Summit.[7]

The woman planning a home birth participates as a partner in her care. Her responsibilities include the following:

- Planning for a normal, healthy, physiologic pregnancy, birth, and initial postpartum transition;
- Arranging a network of support persons to provide emotional, social, and culturally-appropriate support throughout the pregnancy, labor, birth, and postpartum;
- Acknowledging her responsibility for herself and her newborn related to her informed choice of birth site;
- Understanding and agreeing to the scope of care defined within the midwife's clinical practice guidelines for a planned birth at home;
- Preparing all family members or support persons who will be in attendance during the labor, birth, and immediate postpartum period;
- Preparing the birthing environment, including obtaining necessary supplies;
- Ensuring access to the home for the birth team with consideration for parking, weather, neighborhood, and safety; and
- Committing to open, honest, and clear communication with the midwife, including ongoing shared decision making as the events of pregnancy, labor, and birth unfold.

During pregnancy, preexisting conditions or changes in the woman's health status may require consultation, collaboration, or referral with other health care professionals to determine the potential for a spontaneous vaginal birth and a healthy newborn, in order to identify the optimal site for birth.[26] Similarly, during labor or after the birth, changes in the health status of the woman, fetus, or newborn may require transfer of care to a hospital to access resources that may optimize health outcomes.[7,29,30,32] The midwife's clinical practice guidelines outline the process by which consultation, collaboration, and referral occur.[26,27,32] Based on a review of the available scientific evidence, considerations for assessing optimal place of birth from ACNM are provided in Table 1 and Table 2. The needs of an individual woman, resources and limitations of a particular setting, or type of practice may appropriately lead to variations in clinical care.

ELEMENTS TO CONSIDER IN PLANNING A HOME BIRTH

If a woman has a condition that increases the potential for an adverse outcome, but the available evidence is conflicting, the midwife and woman will refer to the midwife's clinical practice guidelines and use a process of shared decision making to determine the optimal plan of care.[28,34] Factors to be considered include but are not limited to the woman's complete obstetric and health history, and her current clinical condition; resources for hospital transfer; availability of consultation and/or referral; the midwife's scope of practice, experience, and skill; and access to other sites for birth.[27]

For some conditions, conflicting evidence makes the evaluation of the harms, benefits, safety, and risks associated with

Table 1. Conditions Indicating Increased Risk Suggesting Planned Birth in a Hospital Setting[a,b]

Prior pregnancy conditions
Previous stillbirth or neonatal death related to intrapartum event
Primary postpartum hemorrhage requiring additional procedures[c]
Prior cesarean birth
Shoulder dystocia with resulting injury
Current pregnancy conditions
Active preterm labor (before 37 0/7 weeks' gestation) or preterm, prelabor rupture of membranes
Essential or gestational hypertension[d]
Evidence of congenital fetal anomalies requiring immediate assessment and/or management by a neonatal specialist
Fetal growth restriction <5th percentile
Insulin dependent diabetes or gestational diabetes requiring pharmacologic management
Malpresentation: breech, transverse lie
Need for pharmacologic induction of labor
Postterm pregnancy more than 41 6/7 weeks' gestation
Multiple gestation
Oligohydramnios with additional complicating factors
Polyhydramnios
Placenta previa in the third trimester
Placental abruption
Preeclampsia[e]
Rh isoimmunization
Medical conditions
Evidence of active infection with hepatitis, HIV, genital herpes, syphilis, or tuberculosis
Psychiatric conditions that may affect intrapartum care management or maternal or neonatal transition following birth
Substantial medical conditions that have required acute medical supervision during the pregnancy and that could impact the birth such as cardiac disease, epilepsy, thromboembolic disease, hemoglobinopathy
Substance abuse/dependence

[a]This list is not exhaustive.
[b]Other obstetric or medical conditions may occur during pregnancy that warrant consultation, collaboration, or referral to determine the optimal site for the birth. Risk assessment for an individual woman may vary based on her prior medical, surgical, and obstetric history as well as resources available for hospital access within her community. Individual midwifery practice guidelines and/or client and/or midwife discretion will affect informed, shared decision making about the selection of site of birth, and this process will be documented.
[c]Such as Bakri-balloon, dilation and curettage, transfusion, and manual removal of placenta.
[d]Diagnosis of gestational hypertension is made following 2 blood pressure recordings 4 hours apart of >140/90 mmHg after 20 weeks' gestation in a woman who was previously normotensive.[33]
[e]Diagnosis of preeclampsia is made following 2 blood pressure recordings 4 hours apart of >140/90 mmHg after 20 weeks' gestation in a woman who was previously normotensive and has proteinuria. Dipstick reading of 1+ can be used if other techniques for detecting proteinuria are not available. Diagnosis can be made in minutes if blood pressure is ≥160/110 mmHg. Hypertension and thrombocytopenia, renal insufficiency, impaired liver function, pulmonary edema, and/or cerebral or visual symptoms may be used for the diagnosis in the absence of proteinuria.[33]

Table 2. Intrapartum, Postpartum, and Newborn Conditions that are Indications for Transfer from Home to a Hospital[a]

Intrapartum indications[b]
Malpresentation: breech, transverse lie identified during labor
Development of signs or symptoms of gestational hypertension[c] or preeclampsia[d]
Evidence of chorioamnionitis[e]
Evidence of fetal intolerance of labor or persistent Category II fetal heart tones[f] that are unresponsive to intrauterine resuscitation when birth is not imminent or in the presence of meconium
Need for pharmacologic augmentation of labor
Signs of placental abruption or unexplained increased vaginal bleeding
Postpartum indications
Management of lacerations beyond the expertise of the attending midwife
Postpartum hemorrhage unresponsive to initial treatments
Retained placenta
Unexplained vaginal bleeding
Newborn indications
Unstable health status

[a]Other obstetric or medical conditions may occur during pregnancy that warrant consultation, collaboration, or referral to determine the optimal site for the birth. Risk assessment for an individual woman may vary based on her prior medical, surgical, and obstetric history as well as resources available for hospital access within her community. Individual midwifery practice guidelines and/or client and/or midwife discretion will affect informed, shared decision making about the selection of site of birth, and this process will be documented.
[b]When birth is imminent, careful consideration of the potential effect of transport on best practice management must be a priority consideration.
[c]Diagnosis of gestational hypertension is made following 2 blood pressure recordings 4 hours apart of >140/90 mmHg after 20 weeks' gestation in a woman who was previously normotensive.[33]
[d]Diagnosis of preeclampsia is made following 2 blood pressure recordings 4 hours apart of >140/90 mmHg after 20 weeks' gestation in a woman who was previously normotensive and has proteinuria. Dipstick reading of 1+ can be used if other techniques for detecting proteinuria are not available. Diagnosis can be made in minutes if blood pressure is ≥160/110 mm Hg. Hypertension and thrombocytopenia, renal insufficiency, impaired liver function, pulmonary edema, and/or cerebral or visual symptoms may be used for the diagnosis in the absence of proteinuria.[33]
[e]Chorioamnionitis is defined clinically as maternal fever of > 38°C or >100.4°F with maternal tachycardia (>100 bpm) and/or fetal tachycardia (>160 bpm).
[f]Guidelines for intermittent auscultation are detailed in: American College of Nurse-Midwives. Clinical bulletin no. 13. Intermittent auscultation for intrapartum fetal heart rate surveillance. *J Midwifery Womens Health*. 2015;60(5):626-632.

home birth challenging. For example, lack of access to planned vaginal birth after cesarean (VBAC) in hospitals has been a leading reason why some women who have had a cesarean birth pursue home births.[35] The primary concern for women with a prior cesarean birth is the risk of uterine rupture.[36] It has been argued that labor management in a woman's home does not include care practices that increase the risk of uterine rupture, such as induction or augmentation of labor.[37,38] Practices commonly used at home births, such as freedom of movement and continuous labor support, are independently associated with increased success for vaginal birth in general and may also contribute to the increased success of VBAC documented in home birth studies.[39–41]

In the process of informed consent and shared decision making regarding place of birth, risk stratification in response to a woman's individual risk factors is important.[39,42] The aggregate incidence of uterine rupture after one prior cesarean birth is 4 to 8 per 1000 for women at term who enter labor spontaneously.[36,43] Of the women who have a uterine rupture, approximately 2 per 100 will result in a perinatal death.[36] This means that approximately 2 perinatal deaths will occur per 10,000 women who undergo labor after a prior cesarean at term.[36] The uterine rupture rate for women with a prior cesarean who give birth at home is similar to that of women who give birth in the hospital,[39,44] yet the neonatal morbidity and mortality is higher for women who give birth at home.[25,39] In addition, the risk of neonatal morbidity or mortality for a woman who had a previous cesarean varies based on whether she had a subsequent vaginal birth after the cesarean or if she had ever had a vaginal birth.[39] Work needs to be done to make care for women who desire a planned VBAC accessible and supported in hospital settings, including access to midwives for this care.[45] In addition, implementation of evidence-based labor care practices in hospital settings will further support women who undergo a trial of labor after cesarean (TOLAC) to have a successful VBAC.[46]

TRANSFER FROM THE HOME TO A HOSPITAL SETTING

Midwifery management during home birth includes planning for unexpected contingencies in order to provide timely interventions and seamless access to consultation, interprofessional collaboration, and respectful hospital-based health care providers when needed.[7,29] In the United States, approximately 9 to 13 of every 100 women planning a home birth will transfer to a hospital setting after the onset of labor at home.[11–13,25] The majority of maternal and newborn transfers are not urgent.[29] The most common reasons for transfer among nulliparous women are the need or request for pharmacologic pain management and failure to progress or labor dystocia.[25,29] ACNM endorses the *Best Practice Guidelines: Transfer from Planned Home Birth to Hospital*.[7] Variations in guidelines may occur based on local standards, regulations, available transportation, access to integrated systems of care, and/or the skill and experience of the midwife, hospital-based consultants, and other health care professionals as needed. Integration of care across birth sites, access to interprofessional collaboration, and respectful care are key components for the provision of high-quality services.[7]

In the rare circumstance of a serious condition that develops quickly, the midwife stabilizes the woman and/or newborn while hospital transport is arranged. During transport, the midwife works within local standards for emergency medical services and provides skilled urgent care. On arrival at the hospital, the midwife reports the condition of the woman and/or newborn to the appropriate hospital staff who may assume care. When possible, the midwife should accompany the woman during transport to the hospital and bring the woman's and/or the newborn's medical records. If the midwife does not accompany the woman during transfer, this may be considered client abandonment.[47] When emergency medical service standards do not permit the midwife to accompany the woman directly, other transportation to the hospital should be arranged for the midwife to facilitate the transfer of care and

provide access to the woman's and/or the newborn's medical records.[7]

ETHICAL PRACTICE

The midwife's ongoing relationship with the woman is informed by the ethical principles of autonomy, beneficence, nonmaleficence, and justice. Midwives are ethically responsible to provide information to a woman and her family when making decisions about the choice of birth setting. Home, birth center, and hospital settings have different resources that can benefit a woman or her newborn.[2,30] It is the midwife's ethical responsibility to provide information about the services the midwife can provide to the woman and her fetus or newborn as the clinical condition evolves. The midwife acknowledges the woman's autonomy in making decisions about her health care that may or may not align with the midwife's recommendations. If a woman makes a decision that calls for care that is outside of the midwife's scope of practice or clinical guidelines, the midwife and woman must discuss what continuing role the midwife will or will not play in her care.

Optimally, the need to change the plan of care or site of birth is identified early in a woman's pregnancy or early in labor so that time is available for exchanging and processing information. This provides greater opportunity to identify the best options to meet the needs of the woman and her fetus/newborn, including other providers or locations for care as needed. Clear communication and a strong relationship between the woman and midwife reduce the likelihood that the woman will decline the midwife's recommendation for consultation, referral, or transfer to another provider or a hospital.[28] If a woman declines the midwife's recommendation for transfer of care in urgent situations, the midwife has an ethical obligation to maintain safe standards of care, potentially including continued provision of care until other resources, providers, or transport can be agreed upon.[47]

Peer Review in Home Birth Practice

Standard VII of the ACNM *Standards for the Practice of Midwifery*[27] stipulates that all midwives participate in peer review. In the United States, laws and regulations regarding protection of the peer review process for home birth providers vary by state. Many states do not protect peer review for practitioners who are not part of an organized health system. Midwives in those states should refer to the ACNM *Home Birth Practice Handbook*,[32] the ACNM Affiliate Peer Review Program sample,[48] and the ACNM *Administrative Manual for Midwifery Practices*[49] to consider alternative options for quality management and peer review approaches. ACNM continues to advocate for mechanisms that ensure protection of peer review for providers who care for women in all birth sites in all states.

CONCLUSION

Home birth provides an unequaled opportunity to investigate physiologic birth, examine the importance of criteria currently used to select birth settings, establish an evidence base for the essential components of midwifery care, and document long-term consequences of birth experiences and birth outcomes in relation to place of birth.[50–53] An annotated bibliography of home birth literature is updated regularly and provides reviews of the available evidence.[53] International and US research results support the conclusion that planned home birth with an educated, skilled attendant can be a safe, satisfying, cost-effective care option for healthy, low-risk women who want to give birth at home.

DISCLAIMER

This document is specific to considerations regarding home birth. This Clinical Bulletin is not intended to dictate an exclusive course of management or to substitute for individual professional judgment. It presents recognized methods and techniques of clinical practice that midwives may consider incorporating into their practices. The needs of an individual woman or the resources and limitations of a particular setting or type of practice may appropriately lead to variations in clinical care.

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Planned Home Birth

ABSTRACT: Although the Committee on Obstetric Practice believes that hospitals and birthing centers are the safest setting for birth, it respects the right of a woman to make a medically informed decision about delivery. Women inquiring about planned home birth should be informed of its risks and benefits based on recent evidence. Specifically, they should be informed that although the absolute risk may be low, planned home birth is associated with a twofold to threefold increased risk of neonatal death when compared with planned hospital birth. Importantly, women should be informed that the appropriate selection of candidates for home birth; the availability of a certified nurse–midwife, certified midwife, or physician practicing within an integrated and regulated health system; ready access to consultation; and assurance of safe and timely transport to nearby hospitals are critical to reducing perinatal mortality rates and achieving favorable home birth outcomes.

In the United States, approximately 25,000 births (0.6%) per year occur in the home (1). Approximately one fourth of these births are unplanned or unattended (2). Among women who originally intend to give birth in a hospital or those who make no provisions for professional care during childbirth, subsequent unplanned home births are associated with high rates of perinatal and neonatal mortality (3). The relative risk versus benefit of a planned home birth, however, remains the subject of current debate.

High-quality evidence to inform this debate is limited. To date there have been no adequate randomized clinical trials of planned home birth (4). In developed countries where home birth is more common than in the United States, attempts to conduct such studies have been unsuccessful largely because pregnant women have been reluctant to participate in clinical trials involving randomization to home or hospital birth (5, 6). Consequently, most information on planned home births comes from observational studies. Observational studies of planned home birth often are limited by methodological problems, including small sample sizes (7–10); lack of an appropriate control group (11–14); reliance on birth certificate data with inherent ascertainment problems (2, 15); ascertainment relying on voluntary submission of data or self-reporting (7, 12, 14, 16); a limited ability to accurately distinguish between planned and unplanned home births (15, 17); variation in the skill, training, and certification of the birth attendant (14, 15, 18); and an inability to account for and accurately attribute adverse outcomes associated with antepartum or intrapartum transfers (8, 15, 19). Although some modern observational studies overcome many of these limitations, the reports describe planned home births within tightly regulated and integrated provincial health care systems, which may not be generalizable to current practice in the United States (7, 8, 10, 11, 15, 16, 20–23). Furthermore, no studies are of sufficient size to compare maternal mortality between planned home and hospital birth and few, when considered alone, are large enough to compare perinatal and neonatal mortality rates. Despite these limitations, when viewed collectively, recent reports have clarified a number of important issues regarding the maternal and newborn outcomes of planned home birth when compared with planned hospital births.

Wax and colleagues recently conducted a meta-analysis of observational studies comparing the newborn and maternal outcomes for planned home birth with those of planned hospital birth (24) (Table 1). Although perinatal mortality rates were similar among planned home births and planned hospital births, planned home births were associated with a twofold-increased risk of neonatal death. When limited to only nonanomalous newborns, the increased risk of neonatal death was even

Table 1. Maternal and Neonatal Outcomes in Planned Home Birth Versus Planned Hospital Births

	Planned Home Birth	Planned Hospital Birth	Odds Ratio	95% Confidence Interval
Neonatal death—all newborns	2.0/1,000	0.9/1,000	2.0	1.2–3.3
Neonatal death—nonanomalous	1.5/1,000	0.4/1,000	2.9	1.3–6.2
Episiotomy	7.0%	10.4%	0.26	0.24–0.28
Operative vaginal delivery	3.5%	10.2%	0.26	0.24–0.28
Cesarean delivery	5.0%	9.3%	0.42	0.39–0.45
Third- or fourth-degree laceration	1.2%	2.5%	0.38	0.33–0.45
Maternal infection	0.7%	2.6%	0.27	0.19–0.39

Data from Wax JR, Lucas FL, Lamont M, Pinette MG, Cartin A, Blackstone DO. Maternal and newborn outcomes in planned home birth versus planned hospital births—a meta-analysis. Am J Obstet Gynecol 2010;203:243.e1–8.

higher—almost threefold higher in planned home births. These results did not change when the investigators performed sensitivity analyses excluding older studies or poorer quality studies. No maternal deaths were reported among 10,977 planned home births (95% confidence interval, 0–27.3/100,000 live births). When compared with planned hospital births, planned home births are associated with fewer maternal interventions, including epidural analgesia, electronic fetal heart rate monitoring, episiotomy, operative vaginal delivery, and cesarean delivery. Planned home births are associated with fewer third-degree lacerations or fourth-degree lacerations, less maternal infection and similar rates of postpartum hemorrhage, perineal laceration, vaginal laceration, and umbilical cord prolapse. Rates of preterm birth before 37 weeks of gestation and low birth weight were lower for planned home birth, likely because of selection bias. The reported risk of needing an intrapartum transport to a hospital is 25–37% for nulliparous women and 4–9% for multiparous women (25). Most of these intrapartum transports are for lack of progress in labor, nonreassuring fetal status, need for pain relief, hypertension, bleeding, and fetal malposition.

It is important to note that reports suggesting that planned home births are safe involved only healthy pregnant women. Recent cohort studies reporting lower perinatal mortality rates with planned home birth describe the use of strict selection criteria for appropriate candidates (21, 22). These criteria include the absence of any preexisting maternal disease, the absence of significant disease arising during the pregnancy, a singleton fetus, a cephalic presentation, gestational age greater than 36 weeks and less than 41 completed weeks of pregnancy, labor that is spontaneous or induced as an outpatient, and that the patient has not been transferred from another referring hospital. Failure to adhere to such criteria (because of postterm pregnancy, twins, or breech presentation) is clearly associated with a higher risk of perinatal death (23, 26). Although patients with one prior cesarean delivery were considered candidates for home birth in both Canadian studies, neither report provided details of the outcomes specific to patients attempting vaginal birth after cesarean delivery at home. Because of the risks associated with a trial of labor after cesarean delivery and that uterine rupture and other complications may be unpredictable, the American College of Obstetricians and Gynecologists recommends that a trial of labor after cesarean delivery be undertaken in facilities with staff immediately available to provide emergency care (27). The American College of Obstetricians and Gynecologists' Committee on Obstetric Practice considers a prior cesarean delivery to be an absolute contraindication to planned home birth.

Another factor influencing the safety of planned home birth is the availability of safe and timely intrapartum transfer of the laboring patient. The relatively low perinatal and newborn mortality rates reported for planned home births from Ontario, British Columbia, and the Netherlands were from highly integrated health care systems with established criteria and provisions for emergency intrapartum transport (12–14). Cohort studies conducted in areas without such integrated systems and those where the receiving hospital may be remote with the potential for delayed or prolonged intrapartum transport generally report higher rates of intrapartum and neonatal death (6, 9, 11, 19). The Committee on Obstetric Practice believes that the availability of timely transfer and an existing arrangement with a hospital for such transfers is a requirement for consideration of a home birth.

A characteristic common to those cohort studies reporting lower rates of perinatal mortality in North America is the provision of care by well-educated, highly trained, certified midwives who are well integrated into the health care system (21, 22). In the United States, certified nurse–midwives and certified midwives are certified by the American Midwifery Certification Board. This certification depends on the completion of an accredited educational program and meeting standards set by the American Midwifery Certification Board. According to the National Center for Health Statistics, more than 90% of attended home births in the United States are attended by midwives (28). However, only approximately 25% of these are attended by certified nurse–midwives or certified midwives. The remaining 75% are attended by other midwives; the category used by the National Center for Health Statistics that includes certified professional midwives, lay midwives, and others. The recognition and regulation of certified professional midwives and lay midwives varies tremendously from state to state. At this time, for quality and safety reasons, the American College of Obstetricians and Gynecologists does not support the provision of care by lay midwives or other midwives who are not certified by the American Midwifery Certification Board.

Summary

Although the Committee on Obstetric Practice believes that hospitals and birthing centers are the safest setting for birth, it respects the right of a woman to make a medically informed decision about delivery. Women inquiring about planned home birth should be informed of its risks and benefits based on recent evidence. Specifically, they should be informed that although the absolute risk may be low, planned home birth is associated with a twofold to threefold increased risk of neonatal death when compared with planned hospital birth. Importantly, women should be informed that the appropriate selection of candidates for home birth; the availability of a certified nurse–midwife, certified midwife, or physician practicing within an integrated and regulated health system; ready access to consultation; and assurance of safe and timely transport to nearby hospitals are critical to reducing perinatal mortality rates and achieving favorable home birth outcomes.

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