MARCH OF DIMES POSITION STATEMENT MIDWIFERY CARE AND BIRTH OUTCOMES IN THE UNITED STATES

Summary

March of Dimes supports increased access to midwifery care for low- and moderate-risk women as part of an integrated system of care. In this statement, midwifery refers to certified nurse–midwives (CNMs), certified midwives (CMs) or midwives whose education and licensure meets the International Confederation of Midwives (ICM) Global Standards for Midwifery Education. Studies document that midwifery care is associated with lower interventions, cost-effectiveness, increased patient satisfaction and improved care.

March of Dimes believes that the approach and philosophy of midwifery, as described by the ICM, should be widely available as a choice for women. Midwifery care:[1]

- Sees pregnancy and childbearing as usually normal physiological processes
- Promotes, protects and supports women's human, reproductive and sexual health and rights and respects ethnic and cultural diversity
- Protects and enhances the health and social status of women and builds women's self-confidence in their ability to cope with childbirth
- Takes place in partnership with women, recognizing the right to self-determination; and is respectful, personalized, continuous and non-authoritarian

Summary of March of Dimes position statement:

- **March of Dimes supports efforts to expand access to midwifery care and further integrate midwives and their model of care into maternity care in all states. This can help improve access to maternity care in under-resourced areas, reduce interventions that contribute to risk of maternal mortality and morbidity in initial and subsequent pregnancies, lower costs, and potentially improve the health of mothers and babies.**

- **March of Dimes encourages states to examine their laws and regulations related to midwifery care to ensure they are not unnecessarily restrictive, foster access to these services for women who desire them, and promote full practice authority for midwives as part of an integrated system of care.**

Definitions, training and scope

CNMs and CMs provide a full range of primary health care services for women, including gynecologic and family planning services; preconception care; care during pregnancy,

MARCH OF DIMES

childbirth and the postpartum period; and care of the normal newborn.[2,3] A number of high-resource countries have a much higher percentage of births attended by midwives (50 to 75 percent of births) compared to the U.S. (less than 9 percent).[4] [5]

- CNMs represent most U.S. midwives, and 95 percent of births they attend occur in hospital settings.[6] CNMs have national certification and are licensed, independent health care providers with prescriptive authority in all states.
- CMs are licensed, independent health care providers who complete the same midwifery education as CNMs but have no prior nursing credential.[7]
- Certified professional midwives (CPMs) and lay midwives practice primarily in out-of-hospital settings, including birthing centers and planned home births. CPMs are legally authorized to practice in 30 states.[8]

March of Dimes endorses ICM minimum education and training standards for all midwives. Both CNMs and CMs meet and exceed these standards. March of Dimes welcomes the movement towards CPMs meeting the ICM standards. All births should be attended by licensed providers who meet the ICM standards, and should have a process in place for consultation, safe transfer of care and transport in the event of complications.

Equity

Higher rates of maternal mortality and morbidity and other adverse birth outcomes among black women in the U.S. has prompted interest in models of care that can improve outcomes, including midwifery and specific evidence-based supportive and preventive care programs developed and led by midwives.[9] Some studies have documented some negative experiences of black women in traditional hospital births,[10] the occurrence of provider implicit bias and poorer quality and differential care experienced by women of color.[11] March of Dimes supports efforts to increase the number of midwives of color and diversify the maternity care workforce with individuals who represent the lived and cultural experiences of the patients they serve.[13]

Full practice authority, state regulations and workforce shortages

March of Dimes supports full practice authority for CNMs/CMs, which means they are able to practice to the full extent of their education and training within a health care system that provides for "consultation, collaborative management or referral as indicated by the health status of the woman or newborn."[12] In the 2018 joint statement from ACOG and ACNM:[13]

- "Ob-gyns and CNMs/CMs are experts in their respective fields of practice and are educated, trained and licensed independent clinicians who collaborate depending on the needs of their patients.
- Quality of care is enhanced by collegial relationships characterized by mutual respect and trust; professional responsibility and accountability; and national uniformity in full practice authority and licensure across all states.
- Shortages and maldistribution of maternity care clinicians cause serious public health concerns for women, children and families."

Studies have revealed the importance of integrated care and collaboration. For example, "when professionals collaborate on decision-making and when coordination of care is seamless, fewer intrapartum neonatal and maternal deaths occur during critical obstetric events."[5]

Twenty-seven states have full practice authority for midwives, while the others impose restrictions including supervision and/or a collaborative agreement with a physician.[14] These restrictions can affect hospital privileges and third-party reimbursement, barriers that restrict the supply of midwives and prevent women in many states from accessing midwifery care.[5] States with full practice authority have approximately double the supply of midwives per 1,000 births than states where CNM practice is more restricted,[15] and maldistribution of care is a serious concern. A March of Dimes 2018 report found that 5 million women live in maternity care deserts (1,085 counties) with no hospitals offering obstetric care and no OB providers.[16] A 2016 study documented the crucial role CNMs play in the maternity care workforce in rural U.S. hospitals and the need to increase the number of midwives in rural maternity practice to address workforce shortages.[17]

A 2018 study found that states that have done the most to integrate midwives into their health care systems, as measured by a composite scoring system, have better outcomes for mothers and babies. Integration of midwifery care was strongly associated with fewer interventions (significantly higher rates of spontaneous vaginal delivery, vaginal birth after cesarean and breastfeeding; and significantly lower rates of cesarean sections).[5]

March of Dimes encourages states to examine their laws and regulations related to midwifery care to ensure they are not unnecessarily restrictive, foster access to these services for women who desire them and promote full practice authority for midwives as part of an integrated system of care.

Midwives and birth outcomes

Some studies have found that women with low- to moderate-risk pregnancies who receive midwifery care, or who have access to collaborative care that integrates midwives, are more likely to experience a low-intervention, spontaneous vaginal birth, more likely to be satisfied with their care and less likely to have a first cesarean delivery,[18] [19] thereby improving outcomes for subsequent births. Safely reducing primary cesarean delivery can play a role in reducing maternal morbidity in initial and future pregnancies.[20] Evidence is reviewed in more detail in the appendix.

March of Dimes supports efforts to expand access to midwifery care and further integrate midwives and their model of care into maternity care in all states. This can help improve access to maternity care providers in under-resourced areas, reduce interventions that contribute to risk of maternal mortality and morbidity in initial and subsequent pregnancies, lower costs, and potentially improve the health of mothers and babies.

August 29, 2019

Appendix

Midwives and birth outcomes: More detailed review of evidence

A 2016 Cochrane review of 15 randomized controlled trials (conducted in Australia, Canada, Ireland and the United Kingdom) compared the midwifery practice model to other models of care, focusing on lower-risk women:

- Women who received midwife-led care were less likely to experience intervention, more likely to have a spontaneous vaginal birth and more likely to be satisfied with their care.
- Women who received midwife-led care were less likely to experience preterm birth, fetal loss before and after 24 weeks and neonatal death. Further research is needed to explore these findings.
- The authors stated that "due to the exclusion of women with significant maternal disease and substance abuse from some trials of women at mixed risk, caution should be exercised in applying the findings of this review to women with substantial medical or obstetric complications."[29]

Other studies have found that midwifery care increases the chance of having a low-intervention birth, lowers costs and reduces the chance of having a first cesarean delivery (when compared to physician care for equally low-risk women),[21] thereby improving outcomes for subsequent births.

- A 2017 U.K. study found that low-risk women giving birth for the first time at interprofessional centers (midwives and physicians) were less likely to experience induction, oxytocin augmentation and cesarean birth than women at centers with only physicians.[22]
- Another U.K. study found that low-risk women who had given birth multiple times had significantly higher rates of vaginal birth, including vaginal birth after cesarean delivery, and lower likelihood of labor induction when cared for in centers with midwives.[23]
- U.S. studies have found that midwifery care is linked to lower cesarean delivery rates among low-risk women.[24] [25] For example, a study of hospital data in New York found that hospitals with more midwife-attended births had lower utilization of obstetric procedures (including cesarean delivery and episiotomy) among low-risk women.[26]

Safely reducing primary cesarean deliveries can play a role in reducing maternal morbidity in initial and future pregnancies. ACOG states that "although the initial cesarean delivery is associated with some increases in morbidity and mortality, the downstream effects are even greater because of the risks from repeat cesareans in future pregnancies."[29] Given the evidence that midwifery care may reduce cesarean deliveries, it can be inferred to play a role in reducing the effects of increased maternal morbidity and mortality in future pregnancies. A 2019 California study found that cesarean delivery was associated with 2.7 times the risk of severe maternal morbidity compared to vaginal delivery, and was estimated to contribute to 37 percent of severe maternal morbidity cases.[27] A 2009 study of a sample of U.S. deliveries from 1998 to2005 found that cesarean delivery was associated with an increasing trend of severe delivery complications.[28]

---

[1]International Confederation of Midwives. Philosophy and Model of Midwifery Care. Available at: www.internationalmidwives.org.

[2] Renfrew MJ, McFadden A, Bastos MH, et al. Midwifery and quality care: findings from a new evidence-informed framework for maternal and newborn care. Lancet 2014 Sep 20;384(9948):1129-45.

[3] ACNM. Definition of Midwifery and Scope of Practice of Certified Nurse-Midwives and Certified Midwives. Available at www.midwife.org.

[4] Martin JA, Hamilton BE, Osterman MJKS, Driscoll AK, Mathews TJ. National Vital Statistics Reports, Volume 66, Number 1, January 5, 2017. 2015 [cited 2017 May 10];66(1).

[5] Vedam S, Stoll K, MacDorman M, et al. Mapping integration of midwives across the United States: Impact on access, equity, and outcomes. PLoS One 2018;13(2):e0192523).

[6] Walker, D, et al. Midwifery Practice and Education: Current Challenges and Opportunities. The Online Journal of Issues in Nursing. 2014 19(2).
[7] ACNM. Essential Facts about Midwives. Available at: http://www.midwife.org/Essential-Facts-about-Midwives
[8] Midwives Alliance of North America. Legal Status of U.S. Midwives. Available at: mana.org.
[9] Black Mamas Matter Alliance. April, 2018. Black Paper: Setting the Standard for Holistic Care of and for Black Women.
[10] Black Women Birthing Justice. (2016). Battling over Birth.
[11] Jain JA, Temming LA, D'Alton ME, et al. SMFM Special Report: Putting the "M" back in MFM: Reducing racial and ethnic disparities in maternal morbidity and mortality: A call to action. Am J Obstet Gynecol 2018;218(2):B9-B17.
[12] ACNM. (2012). Position Statement: Independent Midwifery Practice. Available at midwife.org.
[13] ACOG ACNM. (revised and reaffirmed April 2018). Joint Statement of Practice Relations between Obstetrician-Gynecologists and Certified Nurse-Midwives/Certified Midwives.
[14] Midwifeschooling.com. States that Allow CNMs to Practice and Prescribe Independently vs those that Require a Collaborative Agreement. Available at: midwifeschooling.com.
[15] Yang et al, State Scope of Practice Laws, Nurse-Midwifery Workforce, and Childbirth Procedures and Outcomes. Women's Health Issues 26-3 2016 262-267.
[16] March of Dimes. (2018). Nowhere to Go: Maternity Care Deserts Across the U.S.
[17] Kozhimannil, KB, Henning-Smith, C., Hung, P. The Practice of Midwifery in Rural US Hospitals. Journal of Midwifery and Women's Health 16 Jul;61(4):411-8.
[18] ACNM. Midwifery: Evidence-Based Practice. Available at: www.midwife.org.
[19] Rosenstein MG, Nijagal M, Nakagawa S, Gregorich SE, Kuppermann M. The Association of Expanded Access to a Collaborative Midwifery and Laborist Model With Cesarean Delivery Rates. Obstet Gynecol 2015 Oct;126(4):716-23.
[20] ACOG Obstetric Care Consensus No. 1. Safe Prevention of the Primary Cesarean Delivery. March 2014 (Reaffirmed 2016).
[21] ACNM. Midwifery: Evidence-Based Practice. Available at: www.midwife.org.
[22] Hollowell J, Li Y, Bunch K, Brocklehurst P. A comparison of intrapartum interventions and adverse outcomes by parity in planned freestanding midwifery unit and alongside midwifery unit births: secondary analysis of 'low risk' births in the birthplace in England cohort. BMC Pregnancy Childbirth 2017;17(1):95)
[23] Symon A, Winter C, Cochrane L. Exploration of preterm birth rates associated with different models of antenatal midwifery care in Scotland: Unmatched retrospective cohort analysis. Midwifery 2015;31(6):590-6.
[24] Rosenstein MG, Nijagal M, Nakagawa S, Gregorich SE, Kuppermann M. The Association of Expanded Access to a Collaborative Midwifery and Laborist Model With Cesarean Delivery Rates. Obstet Gynecol 2015 Oct;126(4):716-23.
[25] Rosenstein M, Nakagawa S, King TL, Frometa K, Gregorich S, Kuppermann M. 154: The association between adding midwives to labor and delivery staff and cesarean delivery rates. *Am J Obstet Gynecol*. 2016;214(1):S100.
[26] Symon A, Winter C, Inkster M, Donnan PT. Outcomes for births booked under an independent midwife and births in NHS maternity units: matched comparison study. BMJ 2009 Jun 11;338:b2060.
27 Leonard S, Main E, Carmichael S. The contribution of maternal characteristics and cesarean delivery to an increasing trend of severe maternal morbidity.BMC Pregnancy and Childbirth 2019 19:16
[28] Kuklina EV, Meikle SF, Jamieson DJ, Whiteman MK, Barfield WD, Hillis SD, et al. Severe obstetric morbidity in the United States: 1998-2005. Obstet Gynecol. 2009;113(2 Pt 1):293–9.