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Inside This Issue

CPM2000 Study Published in British Medical Journal

The long awaited publication of the CPM 2000 project was welcomed with cheers and accolades by CPMs and midwifery advocates when published in the June 18, 2005, edition of the prestigious British Medical Journal. The study found that planned home births attended by CPMs are as safe as low risk births in the hospital, and are accomplished with much less medical intervention.

All practicing CPMs were required to submit prospective logs and birth data for all births attended in the year 2000. More than 400 CPMs submitted data on over 5,000 births to researchers Ken Johnson and Betty Anne Daviss, authors of the study.

Of the 5418 women intending to birth at home at the initiation of labor, 655 (12.1%) were transferred to hospital intrapartum or postpartum. Five out of every six women transferred (83.4%) were transferred before delivery, half (51.2%) for failure to progress, pain relief, or exhaustion. After delivery, 1.3% of mothers and 0.7% of newborns were transferred to hospital, most commonly for maternal hemorrhage (0.6% of total births), retained placenta (0.5%), or respiratory problems in the newborn (0.6%). The midwife considered the transfer urgent in 3.4% of intended home births. Transfers were four times as common among primiparous women (25.1%) as among multiparous women (6.3%), but urgent transfers were only twice as common among primparous women (5.1%) as among multiparous women (2.6%). The caesarean rate for intended home births was 3.7% (vs 19% for planned hospital births in 2000). The cesarean rate was 8.3% among primiparous women and 1.6% among multiparous women. Excluding three fatal birth defects and 2 deaths of breech babies (not considered low risk), there were three intrapartum fetal deaths and six deaths postpartum, which yields a rate of 1.7 per 1,000. This is a rate consistent with most North American studies of planned births out-of-hospital and low risk hospital births. There were no maternal deaths in the planned home birth group.

This study validates what most midwives have known from personal experience: home birth with a trained midwife using appropriate screening criteria is as safe as hospital birth for low risk women. The home births use much less intervention and are much less costly, and client satisfaction is rated extremely high. This evidence published by a highly respected medical journal should be of great value in legalizing midwifery in unlicensed states, and in promoting reasonable regulation in licensed states.

Midwives across the nation owe a debt of gratitude to Ken Johnson and Betty Anne Daviss for their tireless work in collecting midwifery statistics since 1993, and especially for their persistence in getting the CPM 2000 study published in this prestigious journal. NARM encourages all CPMs to continue to submit their statistics to the MANA Division of Research so that Johnson and Daviss, and others in the future, may continue to analyze and publish our data.

The complete study and additional information from Ken and Betty-Anne are elsewhere in this newsletter. The study is also on the web site at www.narm.org.

CPM News

CPM News is a newsletter of the North American Registry of Midwives (NARM) published twice a year, Winter and Summer. We welcome submissions of questions, answers, news tips, tidbits, birth art, photographs, letters to the editor, etc.

Deadlines for submissions are December 1 and June 1. Send all newsletter material to: Joanne Gottschall, 200 N. Jasper Avenue, Margate, NJ 08402 or *cpmnews@narm.org*

The views and opinions expressed by individual writers do not necessarily represent the views and opinions of NARM.

Contact Information

NARM General Information
(or to order How to Become a CPM)
888-842-4784
Fax: 404-521-4052

Applications & Recertification:
NARM Applications Department:
P.O. Box 420
Summertown, TN 38483

NARM Board
Debbie Pulley, CPM
5257 Rosestone Drive
Lilburn, GA 30047
888-842-4784
info@narm.org

Test Department information:
Ida Darragh, CPM
PO Box 7703
Little Rock, AR 72217-7703
888-353-7089
testing@narm.org

CPM News Editor:
Abby J. Kinne, CPM
58 South Center Street
West Jefferson, OH 43162
614-879-9835
editor@narm.org

Outcomes of planned home births with certified professional midwives: large prospective study in North America

Kenneth C Johnson, senior epidemiologist[1], Betty-Anne Daviss, project manager[2]

[1] Surveillance and Risk Assessment Division, Centre for Chronic Disease Prevention and Control, Public Health Agency of Canada, PL 6702A, Ottawa, ON, Canada K1A OK9, [2] Safe Motherhood/ Newborn Initiative, International Federation of Gynecology and Obstetrics, Ottawa, Canada

Abstract

Objective To evaluate the safety of home births in North America involving direct entry midwives, in jurisdictions where the practice is not well integrated into the healthcare system.

Design Prospective cohort study.

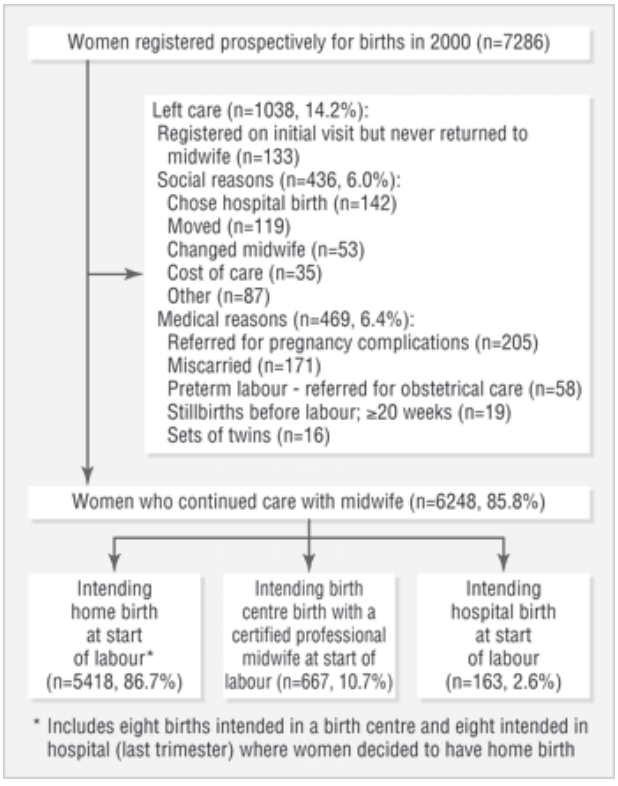
Setting All home births involving certified professional midwives across the United States (98% of cohort) and Canada, 2000.

Participants All 5418 women expecting to deliver in 2000 supported by midwives with a common certification and who planned to deliver at home when labour began.

Main outcome measures Intrapartum and neonatal mortality, perinatal transfer to hospital care, medical intervention during labour, breast feeding, and maternal satisfaction.

Results 655 (12.1%) women who intended to deliver at home when labour began were transferred to hospital. Medical intervention rates included epidural (4.7%), episiotomy (2.1%), forceps (1.0%), vacuum extraction (0.6%), and caesarean section (3.7%); these rates were substantially lower than for low risk US women having hospital births. The intrapartum and neonatal mortality among women considered at low risk at start of labour, excluding deaths concerning life threatening congenital anomalies, was 1.7 deaths per 1000 planned home births, similar to risks in other studies of low risk home

Flow chart for mothers using certified professional midwives, 2000



and hospital births in North America. No mothers died. No discrepancies were found for perinatal outcomes independently validated.

Conclusions Planned home birth for low risk women in North America using certified professional midwives was associated with lower rates of medical intervention but similar intrapartum and neonatal mortality to that of low risk hospital births in the United States.

Introduction

Despite a wealth of evidence supporting planned home birth as a safe option for women with low risk pregnancies,[1-4] the setting remains controversial in most high resource countries. Views are particularly polarised in the United States, with interventions and costs of hospital births escalating and midwives involved with home births being denied the ability to be lead professionals in hospital, with admitting and discharge privileges.[5] Although several Canadian medical societies[6 7] and the American Public Health Association[8] have adopted policies promoting or acknowledging the viability of home births, the American College of Obstetricians and Gynecologists continues to oppose it.[9] Studies on home birth have been criticised if they have been too small to accurately assess perinatal mortality, unable to distinguish planned from unplanned home births accurately, or retrospective with the potential of bias from selective reporting. To tackle these issues we carried out a large prospective study of planned home births. The North American Registry of Midwives provided a rare opportunity to study the practice of a defined population of direct entry midwives involved with home birth across the continent. We compared perinatal outcomes with those of studies of low risk hospital births in the United States.

Table 1 Characteristics of 5418 women planning home births with certified professional midwives in the United States, 2000, compared with all singleton, vertex births at =37 weeks' gestation in the United States, 2000. Values are percentages unless stated otherwise

Characteristics	All No (%) of women planning home birth* (n=5418)	singleton, vertex births at ≥ 37 weeks gestation in USA 2000† (n=3 360 86)	Characteristics	All No (%) of women planning home birth* (n=5418)	singleton, vertex births at ≥ 37 weeks gestation in USA 2000† (n=3 360 86)
Mother's age:			Location:		
<=19	130 (2.4)	11.6	City	1891 (34.9)	NA
20-24	930 (17.2)	25.3	Small town	1506 (27.9)	NA
25-29	1554 (28.7)	27.1	Rural	1734 (32.0)	NA
30-34	1423 (26.3)	22.9	Time (trimester) prenatal care began:		
35-39	969 (17.9)	10.9	1st	2483 (45.8)	81.8
≥40	327 (6.0)	2.1	2nd	2075 (38.2)	12.6
Parity:			3rd	803 (14.8)	2.7
0	1690 (31.2)	40.2	Smoked during pregnancy:		
1	1295 (23.9)	32.8	No	5099 (94.1)	76.2
≥2	2415 (44.6)	27	Yes:	164 (3.0)	8.9
Mother's formal education:			1-9 cigarettes/day	86 (1.6)	6.4
High school or less	2152 (39.2)	52.4	≥10 cigarettes/day	78 (1.4)	2.5
Any college	1272 (23.2)	21.6	Unknown or not stated	155 (2.9)	14.9
College graduate	1169 (21.3)	22.7	Alcohol intake (drinks/week) during pregnancy:		
Postgraduate	692 (12.7)	6.0	None	5162 (95.3)	85.7
Partner status at time of birth:			Yes:	136 (2.5)	0.8
Has partner	5169 (95.4)	NA	<2	113 (2.1)	NA
No partner	164 (3.1)	NA	≥2	23 (0.4)	NA
Ethnicity:			Unknown or not stated	120 (2.2)	13.6
White	4846 (89.4)	58.2	Gestational age of infants (weeks):		
Hispanic	216 (4.0)	20.2	<37	77 (1.4)	—
African-American	70 (1.3)	14.1	37-41	4834 (89.2)	91.7
Other	140 (2.6)	5.8	≥42	361 (6.7)	8.3
Other special groups:			Birthweight (g):		
Amish	467 (8.7)	NA	<2501	60 (1.1)	2.4
Mennonite	194 (3.6)	NA	2501-3999	3787 (69.8)	86.5
Socioeconomic status‡:			≥4000	1319 (24.3)	11.1
Low	1256 (23.2)	19			
Middle	3244 (59.9)	44			
Upper	664 (12.3)	21			

NA=Not available.
*Percentages do not always add up to 100 owing to missing values.
†Based on data from birth certificates for all 3 360 868 such births. Data reported by National Center for Health Statistics.10

Methods

The competency based process of the North American Registry of Midwives provides a certified professional midwife credential, primarily for direct entry midwives who attend home births, including those educated through apprenticeship. Our target population was all women who engaged the services of a certified professional midwife in Canada or the United States as their primary caregiver for a birth with an expected date of delivery in 2000. In autumn 1999, the North American Registry of Midwives made participation in the study mandatory for recertification and provided an electronic database of the 534 certified professional midwives whose credentials were current. We contacted 502 of the midwives (94.0%); 32 (6.0%) could not be located through email, telephone, post, or local associations, 82 (15.4%) had stopped independent practice, and 11 (2.1%) had retired. We sent a binder with forms and instructions for the study to the 409 practising midwives who agreed to participate.

Data collection

For each new client, the midwife listed identifying information on the registration log form at the start of care; obtained informed consent, including permission for the client to be contacted for verification of information after care was complete; and filled out a detailed data form on the course of care. Every three months the midwife was required to send a copy of the updated registration log, consent forms for new clients, and completed data forms for women at least six weeks post partum. To confirm that forms had been received for each registered client, we linked the entered data to the registration database. We reviewed the clinical details and circumstances of stillbirths and intrapartum and neonatal deaths and telephoned the midwives for confirmation and clarification. To verify this information we obtained reports from coroners, autopsies, or hospitals on all but four deaths. For these four, we obtained peer reviews.

Validation and satisfaction

We contacted a stratified, random 10% sample, of over 500 mothers, including at least one client for every midwife in the study. The mothers were asked about the date and place of birth, any required hospital care, any problems with care, the health status of themselves and their baby, and 11 questions on level of satisfaction with their midwifery care.

Data analysis

Our analysis focused on personal details of the clients, reasons for leaving care prenatally, the rates and reasons for transfer to hospital during labour and post partum, medical interventions, health and admission to hospital of the newborn or mother from birth up to six weeks post partum, intrapartum and neonatal mortality, and breast feeding. We compared medical intervention rates for the planned home births with data from birth certificates for all 3 360 868 singleton, vertex births at 37 weeks or more gestation in the United States in 2000, as reported by the National Center for Health Statistics,[10] which acted as a proxy for a comparable low risk group. We also compared medical intervention rates with the listening to mothers survey,[5] a national survey weighted to be representative of the US birthing population aged

Table 2 Transfers to hospital among 5418 women intending home births with a certified professional midwife in the United States, 2000, according to timing, urgency, and reasons

Variable	No (%) needing urgent transfer	No (%) needing transfer
Timing of transfers		
Stage before delivery:		
1st*	62 (1.1)	380 (7.0)
2nd*	51 (0.9)	134 (2.5)
Not specified	4 (0.1)	32 (0.6)
After delivery:		
Maternal transfers	43 (0.8)	72 (1.3)
Newborn transfers	25 (0.5)	37 (0.7)
All	185 (3.4)	655 (12.1)
Reasons for transfer†		
During labour:		
Failure to progress in 1st stage	4 (0.1)	227 (4.2)
Failure to progress in 2nd stage	12 (0.2)	80 (1.5)
Pain relief	4 (0.1)	119 (2.2)
Maternal exhaustion	1 (<0.1)	112 (2.1)
Malpresentation	20 (0.4)	94 (1.7)
Thick meconium	13 (0.2)	49 (0.9)
Sustained fetal distress	31 (0.6)	49 (0.9)
Baby's condition	5 (0.1)	21 (0.4)
Prolonged or premature rupture of membranes	0	19 (0.4)
Placenta abruptio or placenta previa	5 (0.1)	10 (0.2)
Haemorrhage	5 (0.1)	7 (0.1)
Pre-eclampsia or hypertension	5 (0.1)	13 (0.2)
Cord prolapse	3 (0.1)	6 (0.1)
Breech	1 (<0.1)	3 (0.1)
Other	9 (0.2)	17 (0.3)
Post partum:		
Newborn transfers:		
Respiratory problems	14 (0.3)	33 (0.6)
Evaluation of anomalies	2 (<0.1)	8 (0.1)
Other reasons	9 (0.2)	17 (0.3)
Maternal transfers:		
Haemorrhage	21 (0.4)	34 (0.6)
Retained placenta	14 (0.3)	28 (0.5)
Suturing or repair of tears	1 (<0.1)	14 (0.2)
Maternal exhaustion	2 (<0.1)	4 (0.1)
Other reasons	5 (0.1)	8 (0.1)

*104 of these women were transferred to hospital after midwives' first assessment of labour (1.9% of labours), 38 of which were considered urgent.
†Totals for urgent transfers are based on primary reason for transport only, but column for all transfers adds up to more than number transported as both primary and secondary reason (if reported) for transport to hospital are presented.

18-44. Intrapartum and neonatal death rates were compared with those in other North American studies of at least 500 births that were either planned out of hospital or comparable studies of low risk hospital births.

Results

A total of 409 certified professional midwives from across the United States and two Canadian provinces registered 7623 women whose expected date of delivery was in 2000. Eighteen of the 409 midwives (4.4%) and their clients were excluded from the study because they failed to actively participate and had decided not to recertify or left practice. Sixty mothers (0.8%) declined participation. The figure provides an overview of why women left care before labour and their intended place of birth at the start of labour.

Characteristics of the mothers

We focused on the 5418 women who intended to deliver at home at the start of labour. Table 1 compares them with all women who gave birth to singleton, vertex babies of at least 37 weeks or more gestation in the United States in 2000 according to 13 personal and behavioural variables associated with perinatal risk. Women who started birth at home were on average older, of a lower socioeconomic status and higher educational achievement, and less likely to be African-American or Hispanic than women having full gestation, vertex, singleton hospital births in the United States in 2000.

Transfers to hospital

Of the 5418 women, 655 (12.1%) were transferred to hospital intrapartum or post partum. Table 2 describes the transfers according to timing, urgency, and reasons for transfer. Five out of every six women transferred (83.4%) were transferred before delivery, half (51.2%) for failure to progress, pain relief, or exhaustion. After delivery, 1.3% of mothers and 0.7% of newborns were transferred to hospital, most commonly for maternal haemorrhage (0.6% of total births), retained placenta (0.5%), or respiratory problems in the newborn (0.6%). The midwife considered the transfer urgent in 3.4% of intended home births. Transfers were four times as common among primiparous women (25.1%) as among multiparous women (6.3%), but urgent transfers were only twice as common among primparous women (5.1%) as among multiparous women (2.6%).

Medical interventions

Individual rates of medical intervention for home births were consistently less than half those in hospital, whether compared with a relatively low risk group (singleton, vertex, 37 weeks or more gestation) that will have a small percentage of higher risk births or the general population having hospital births (table 3). Compared with the relatively low risk hospital group, intended home births were associated with lower rates of electronic fetal monitoring (9.6% versus 84.3%), episiotomy (2.1% versus 33.0%), caesarean section (3.7% versus 19.0%), and vacuum extraction (0.6% versus 5.5%). The caesarean rate for intended home births was 8.3% among primiparous women and 1.6% among multiparous women.

Outcomes

No maternal deaths occurred. After we excluded four stillborns who died before labour but whose mothers still chose home birth, and three babies with fatal birth defects, five deaths were intrapartum and six occurred during the neonatal period (see box). This was a rate of 2.0 deaths per 1000 intended home births. The intrapartum and neonatal mortality was 1.7 deaths per 1000 low risk intended home births after planned breeches and twins (not considered low risk) were excluded. The results for intrapartum and neonatal mortality are consistent with most North American studies of intended

Table 3 Intervention rates for 5418 planned home births attended by certified professional midwives and hospital births in the United States

Intervention	No (%) of intended home births with certified professional midwives in US in 2000 (n=5418)	`Singleton, vertex births at >=37 weeks gestation in US 2000* (n=3 360 868)	Survey of singleton births in all risk categories in US 2000-1† (n=1583)(%)
Electronic fetal monitoring	520 (9.6)	84.3	93
Intravenous	454 (8.4)	NR	85
Artificial rupture of membranes	272 (5.0)	NR	67
Epidural	254 (4.7)	NR	63
Induction of labour‡	519 (9.6)	21.0	44
Stimulation of labour	498 (9.2)	18.9	53
Episiotomy	116 (2.1)	33.0	35
Forceps	57 (1.0)	2.2	3
Vacuum extraction	32 (0.6)	5.2	7
Caesarean section	200 (3.7)	19.0	24

NR=not reported on birth certificate.

*Based on data from birth certificates for all 3 360 868 such births in United States in 2000. Data reported by National Center for Health Statistics.10 This subset of birthing women would generally be low risk, but would include a small percentage of higher risk women who would likely require more medical intervention.

†Results from listening to mothers survey, October 2002. Percentages weighted to reflect US population of birthing women, aged 18-44.5 Includes about 20% of women not at low risk who may experience higher intervention rates.

‡For certified professional midwives 2000 study and listening to mothers survey, both attempted and successful inductions were reported; for US birth certificate data only successful inductions are reported.

births out of hospital[11-24] and low risk hospital births (table 4).[14 21 22 24-30]

Breech and multiple births at home are controversial among home birth practitioners. Among the 80 planned breeches at home there were two deaths and none among the 13 sets of twins. In the 694 births (12.8%) in which the baby was born under water, there was one intrapartum death (birth at 41 weeks, five days) and one fatal birth defect death.

Apgar scores were reported for 94.5% of babies; 1.3% had Apgar scores below 7 at five minutes. Immediate neonatal complications were reported for 226 newborns (4.2% of intended home births). Half the immediate neonatal complications concerned respiratory problems, and 130 babies (2.4%) were placed in the neonatal intensive care unit.

Health in first six weeks post partum

Health problems in the six weeks post partum were reported for 7% of newborns. Among the 5200 (96%) mothers who returned for the six week postnatal visit, 98.3% of babies and 98.4% of mothers reported good health, with no residual health problems. At six weeks post partum, 95.8% of these women were still breast feeding their babies, 89.7% exclusively.

Outcome validation and client satisfaction

Among the stratified, random 10% sample of women contacted directly by study staff to validate birth outcomes, no new transfers to hospital during or after the birth were reported and no

Table 4 Combined intrapartum and neonatal mortality in studies of planned out of hospital births or low risk hospital births in North America (at least 500 births)

Type of studies and references	Location, period	No of births and neotatal mortality	Combined intrapartum (per 1000)*
Low risk out of hospital births attended by midwives:			
Burnett et al11	North Carolina, 1974-6	934	3.0†
Mehl et al12	United States, 1977	1146	3.5
Schramm et al13	Missouri, 1978-84	1770	2.8
Janssen et al14	Washington State, 1981-90	6944	1.7†
Sullivan and Beeman15	Arizona, 1983	1243	2.4
Tyson16	Canada, Toronto, 1983-8	1001	2.0†
Hinds et al17	Kentucky, 1985	575	3.5†
Durand18	Farm, Tennessee, 1972-92	1707	2.3
Rooks et al19	84 birth centres across United States, 1985-7	11 814	0.6
Anderson et al20	90 home birth practices across United States, 1987-91	11 081	0.9
Pang et al21	Washington State, 1989-96	6133	2.0†
Schlenzka22	California, 1989-90	3385	2.4
Murphy et al23	United States, 1993-5	1350	2.5
Janssen et al24	Canada, British Columbia, 1998-9	862	2.3
Johnson and Daviss37	United States and Canada, 2000	5418	1.7
Low risk births attended by physicians or obstetricians in hospitals:			
Neutra et al25	One academic hospital in Boston (lowest risk women), 1969-75	12 055	0.5-1.1†
Amato26	One community hospital, 1974-5	4144	3.4†
Adams27	15 hospitals	10 521	1.7
Rooks et al28	National natality survey, 1980	2935	2.5†
Janssen et al14	Washington, 1981-90	23 596	1.7†
Leveno et al29	One academic hospital in Dallas, 1982-5	14 618	1.0
Eden et al30	Twelve hospitals Illinois, 1982-5	8135	1.9
Pang et al21	Washington State, 1989-96	10 593	0.7†
Schlenzka22	California 1989-90	806 402	1.9
Janssen et al24	Canada, British Columbia, 1998-9	733	1.4

Table is presented for general comparison only. Direct comparison of relative mortality between individual studies is ill advised, as many rates are unstable because of small numbers of deaths, study designs may differ (retrospective versus prospective, assessment and definition of low risk, etc.), the ability to capture and extract late neonatal mortality differs between studies, and significant differences may exist in populations studied with respect to factors such as socioeconomic status, distribution of parity, and risk screening criteria used. For example, see the study by Schlenzka. Although the crude mortality for low risk babies weighing over 2500 g intended at home was 2.4 per 1000 and intended in hospital was 1.9 per 1000, when standard methods were employed to adjust for differences in risk profiles of the two groups (indirect standardisation and logistic regression), both methods showed slightly lower risk for intended home births.

*Excludes lethal congenital anomalies.

†Neonatal mortality only, intrapartum mortality unreported.

new stillbirths or neonatal deaths were uncovered. Mothers' satisfaction with care was high for all 11 measures, with over 97% reporting that they were extremely or very satisfied. For a subsequent birth, 89.6% said they would choose the same midwife, 9.1% another certified professional midwife, and 1.7% another type of caregiver.

Discussion

Women who intended at the start of labour to have a home birth with a certified professional midwife had a low rate of intrapartum and neonatal mortality, similar to that in most studies of low risk hospital births in North America. A high degree of safety and maternal satisfaction were reported, and over 87% of mothers and neonates did not require transfer to hospital.

A randomised controlled trial would be the best way to tackle selection bias of mothers who plan a home birth, but a randomised controlled trial in North America is unfeasible given that even in Britain, where home birth has been an incorporated part of the healthcare system for some time, and where cooperation is more feasible, a pilot study failed.[31] Prospective cohort studies remain the most comprehensive instruments available.

Our results for intrapartum and neonatal mortality are consistent with most other North American studies of intended births out of hospital and studies of low risk hospital birth (table 4). A meta-analysis[2] and the latest research in Britain,[3 4 32] Switzerland,[33] and the Netherlands[34] have reinforced support of home birth. Researchers reported high overall perinatal mortality in a study of home birth in Australia,[35] qualifying that low risk home births in Australia had good outcomes but that high risk births gave rise to a high rate of avoidable death at home.[36] Two prospective studies in North America found positive outcomes for home birth,[23 24] but the studies were not of sufficient size to provide relatively stable perinatal death rates. None of this evidence, including ours, is consistent with a study in Washington State based on birth certificates.[21] That study reported an increased risk with home birth but lacked an explicit indication of planned place of birth, creating the potential inclusion of high risk unplanned, unattended home births.[28 37]

Our study has several strengths. Internationally it is one of the few, and

Categories of intrapartum and postpartum deaths (n=14) among 5418 women intending at start of labour to deliver at home

Intrapartum deaths (n=5)

Term pregnancy, transferred in first stage, cord prolapse discovered with artificial rupture of membranes in hospital

Term pregnancy, breech transported in second stage because of decelerations, delivered during transport

Term pregnancy, breech, transport after birth at home

Term pregnancy, 41 weeks five days. Subgaleal, subdural, subarachnoid haemorrhage. No fetal heart irregularities detected with routine monitoring. Apgar scores 1 and 0

Post-term pregnancy at 42 weeks three days, nuchal cord 6X and a true knot

Neonatal deaths (n=9)

Lethal congenital anomalies (n = 3):
- Dwarf and related anomalies
- Acrocallosal syndrome
- Trisomy 13

Other causes (n = 6):

Term pregnancy, average labour. Apgar scores 6/2. Transported immediately, died at of age in hospital. Autopsy said "mild medial hypertrophy of the pulmonary arterioles which suggest possible persistent pulmonary hypertension of a newborn or persistent fetal circulation...some authorities would argue this is a SIDS and others disagree based on the age. Regardless, infant suffered hypoxia and cardiopulmonary arrest"

Term pregnancy, Apgar scores 9/10. Suddenly stopped breathing at 15 hours of age. Died at five days in hospital, sudden infant death syndrome

Term pregnancy, transport at first assessment because of decelerations, rupture of vasa previa before membranes ruptured, caesarean section, died in hospital two days after birth

Term pregnancy, Apgar scores 9/10. Baby died at 26 hours. Sudden infant death syndrome

Post-term pregnancy, 42 weeks two days age based on clinical data as mother not aware of last menstrual period and refused ultrasonography. One deceleration during second stage, which resolved with position change. Apgar scores 3/2. Brain damage associated with anoxia, baby died at 16 days

Term pregnancy. Mother and baby transported to hospital because mother, not baby, seemed ill, but both discharged within 24 hours. Mother, not baby, given antibiotics by physician a few days after the birth for general sickness. Baby readmitted from home at 16 days because of nursing problems, died at 19 days of previously undetected Group B streptococcus

the largest, prospective studies of home birth, allowing for relatively stable estimates of risk from intrapartum and neonatal mortality. We accurately identified births planned at home at the start of labour and included independent verification of birth outcomes for a sample of 534 planned home births. We obtained data from almost 400 midwives from across the continent.

Regardless of methodology, residual confounding of comparisons between home and hospital births will always be a possibility. Women choosing home birth (or who would be willing to be randomised to birth site in a randomised trial) may differ for unmeasured variables from women choosing hospital birth. For example, women choosing home birth may have an advantageous enhanced belief in their ability to give birth safely with little medical intervention. On the other hand, women who choose hospital birth may have a psychological advantage in North America associated with not having to deal with the social pressure and fears of spouses, relatives, or friends from their choice of birth place.

Our results may be generalisable to a larger community of direct entry midwives. The North American Registry of Midwives was created in 1987 to develop the certified professional midwife credential—a route for formal certification for midwives involved in home birth who were not nurse midwives and who came from diverse educational backgrounds. Thus the women who chose to become certified professional midwives were a subset of the larger community of direct entry midwives in North America whose diverse educational backgrounds and midwifery practice were similar to certified professional midwives. From 1993 to 1999, using an earlier iteration of the data form, we collected largely retrospective data on a voluntary basis mainly from direct entry midwives involved with home births approached through the Midwives Alliance of North America Statistics and Research Committee and the Canadian Midwives Statistics' Collaboration. This earlier unpublished data of over 11 000 planned home births showed similar demographics, rates of intervention, transfers to hospital, and adverse outcomes.

As with the prospective US national birth centre study[19] and the prospective US home birth study,[23] the main study limitation was the inability to develop a workable design from which to collect a national prospective low risk group of hospital births to compare morbidity and mortality directly. Forms for vital statistics do not reliably collect the information on medical risk factors required to create a retrospective hospital birth group of precisely comparable low risk,[38-40] and hospital discharge summary records for all births are not nationally accessible for sampling and have some limitations, being primarily administrative records.

One exception, and an important adjunct to our study, was Schlenzka's study in California.[22] In this PhD thesis, Schlenzka was able to establish a large defined retrospective cohort of planned home and hospital births with similar low risk profiles, because birth and death certificates in California include intended place of birth and these had been linked to hospital discharge abstracts for 1989-90 for a caesarean section study. When the author compared 3385 planned home births with 806 402 low risk hospital births, he consistently found a non-significantly lower perinatal mortality in the home birth group. The results were consistent regardless of liberal or more restrictive criteria to define low risk, and whether or not the analysis involved simple standardisation of rates or extensive adjustment for all potential risk variables collected.[22]

An economic analysis found that an uncomplicated vaginal birth in hospital in the United States cost on average three times as much as a similar birth at home with a midwife[41] in an environment where management of birth has become an economic, medical, and industrial enterprise.[42] Our study of certified professional midwives suggests that they achieve good outcomes among low risk women without routine use of expensive hospital interventions. Our results are consistent with the weight of previous research on safety of home birth with midwives internationally. This evidence supports the American Public Health Association's

What is already known on this topic

Planned home births for low risk women in high resource countries where midwifery is well integrated into the healthcare system are associated with similar safety to low risk hospital births

Midwives involved with home births are not well integrated into the healthcare system in the United States

Evidence on safety of such home births is limited

What this study adds

Planned home births with certified professional midwives in the United States had similar rates of intrapartum and neonatal mortality to those of low risk hospital births

Medical intervention rates for planned home births were lower than for planned low risk hospital births

recommendation[8] to increase access to out of hospital maternity care services with direct entry midwives in the United States. We recommend that these findings be taken into account when insurers and governing bodies make decisions about home birth and hospital privileges with respect to certified professional midwives.

We thank the North American Registry of Midwives Board for helping facilitate the study; Tim Putt for help with layout of the data forms; Jennesse Oakhurst, Shannon Salisbury, and a team of five others for data entry; Adam Slade for computer programming support; Amelia Johnson, Phaedra Muirhead, Shannon Salisbury, Tanya Stotsky, Carrie Whelan, and Kim Yates for office support; Kelly Klick and Sheena Jardin for the satisfaction survey; members of our advisory council (Eugene Declerq (Boston University School of Public Health), Susan Hodges (Citizens for Midwifery and consumer panel of the Cochrane Collaboration's Pregnancy and Childbirth Group), Jonathan Kotch (University of North Carolina Department of Maternal and Child Health),, Patricia Aikins Murphy (University of Utah College of Nursing), and Lawrence Oppenheimer (University of Ottawa Division of Maternal Fetal Medicine); and the midwives and mothers who agreed to participate in the study.

Contributors: KCJ and B-AD designed the study, collected and analysed the data, and prepared the manuscript. KCJ is guarantor for the paper.

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Competing interests: None declared.

Ethical approval: Ethical approval was obtained from an ethics committee created for the North American Registry of Midwives to review epidemiological research involving certified professional midwives.

(Accepted 20 April 2005)

Dear Certified Professional Midwife:

We would like to take this opportunity to discuss several issues with you:

1. How to get a copy of the study.

Because of the BMJ's free web-based distribution, anyone can read and download the entire article. We understand they get 700,000 hits a month.

To Retrieve a Free Copy of the CPM2000 Article for Yourselves and Your Clients:

Go to www.bmj.com, choose past issues, choose the June 18th issue , then go to "Papers." It is called "Outcomes of planned home births with certified professional midwives: large prospective study in North America." If you want the complete and most pristine-looking version download the PDF.

Also, below the abridged or full version you will find a number of Rapid Responses (online letters to the editor about the study). Then go back and look under "This week in the BMJ" for the June 18th Issue and you will find the BMJ's short sum-up of the article entitled, "Giving Birth: Home Can Be Better Than Hospital." Under that title there are some other rapid responses to the article. We found the Rapid Response interesting reading.

2. Contacting your local media

We invite you, if you have not already done so, to contact your local radio stations and newspapers this week about the study, and if you cannot get to it this week, to contact any media people you know in local, national, or international community newspapers or magazines over the next week or two. Try the health reporters. Strategize with your consumer groups to figure out the best talk shows that might pick this up in your home town. The study has already appeared in numerous national media (see below), and your actions to bring the study to the attention of your local news media can generate more news coverage for the public as well as draw attention to your CPM credential and/or to local advocacy efforts. If you participated in the study, that might be a special interest story for the local press.

For ideas and materials you can give to a reporter, the following are available: the BMJ press release (at www.bmj.com); the Citizens for Midwifery press release and relevant grassroots network message (at http://www.cfmidwifery.org/Resources/Item.aspx?ID=84); the NACPM press release (at http://www.nacpm.net/) ; the ICAN press release (at www.ican-online.org). Also see "What to emphasize" below.

When contacting the media take the time to educate them on the CPM credential and make sure they know that NARM, MEAC, CfM, MANA, and NACPM have information on these maternity care providers.

We also want to formally thank all of you who have taken the time to contract your local newspaper or disseminate news of the article by postings on websites and listserves. We understand that Katie Prown and Steve Cochran helped organize an effective grassroots effort through the BirthPolicy network. Please be sure to write to us about your interactions with the press.

3) Media Coverage as of 6/23/05:

Phone up any talk shows you know of locally that might consider it, as the event of having the article published is newsworthy and your own local media need to tap in to the experts in their

own area – this is YOU. Already to date it has received more press than we had ever hoped:

On Reuter's website: "Home birth as safe as hospital delivery for low-risk pregnancies"

On Fox News website: "Giving Birth at Home Is Safe, Study Shows"

On MSNBC website: "Home births Safe for low-risk women"

On CNN website MedPage: "Study: Low-risk home births safe"

On the CBC.CA (Canadian) Betty-Anne was on the national television news Friday, the 17th: "Home births safe for low-risk pregnancies: North American study" and if you look to the right of this article, the video clip is available, a story of Barbara Scrivers, Alberta midwife, in her practice and Betty-Anne as co-author of the study explaining its importance. You can go to http://www.cbc.ca/story/science/national/2005/06/16midwives050616.html and if you go to the story to the right of the written story, click on the video by Terry Reith.

In the Boston Globe: "Home Births as safe as hospital deliveries for low-risk mothers"

In the Washington Post: "Home Births"

On Yahoo! News: "Home Birth safe for low-risk pregnancies"

On Forbes: "Childbirth at Home as Safe as Hospital Delivery: Study"

On KOMO 4 News & ABC News: "Midwives a Safe Alternative to Hospital Births, Study Finds"

On eMediaWire: "Study Shows Home Birth Lowers Cesarean Risk" I-Newswire.com: "Home>Friends of Wisconsin Midwives: Study Shows Benefits of Licensed Home Birth Midwives"

On Kaisernetwork: Planned, Low-Risk Home Births With Nurse-Midwives as Safe as Hospital Births, Involve Fewer Interventions, Study Says <http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=30842>

4) What to emphasize with the media:

You can still phone your local media today. Here are some pointers about things to emphasize:

* **Why This Study Is Special: The study is groundbreaking because former studies have been criticized for not being big enough, for not being able to distinguish between planned or unplanned births, and/or for being retrospective, that is only looking at old records as opposed to engaging health professionals in the requirement of registering births they are going to do and then accounting for all outcomes. This is the only study ever published that has met all three of these criteria: the study is big enough, the study distinguished between planned and unplanned home births, and the data are prospective.**
* **Emphasize the low intervention rate: For the year 2000, your chances with a CPM in a planned home birth of having some kind of medical intervention — a cesarean section, forceps or vacuum delivery, induction, episiotomy, epidural — were 1/10 to ½ (depending on the intervention) of what they were if you planned a hospital birth, using statistical outcomes from the US population from the same year and comparing to largely low risk group in hospital by using US birth certificate data for all vertex, term, singleton births.**
* **Low Rate of Transfers: We purposely reported transfers as: "over 87% of mothers and neonates did not require transfer to hospital," and most of the transfers were for lack of progress, because the mother was tired or wanted pain relief. This kind of detail is especially important when communicating with the media. For example "over 87% of the mothers…" conveys a sense of confidence, while "thirteen per cent of women still had to be transferred," which one television broadcast did (even though it was overall a positive study) focuses on the negative end of the curve. And to be clear: only 3.4% of women who began labour at home had a transfer which the midwife thought was urgent, and even these "urgent" transfers did not necessarily mean there was some avoidable trauma involved, just that it was felt that things needed to be checked out right away, e.g., anomalies in a baby, observation of babies having breathing difficulties but who had oxygen and bag and mask at home as they would in hospital, mothers losing more blood than was felt safe. The outcomes speak for themselves, but the rapid response from Rivet, and others which may follow, has said that the doctors don't have the luxury of taking only low risk women. This clouds the point of the article; it is like saying, obstetricians don't have the luxury like the midwives and family docs, of not doing cesareans. That is precisely a good use for their skills, so why complain? It is not that the CPMs do not get high risk women; we showed in our study precisely how the CPMs handle them – generally screen them out for hospital birth, but did the low risk women at home with good results , except in cases where obviously the mother chose not to go, which is an informed decision.**
* **Only "low risk" births were appropriate for this study. The study shows that, if you are not a high risk Mom — that is, carrying twins or multiples, having a premature baby or having a baby coming bottom first or trans-**

verse, all of which can be judged before the baby is born —your chance of having a healthy normal safe delivery are the same whether you plan a home or hospital birth. One journalist actually tried to fault the study for this. It is precisely the methodology necessary – to compare as closely as possible to a similar low risk population in the U.S.

* A Validation Study Verified the Data. Over 500 mothers were phoned, including at least one client from every midwife, to verify that what the midwives said happened at the births actually did occur.
* Policy Implications: The study suggests that legislators and policy makers should pay attention to the fact that this study supports the American Public Health Association's resolution to increase out of hospital births attended by direct entry midwives. The American College of Obstetricians and Gynecologists still opposes home birth, but has no valid evidence to support this position. The Society of Obstetricians and Gynecologists of Canada and several provinces have written statements either acknowledging that women have the right to choose their place of birth or supporting it.

For continuing information on creative and effective ways to highlight this study in the policy arena, consider joining the BirthPolicy listserve (birthpolicy@yahoogroups.com). It is a great resource for midwifery policy discussion. Plus list moderators Katie Prown and Steve Cochran have their own personal tips on how to become more media savvy.

6) Regarding Our Long term effort:

We understand that there are critics who do not understand the length of time it takes for scientific articles to be written and actually published. Let us assure you, our diligence has paid off, as we had anticipated: we made sure our methodologies met the highest standards; we followed up all CPMs who wanted to remain CPMs to make sure they got their data to us; and we had draft articles scrutinized by other professional epidemiologists. As some of you know, we originally sent the study to JAMA (the Journal of the American Medical Association), a publication that told us that they did not think their readers would be interested. Then, in December, 2004, we sent it to the BMJ. In contrast to the BMJ, the ACNM Journal takes one year from submission to publication, largely because they are an organization that very positively helps and encourages new researchers. On the other hand, the BMJ publishes only about 9% of papers they receive, and, although this study was accepted unanimously by all editors, it still took six months to process between submission and publication. We went the extra mile because we knew that at this time in North American history, home birth needs a credible boost, and this study will be critical for parents and professionals for many years to come.

We hope to hear from you soon and feel privileged to have worked with you on this effort which has already changed some policy statements in the U.S.

Yours truly,

Ken Johnson, senior epidemiologist at the Surveillance and Risk Assessment Division, Centre for Chronic Disease Prevention and Control, Public Health Agency of Canada, co-principal investigator of the study (613) 957-0339 email: Ken_LCDC_Johnson@phac-aphc.gc.ca

Betty-Anne Daviss, Registered Midwife, Project Manager of the International Federation of Gynecology and Obstetrics' Safe Motherhood/Newborn Health Initiative, co-principal investigator of the study (613)730-0282 email: badaviss@sogc.com But send emails to cpmstats@rogers. com

Dear CPM:

We would like to take this opportunity to personally thank the 391 CPMs who each worked with us intensively for a year and a half to participate in the CPM2000 study. Each of your contributions helped to make the study a great success. As many of you may already know, the CPM2000 study was published in the British Medical Journal (BMJ) June 18th. We are thrilled with the amount of mainstream media it has attracted. This is the largest prospective home birth study ever done, the methodology met important criteria for home birth research, we were able to get it published in what is considered by many to be the most prestigious medical journal in the world, and the BMJ has its own worldwide media distribution, all of which contributed to getting the study noticed by the media.

We would also like to take this opportunity to thank the more than 7,000 moms who agreed to participate, the NARM Board for helping facilitate the study, the MANA Board for their support over many years, Citizens for Midwifery for their ongoing encouragement, the Foundation for the Advancement of Midwifery and its supporters for financial assistance and the Ethics Committee, established to provide an independent ethics review of the research done using data provided by CPMs. In 1998-1999 NARM, acting on our suggestion that this kind of rigorous methodology was required to get the credibility home birth practitioners deserve, agreed to tie participation of CPMs to recertification.

Keeping in Contact with us

Please send an email to us at cpmstats@rogers.com if you are running into difficult responses when discussing the study with your local obstetricians or other health care providers, if you would like to continue to be in-

formed about additional research we will be pursuing using the CPM database, if you want to find out where else the study is being picked up by the media, or just to let us know that this letter has reached you, because we feel a responsibility to make sure good use is made of this study.

In the rather large effort to get the article published our old email of cpmstats at istar began to have problems we could never get rectified, and we had difficulty in keeping up the current list of emails. Just send a quick, "I am a current CPM; I participated in the study; got your email," or I am not a current CPM but I participated in the study," or "I am a current CPM but I did not participate in the study but want to be informed, etc., would be great. Whether or not you are a CPM, if you have questions or difficulties with local media, please contact.

Please let us know if you manage to get media coverage of the BMJ article in your local news.

And finally, as we needed to do this week, we are available to provide information (epidemiologic evidence about how midwives practice) for any legal problems you may get into, and to speak directly with your legislators, as we have been all along, even throughout the gestation and birth of the CPM2000 study.

We will pass another email in the next day or two, concerning getting a free copy of the article and details of working with the media.

Yours truly,

Ken Johnson, Senior epidemiologist at the Surveillance and Risk Assessment Division, Centre for Chronic Disease Prevention and Control, Public Health Agency of Canada, co-principal investigator of the study (613) 957-0339 email: Ken_LCDC_Johnson@phac-aphc.gc.ca

Betty-Anne Daviss, Registered Midwife, Project Manager of the International Federation of Gynecology and Obstetrics' Safe Motherhood/ Newborn Health Initiative, co-principal investigator of the study (613)730-0282 email: badaviss@sogc.com

Introducing.....MANA

Pamela Dyer Stewart

In the 1970's, as the women's movement was gaining momentum, there was a resurgence of women giving birth at home where they were assured of greater autonomy, a private and familiar setting, and the possibility of a more empowering experience. Women helped women give birth. Mothers began reading all they could, learning together about birth. Out of this time, grew the homebirth midwife, experienced-trained, apprenticed to the birthing women with whom she worked. By the end of that decade, midwives were emerging in cities, towns and communities across the country. The time was ripe for gathering this energy into a New Voice of the Ancient Art.

In October, 1981, Sr. Angela Murdaugh, President of the American College of Nurse Midwives (ACNM) and a woman of vision, called a meeting in Washington D.C. to have a day of dialogue about the profession of midwifery. She invited seven midwives from a variety of educational backgrounds and practices. Out of this day of energized and intense conversation came the decision to form a "Guild" that would be inclusive of all midwives. Four goals were established:

- To expand communication among midwives.
- To set educational guidelines for the education of midwives.
- To set guidelines for basic competency and safety for practicing midwives.
- To form an identifiable professional organization for all midwives in this country.

This dynamic core of women made the decision to have an open meeting preceding the ACNM convention that was scheduled for April, 1982 in Lexington, Kentucky. With little time for organization and communication in the months leading up to the convention, almost one hundred women from around the country managed to make their way to Lexington that spring for the preconference dialogue. The Midwives Alliance of North America was born. Both Canada and Mexico were included in the original Alliance. However, in the late 1990's, as Canada made dramatic progress in establishing legal recognition of midwives in their country, and as midwives joined the Canadian Association of Midwives, fewer Canadian midwives belonged to MANA and Canada withdrew as a region. MANA continues to have members from Canada, and the Mexico region is active.

In that spring meeting in 1982, the rudimentary work of drawing up a rough draft of the Articles of Incorporation, establishing a means of communication, and choosing officers, was accomplished. During the next year, communication lines were strengthened and the groundwork for the organization was laid. In May of 1983, the new governing board decided to publish the newsletter, MANA News. This decision reflected the primary goal of the initial meeting held in Washington in 1981, which was to offer expanded opportunities for midwives around the country to be in communication with one another.

In the almost twenty-four years since the initial core of seven women met, MANA has grown to close to one thousand members and continues to be a voice for all midwives. The four goals established at that first meeting continue to be central to MANA's mission. MANA News is published quarterly and includes reports from all regions and most states on political and practice issues. A recent addition to the newsletter is the "Issue of the Issue" which invites readers to send in their thoughts on a particular question, such as "Do you do VBACs at home and what are your parameters?" or "Do you think licensing of midwives is a good idea?" Another new feature is

"Portraits of Our Sisters", an interview with a midwife. The MANA news is also a link to our sister organizations, NARM, MEAC, CfM and FAM. Another vehicle of communication is the MANA webpage www.mana.org.

Since 1983, the annual fall conference has been an exciting way to meet other midwives, take part in dynamic conversations, attend a diverse array of educational workshops, rediscover broad support for your work, and feel the community of sister midwives. There's nothing like a MANA conference for breathing energy into your heart. This year the conference is scheduled for Sept.30 through October 2 in Boulder, Colorado.

MANA's current structure includes a volunteer board with five executive members, seven regional representatives from around the United States and a rep from Mexico. There is also a representative from the Midwives of Color Section who sits on the board. More than a dozen committees carry out the work of MANA, including affirmative action, MANA documents, newsletter, membership, conference, public relations, legislative, insurance. Any MANA member can be involved in committee work according to her particular interest. New blood and new ideas are always welcome. Our Statistics and Research Committee recently expanded to become the Division of Research which includes five sections. The dream of expanding the research on the safety of homebirth is becoming a reality.

This past spring, MANA renewed its strategic plan for the coming years. Four goals were identified: establishing midwifery as the gold standard, building alliances, claiming MANA's identity and increasing financial resources. To reach the goal of making midwifery the gold standard, MANA is launching a PR campaign this year with the help of a start up grant from the Foundation for the Advancement of Midwifery. The purpose of the campaign is to educate the public about midwives and normal birth, increase visibility of midwifery care and normalize the use of midwives for maternity care. We have a vision of challenging the status quo of birth today which includes heavy doses of technology, interventions and drugs, and a high infant mortality rate relative to other industrialized countries. We envision increasing conversation among midwives of all backgrounds on the most pressing issues affecting their practices.

We invite you to join MANA, engage in the conversation and find the support it offers through its many resources: the MANA news, your regional representative, the MANA webpage, the annual fall conference, the midwife referral list, information regarding midwifery legislation. We are all stronger when we connect with one another, share our experiences, and grow our encouragement of each other in order to sustain the art and profession of midwifery. To become a member, go to our webpage www.mana.org or contact our membership chair, Nina McIndoe at (614) 237- 9771.

MANA Conference

All CPMs should have received a brochure for this year's MANA conference, which will be in Boulder, Colorado, on September 29 - Oct 2. NARM encourages all CPMs to attend MANA conferences, and to participate in the workshops and meetings. If you plan to attend, please note that the brochure you received in the mail is the only copy you will receive. Please bring it with you to the conference so you will know when and where to meet for each workshop. If you cant make it to the conference this year, send your copy of the brochure with someone who is going. Someone who forgets theirs will be grateful!

For more information about the conference, or to register, go to *www.mana.org*.

NARM Workshops

NARM Workshops Can Come to You!

NARM can offer a variety of workshops to be presented at state midwifery association meetings or regional conferences. If a minimum of 9 CPMs will attend the Test Writing workshop, there will be no fees charged for any workshops except the Qualified Evaluator workshop which has a $75 fee. Without the Test Writing workshop, there may be fees necessary to cover travel and lodging expenses. Continuing Education credits will be awarded for all workshops. For more information, call 1-888-353-7089 or write testing@narm.org.

Test Writing Workshop

The Test Writing workshop can be done as a 7 hour (full day) or 10 hour (evening and full day) workshop.

The test writing workshop brings together groups of CPMs to discuss the midwifery knowledge and skills that are essential components of the practice of midwifery. Based on real-life experiences, teams of midwives craft scenarios related to problems they have encountered in prenatal, birth, or postpartum situations, research these scenarios in the reference texts, identify the knowledge necessary to solve the problem, and develop multiple choice answers to evaluate that knowledge. Discussions are lively and stimulating, and participants find the process to be rewarding on a personal and professional level. Additionally, participation by CPMs in the development of test questions is integral to the reliability and validity of the Certified Professional Midwife credential. NARM Certification was created by midwives, for midwives, and is administered by midwives on the NARM Board. The NARM exam is written by midwives, with focus on the practical aspects of midwifery care and knowledge. Your participation makes a better exam! Participants must be CPMs.

Qualified Evaluator Training

Qualified Evaluator training: 4 hours. This workshop trains CPMs to administer the NARM Skills Assessment. This workshop is open only to CPMs with at least 2 years and 30 births additional experience beyond the CPM. There is a $75 fee for the QE workshop and participants are eligible to administer the Skills Assessment, for which they are paid $75.

The following 2-hour workshops are open to anyone:

Midwifery Ethics

In today's maternity services ethical issues are everywhere, and yet there is often a poor understanding of how practitioners deal with them. Many qualified midwives, while believing that they are ethical in their work and lives, might find it difficult to define what this means in practice. We all have to make decisions everyday with clients, other health care providers and our own families. While ethics is seen by some as a theoretical issue, to be debated in classrooms and at conferences, the everyday import of ethical decision-making means that the theory-practice gap needs to be bridged. Our exploration of ethical midwifery is a critical reflection of moral issues as they pertain to maternal/child health on every level. This workshop explores the ethical issues that face midwives in today's world, as well as strategies for resolving these issues. Participants will discuss the ethical issues relating to accountability, autonomy, confidentiality, informed consent, and the use of technology.

Preceptor-Apprentice Relationships

This session is designed to meet the needs of both preceptors and apprentices and to help avoid common problems in the preceptor-apprentice relationship. Discussion includes the role and responsibility of the preceptor and apprentice, advantages and disadvantages to the apprenticeship model of education, avoiding common misunderstandings between preceptors and apprentices, and documenting the apprenticeship for the NARM application process.

NARM and the CPM Process

This workshop explains the development of the NARM process and the requirements for CPM certification. The session is designed for apprentices who intend to apply for CPM certification and for the preceptors who will train them to meet these requirements. It is also a very valuable workshop for anyone who is interested in seeking legislation to license midwives using the CPM process as a basis for licensure. Participants will become familiar with all routes of entry into the CPM process, how the criteria for certification were determined, and how each element of the process contributes to the reliability and validity of the credential.

Charting: One of Your Most Critical Skills and Your Legal Defense

Midwives often view documentation as a necessary chore, but one that is not as important as providing hands-on care. Yet documentation is one of the most critical skills that a midwife will perform. Although we tend to approach documentation casually, our entire career could depend on the accuracy and completeness of our charting. How much should be charted and why? In documenting, we need to keep in mind the possible legal and ethical complications, and the legal relevance

of malpractice. Failure to document appropriately has been a pivotal issue in many malpractice cases.

Preparing for Legislation

Available as both a 2 hour workshop and a full day workshop. This workshop is for midwives and consumers who are preparing to lobby for legislation to license midwives in their state. The 2-hour workshop is an overview of the legislative process and lobbying strategies. The full day workshop goes into more depth and includes actual training for lobbying, including writing fact sheets, giving interviews, making the best use of the 15 minute or 2 minute opportunities for speaking with legislators, giving testimony at public hearings and legislative committee sessions, and answering tough questions spontaneously.

MANA Statistics Web Based Data Entry

2 hours. This workshop explains the new MANA Statistics Collection Project, including the web based data entry system, so that all midwives can enter their personal statistics into the MANA database for use in analyzing and publishing research on direct-entry midwifery. Participants will learn how to enter their date on the web (and options for not entering on the web), how this information may be used, and how to retrieve their own personal or group statistics.

Midwifery Supporters!

Amy Chamberlain

Texas midwives are proud to celebrate the passage of our midwifery bill, House Bill 1535! Today the Texas Senate passed this legislation renewing the Midwifery Board, which licenses and regulates Texas midwives.

Despite efforts to weaken this legislation, midwives and their supporters prevailed when we visited, called and emailed legislators on the merits of this bill. In fact, challenges like these over the last 2 legislative sessions have made us stronger. Never before have midwifery supporters been as educated and organized as we have been these last several months! And we will NEED this level of organization in 2007, when we will face new challenges. Because of us, every legislative office knows what a midwife does and how much their services are valued by Texans. This is about more than midwifery, it is about protecting birth options and about keeping birth normal at a time when the C-section rate is approaching 1 in 3 births, more than double the rate that is considered necessary by the World Health Organization.

What This Legislation Will Do as of September 2005:

1. The Midwifery Board at the Texas Department of State Health Services will continue to license and regulate midwives for 12 more years;
2. "Documented midwives" will shed this moniker for the more accurate title "licensed midwives", and
3. Like other licensing boards at the Department, the Midwifery Board will have a majority of licensees serving on the board, while maintaining 2 public member positions and two physician positions.

Now that we can relax a little and enjoy the long weekend, pick up a the May/June issue of Mothering Magazine!

The cover story is "Speak up for Natural Birth: 10 easy things you can do", and there is an additional article titled: "Networking for a Better Birth: here's how you can help foster awareness of the benefits and availability of healthy, normal birth in your own community"

Its my hope that midwives, doulas, childbirth educators, nurses, doctors, and parents buy copies of this issue to share with their clients and friends!

As a supporter of Texans for Midwifery-Austin, I LOVED reading about others across the country doing many of the same things we are to talk about healthy birth options— organizing "Birth Fairs," rallying a the Capitol to protect our access to midwifery care, presenting to college students on the history of childbirth in America and on normal birth. There are some more good ideas in this issue, but I think the greatest value I got from it is knowing that I can be doing as little or as much as I can at a particular time. Volunteering with a local birth group, reading emails, or simply writing a $10 check are all extremely valuable ways to make a difference!

If you know friends or clients who want to join us, please direct them to our website or request membership brochures. Thanks again for your support!

Amy Chamberlain
Texans for Midwifery - Austin
texansformidwifery.org/austin

New Jersey Consumer Obtains Stats

Stacey Gregg

I first began my quest for birth statistics in New Jersey by requesting information from the New Jersey Center for Health Statistics. This is the response that I got:

Dear Stacey,

Thank you for your inquiry. Birth data by hospital is considered sensitive data. In order to proceed with your request you need to obtain Institutional Review Board (IRB) approval.

The website for IRB is below.
http://www.state.nj.us/health/rspp/

Please note that we do not collect waterbirth data as of yet. I'll pass the inquiry along, maybe in the future we might start collecting this data.

You might want to contact the Hudson Perinatal Consortium at 20.876.8900 for more info on prevalence of waterbirths. Also the NJ Hos-

pital Association (URL below) might also have some information.

www.njha.com

I hope the information is helpful.

Thanks,
Center for Health Statistics
New Jersey Department of Health and Senior Services PO Box 360 Trenton, NJ 08625-0360
(609) 984-6702
www.state.nj.us/health/chs

This original response from them sent me on a wild goose chase. It was inaccurate and I did not need to obtain Institutional Review Board (IRB) approval. Which if you look at what is involved with getting the approval it is a very daunting task of filling out numerous forms; none of which applied to me as a consumer since I was not doing research for a University or Medical Corporation and was only interested in aggregate statistics not confidential health information on individual patients.

My advice to anyone that is pursuing childbirth statistical data from their state Department of Health is to not waste time. Follow up on any information given and do not let any road blocks that are put in your way interfere with your goal of getting the data. Also I suggest that they establish a good timeline by keeping copies of emails and people they spoke with; and then refer to them when making later inquires. This builds credibility and shows determination on your part that you are not going to give up. Every time you are promised something or that they do not respond to an inquiry for statistics you can use the information to your advantage in the future and or if needed when speaking to the press about not being able to get statistics after numerous inquiries it also will be handy.

I was very discouraged and alarmed by the first very inaccurate information that I was given in regards to how this information could be attained. It took me over a month to face the forms for the IRB approval and it was only when I started having difficulty with the WEB site for the IRB form that I picked up the phone and called the CHS dept head responsible for the form directly (did this after searching the WEB site and finding out who was in charge of the IRB approval process). I explained that I was basically just a concerned consumer and I resented the fact that this information was not readily available; I shared with the state official that filling out the forms nearly had me in tears and were a big waste of my precious time since none of it applied to my request or situation. In addition this was important information and needed to be readily available to all women in the state so that they have the knowledge to make educated choices regarding what care facility they want to use. (helps to have young children in background making noise, but only if you can think clearly enough to get across your point). I also explained that I did not see how this data could be considered sensitive data as I was told by email and several times by phone.

When speaking with state officials I did it in a pleasant, but firm and inquisitive manner and I was asking for solution to my problem not accusing or demanding just expressing surprise at the misinformation being given and the need for the statistical information. I must state that my background pre-kids was as a Corporate Quality Assurance Investigator for a Major US Corporation you may of heard of before; UPS, United Parcel Service. I was accustomed to tracking down where problems originate, starting an investigation, following up on responses, verifying accuracy of all responses given and corrective actions taken and then sending reports to Corporate Department Heads so as to get their input regarding improvement and corrective actions needed to rectify and prevent repetition of same problem(s) in the future. Most importantly when all investigating was done I got the final report to all involved. This process was not much different.

To the state of NJ's credit I must tell you the following, I:

1) Did get an apology for the misinformation I was given
2) Was told that it was not in fact sensitive data since it was aggregate information I was requesting
3) Did not need IRB approval as originally told, that it was a mistake on behalf of his employees interpretation of new policy put in place since Sept 11th.
4) It was stated that no one had asked for the information before. (No way to verify this statement) Tend to believe that a lot of people don't ask for much information since process seems so overwhelming and there is what seems like a huge bureaucratic maze to get through.
5) State employee did tell me that under the Freedom of Information Act I was entitled to it.
6) Was hooked up with the person that eventually provided the information that I was requesting along with future request for information.
7) Information was going to be made available on State Website.

After News stories came out in the press about the C-rate.

1. I was not given additional data that was promised regarding other birth statistics.
2. Needed to follow up with multiple phone calls and emails to request NJ CHS to give me the additional data.

Please feel free to contact me if there are any additional questions or if help is needed obtaining statistics in your state and I would be happy to offer support and suggestions.

In Sisterhood,
Stacey Gregg, CD DONA
greggs@optonline.net
973-627-4120

Jersey delivers wide range of C-section rates
State has the nation's highest average of surgical births

Saturday, March 05, 2005

BY CAROL ANN CAMPBELL

Star-Ledger Staff

Hospital-by-hospital Caesarean rates, made public for the first time, show that New Jersey institutions vary widely when it comes to the percentage of women who have the procedure.

The rates ranged from a low of 17 percent to a high of 43 percent, according to 2003 preliminary figures provided by the state Department of Health and Senior Services.

The figures come on the heels of federal data that show New Jersey has the highest average Caesarean rate in the nation — 33.1 percent, according to the National Center for Health Statistics in Hyattsville, Md. The national average in 2003 was 27.6 percent.

Activists trying to lower C-section rates have pushed the state to release the hospital data. Stacey Gregg, a childbirth assistant in Rockaway, said she sought the figures so women could make informed choices about childbirth.

"We need women to question the rates and for health care providers to change their methods of practicing," Gregg said. Advocates of lower C-section rates called the figures at some hospitals alarming. They said the mother's choice of physician and hospital can significantly influence whether she gives birth surgically or not.

Several hospitals, including Bayonne Medical Center, had rates above 40 percent.

"What we look at is what is best for the mother and baby," said Lynne Nouvel, a spokeswoman for Bayonne Medical Center. "We have low mortality and infection rates and high patient satisfaction," she said.

But while some hospitals had rates above 40 percent, others had rates just over 20 percent. One hospital with low rates was Muhlenberg Regional Medical Center in Plainfield.

"Our nurses are eager to encourage Lamaze and help patients push, and our nursing staff turnover has been low for many years," said Maryann Huhn-Werner, an ob-gyn at the hospital.

But many obstetricians argued that few conclusions can be drawn from the disparate rates. They said hospitals cater to different types of women whose pregnancy risks, and the need for surgical intervention, can vary greatly.

Hospitals with neonatal intensive care units, for instance, attract more women with high-risk pregnancies, especially those having multiple births from fertility treatments. These women are far more likely to have Caesareans. Meanwhile, some hospitals and doctors will no longer perform vaginal births after Caesarean for fear of complications and subsequent lawsuits.

"I'm not saying the hospitals do not contribute, but there are multiple factors going on," said Francine Sinofsky, president of the New Jersey Ob-Gyn Society.

"If you just compare hospital to hospital and you do not know the underlying populations it is hard for the public to make judgments," she said.

Sinofsky said the figures could needlessly scare patients away from good hospitals. "To offer these to the public without any explanation will make people jump, 'I don't want to go there!'" she said.

New Jersey's C-section rates have been rising steadily in recent years and jumped three percentage points from 2002 to 2003.

Many in the field blame litigation. Doctors fearful of being sued, and already hit with high malpractice premiums, may be quicker to perform the surgical procedure than in the past, according to some doctors.

Some women, meanwhile, are requesting C-sections for convenience, or to avoid the potential for future urinary difficulties. In addition, the age of new mothers has been rising, another risk factor for Caesarean section.

Financial motives no longer seem likely to influence rates. A vaginal delivery costs a hospital about $3,000 and a C-section $5,000 to $6,000. But most insurers no longer pay extra for C-section, eliminating any financial incentive for the surgery, several doctors said.

State health officials said the C-section statistics have been collected for years, but that no one asked for them before Gregg began pushing for the data. State officials have not decided whether they will post the data on the health department Web site, though it is available to anyone who asks, said Eddy Bresnitz, state epidemiologist.

Advocates of natural births have said they hope that publicizing the data will force hospitals to rethink their practices.

"It's outrageous to see hospitals with some of these numbers," said Tonya Jamois, president of the International Caesarean Awareness Network, which advocates for lower C-section rates. Jamois said the World Health Organization is pushing for a 15-percent C-section rate.

A Caesarean section is major abdominal surgery to deliver the baby. The procedure requires anesthesia and several days in the hospital. A release by the American College of Obstetrics and Gynecology cited a study that found a woman's risk of dying in childbirth was "significantly" higher with Caesarean, or 35.9 deaths per

100,000 deliveries, compared with 9.2 deaths per 100,000 vaginal deliveries.

Kimball Medical Center in Lakewood was the hospital with the state's lowest C-section rate. Doctors said patient population was not the only reason.

"We have an excellent midwife staff," said Bruce Feinberg, an ob-gyn on the staff. "We have a lot of one-on-one labor support that can make a huge difference." He said women in labor are encouraged to walk around, or to use a "birth ball," or maybe a birthing stool or a hot tub to relieve pain.

"The bottom line is that we have support for the mother who wants the most comfortable vaginal delivery," he said.

Charlene Teo of Millington has experienced both types of birth. She had a C-section with her first child and planned a second for her next pregnancy. However, before the scheduled operation she went into labor and her nurse at Morristown Hospital encouraged her to proceed. All went well. She had some vaginal tearing, but found the recovery far easier the second time.

"Right away I could get up, walk around, hold the baby," she said. "I felt this was the only choice for me."

Carol Ann Campbell covers medicine. She may be reached at ccampbell@starledger.com or (973) 392-4148.

"Bridging the Gap"

The Childbirth Education Association of Orange County (CA) will be holding their semi-annual conference on November 11th & 12th.

"Bridging the Gap: Addressing current birth practices and their impact on Mother-Infant attachment"

Keynote speakers include: Suzanne Arms, Wendy Anne McCarty, Breck Hawk & Sarah J Buckley.

CEU's are offered as well

More information about this conference will be posted at *www.ceaorangecounty.com*

Blue Cohosh Survey

Aviva Romm and Tieraona Low Dog

Biographical Information about the Survey Authors

Aviva Romm, CPM, RH(AHG) has been a midwife since 1985 and is the author of The Natural Pregnancy Book, Natural Health After Birth, Natural Healing for Babies and Children, and Vaccinations: A Thoughtful Parent's Guide, among others. She is the President of the American Herbalists Guild and an entering first year medical student. Aviva teaches widely on the use of herbs for women and children.

Tieraona Low Dog, MD is Director of Botanical Medicine and Clinical Asst. Professor for the University of Arizona School of Medicine, Program in Integrative Medicine in Tucson, AZ. She serves on the Advisory Board for the National Institute's of Health National Center for Complementary and Alternative Medicine and is Chair of the United States Pharmacopoeia Dietary Supplements/Botanicals Expert Panel. Dr. Low Dog is the author of Women's Health: Complementary and Integrative Medicine and has published numerous articles on women's health in peer-reviewed journals.

Introduction

The use of blue cohosh (Caulophyllum thalictroides)* as a partus preparator and labor stimulant is well known amongst midwives. Research identifying potentially toxic compounds and published case reports of neonatal harm presumably due to maternal ingestion of blue cohosh have led to new questions about the safety of this herb. As midwives and herbalists, it is for the benefit of our clients that we gain a better understanding of the relative clinical safety of this herb and the volume of actual use amongst pregnant women, and for our own benefit to determine whether this herb is safe to recommend. We hope you will take approximately 15 minutes to complete this survey, which is part of a preliminary data collection process we are undertaking to evaluate the safety of blue cohosh use in pregnancy.

As midwives, we fully recognize the need for anonymity. This survey is entirely anonymous; there will be no identifying features connecting survey respondents to their responses.

** (Please note that this is a survey about blue cohosh (Caulophyllum thalictroides), not black cohosh (Cimicifuga syn. Actaea racemosa).*

This survey is available on the NARM webpage. or you may copy this page and return the survey to:

Aviva Romm and Tieraona LowDog
1931 Gaddis Rd
Canton, GA 30115

Or Email to: avivajill@aol.com

Return by: August 17, 2005

Blue Cohosh Survey

1. Specify your profession: (circle all relevant options)
   a. Certified Professional Midwife
   b. Certified Nurse Midwife
   c. CM or LM
   d. OB-GYN
   e. Family or General Practitioner
   f. Nurse-Practitioner
   g. Childbirth educator or Doula
   h. ND or herbalist
   i. OTHER: (specify)

2. How many births do you attend per year?
   a. 0-10
   b. 10-25
   c. 25-50
   d. 50-100
   e. 100-500
   f. >500

3. In what setting do you practice? (Circle all relevant options)
   a. Homebirth
   b. Private practice
   c. Hospital or Birthing Center
   d. Other (please specify)

4. What do you consider postdates pregnancy?
   a. Any time after term (40 weeks)
   b. After 41 weeks
   c. After 42 weeks

5. What is the induction rate in your practice?
   a. 0-10%
   b. 10-20%
   c. 20-30%
   d. >50 %

6. What is the most common reason for induction in your practice? (Circle all relevant options)
   a. Postdates pregnancy
   b. Premature rupture of membranes (PROM)
   c. Obstetric pressure on mother/ midwife to induce labor by a certain date
   d. OTHER

7. What is the most common form of induction in your practice?
   a. Prostaglandin-based (i.e., Cytotech, prosgel)
   b. Pitocin
   c. "Stripping membranes"
   d. Herbal (i.e., blue cohosh, castor oil)
   e. Other?

8. Have you ever used blue cohosh for labor induction? (circle one)
   YES NO

9. What is the most common reason for blue cohosh use in your practice? (Circle all relevant options)
   a. As a uterine tonic during late pregnancy
   b. To induce labor
   c. For postdates pregnancies
   d. For stalled labor
   e. As an abortifacient
   f. Other

10. Have you ever mentioned, suggested, or recommended the use of blue cohosh during prior to 38 weeks pregnancy? (circle one)
    YES NO

    If yes, check one:
    ___Rarely
    ___Occasionally
    ___Frequently

11. Have you ever mentioned, suggested, or recommended the use of blue cohosh during labor? (circle one)
    YES NO

    If yes, check one:
    ___Rarely
    ___Occasionally
    ___Frequently

12. What is your training in the use of herbal medicines? (Circle all relevant options)
    a. No training
    b. Self-study (books, magazines, journal articles)
    c. Formal school (specify)
    d. Distance learning (specify)
    e. Professional in-service training
    f. Other

13. How did you learn about the use of blue cohosh? (Circle all relevant options)
    a. Word of mouth
    b. Books/articles
    c. Professional training

14. In what form do you typically use blue cohosh? (Circle all relevant options)
    a. Pills or capsules
    b. Tincture/ alcohol extracts
    c. Tea
    d. Other

15. Do you generally recommend blue cohosh in combination with other herbs? (circle one)
    YES NO

    If yes, can you list some of the other herbs?

    _____

    _____

    _____

    _____

16. Are any particular brand(s) of blue cohosh product you suggest?

    _____

    _____

    If yes, Why?

    _____

    _____

17. If you recommend blue cohosh, what dose information do you provide?

    _____

18. Do you consider blue cohosh safe for use when taken for several weeks during late- pregnancy? (circle one)
    YES NO

19. Have you found blue cohosh to be an effective labor stimulant? (circle one)
    YES NO

20. Do you consider blue cohosh safe when used as a uterine stimulant during labor? (circle one)
    YES NO

21. Have you seen any of the following adverse outcomes with the use of blue cohosh? (Circle all relevant options)
    a. Meconium at birth
    b. Fetal bradycardia
    c. Fetal tachycardia
    d. Need for resuscitation at birth
    e. Increased postpartum bleeding
    f. OTHER
    If other, please describe briefly:

    _____

    _____

    _____

    _____

Thank you for taking the time to help us with this important research. We value your participation and will publish the results in the midwifery community when the project is complete.

NARM Proposes Alternative to Skills Assessment

When the CPM certification was being developed in the early 1990's, participants at a series of Certification Task Force (CTF) meetings met to determine the training and experience that would be necessary for certification. This group set the minimum number of clinical experiences necessary for competent entry-level practice. A job analysis determined the exact knowledge and skills that would be documented by the preceptor and verified by the examination processes. The CTF set the number of births required in the training phase, and the Job Analysis determined a list of 750 skills to be documented during training. The first groups to be issued certification upon passing the Written Exam were the experienced midwives with at least ten years experience and at least 75 births as primary midwife. These midwives verified their skills by self documentation and by virtue of their high levels of documented clinical experience. As NARM prepared to certify entry-level midwives, the question was how to best assess the skill level at which an entry-level midwife was competent to enter practice. Educational consultants advised us that an appropriate mechanism would be for credentialed midwives (CPMs) to serve as preceptors and to also have a second check-off of specific skills by a CPM who was not the primary preceptor. The preceptor would verify the training of the apprentice, document the required clinical experiences, and check off the candidate on the list of 750 individual skills. At that time, there were not enough CPMs nationwide to require that all entry-level candidates complete their training with only CPMs. So, the solution at that time was to require that all preceptors have either a recognized credential or have extra experience as a primary midwife, AND all entry-level candidates would also pass a Skills Assessment (demonstration of selected skills) with a CPM who would be trained to reliably assess the performance of the skills. CPMs with additional experience beyond the entry level were trained as Qualified Evaluators to administer the NARM Skills Assessment to entry-level candidates.

Over the next few years, NARM established formal relationships with several states that already had licensure programs for direct-entry midwives. Those states wanted to continue to oversee their apprenticeship training programs, but to use the NARM Written Exam as a state licensure exam. Eventually, all states licensing direct-entry midwives to attend home births were using the NARM Written Exam. Candidates in those states were verifying their skills through the state-supervised programs, and verifying their knowledge through the NARM Written Exam. States with clinical requirements that met the NARM clinical requirements were considered equivalent in educational requirements, and midwives licensed in those states were allowed to qualify for the CPM by virtue of having documented their skills and clinical experiences through the state program. Those candidates did not have to take the NARM Skills Assessment, as their skills were verified by the state. Also, the Midwifery Education Accreditation Council (MEAC) was developed to accredit direct-entry midwifery schools. Students in MEAC-accredited schools verified their skills and their clinical experiences through the schools, and could qualify for the CPM after passing the NARM Written Exam.

Initially, candidates documented their clinical experiences under supervision on the NARM application, passed the Written Exam, and then passed the Skills Assessment. NARM revised the applications process so that all candidates would document their skills and clinical experiences prior to sitting for the Written Exam. Candidates could qualify for the Written Exam by having NARM evaluate their clinical experiences and skills, or by having those skills and experiences evaluated by a state licensure program or a MEAC school. NARM's evaluation was named the Portfolio Evaluation Process (PEP), and consisted of documentation by a preceptor of the candidate's required clinical experiences and check-off on the 750 skills. Those candidates then took the NARM Skills Assessment with a Qualified Evaluator who was not one of her preceptors. This double-check of the skills was considered to be equivalent to the educational consultant's recommendation of having only CPMs as preceptors.

NARM now has over 1,000 CPMs. There are still not enough CPMs in all states to require that all entry-level midwives train only with a CPM. However, more and more incoming midwives are being trained by CPMs. At this time, all PEP candidates must be evaluated also by a Qualified Evaluator who is a CPM. NARM is considering revising the process for documentation of skills to allow more flexibility in meeting the original intent of verification by two CPMs.

NARM is considering an alternate proposal for verification of skills:

1) Current process: verification of clinical experiences and skills by a credentialed midwife (CPM, LM, CNM) or experienced non-credentialed midwife, and passing the NARM Skills Assessment with a Qualified Evaluator.
2) New additional process: verification of all clinical experiences and the 750 item skills checklist by one or more CPMs, and second check-off of selected skills by another CPM who is not among the preceptors listed in the first verification.

Selected skills would probably be : initial exam; routine prenatal exam, newborn exam, and postpartum exam.

If the above proposal is accepted, NARM candidates would have the option of verifying skills in the current

manner, or if ALL clinicals and skills are verified by a CPM, and a second verification of specific skills is also verified by another CPM, the candidate would not be required to take the NARM Skills Assessment.

Feedback on this proposal is being solicited from all CPMs through any of the following mechanisms:

a) e-mail to skills@narm.org
b) e-mail discussion on the e-list of the CPM section of MANA (contact manamw@aol.com if you wish to become a member of that group and are a current member of MANA)
c) open mike discussion during the CPM Section meeting at the MANA conference in Boulder.

Following the MANA conference at the end of September, the NARM board will consider all feedback that has been received at that point. If the Board approves this proposal, it would be implemented beginning in January of 2006.

CPM Process Streamlined for UK Midwives

Sara Wickham

Following several months of work, discussion and lots of transatlantic emails, we are delighted to announce that we have now successfully streamlined the Certified Professional Midwife application process for Registered Midwives who have been educated in the United Kingdom and whose names are entered on the relevant part of the NMC (Nursing and Midwifery Council) register.

As you will know, the first part of the CPM process includes the completion of a skills and education profile to evidence of the numbers of different episodes of care the student has undertaken. Because midwives in the UK ~ and, indeed, across the European Community ~ have already had to undertake a very similar process, it seemed obvious that we could streamline the process and make things easier both for European midwives and for NARM. Although the numbers and basic principles of midwifery education are the same across the European Community, there are a few differences in the content of the educational programmes that midwives undertake in different European countries, which is why the current project has only included the UK. There is no reason that midwife educationalists from European countries could not also undertake the same exercise with NARM.

There are a few things that midwives learn in the UK that are not included in the CPM assessment and, more importantly here, a few things on the CPM assessment that are not absolute requirements in the UK, so British midwives will still have to provide additional evidence of these. These include the imperative to have offered continuity of care and attendance at out-of-hospital births. Although many midwives in the UK will have achieved these things, they are not standard, so they will still need to be evidenced separately. British midwives wanting to apply for the CPM would also be well-advised to look carefully through both curricula to ensure that they are aware of any subtle differences before they move on to the next stage of the CPM process and apply for testing.

Sara Wickham is a midwife who has worked in the UK and USA. She currently works part-time as a Senior Lecturer in Midwifery and spends the rest of her time working internationally as a consultant in midwifery. She is the author of several birth-related books and editor of the Midwifery: Best Practice series.

New On Our Webpage

We have added a new section to the webpage. If you go to www.narm.org you will see Certification Process on the left. Cursor over that then click on Application Files. That page includes reference letters, ICA forms and General Form 100. There are also some supplemental pages for MEAC graduates.

NARM Exam Again Available in Spanish

NARM's Written Examination will once again be available in Spanish beginning with the August 17, 2005 administration of the exam.

A previous version of the exam had been translated and was in use for several years ending in 2000. The request for exams in Spanish is infrequent, but NARM feels that it should be available especially to our candidates in border states.

Candidates requesting the exam in Spanish will also be allowed to use an English version for comparison while taking the exam.

Due to the expense of translation and the infrequency of its use, not every form of the exam will be translated in the future.

We do hope to always have at least one version available in Spanish for future candidates.

NARM Workshop: Preparing for Legislation

The NARM Board has developed a workshop to assist midwives and consumers in preparing to submit legislation. This workshop has been developed with input from Susan Hodges of Citizens for Midwifery, Pam Maurath of the Midwifery Task Force, Debbie Pulley of the MANA Legislative Committee, and several midwives from Utah and Virginia who were successful in passing recent licensure legislation for CPMs.

Though the most intense work is done during a legislative session, the year preceding the submission of legislation is critical to successful passage. Legislators rarely have time for more than very brief discussion during the session, and their education about midwifery needs to take place between sessions, preferable in their home towns with their own constituents. This is best accomplished by a well-organized group, developing a database linking all state legislators with constituents who are supportive of midwifery. Strategies for effective lobbying, talking points, and dealing with controversial issues will be covered in the workshop. Making the best use of handouts and fact sheets, especially concerning the new CPM2000 article recently published in the British Medical Journal, will be part of the workshop.

Each participant will receive a copy of NARM's new Handbook for Legislation, which will also be available for sale in the Exhibit Hall. Participants will also be given information about working with NARM, CfM, MANA, and other support systems during their lobbying year and legislative session.

Although this workshop is designed for those who are working on licensure legislation, the information presented would also be helpful for those who are working on other midwife-related legislation, such as revisions to their licensure law, or Medicaid or insurance reimbursement laws. Lobbying and organization strategies would apply to any grassroots legislative proposals.

Every state even considering the possibility of introducing legislation should send one or two representatives to this half day pre-conference workshop at the MANA conference. NARM can also present this workshop in your state. For more information on hosting this or any NARM workshop in your state, call NARM at 1-888-353-7089. CEUs will be granted.

Come to NARM's Preparing for Legislation Workshop at the MANA Conference!

NARM Qualified Evaluator Workshop

NARM will present the Qualified Evaluator Workshop as a half-day pre-conference workshop at the MANA conference this year. Participants passing this workshop will become NARM Qualified Evaluators and will be eligible to administer the NARM Skills Assessment to candidates in NARM's Portfolio Evaluation Process. The workshop trains CPMs to administer the Skills Assessment in a fair and standardized manner. To take the QE workshop, you must be a CPM with two years additional experience beyond the CPM requirements, including 30 additional births, newborn exams, and postpartum exams, and 300 additional prenatal exams. QEs are paid $75 for administering the assessment. CEUs will be granted for the workshop. Current QEs may also take this workshop at a reduced fee for recertification as a QE. Interested CPMs should contact NARM at 1-888-353-7089 before registering for the QE Workshop.

Division of Research Deep Review Committee

Two of the NARM Board members are also participants on MANA's Division of Research (DOR) Deep Review Committee, which met on May 31 in Atlanta to discuss the particulars of data collection as it relates to the new web-based system. Carol Nelson and Ida Darragh met with fourteen other members of the DOR in a meeting sponsored by the Center for Disease Control (CDC). Three members of the CDC participated in the review to offer advice and comments on questions posed by the committee. The committee discussed many issues relevant to the data collection, including what data to collect, protocols for use and revision of the database, making sure the data collected is useful to the research agenda, security and confidentiality, and access to the data. The CDC advisors gave some good advice on maintaining the integrity of the data from collection through final publication. This meeting was funded through a generous grant from the CDC that paid the travel and lodging expenses of the invited participants. The Deep Review committee communicates throughout the year by e-mail, and plans to meet again in late August in San Francisco. The Division of Research will have an open meeting during the MANA conference and a working meeting the day following the conference.

Come to NARM's Preparing for Legislation Workshop at the MANA Conference!

NARM Applications Department Update 2005 Mid-Year Report

Carol Nelson, LM, CPM-TN, Director of Applications, Summertown, TN

Greetings from the NARM Applications Department. We hope you are all having a wonderful summer. We continue to get busier every month.

As of June 30th, NARM Applications Department has received a total of 76 applications in 2005.

There were 138 applications sent out to people requesting application packets. There are currently 87 applicants in some stage of the certification process.

CPMs

46 New CPM certificates have been issued so far in 2005.

TABLE OF COMPARISON Total number of CPM's	
2005-June	1042
2004	996
2003	893
2002	804
2001	724
2000	624

Recertification

The Applications Department now has a Recertification Table to keep track of incoming and outgoing recertifications. We will be sending out Recertification reminders a few months before your recertification is due. Debbie Pulley, Public Education and Advocacy Department, can look in the recertification Table, should a CPM want to know their status.

We have had 105 CPM's recertify so far this year

Table of Recertification Comparison	
2004	168
2003	126
2002	143
2001	148
2000	72

Inactive Status

As of June 30, 2005 we had 15 people take advantage of the inactive status this year, making a total of 42. Inactive CPMs will continue to receive the CPM News and may recertify within a six year period. Inactive status must be established within 90 days of the CPM expiration, and is maintained annually for up to six years. Inactive status in renewed each year by filing an intent to be inactive and a fee of $35.00. During this period, inactive CPMs will receive the CPM News and all NARM mailings, but may not use the CPM designation or refer to themselves publicly as a CPM or as certified by NARM. During the six year period, an inactive midwife may renew the certification by submitting the recertification form and fees ($150.00, 25 continuing education hours, five hours of peer review, plus the recertification form documentation.).

Expired CPMs

CPMs whose certification has been expired for more than 90 days, or who have not declared inactive status, will be given expired status and will be required to follow the new policy on reactivation in order to be recertified. All of NARM's policies regarding recertification, certification status, or reactivation are available on the web at www.narm.org

Audits

The Applications Department generates random audits from all applicants and CPM's recertifying. One (1) out of every five (5) applicants will be audited. Items required are Practice Guidelines, an Informed Consent document, forms and handouts relating to midwifery practice and an Emergency Care Plan.

Delinquent Applications

If, at the end of 1 year the application is either incomplete or an examination is not scheduled, a letter will be sent to the applicant giving notice of expiration of the extension. An applicant may request an additional 1 year extension on the application process by submitting the following:

- ❑ **A letter of request with an explanation of the need for an additional time.**
- ❑ **Resubmit 1 copy of a current driver's license.**
- ❑ **Resubmit 1 copy of a current CPR card.**
- ❑ **Resubmit 1 copy of current photo.**
- ❑ **Submit additional fee (money order or Cashier's check) in the amount of $200.00**

Failure to respond or submit additional requirements will result in the applicants file being closed and the application being archived. The applicant will have to resubmit new application with appropriate fees.

Just a reminder the current address is
NARM Applications
P.O. Box 420
Summertown, TN 38483

Please include your Social Security number and CPM number in any correspondence.

Please note, mail sent to the Alaska address will not be forwarded!

Attention Preceptors!

Please go to www.narm.org and fill out the preceptor survey. Thank you if you have already done so.

New NARM Webpage

NARM is pleased to announce the birth of its new webpage. Visiting hours are unlimited. Please feel free to stop by for a look! www.narm.org

MANA Conference 2005

Standing Tall, Growing Together

Join

- the Midwives Alliance of North America
- the Colorado Alliance of Independent Midwives, and
- the American College of Nurse Midwives - Denver Chapter

as they present MANA 2005

Sept. 30 through October 2, 2005

Registration information can be found
on the MANA website at
www.mana.org.
Click the Conference button on the left.

CPM News

P.O. Box 420
Summertown, TN 38483

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