

The Minnesota Midwives' Guild

Standards of Care

(c) Copyright 1989-2006, ALL RIGHTS RESERVED

Revised and updated June, 1996

Revised and updated October 2001

Revised and updated July 2004

Revised and updated November 2005

Revised and updated October 2007

Revised and updated March 2009

Address all inquiries and requests to:

The Minnesota Midwives Guild
Attention: Secretary, Gail Tully, CPM
10545 Humboldt Ave. So.
Bloomington, MN 55431-3118

Introduction and History

In 1975, Genesis was formed as a midwifery group in the Twin Cities area. The founding mothers of Genesis were and are women who spontaneously evolved from being mothers to being midwives to fill the void left by the retirement of Minnesota's last licensed midwife, Ebb Kirschbaum.

In time, other women in the Twin Cities and throughout the state began to attend to the needs of pregnant women desiring to birth at home. The Minnesota Midwives' Association (MMA) was formed in 1985 to provide a cohesive network for midwives in the state.

The Minnesota Midwives' Guild was formed in the fall of 1988 in response to a need for an all-inclusive statewide network for traditional midwives.

We see traditional midwifery as an art and a craft uniquely passed from one woman to another; from one generation of women to the next generation of women yet unborn. In our work, we honor the knowledge and the wisdom of our mothers, our grandmothers, and the mothers that came before them. We draw from the commonality and the diversity of our cultural and ethnic heritages to provide care that is unique to our area and its people.

We seek egalitarian relationships between ourselves and the families we serve. In educating, supporting, and counseling the women and their families before, during, and after childbirth, we impart our expertise and remove ourselves from the role of experts. Our care emphasizes the time tested principle, methods, and values of traditional midwifery as well as modern and innovative concepts that are compatible with long standing midwifery traditions.

1996: This guide defines and delineates the practice of professional midwifery in the state of Minnesota for the purposes of self-regulation and certification of NARM. The intent is to have Certified Professional Midwife status to be recognized by the State of Minnesota. Until a mutually satisfying agreement can be made for both parties, the MMG will continue to uphold independent midwifery in Minnesota while supporting safe practice standards and basic competency requirements for its midwife members.

2001: The Minnesota statute providing licensure for Minnesota midwives was successfully re-activated and put into law. Traditional midwives in Minnesota may now apply to the Minnesota Board of Medical Practice for a license to practice traditional midwifery. The CPM credential is a licensure requirement but the licensing law is voluntary which does not require a midwife possess a license in order to practice. An

Advisory council has been set up through the Board of Medical Practice to oversee and advise the BMP on licensure applications and complaints/grievances. MidwiferyNow! (MNow!) is a legal/political action group and umbrella for legislative work, peer review, and support for midwives in Minnesota.

The MMG's most recent role in these historical changes is concerned with the maintenance and integrity of the Standards of Care. Licensed traditional midwives in Minnesota are required to adhere to and abide by these Practice Standards. The Standard of Care committee within the MMG is comprised of licensed midwives and CPMs.

Prenatal Care Standards

“Parents who choose to give birth at home are, in essence, saying that they are accepting full responsibility for their bodies, their pregnancies, and their babies.”

Cheryl Bates

Acknowledging the need for common language, we define the prenatal period as the time from the first day of the last menstrual period (LMP) prior to conception to the onset of labor.

Pregnancy is a healthy life event. It is a unique and highly individual experience that brings commonality to the lives of most women. The obvious and subtle changes brought about by pregnancy prepare the woman for giving birth and mothering.

To optimize the health and well-being of the mother, the baby, and thus the family, every pregnant woman needs thorough prenatal care that entails observation, evaluation, education, and guidance toward making pregnancy a safe and satisfying time. The best possible outcome for both mother and baby occurs when prenatal care is complete and is started in the first trimester of pregnancy. In recognizing that, we set forth the following guidelines:

The focus of the midwife must be a healthy mother and baby. The place of birth is secondary. The pregnant woman and her family need to realize this and be open to accepting the advice of the midwife while retaining ultimate responsibility for their individual situation.

The midwife needs to stress the importance of good nutrition, exercise, sleep, rest, relaxation, and spiritual/religious resources in coping with the stresses of pregnancy, labor, and birth.

The midwife must be alert to the potential complications arising from the woman's unresolved anxieties surrounding her previous pregnancy/childbirth/mothering experiences or childbirth in general.

The midwife's agreement to help the pregnant woman and her family can be terminated at the midwife's discretion at any time she deems necessary for reasons of emotional or physical safety. A note specifying the date and reason for termination of care should be made in the chart. A formal written notice of care transfer should be given to the woman and should include an advisement on alternate sources of care.

The need for safety and appropriate care must not be compromised because of fear of transfer of care politics during the pregnancy, or during the labor, birth, and postpartum period.

All licensed traditional midwives are currently required by law to provide, discuss, and mutually sign an Informed Consent Agreement & Medical Consultation Plan with each family they work with. It is recommended that all practicing midwives utilize the informed consent process as a clarifying and communication tool / resource. A prototype of the Informed Consent form approved by the Advisory Council for Traditional Midwifery is included in the appendix for your convenience.

Initial Visit

The midwife meets with the pregnant woman and her family to decide on the feasibility of establishing a midwife-to-family relationship. It is of utmost importance to keep in mind the intimate and long-lasting nature of this relationship and make decisions accordingly. The midwife needs to feel comfortable with the pregnant woman's reasons for wanting to have a home birth, her family's lifestyle and belief system, and her commitment to breastfeeding. The family seeking midwife care must be in agreement as to their responsibility for home birth plans. Indecision or conflict in this area may manifest itself as a physical complication, placing the mother, baby, and midwife at risk.

The midwife should not assume the home to be the only safe place for birth. The midwife needs to ascertain on the initial visit, both verbally and in writing, a detailed health history that will help in evaluating the presence of situations or conditions that would contraindicate planning a home birth. The health history needs to be inclusive of the pregnant woman's social, medical, surgical, gynecological, contraceptive, obstetrical, family, nutritional, and drug/chemical use histories. The midwife will develop a form to help her gather all of this information in a thorough, systematic fashion.

In determining an accurate Estimated Due date (EDD) the following must be taken into account: date of the last menstrual period and whether there is any question as to normality of the quality or quantity of flow; the previous menstrual period to ascertain probable cycle length; the range of cycle in recent months; the possible or probable date of conception; the date of the positive pregnancy test, if available; the date of the first signs and symptoms suggestive of pregnancy; the date of quickening; and the week the fundus reached the umbilicus.

If the pregnant woman contacts the midwife after the first trimester of her pregnancy, the midwife shall assess the quality of any previous care and/or self care, including nutrition, and shall assume responsibility for care only if satisfied that the prior care has been adequate. It is up to the pregnant woman to obtain copies of the records for the care she has received elsewhere.

Before the midwife can make a final decision on assuming care she must obtain the following information:

LABORATORY TESTS

The following must be obtained and evaluated:

1. The results of initial lab pregnancy screening (blood group and type, antibody screen, Indirect Coombs, rubella titer, CBC with differential, and syphilis serology).
2. Gonorrhea and Chlamydia cultures.
3. UA for protein and glucose. Culture as indicated.
4. Hepatitis B panel, if indicated.
5. Sickle cell screening, if indicated.
6. HIV, if indicated.
7. Other vaginal cultures, if indicated.

The midwife should request any other information she deems pertinent to making a decision to work with a family.

First Prenatal Visit

The midwife shall maintain an individual chart for each woman in her care. The completed chart shall include the completed health history form, the laboratory results, labor and birth records, prenatal and postpartum flow sheets that include the information set forth in these guidelines.

The chart maintained by the midwife and the communications between the midwife and the women under her care shall be privileged and confidential information. The chart shall be made available upon request, and with the woman's consent, to any health care provider who is called upon for consultation or referral. Consultations, referrals, and visits with any other health care practitioners throughout the pregnancy, labor, birth, and the postpartum period need to be noted in the chart.

Included in the first prenatal visit is a thorough examination and discussion of the pregnant woman's diet history. The midwife needs to help the pregnant woman assess her nutritional status. The midwife may choose to refer the woman to another health care provider for nutritional consultation. The mother's nutritional status should be monitored throughout the pregnancy.

Also to be included in the first prenatal visit is a detailed discussion of the information gathered through the health history and lab results. Suggestions and recommendations need to be made immediately to optimize fetal and maternal well being.

The midwife needs to address the family's postpartum plans throughout the pregnancy: postpartum expectations, needs, and plans require definition and redefinition.

Prenatal Education

Education for the pregnant woman and her family is an essential part of midwifery care. In pregnancy, there is much to be experienced and understood. By nurturing the pregnant woman and her family with information, support, counseling and referral, the midwife contributes to the well being of the whole family.

A pregnant woman or family member who is helped to understand what is happening during pregnancy, childbirth, and the postpartum period will be better able to cooperate with the natural processes. This is realistically a preventative health measure to ensure healthy childbearing.

Education during pregnancy may include explanation of changes and needs related to pregnancy and childbirth, newborn and infant care, anticipatory guidance, short term counseling, crisis, intervention, and referral to health care providers and community groups and services. Education needs to continuously change as new information becomes available to the midwife. Time needs to be allotted during each prenatal visit for the purposes of education and counseling. The midwife needs to make herself available to answer pressing questions that may arise in between prenatal visits.

Components that may be addressed prenatally may include but are not limited to:

1. Nutrition during pregnancy and the postpartum period
2. Fetal development
3. Exercise and activity
4. Relaxation
5. Spiritual/religious resources
6. Sleep and rest requirements
7. Danger signs and symptoms during pregnancy
8. Breastfeeding
9. Family relationships
10. Fears and emotional aspects of pregnancy, birth, postpartum
11. Sexuality during pregnancy and postpartum
12. Pelvic floor preparation for birth
13. Signs of end of pregnancy
14. Normal labor and birth
15. Preparing children for the birth experience
16. Complications of labor, birth, and immediate postpartum, including neonatal death
17. Emergency plans
18. Essentials of newborn care
19. Contraception
20. Common labs and screening

Prenatal Visits

Throughout the pregnancy, dialogue and discussion as to mutual expectations, rights, responsibilities, and limits needs to be encouraged and sustained. The relationship between the midwife and the families under her care is an egalitarian one in which the midwife imparts her expertise to empower the family and thus removes herself from the role of expert.

The midwife shall see the pregnant woman (and her family if possible) every three to four weeks until the 28th week; every two weeks between the 28th and the 36th week; and weekly from the 36th week to the time of birth. At least one of these visits needs to take place in the pregnant woman's home (around 36-38 weeks). If there is an indication of potential or existing problems/difficulties/complication, the above schedule needs to be amended to include more frequent visits.

At each prenatal visit, the midwife should assess the pregnant woman's:

1. Weight
2. Blood pressure
3. Pulse
4. Edema
5. Nutrition
6. Exercise/rest/relaxation/sleep/stress/fatigue
7. Gross urinalysis (protein, glucose)
8. Emotional well being
9. Discomforts associated with pregnancy: nausea, vomiting, backaches, leg cramps, sciatica, digestive difficulties, constipation, diarrhea, hemorrhoids, and varicosities
10. Signs and symptoms requiring evaluation: vaginal or rectal bldg., vaginal discharge, recent or current bacterial or viral infection, vertigo, visual changes, shortness of breath, structural problems, muscular problems, circulatory problems, contractions, swelling, ligament pain and/or tenderness, pelvic pressure, pubic tenderness, pain and any other complaint voiced by mother
11. Need for education as to cause, treatment, and prognosis of any symptoms, problems or concerns including the expected physical, emotional, spiritual, and mental changes brought about by pregnancy
12. Need for ongoing discussions about the benefits of good nutrition, exercise, sexuality, emotional changes, family relationships and other concerns that may arise
13. Need for information regarding community resources

At each prenatal visit, the midwife should assess the developing baby in terms of:

1. Fundal height
2. Gestational age assessment by dates and clinical examination
3. Presentation and position
4. Estimated fetal weight
5. Fetal activity (note quickening and monitor each visit thereafter)
6. Rate and location of fetal heart tones (note date of first FHT's heard by fetoscope and auscultate FHT's thereafter) HGB/HCT should be done at the time of acceptance of care, at approximately 28 weeks, and repeated as necessary.

In cases of Rh negative mother, it is advisable to secure the father's blood group and type; and antibodies screening of the mother should be done at the time of acceptance of care, and again at 28 weeks to rule out sensitization.

Pelvimetry may be done at any point during the pregnancy the midwife deems appropriate. Shape is of greater importance than size. Clinical pelvimetry includes: the diagonal conjugate, the bi-ischial diameter, the ischial spines, the pubic arch, the A P diameter, the shape of the sacrum, and mobility of the coccyx, as well as visual inspection of vulva and perineum.

Last Trimester

The midwife shall discuss with the family the selection of a health care provider who will be consulted for newborn care. The midwife needs to formulate a written medical consultation plan in case of a medical emergency.

The midwife and the family should discuss issues relating to the birth plan including:

1. Facilities in the home
2. Necessary supplies
3. Adequate heat
4. Availability of telephone and list of emergency numbers
5. Names and phone numbers of designated health care providers
6. The partner/father's preparation and participation
7. Preparation and care of older children
8. Those invited to be present at the birth
9. Signs of labor
10. When and how to contact the midwife

As the pregnancy comes to an end, it is imperative that the midwife guide the expectant family through an overview of the initial postpartum period. The expectant mother and her family should receive from the midwife an after-care sheet: as a minimum it needs to outline the basics of maternal and newborn care in the immediate postpartum and list signs that signal the parents should contact the midwife or a health care provider immediately.

The midwife needs to determine if a realistic postpartum plan has been developed by the family prior to the time of birth: ideally, the new mother will be free of all responsibilities beyond care for herself and her baby for a minimum of 1-2 weeks, although the time might be greater in case of a difficult birth or if there are small children in the family.

During the 36-38 week home visit, the midwife shall evaluate:

1. If all birth supplies are present
2. Alternate plans for the care of other children
3. Review plans for postpartum
4. Review parental and midwife expectations
5. Need for further plans

During this visit (sooner), the midwife needs to initiate a discussion with the expectant family in which the original birth plans are re-evaluated in terms of the course of the pregnancy. It is important to address at this time the changes that have taken place physiologically, emotionally, and socially that bear significance on the original home birth plans.

The midwife is not to assume that the home is the only place for the birth to take place. Thoughts and feelings that have evolved or remain consistent need a closer look. Late pregnancy referral is almost always a better option than transporting to the hospital in labor.

Each midwife shall be responsible for having written protocols or resources regarding her care guidelines for the following prenatal conditions/situations:

1. Parameters of nutritional needs including the use of food supplements
2. Exercise/rest/relaxation/sleep guidelines
3. Minor prenatal problems/discomforts: nausea and/or vomiting, constipation, heartburn, hemorrhoids, low back pain, insomnia, leg cramps, round ligament pain
4. Anemia
5. Viral or bacterial infection
6. Urinary tract infection
7. Vaginal infection
8. Genital herpes
9. Pre-eclampsia
10. Excessive or insufficient weight gain
11. Elevated blood pressure
12. Proteinuria
13. Pitting edema
14. Suspected gestational diabetes
15. Signs of pre term labor
16. Premature labor onset
17. Suspected placenta previa
18. Suspected placental abruption
19. Malpresentation at or beyond 36 weeks

Labor and Birth Care Standards

“I never brought a baby without a prayer.”

Ebba Kirschbaum, 1897-1984

Minnesota Licensed Granny Midwife

During labor and birth the midwife helps the laboring woman and her family in the following:

1. Ascertaining that labor is in progress
2. Assessing the well-being of mother and baby
3. Noting the progress of labor
4. Assisting with labor support, guidance, and comfort measures
5. Preparing the equipment and supplies for the birth
6. Monitoring the emotional atmosphere
7. Maintaining the integrity of the birth environment
8. Assisting in the birth of the baby and placenta
9. Assessing the newborn
10. Inspecting the placenta, membranes, and cord vessels
11. Inspecting the perineum, vagina, and if necessary, the cervix
12. Assuring that lacerations are repaired as necessary
13. Establishing breastfeeding
14. Dealing with any difficulties, problems and/or complications according to the guidelines cited elsewhere in this document and in accordance with traditional midwifery practice

The midwife shall have the ability to recognize and control postpartum hemorrhage and perform emergency resuscitation of the cause and/or newborn. The midwife shall have a current CPR card.

Pre -Labor

Pre labor activity can last for days and is unique to each birthing woman. The midwife needs to keep in close contact with the mother.

In case of ruptured membranes:

The pregnant woman and her family must receive prenatally from the midwife information about self-care in case of spontaneous rupture of membranes before onset of labor or early in labor prior to the midwife's arrival at the home. Unless the midwife is already en route to the home, she needs to be notified immediately of the spontaneous rupture of membranes.

First Stage

The first stage of labor is characterized by a history and timing of contractions, the existence or non-existence of bloody show, possible rupture of membranes and subjective feelings on the part of the laboring woman. On the part of the midwife, assessment of the labor depends on contraction strength, duration and frequency; observation of the laboring woman's behavior; and occasionally a vaginal exam to determine dilation, effacement, and station.

Whereas we recognize that the father/partner/labor support person(s) are valuable, they cannot be used in lieu of the midwife's assessment.

The midwife shall remain with the laboring woman continuously once contractions are established at a regular frequency of five minutes, or she is more than five centimeters dilated, or she feels the need for the midwife's presence. The presence of any factors that place the health and well being of the pregnant/laboring woman and her soon to be newborn child at risk is more than sufficient reason to demand continuous and uninterrupted midwife attendance. For example, midwife presence must be continuous after ruptured membranes if vaginal exam(s) have taken place. Labor support people must not be used in lieu of the midwife's presence at the labor.

Professional midwife care of the laboring woman is directed toward total emotional, physical, and spiritual support of the woman. Assessing labor changes through subjective signs is one of the most important skills of traditional midwives. Objective assessments need to be made as per guidelines in the Labor and Birth Flow Sheet. Occasionally, a labor will slow down or stop altogether during the first stage. The woman needs to be fed, hydrated, and well rested if this occurs. The woman and her midwife can wait for resumption for as long as is needed and tolerated. In case of ruptured membranes, follow the guidelines/instructions regarding self-care and hygiene. Each midwife is responsible for maintaining and following protocols regarding ruptured membranes.

With prolonged labor, dipstick for ketones is necessary to evaluate the laboring woman's need for metabolic energy: fluid and carbohydrates. The midwife is to encourage the woman to maintain activity as long as possible throughout the labor. Periods of activity need to alternate with periods of rest in longer labors. The laboring woman needs to be reminded of the importance of eating and drinking. Elimination is also important, and the laboring woman is reminded of the need to void frequently.

Signs and symptoms of transition: nausea, shaking, chills, increased perspiration, catch in the throat, increase in rectal pressure, subjection feeling of inability to cope, malor flush. Most women are very inner directed at this time. This is also the most common time for the spontaneous rupture of membranes.

Second Stage

The laboring woman is encouraged hold off voluntary pushing as long as possible to avoid pushing against the cervical rim and to allow the baby to find the best possible angle of entry into the birth canal. The woman should empty her bladder prior to voluntary pushing efforts.

The laboring woman needs to be supported during this phase of the birth process in any position that she chooses. If a particular position does not bring steady progress, the woman should be encouraged to try other positions until an effective one for that woman and her baby is discovered. With posterior babies, it is recommended that the mother change position after every couple contractions. Whenever possible, the supine position should be avoided. Large babies, because of the possibility of large shoulders, need to be birthed in any position but supine or semi-sitting.

The midwife should make every attempt to help the woman keep her perineum intact. Hot compresses, perineal massage with oil, controlled pushing and attempting to birth the baby's head as gently possible are all useful for avoiding perineal lacerations.

In rare occasions where it may be necessary to protect the health of the baby, an emergency episiotomy may be done. This may most likely occur with:

FHT decelerations (less than 80 bpm lasting more than 20 seconds after pushing)

Thick, tight, resistant perineal muscle that is arresting crowning causing change in scalp color or change in FHT's

It is usual traditional midwifery practice to ask the mother to stop pushing after the birth of the baby's head in order to allow the midwife to check for a nuchal cord, to allow shoulders to rotate, and to perform any suctioning that may be indicated. In the event of any meconium staining, OSHA approved suctioning of the infant's airway needs to be done prior to the expansion of the chest.

The exact time of birth needs to be noted and recorded. In conjunction with any efforts necessary to encourage breathing, maintenance of warmth of the baby is of utmost importance. The most efficient method of warming is skin to skin contact. The baby needs to be dried and covered with warm blankets. A soft cotton hat is used to cover the baby's head.

Ideally, clamping and cutting the cord is done after it has stopped pulsating and the woman has birthed the placenta. Sometimes due to a short cord or a history of ABO or Rh negative blood (cord blood sampling), the cord needs to be cut as soon as the baby is breathing well by its own efforts.

Once the baby is born, every attempt should be made to minimize the presence and impact of the midwife and other birth attendants on the environment as the new family bonds.

Third Stage

It is important for the midwife as well as the new family to remember that the birth is not complete until after the birth of the placenta.

Once the baby is born, the contractions become progressively weaker and occur at increasingly longer intervals. Because of this, it is necessary to attend to the birth of the placenta as soon as possible after the birth of the baby. Phone calls to family and friends should be delayed until the placenta has been passed.

If there are signs of extensive bleeding or concealed bleeding, the placenta must be passed at once. Otherwise the midwife can observe for signs of placental separation including lengthening of the cord, gush of fresh blood from the vagina, and the uterus rising up to the umbilicus and becoming globular and mobile. It is important not to massage the uterus until placental separation is certain as this may cause undue bleeding.

Gravity and maternal efforts are the safest methods to accomplish the birth of the placenta. Controlled cord traction could prove dangerous in cases of partial placental separation. The midwife shall examine the placenta for completeness and note gross anatomic characteristics: unusual coloration, calcifications, adipose accumulations, and integrity of cord insertion. The midwife shall examine the umbilical cord for the appropriate number of vessels. The midwife should also note if there is any unusual odor to the placenta. The midwife must do her best to keep the mother and her baby together throughout the third stage.

Fourth Stage

This is the beginning of the postpartum period, starting with the birth of the placenta and continuing for one hour.

During this time, the midwife needs to check the fundus every 5-10 minutes. In cases of excessive bleeding during third stages, the uterus needs to be guarded by the midwife throughout the entire hour.

Professional midwife care at this time includes:

1. Maintaining the baby's airway
2. Keeping the baby warm and dry
3. Checking maternal and infant vital signs
4. Encouraging the nursing relationship
5. Cleaning the mother and infant
6. Seeing to it that the mother is fed
7. Having the mother drink a minimum of one quart of nutritious fluids
8. Inspecting the perineum and the vagina
9. Making an ongoing assessment of mother and newborn well being

This is the transitional point between birth and postpartum. See postpartum section for more detailed guidelines.

Postpartum Care Standards

“We are assisting not only in the birth of the baby but in the birth of a family . . . that’s our focus.”

Anne Froehlich

Postpartum care presupposes thorough prenatal care and education. It also presupposes preparation in the preventative sense to offset problems and difficulties that may and will arise once the baby is born. We define the postpartum period as encompassing the time between the birth of the baby and the end of the weaning.

The midwife needs to provide guidance so that parents are well prepared in terms of knowledge and confidence in their new roles. The emotional needs of the family need to be acknowledged and addressed. The postpartum environment needs to be guarded in many of the same ways as the birth environment: the home needs to be kept clean, well-supplied, and smooth running. The network of family and friends needs to be organized to ensure after-birth care and support for the family.

In recognition of the significance of the postpartum period for the physical, emotional, and spiritual well-being of the newborn, the mother and the growing family, we set forth the following guidelines.

The expectant family should receive prenatally from the midwife complete information (and resources) on the following:

BREASTFEEDING. Breastfeeding is the best way for a new mother to feed and nurture her baby. The midwife should be prepared to make La Leche League referrals, offer a variety of books and publications on the various aspects of breastfeeding, and share in her own experiences.

NUTRITION. To maintain a nutritionally sound diet is just as important in the postpartum period as it was prenatally. The continuation of the prenatal diet (including supplements) with an increase in fluid intake, protein, and calories is essential to insure maternal health and provide for successful nursing of the baby. It is important for the midwife to consider postpartum difficulties in the context of possible nutritional deficiencies.

FAMILY HEALTH CARE. The midwife should make available prenatally to the family referral to a wide array of routine and acute health care providers that could serve the family’s needs postnatally, including family practitioners, pediatricians, obstetricians / gynecologists, osteopaths, chiropractors, and naturopaths.

JAUNDICE. Information needs to be given to the parents on preventing and / or minimizing newborn jaundice. Preventative care must be emphasized in cases of potential Rh and / or ABO blood incompatibility.

EYE PROPHYLACTICS AND PROPHYLACTIC VITAMIN K Expectant parents need to be educated as to what they are, the rationale for prophylactic use, indications, and pros and cons of use. If the expectant parents wish to decline their use they must be provided with an informed consent waiving their use.

PKU / METABOLIC SCREENING. Parents need to be educated about phenylketonuria, hypothyroidism, galactosemia function, hemoglobinopathy adrenal hyperplasia, and how to obtain this metabolic screening for their newborn if not done by the midwife.

CIRCUMCISION. Parents should be informed that circumcision is a surgical procedure, and as such, it carries certain risks. Written information should be available explaining the reasons why circumcision is medically unnecessary, traumatic, and potentially dangerous to the newborn.

POSTPARTUM SEXUALITY. It is important to prepare prenatally for a wide range of possibilities. Recovery is a very individual process. The effects of breastfeeding on sexuality need to be discussed. The couple needs to be encouraged in maintaining a loving attitude of mutual support, patience, and gentleness. In physical terms, intercourse should wait until the mother feels well healed and ready.

CONTRACEPTION. The parents should know that ovulation may resume rather quickly even though it is delayed for most women who exclusively breastfeed for a prolonged period of time. The midwife should provide education on the cooperative methods of contraception. Individual decisions need to be made by each couple on the advantages and disadvantages of the various methods including short and long term side effects.

BIRTH CERTIFICATES. It is the responsibility of the parents to register their baby's birth with their county's Vital Statistics office within six months following the birth. The midwife should assist the family in filling out the birth certificate.

IMMEDIATE POSTPARTUM

The midwife will perform an Apgar score evaluation at one and five minutes.

In the immediate postpartum the midwife is responsible for the following guidance, observations, and assessments:

THE NEWBORN

1. Has a clear airway
2. Is stable and alert
3. Has proper cord care
4. Is establishing a healthy pattern of waking, feeding, and sleeping

The newborn needs to be kept warm, dry, and as physically close to the mother as possible. It has been established that the baby's desire to nurse is greatest during the first hour after the birth. Every effort should be made to allow the baby to nurse as long and frequently as possible. Keeping the mother and baby together at this point will reinforce bonding and help prevent later nursing difficulties.

THE MOTHER

1. Has a normal lochia
2. Has a firm fundus
3. Has no fever or other signs of infection
4. Is voiding properly
5. Is getting adequate rest, nourishment, and support

The midwife shall examine the mother's vagina, perineum, and cervix (if indicated) for lacerations. For an Rh negative mother, the midwife shall obtain a specimen of cord blood to determine baby's blood type. When indicated, RhoGam should be given to the mother within 72 hours.

The midwife shall remain with the mother and newborn for at least two hours postpartum or until she is certain that both mother and baby are in stabilized condition :the mother has eaten, voided, has had a generous amount of fluids, has a firm fundus, normal lochia flow; the newborn is nursing and has a normal body temperature and respirations.

The midwife shall leave detailed written instructions with the parents regarding care for both mother and newborn including:

NEWBORN

Temperature regulation
Observation for passage of meconium and urine by 24 hours
Observation for any nursing problems
Observation of newborns color, respirations, and general appearance
Cord care

MOTHER

Amount of bleeding and condition of fundus
Perineal hygiene
Breastfeeding and breast care
Adequate rest and nutrition
Adequate elimination. Particularly urination
General condition

The items above should be carefully discussed so that everyone involved understands their importance.

NEWBORN ASSESSMENT

The newborn assessment must be completed during the immediate postpartum period.

The assessment shall include:

Weight
Length
Heart rate
Respirations
Temperature
Head circumference

The physical assessment includes assessment of the head, eyes, mouth, skin, auscultation of the heart and lungs, abdominal palpation, palpation of femoral pulses and assessment of hips. A general assessment is made of the newborn's color and appearance, skeleton, and back. An assessment of the newborn's genitalia is also indicated.

The newborn neurological assessment includes gestational assessment, if appropriate, and evaluation of the presence of Moro, suck, root, Babinski, and any other neurologic responses that may be appropriate. The newborn should exhibit an adequate sucking reflex to avoid feeding difficulties, and should show no signs of respiratory or circulatory distress.

After assessing the baby, the midwife may recommend that the family contact their family health care provider.

The midwife should discuss that the newborn be seen by a qualified health care provider within the first two weeks of life.

POSTPARTUM VISITS

There should be at least one phone call at 8-16 hours postpartum and before the first visit to follow up on the events of the birth. At this point the midwife will remind the family to initiate the prearranged postpartum care plan.

The midwife needs to arrange a minimum of four postpartum visits:

The first at 18 - 36 hours postpartum

Second visit at 3 -5 days postpartum

Third visit at 7 -10 days postpartum

Final visit at 6 wks

More visits may be arranged if any unusual circumstances are encountered in the course of postpartum care.

The midwife is to remain on-call for the family during the first postpartum week. If she needs to leave town for any reason, arrangements should be made with another midwife and the family must be properly notified beforehand.

Early follow up care should address:

Newborn:

Cord

Skin (color/hydration)

Airway / respirations

Breastfeeding

Elimination

Sleep / awake patterns

Auscultation of heart / lungs

Weight

Muscle tone

Reflexes

Skull condition

Jaundice

Temperature

Eye discharge, if any

Mother:

Emotional state

Breasts and nipples

Fundus and lochia

Perineum

Elimination

Hygiene

Rest / sleep

Nutrition / fluid intake

Vital signs

Activity level

Abdomen

Legs

Beyond the 2 - 3 visits of the first postpartum week, phone contact should be made during those first 7 – 8 days postpartum as needed. It is the midwife's responsibility to initiate two calls during the second week and additional calls between the second postpartum week and the 6 week check up.

Later postpartum visits should cover:

Newborn:	Mother:
Feeding / elimination	Breasts / breastfeeding
Skin	Fundus / lochia / perineum
Cord	Uterine size and position
Sleep / awake patterns	Rest and sleep pattern
Weight	Exercise / activity level
Sensory awareness	Nutrition / elimination
Jaundice	Sexuality / contraception
	Emotional adjustments

The midwife should remain available by phone during the first six postpartum visits. If she is unavailable for any reason, arrangements need to be made so that the family can maintain phone contact / consultation throughout this period.

In case of a birth perceived to have been traumatic by either the parents or the midwife, a meeting of all persons present at the birth needs to be arranged at 2 – 4 weeks postpartum to collectively process the events of the birth.

Six-week postpartum visit:

Every effort should be made to have this visit take place. This is the time to discuss the degree of satisfaction with the pregnancy, birth, and baby. At this time contraceptive counseling can take place. It is a time to answer questions that have come up and evaluate adjustments. Tears and repairs need to be examined to ascertain that proper healing has occurred and a pelvic exam may be done to determine uterine and pelvic involution.

Written Protocols

Each practicing midwife shall be individually responsible for maintaining protocols for the following conditions and situations:

1. After care sheet
2. Cord care
3. Jaundice
4. Newborn conjunctivitis
5. Newborn thrush
6. Unusual skin eruptions
7. "Failure to Thrive" babies
8. Minor postpartum discomforts and problems:
 - Engorged breasts
 - Sore nipples
 - Plugged milk ducts
 - Constipation
 - Hemorrhoids
9. Perineal care
10. Mastitis
11. Cystitis
12. Prolonged lochia
13. Vaginal infections
14. Uterine infections

Appendix A

Contraindications for Home Birth Based On Health History

Conditions exist that require care outside the scope of practice of traditional midwives. Due to their potential life and health threatening nature, midwives should refer pregnant women who exhibit the following conditions to a medical health provider for prenatal care and birth attendance:

1. Regular alcohol use or drug use / abuse / dependency
2. Cardiac disease
3. Diabetes Mellitus
4. Renal disease
5. Liver disease
6. Lung disease caused by emphysema, cystic fibrosis, scoliosis, active TB, or severe pathological asthma
7. Unresolved seizure disorder
8. Systemic Lupus
9. Sickle Cell disease
10. Active Hepatitis
11. Marked skeletal abnormalities that would interfere with the birthing process
12. Congenital defects of the reproductive organs that would interfere with the birthing process
13. Essential Hypertension
14. Bleeding disorders
15. Thromboembolism or thrombophlebitis
16. Mother has PKU disease
17. Rh negative disease as indicated by positive titers
18. History of low birth weight infants (of less than 5 lb.), stillbirths or neonatal deaths which are related to intrinsic maternal health problem
19. Unwillingness to accept midwife's limitations, prohibitions, and responsibilities for safe practice
20. Any other condition which may preclude the possibility of a normal birth, at the midwife's discretion
21. Any other major medical problem or congenital abnormality that affects childbearing

Appendix B

Contraindications for Homebirth

Based on Conditions Identified During Prenatal Care

At any point during prenatal care, conditions may be identified that show a contraindication for home birth. Except in emergency situations, a midwife should not assume or continue to share responsibility for prenatal and / or birth attendance for women with the following conditions:

1. Failure to document adequate prenatal care:
 - (a) Prenatal lab work; Rh antibody screening, Rubella titer, VDRL, Blood Group and Type, Hemoglobin, Hepatitis, GBS screening (or signed waiver)
 - (b) Must have initiated prenatal care by 28th week gestation.
2. Rubella during the first trimester
3. Primary outbreak of genital herpes
4. Persistent pregnancy induced hypertension
5. Pre-eclampsia
6. Convulsions
7. Central Placenta Previa
8. Placental abruption or signs indicative of placental abruption
9. Placenta located over previous uterine scar
10. Suspected or diagnosed congenital fetal anomaly that may require immediate medical care after birth
11. Hemoglobin less than 9 at 36 weeks
12. Premature labor: 36 weeks or less
13. Serious viral/bacterial infection at term
14. SGA
15. Suspected IUGR
16. Unresolved fearfulness regarding home birth or midwife care, or otherwise desires transfer of care
17. Any other condition or situation which may preclude the possibility of a healthy birth, at the midwife's discretion

Appendix C

Situations / Conditions Requiring Documented Medical Consultation

During the course of midwifery care, conditions may arise that need special expertise.

Conditions which require additional help or consultation include:

1. Vaginal or urinary tract infection unresolved
2. Suspected inappropriate gestational size for more than 2 consecutive prenatals
3. Suspected IUGR
4. Suspected multiple gestation
5. Unresolved anemia (HGB 10 or less)
6. Observed maternal cardiac irregularities
7. Kidney infection, shown as fever and shaking, chills, low back pain, hematuria, loss of appetite, nausea and vomiting, cystitis, urinary frequency, and dysuria due to cystitis, and supra pubic pain
8. Elevated blood glucose levels unresponsive to dietary and exercise management
9. Abnormal vaginal bleeding before onset of labor
10. Maternal leg pain, persistent and unresolved
11. FHT's not heard by 24 weeks gestation or at any later point in the pregnancy
12. Abnormal fetal heart tones detected prenatally
13. Marked decrease or cessation of fetal movement
14. Suspected malpresentation or abnormal presentation at 36 weeks gestation or later
15. Suspected or known postdates pregnancy beyond 42 weeks gestation with biophysical score of 6 or less
16. Active pushing longer than 4 hours on first time mother with no descent or 3 hours on subsequent births with no descent
17. Indications that the baby has died in utero
18. Indications of infection in the immediate postpartum
19. Medical significant newborn anomaly
20. Newborn temperature of 100.8 or greater for 2 consecutive readings in 1 hour
21. Newborn cardiac irregularity
22. Signs of prematurity, dysmaturity, or postmaturity
23. Birth weight of less than 5 lbs.
24. 2 vessel cord
25. Jaundice within the first 24 hours
26. Failure to pass meconium or urine within the first 24 hours
27. Signs of umbilical infection
28. Unresolved bleeding in excess of normal lochia flow
29. Subinvolution
30. Failure of laceration / episiotomy site to heal properly with signs of infection or breakdown
31. Signs of serious postpartum depression or psychosis
32. Tremors, hyperactivity or seizures
33. The pregnant woman or midwife wishes such care or consultation

Appendix D

Situations / Conditions in Which Consultation With Another Midwife Is Suggested

1. Recurrent / chronic situation, condition, or disease requiring regular intake of medication(s)
2. History of genetic problems
3. Previous stillbirth or neonatal death
4. Repeated elective abortions (more than two)
5. History of hypertension of pregnancy (pre - eclampsia, eclampsia, or toxemia)
6. Two or more consecutive premature labors or history of low birth weight babies (less than 5 lbs.)
7. History of post date pregnancy
8. Previous post - mature sick infant because of gestational age of more than 42 weeks
9. History of long difficult labor(s) (more than 24 hours of active labor with the first baby and 10 hours active labor with the next baby)
11. Previous traumatic birth history
12. History of obstetrical complication (e.g. prematurity, uterine abnormalities, placental abruption, hemorrhage, second trimester miscarriage, uterine infection)
13. History of difficulty controlling hemorrhage with previous births, miscarriages and/or abortions, or severe postpartum hemorrhage requiring transfusion
14. History of cesarean birth
15. Family has not initiated care with attending midwife by 36th weeks.
16. Multiple gestation
17. HGB of less than 11 at 36 weeks gestation
18. Breech presentation at term
19. Possible dehydration due to diminished or absent fluid intake and/or frequent vomiting and/or diarrhea and/or ketonuria for more than 4 hours
20. The pregnant woman and/or midwife wish for such a consultation

Appendix E

Situations / Conditions Requiring Hospital Transport

1. Cardiac arrest
2. Chest pain or cardiac irregularities
3. Signs of postpartum pre - eclampsia, or eclampsia
4. Eclampsia / maternal convulsions
5. Maternal respiratory distress
6. Unresolved signs of fetal distress
7. Cord prolapse
8. Transverse lie (in labor)
9. Heavy meconium staining and deviations in FHT's (if the expected time of birth is greater / longer than the projected transport time)
10. Foul smelling amniotic fluid
11. Infection: maternal temp. above 100.8, shaking, chills, elevated pulse
12. Excessive antepartum and intrapartum painless vaginal bleeding
13. Placental abruption
14. Suspended placenta accreta
15. Hemorrhage not responsive to treatment
16. Unresolved maternal shock
17. Apnea
18. Persistent uterine atony
19. Uterine inversion
20. Laceration requiring medical attention
21. Suspected meconium aspiration
22. Apgar score of 6 or less at 5 minutes and not improving
23. Unresolved respiratory distress of newborn
24. Abnormal color in newborn: persistent central cyanosis
25. Unresolved abnormal cry in newborn: weak, or high pitched
26. Obvious or suspected birth injury
27. Newborn cannot maintain body temperature
28. Projectile vomiting
29. Inability of newborn to feed well due to lethargy
30. Newborn temperature of 100.8 two consecutive readings ten minutes apart
31. Birthing woman desires transport for herself and / or her newborn

Every effort must be made to transport in good condition. The midwife will accompany the mother and / or baby to the hospital if hospitalization is necessary. If possible, the midwife may remain with the mother and / or baby to ascertain outcome and provide continuity of care. A transport form should accompany the mother and / or baby to the hospital.

Documentation of Annual Peer Review

The MN. Midwives' Guild upholds the value of annual peer review as a supportive and educational means for midwives to insure the safe and professional practice of midwifery. For this reason we encourage, support, and recommend the peer review process be utilized by midwives.

Midwives are strongly encouraged to seek the benefits of peer review opportunities at least annually, to review practice standards and gain valuable input from the greater community of midwives in their geographical area.

Annual peer review should include (but may not be limited to):

* A review of all births attended since last review

* Evidence of current CPR certification

Name _____ Lic. No. _____

Address _____ Date _____

CPR Current? _____ Review Completed? _____

Review approved by _____

Title/Office _____

All peer reviews should remain strictly confidential.

Minnesota Midwives' Guild Statement of Ethics

Midwifery is a feminine art and calling. It is very demanding work, both physically and emotionally. With this in mind, we set forth the following principles of proper conduct for the common good:

Each midwife shall tend to herself, to strive to be as aware of herself as she can be. In this way she will stay healthy and will keep her personal issues separate from the issues of the families she assists.

Family is the basis of traditional midwifery practice. If a midwife or her family is suffering as a result of her work, she is encouraged to step back and reevaluate/reprioritize her situation. Midwives with a newborn or toddler of their own need to be aware of the high needs of their children and their own need to be at home.

Midwives need to respect a woman's right to choose her place of birth and attendants. Therefore, the midwife should not proselytize, persuade, or coerce a pregnant woman or her family toward choosing a home birth with a traditional midwife as an option for all women. The MMG recognizes that public education concerning the safety of home birth can be a benefit to all pregnant women considering their options.

Each midwife will disclose to every family she assists, any information they request regarding her midwifery background, training, and experience. A midwife must not attend the birth of a family she does not care for and respect.

The midwife will respect as confidential all information shared with her by the families she assists. If consultation becomes necessary, the family must be told and the consulting midwife or health care provider must respect this confidentiality. If the birth is discussed in a group meeting, the family shall remain anonymous.

Midwives need to treat one another in a considerate and respectful way. Although the midwife's work revolves around the birthing family, one needs to bear in mind that families will give birth and go on; but the midwives will continue to work together within the community. We ask that midwives be committed to resolving conflicts in a respectful way.

Interaction among midwives should happen in a supportive cooperative way. If a family approaches a new midwife, expressing dissatisfaction with a previous midwife, the approached midwife will encourage the family to resolve their conflict with the original midwife. Aside from being respectful behavior, this will help the family heal their past birth experience(s). A midwife must be careful not to try to "rescue" a woman from another midwife. If a midwife finds herself in a situation where she is competing or acting disrespectfully toward another midwife, she should carefully look at herself to see whether her own sense of worth is suffering and take whatever steps necessary and appropriate to better care for her own emotional needs.

Traditional midwives use the resources within the midwifery community as safety and appropriateness dictate before contacting the medical community for assistance, while following Standards of Care guidelines. Traditional midwives must understand that their decisions and actions have an impact on the larger community. When safety permits, consultation within the traditional midwifery community is encouraged prior to seeking medical consultation.

Intuition may be an integral part of the midwife's practice. Respect your intuition and carefully weigh all factors.