

political updates

Overriding Vetoes: Maine's Legislative Success Story

by HEIDI FILLMORE, CPM, NHCM

On April 29, 2016, the Maine Legislature overrode Governor Paul LePage's veto of LD 690, "An Act to Ensure the Safety of Homebirth," with overwhelming bipartisan support in both houses. This bill, which regulates the practice of CPMs and CMs in the state of Maine, is the very happy end of a very long story of negotiation, collaboration, compromise, and a lot of hard work—it's a story I will try to retell here.

A rural state that's not on the way to anywhere, Maine has maintained a strong and continuous tradition of home and birth center birth. Maine's independent Yankee spirit and appreciation for the natural world lends itself well to normal physiological birth, so it is not uncommon to find, when chatting with the older generation of Mainers, that they had been born at home or in the local birthing home with a midwife or the community physician. Currently, approximately 2% of all Maine births occur outside the hospital, mostly at home with a CPM in attendance.

Maine midwives began to discuss pursuing a license for CPMs in the 1990s. Since the local midwifery organization Midwives of Maine worked by consensus, the discussion continued over many years until no blocking concerns lingered, although support for licensure was not strong in the group. In 2005, a new organization, the Maine Association of Certified Professional Midwives (MACPM), was formed specifically to work towards legislation to license CPMs. The first MACPM-initiated bill was introduced to the Maine legislature in 2007. This bill was not negotiated with any other stakeholders prior to submission, which proved to be its downfall in

the end. The Maine Medical Association (MMA), the Maine Chapter of ACOG, the Nurse Practitioners Association, and even the Maine Chapter of the American College of Nurse-Midwives did not support the bill, and particularly, the MMA actively opposed it.

From 2008 until the submission of our successful licensure bill in 2014, much happened in the midwifery profession on state, national, and international levels, setting a very different stage for us in Maine. In 2010, the International Confederation of Midwives (ICM) issued Global Standards for Midwifery, which challenged the 3 midwifery credentials in the US (CPM, CNM, and CM) to begin an earnest dialog with the goal of strengthening midwifery in our country. From this challenge, US MERA was born, and through its conversations with the national ACOG leadership, the organization achieved both recognition of CPMs and a change in ACOG's stance regarding the CPM credential. At the same time, rising homebirth rates in the US caught the attention of the media and the medical organizations, quality evidence from around the world continued to show the safety of birth outside the hospital, and a workforce shortage for OB/GYNs was predicted in the near future.

This was the fertile soil we found as we moved towards submitting another bill in Maine. When the Maine CDC convened a task force in 2011 to look at the safety of homebirth in Maine, CPMs were invited to the table, along with the other maternity care players in the state, to discuss ways to make homebirth safer. Relationships began to form and trust was built over the two years we met. It became



apparent to many of us that licensure would be a necessary first step toward implementing structures of accountability, scope of practice boundaries, and a system of seamless collaboration among the spectrum of maternity care in the state.

In 2013, MACPM decided to write another bill to license CPMs for submission in the 2014 legislative session. MACPM tentatively agreed to collaboration with the MMA in hopes of avoiding the pitfalls of the 2008 experience. In January of 2015, the Homebirth Collaborative began meeting at the offices of the MMA every two weeks and, with a neutral facilitator, began the bill-writing process. Over the next year, our multi-stakeholder group wrote a bill that included many compromises on the part of the CPMs but also by the other stakeholders. The bill reflected US MERA language regarding both the requirement of an accredited education after 2020, and, for already certified CPMs, the requirement of attaining the NARM Bridge Certificate was included. The existing Complementary Healthcare Board was named as the regulatory body, and a clause exempting midwives who are from and who serve distinct religious or ethnic communities was included. The bill also includes the au-

thority to order lab tests and ultrasounds; a clause giving other providers immunity in cases of consultation and transfer of care; and mandatory reporting requirements for data collection.

By far the most contentious point in the negotiations was around VBAC. It became clear that ACOG and the MMA, at the direction of their national leadership, would not budge on this issue. After spending many hours trying to find a middle ground, an unopposed but less-than-optimal solution was found. The result included both a prohibition on twins, breeches, and VBAC until 2020 when this would sunset in the statute, and the provision for non-mandatory licensing until 2020. Those who want to continue to attend VBACs could wait to apply for their license until that time. Between enactment of the law and 2020, rules and regulations that would replace these prohibitions would be written in committee and jointly with the Maine Board of Medicine. We are confident that with the current evidence supporting VBAC, and with careful rules around its practice, we will maintain the ability to attend VBAC in this rule-writing process.

When the bill passed easily through both houses in early April of this year, without any discussion on the floor, we were amazed. When it was vetoed by Governor LePage (who vetoed 33 bills this session, mostly because he saw them as an expansion of government), we were prepared and continued to lobby the legislators to override the veto. When the veto was overridden easily in both houses, I was both ecstatic and astounded by the bone-deep relief and excitement I felt about the future possibilities that a unified and integrated midwifery profession could have on maternity care in Maine. I have always viewed licensure

as a necessary threshold over which our profession must pass if we are to participate in a global movement and vision of a maternity care system that truly serves pregnant people and their families, offers a real choice of physiological birth, and has the potential to transform mater-

nity care in the US. This is the visionary fuel that has kept me engaged in this effort in Maine for many years.

We could not have accomplished this political feat without the amazing wisdom and leadership of our lobbyists from Moose Ridge Associates, Laura Harper and Betsy

Sweet, and the incredible commitment to this bill by our lead sponsor, Senator Amy Volk (whom we discovered, quite by accident, had a home birth with her last baby). Thanks to all who helped in this effort from one very grateful CPM in Maine. ●

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A Seat at the Table: Building Equity and Understanding for Black Midwives in the US

by SHAFIA M. MONROE, DEM, CDT, MPH

In February of 2016, after many months of hard work between the International Center for Traditional Childbearing (ICTC) and United States Midwifery Education, Regulation, and Association (US MERA), ICTC was invited into the folds of US MERA and attended its first leadership meeting in April. Together, we slowly built a bridge of understanding towards an important “seat at the table” of the strongest, and now most inclusive, midwifery organization in the nation.

ICTC is an infant mortality prevention, breastfeeding promotion, and midwife and doula training organization. Our mission is to increase the number of Black midwives, doulas, and healers in order to empower families, reduce infant and maternal mortality, and increase breastfeeding rates in communities of color. Established in 1991 and headquartered in Portland, Oregon, ICTC has chapters and members in the US and around the globe, each focused on improving birth outcomes and building capacity in cities, towns and villages, large and small. As an organization whose mission is to represent the needs of midwives of color, ICTC believed that it was critical to become a member of US MERA. ICTC aligns with US MERA's core values, particularly the need to work to create a larger, more robust, diverse, and high-quality maternity care workforce.¹

ICTC felt it was important to be recognized by US MERA as an autonomous organization, serving midwives of color right in the communities

in which they live and work. Our community-focused work offers a unique lens on the needs of midwives of color, who are underrepresented in the profession, as well as those of families of color seeking midwifery care options from trusted, culturally competent providers. ICTC acknowledges that our current midwifery workforce is challenged by its lack of diversity and is glad that workforce development is a part of US MERA's national strategy.

As US demographics shift toward a nation where 50% of the population will be people of color by 2020, the infant mortality gap between Black and white babies is at risk of increasing even more. ICTC felt strongly that being at the US MERA table could build the collective process and begin to address these health and professional inequities as one voice. On every level, ICTC witnesses the impact of racial inequity and healthcare disparities, both on birth outcomes in communities of color and in the underrepresentation of midwives of color in health care institutions and schools. While the research shows that midwives lower the infant mortality rate, there remains a shortage of midwives of color to service their communities in culturally appropriate, trusted ways that improve birth outcomes. Currently the national profile of midwives is majority white women, with less than 2% being Black women. Only 13% of Black women are being served by Certified Nurse-Midwives (CNMs), compared to 57% of white women.²

ICTC receives regular inquiries by women of color seeking midwives of color for their perinatal care who reflect their community composition and racial background and who understand their cultural lifestyle. Nationally, according to the March of Dimes health database Peri-Stats,³ the Black infant mortality rate in 2013 was 9.1 per 1,000 live births compared to the US national average of 6.1 per 1,000 live births. There are even worse statistics in certain US communities: in Cincinnati, Ohio, the Black infant mortality rate is 15.1 per 1,000 live births. Additionally, ICTC's 2011 quantitative analysis, titled “The Oregon Black Women's Birth Survey,”⁴ revealed that nearly one-third of Black women were concerned about their treatment during the birth of their baby and that only one-third were offered a doula of any race. The study also noted that only 25% of Black women were still breastfeeding at 6 months compared to both 60% of the general Oregon population overall and over 40% as the national average. Black women are experiencing higher maternal mortality rates, and these are issues that a robust and diverse midwifery workforce will be able to address. Through alignment with and endorsement of the International Confederation of Midwives' (ICM) Global Standards for Midwifery, we can strengthen midwifery in the US with the final goal of building a highly qualified and diverse workforce that increases midwifery access for all women to improve mater-



nal, infant, child and family health in all communities in our country.

ICTC is excited to be a part of US MERA and to contribute to the future of midwifery for better birth outcomes using the ICM Global Standards for Midwifery and endorsing national certification, licensing, and accredited education for midwives in the US. Consistent with ICM standards, ICTC believes both that we should grow the workforce so that every woman can access and choose a midwife from her community and that we should diversify the profession in order to achieve equity in maternal healthcare delivery.

Women of color want to join the midwifery profession and make a difference in their communities, but many barriers still remain, built by historic racism and the seeming isolation of many of our Black communities. It's time to take down those walls to ensure that every mother and child has a healthy, safe and joyful birth process. Being a member of US MERA will certainly help us get there, and we are looking forward to being on this journey together. ●

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References

1. United States Midwifery Education, Regulation, and Association. 2014 US MERA meeting: a summary report [Internet]. Potomac (MD): US MERA; 2014 [cited May 2 2016]. Available from: <http://www.usmera.org/index.php/2014/05/01/2014-annual-meeting-report/>
2. Goode KL. Birthing, blackness, and the body: black midwives and experiential continuities of institutional racism [dissertation]. New York: City University of New York; 2014.
3. PeriStats [Internet]. White Plains (NY): The March of Dimes. c2016 - [cited May 2 2016]. Available from: <http://www.marchofdimes.org/peristats/Peristats.aspx>
4. International Center for Traditional Childbearing. The Oregon black women's birth survey [Internet]. Portland (OR): ICTC; 2011 [cited May 2 2016]. Available from: <https://ictcmidwives.org/wp-content/uploads/2012/07/Black-Womens-Birth-Survey2012-SMM.pdf>

Birthing a New Profession: The Midwifery Assistant

by ABBY HALL LUCA, MA, CPM

In the fall of 2015, the State of California made history by signing a revolutionary new bill into law. SB-408, "An act to add Section 2516.5 to the Business and Professions Code, relating to healing arts," added the profession "midwife assistant" to the state code, effectively increasing access to care for the women of California, removing undue burden from more rural care providers, and legally defining scope of practice for the assistant birth attendant, a non-licensed second set of capable hands at a birth.

The Licensed Midwifery Practice Act of 1993 provided for the licensure and regulation of midwives in the state of California, creating the "LM" credential and defining scope of care. It was further refined in 2000 by SB-1479, which relieved the incredibly limiting requirement that midwives be formally supervised by physicians and emphasized a woman's right to choose her own care provider. Currently, state regulations require that every birth be attended by at least two people, one of whom must be a physician and surgeon, a Licensed Midwife (LM), or a Certified Nurse-Midwife (CNM). Midwives are only allowed to take students to births as assistants if the student attends one of 11 educational programs currently approved by the Medical Board of California.

Attendance at every birth by at least two trained professionals is a gold standard of care. Many situations, such as complicated neonatal resus-

citations or combination maternal/neonatal emergencies necessitate the focused attention of two skilled care providers. The problem arises, however, when because of rural locale or lack of a community of providers, midwives are unable acquire assistance from other Licensed Midwives. Outside of California, many rural midwives know this struggle all too well.

California's creation of the midwife assistant as someone who, only ever acting under the direction and supervision of a midwife, can perform simple but vital tasks such as administration of medications, collection of fetal, maternal, and neonatal vital signs, performance of neonatal resuscitation, and the preparation of basic labs, has the potential to relieve pressure on midwives working in solo or isolated practices, and it means the provision of safe and effective care for more women than ever in the state of California.

Lest codification be mistaken for invention, however, it is important to put California's recent maternity care expansion into context and remember that "midwifery assistants," "midwife assistants," and "birth assistants" are not new in existence—only in regulation. There are many entities, from birth centers, to midwifery practices, to freestanding certificate programs that offer, or have long offered, training to people interested in assisting midwives with out-of-hospital birth. Many of the programs currently available involve 2 days to 1 week of in-person,

hands-on training, while other longer programs tend to be offered via 100% online or distance learning modules.

With the passage of California SB-408, the increasing nation-wide interest in and demand for skilled birth assistants, and the burgeoning availability of education and training for interested parties, midwifery assisting seems to be a profession both on the move and on the cusp of exciting new possibilities. That excitement and sense of possibility has not been lost on Birthwise Midwifery School, which plans to open enrollment very soon for its new Midwifery Assistant Certification Program's 2017 student cohort. The program seeks to completely re-invent the idea of education for midwifery assistants, marrying a rigorous theoretical learning and hands-on skill experience in the classroom with clinical training in students' hometowns.

Birthwise's Midwifery Assistant Certificate Program will be a 16-month, low-residency program where enrolled students will travel to Bridgton, Maine, 6 times over the course of the program for week-long on-campus intensives. Coursework will train students not only for birth assisting, but also in adjunct maternity services such as prenatal and postpartum doula work, breastfeeding and nutritional support, childbirth education, fertility awareness education, placenta medicine, basic business administration, and birth art. When students aren't exploring information and develop-

ing skills in class, they will be working in Clinical Assistantships with midwives in their own hometowns. At the end of the program, after students have demonstrated both theoretical and skill proficiency, they will be able to offer services in any of their trained areas.

Although California's SB-408 was signed by the governor in September of 2015, protection of midwife assistants in that particular state will not apply until the regulatory process has been completed, standards of education/training are established, and those wishing to provide care as midwife assistants are able to take approved trainings. As a recognized and established profession, midwife/midwifery/birth assisting is in its infancy to be sure. As more states realize the value of a trained second set of hands at a birth, one that is more than a doula and not quite a midwife, assisting, like midwifery, will become more professionalized and legally recognized. Birthwise Midwifery School hopes to lead the way with its Midwifery Assistant Certificate Program, setting standards for education and training highly skilled, competent, and confident care providers. ●

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