
# HANDBOOK

*Few fruits have as many myths associated with them as the pomegranate.*

*It has been used as a symbol of fertility since the earliest records of life on Earth. Juicy and full of seeds, it represents abundance and happiness. In Arabic folklore and poetry, it symbolizes the female breast. In ancient Greece, it was the fruit of Aphrodite, goddess of love and beauty, and that of goddess Persephone, who descended to the underworld and fed its seeds to the souls of the dead to help them with their crossing.*

*Today, the juice of the pomegranate is used for its many healing properties. We embrace it as a symbol of fertility, birth, and birthing new midwives!*


**Admissions**

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**National Midwifery Institute 2016 Handbook**
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# Accreditation Status

National Midwifery Institute, Inc. is accredited by the national accrediting body for direct entry midwifery education, Midwifery Education Accreditation Council (MEAC), 850 Mt. Pleasant Ave, Ann Arbor, MI 48103.

Graduates of National Midwifery Institute, Inc. qualify for the North American Registry of Midwives (NARM) MEAC Program Graduate application for the Certified Professional Midwife (CPM) credential.

National Midwifery Institute, Inc. has received program approval from the Medical Board of California. NMI graduates are eligible to sit the California licensing exam.

**National Midwifery Institute, Inc. does not grant credit or degrees; NMI is not a nursing program. National Midwifery Institute, Inc. is a vocational education and training program.**

# Program History

National Midwifery Institute, Inc. began as Midwifery Institute of California in 1995. Midwifery Institute of California was pre-accredited in 1996 by MEAC.

Due to substantive changes in the program - relocating the office to Vermont, and changing its name to National Midwifery Institute, Inc. - Midwifery Institute of California, Inc. relinquished (in good standing) pre-accreditation status in September, 2000. National Midwifery Institute, Inc. was again pre-accredited in March 2002

**National Midwifery Institute, Inc. was granted full MEAC accreditation in October, 2002.**


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## Appendix Contents



## NMI Policy



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National Midwifery Institute, Inc., informational and promotional materials make only justifiable and provable claims regarding the nature of the courses, their location, the instruction, the instructional personnel, and about professional certification or licensure after completion.

# Philosophy and Purpose Statement

We believe that the study of midwifery is a self-motivated and organic process, springing forth from the fertile ground of community and family. Just as there have always been and will always be birthing women and birthing people, so the midwife is called into practice. It is our experience that the midwifery model of care is best upheld by students who have trained in their own communities and have become an integral part of the local birth network by the time they are ready to work independently.

We further believe that birth is a transformational process for everyone involved, with its own intrinsic value for personal growth and development. We support women-centered and pregnant person-centered birth and seek to uphold the rights of women and pregnant people to define their needs and identify their support systems. While midwives set parameters of safety, it is birthing women and birthing people who, through the process of informed consent, make decisions regarding their care and the care of their babies.

It is our purpose to prepare midwives for the scope of practice outlined by the Midwives Alliance of North America (MANA) core competencies, the North American Registry of Midwives (NARM) certification guidelines, the California Midwifery licensing requirements, and International Confederation of Midwives (ICM) International Definition of the Midwife (see opposite page).

*"I have been very happy with my experience with NMI. I would recommend the school to anyone interested in midwifery."*

*~ an NMI Graduate*

## ICM International Definition of the Midwife

A midwife is a person who has successfully completed a midwifery education program that is duly recognized in the country where it is located and that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title 'midwife'; and who demonstrates competency in the practice of midwifery.

## *Scope of Practice*

The midwife is recognized as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labor and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures.

The midwife has an important task in health counseling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and childcare.

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

# Mission Statement

National Midwifery Institute was founded to preserve community-based midwifery education by developing curriculum that enhances and supports the apprenticeship model. It is our mission to foster the traditional midwifery learning cycle: knowledge being passed from person to person, experienced midwife to apprentice. We believe that client-centered practice springs from student-centered education, and maintain the critical importance of a program that midwifes students to know their strengths and weaknesses, believe in themselves, and be confident in their abilities. It is our mission to continually review and revise program structure and content with this goal ever in mind.

*"Now I'm much more aware of the psychological/spiritual aspects of not just pregnancy, birth and postpartum, but of midwifery care itself."*

*~ an NMI Student*

Midwifery education is at a crossroads: it is no longer a question of whether we will have midwifery but of what kind of midwifery we will have. As medicine seeks to limit the midwife's role to that of obstetric technician, NMI is ever more deeply committed to fostering the ability of midwives to practice independently. We believe that independent midwifery is most readily practiced out of hospital, and so support home and birth center not only as ideal settings for birth, but for training as well. We envision a new era of midwifery education that is decentralized, with midwives studying in their own communities, fully in touch with the individuals and families they serve. NMI has received a number of requests for assistance with program development from midwives in other countries, and we are both humbled and gratified to find that our model has international relevance.

# Program Objectives

## Our program objectives are:

- To prepare students to practice skillfully, artfully, and sensitively.
- To stimulate students' curiosity and love of learning, for a lifelong commitment to continuing education.
- To support students in forming healthy, egalitarian relationships with instructors, preceptors, clients, fellow students, and other professional colleagues.
- To prepare students to practice in out-of-hospital settings, with the ability to transport to hospital if necessary.
- To teach students to take responsibility for themselves both personally and professionally.
- To ready students to practice in accordance with the Midwives Model of Care, upholding principles of woman-centered and pregnant person-centered care giving.

These objectives reflect the knowledge, skills, art and science of midwifery we believe students must master in order to practice competently, which are further detailed in the MANA Core Competencies for Midwifery Practice available online at **www.mana.org.**

*"I love and struggle with how midwifery challenges me to grow spiritually and emotionally."*

*~ an NMI Student*

# Curriculum

**The curriculum at National Midwifery Institute, Inc. is designed to:**

- Incorporate program objectives that prepare students to meet MANA core competencies;
- Fulfill our purpose of preparing students for a scope of practice consistent with that jointly defined by MANA and ACNM;
- Uphold our philosophy by addressing principles of community health, communication and counseling skills, and informed consent.

*"I'm finding information that makes so much sense that I feel somewhere inside I've always known it, and the study materials have helped me to discover it."*

*~ an NMI Student*

Our philosophy of woman-centered and pregnant person-centered care is further upheld by a student-centered curriculum. Research has shown that when studying, women are practical; they want to know the relevance of material before taking the time or making the effort to learn it. So too, when students have a concern or problem, they tend to cast a circle of inquiry around the matter, creating sufficient context to draw their own conclusions. The Heart & Hands Course Work provides this context, so that students may be genuinely motivated to pursue the in-depth, topical studies of Study Group Course Work. Students in apprenticeship further find context for Study Group topics in their clinical experience. Our curriculum is specifically designed to enhance integration of experience and study.

# Program Overview

Our program consists of a three part formula incorporating antepartum, intrapartum, postpartum, newborn, and lifelong reproductive health care, plus beginning, intermediate, and advanced practica.

## Three part formula:

1) Heart & Hands Course Work: completion of thirteen modules (beginning and advanced levels) requires approximately 810 hours of study (and must be completed before Study Group Course Work);
2) Study Group Course Work: completion of fifty-two modules requires approximately 1080 hours of study;
3) Supervised Apprenticeship: providing clinical experience meeting the requirements of NARM CPM certification and California Midwifery Practice Act.

NMI students also complete a March of Dimes Cultural Competence module for perinatal health-care professionals.

Meeting NMI curricular requirements requires a high degree of self-motivation. Correspondence education means that there is no classroom, thus students must be well organized and prepared to maintain their commitment to studying and completing assignments. Course work is submitted to instructors through email. Students work at their own pace within the framework of NMI's minimum clinical and academic progress policies. A student may use the flexibility of these policies to better maintain their other adult responsibilities.

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## Program Overview, *continued*

Students are responsible for securing an apprenticeship. While apprenticing, students should expect to make a full time commitment, as most situations require 24/7, on-call availability. Not only must students work to master clinical skills but must also work to develop mature working relationships with their precepting midwife. They are at all times held accountable to professional ethics of practice and personal behavior.

NMI offers year-round open enrollment; there are no application deadlines. If a student is studying full time (25 hours per week or more spent on course work and clinical training), program requirements can be completed in approximately three years. On the other hand, a student who chooses a preceptor with a relatively low client volume may need more time to complete the program whereas a student in a high-volume apprenticeship might finish in less than three years. NMI is required by accreditation standards to designate a maximum time frame for program completion; our students are guided by NMI Student Academic Progress and Student Clinical Progress policies to complete the program within seven years.

NMI acknowledges its students as adult learners, and values the dynamic potential they bring to their education based on cumulative life experience, philosophy, and belief system. Faculty and administration are committed to helping students integrate their personal, didactic, clinical, and professional experiences.

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Based on MANA Core Competencies, the North American Registry of Midwives qualifications for the CPM credential, ICM Essential Competencies for Basic Midwifery Practice, and requirements stated in California Midwifery Practice Act, our curriculum provides preparation in the following areas:

A. The art and science of midwifery, including but not limited to prenatal, labor and delivery, neonatal well care and post partum care;
B. Communication skills;
C. Anatomy and physiology, genetics, obstetrics and gynecology, embryology and fetal development, neonatology, applied microbiology, chemistry, child growth and development, pharmacology, nutrition, laboratory diagnostic tests and procedures, and physical assessment;
D. Concepts in psychosocial, emotional and cultural aspects of maternal and child care, human sexuality, counseling and teaching, maternal and infant and family bonding process, breastfeeding, family planning principles of preventative health and community health;
E. Aspects of normal pregnancy, labor and delivery, postpartum period, newborn care, family planning or routine gynecological care in alternative birth centers, homes and hospitals;
F. Midwifery process, including interventive skills in preventative, remedial and supportive midwifery; development of collegial relationships with health care providers from other disciplines; and behavioral and social sciences;
G. Personal hygiene, client abuse, cultural diversity, and the legal, social and ethical aspects of midwifery;
H. Midwifery management process.

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Foundation curricula such as anatomy and physiology, chemistry, genetics, embryology, applied microbiology, child growth and development, nutrition and required social sciences are woven throughout program course work.

*"I enjoy the flexibility of a correspondence program that allows me to submit work from wherever I am."*

*~ an NMI Student*

# NMI Curriculum Course Work

## *1. Heart & Hands Course Work Overview*

In 1982, Elizabeth Davis founded Heart & Hands Midwifery Intensives in San Francisco, California. The course was developed at the request of a group of birth assistants seeking to acquire practical midwifery skills. Over the years and by demand, the course evolved to include basic introductory information and emphasis on the intuitive, interpersonal skills essential to effective midwifery care.

Heart & Hands Midwifery Intensives have long been the starting point of instruction for aspiring midwives in California. As people in other parts of the country began to express interest in the course, Heart & Hands was adapted to a correspondence format so that students could have access to this material regardless of their location. Thirteen modules—ten beginning and three advanced—incorporate study guidelines and tasks, activities for hands-on learning, post-tests, and a list of items to be submitted to the instructor. Completion of Heart & Hands Course Work requires approximately 810 hours of study. While enrolled in National Midwifery Institute, Heart & Hands Course Work students are required to submit a minimum of 2 modules per quarter.

This modular course is part of the curriculum of the National Midwifery Institute, Inc. However, Heart & Hands Course Work is open to students regardless of enrollment in NMI, in keeping with our belief that detailed information on birth, midwifery, and health of the female body should be available to anyone interested in exploring these subjects. Doulas, nutritionists, psychotherapists, herbalists, acupuncturists, massage therapists, and mothers/gestational parents —all those wishing to empower women and people in the act of giving birth are encouraged to participate. Any student who successfully completes the Heart & Hands Course Work and later decides to enroll in NMI will receive credit for the course and fees paid to the instructor.

Heart & Hands Midwifery Intensives students wishing to enroll in NMI should consult with the instructor regarding additional requirements for Heart & Hands Course Work completion. Students enrolled with National Midwifery Institute must complete Heart & Hands Course Work prior to beginning to submit Study Group Course Work.

## *2. Study Group Course Work Overview*

Study Group was initiated by Shannon Anton in 1994, in response to apprentice midwives in the San Francisco Bay Area who expressed a need for a midwife-facilitated group learning process. Students who attended the first eighteen months of Study Group worked together to define their curriculum; based on experiential learning, they moved organically from topic to topic. Study Group Course Work was developed from the outline this original group made manifest. It is designed to stimulate the self-motivation and passion for learning that are hallmarks of the midwifery profession.

Study Group Course Work follows successful completion of Heart & Hands Course Work. Students must be enrolled in NMI to begin Study Group, and they must submit modules according to NMI's Satisfactory Academic Progress policy. They are not, however, required to have started their apprenticeship, although Study Group Course Work is designed to help students integrate theoretical learning with clinical experience.

Study Group Course Work is comprised of fifty-two modules, which are highly focused on specific topics. The modules may be approached in any order the student finds appropriate, and may reflect current issues in clinical training. Completion of the modules requires approximately 1080 hours of study. With a focus on the integration of clinical and didactic knowledge, students set their own pace for completion; however, they are required to submit a minimum of 2 modules per quarter while actively enrolled in NMI.

While Study Group modules are well suited to independent study, students are encouraged to organize facilitated discussions in their own communities. Practical written guidelines, drawn from the shared experience of other students, are provided for organizing local Study Group sessions. These student-driven meetings may be reminiscent of a one-room schoolhouse, with participants at various levels of expertise. Additional support is available from the instructor.

Enrolled students are also encouraged to attend NMI's weekly virtual Study Forum meetings using an online videoconferencing platform. Led by NMI Course Work instructors, these weekly meetings are open to all enrolled NMI students (including Heart & Hands students) and NMI graduates. Contact NMI administrators for current schedule.

# Heart & Hands Course Work

810 contact hours for completion

**1a. Orientation to Midwifery / *45 contact hours***

History of Midwifery
The Three Paradigms of Healthcare
Clinical Training Options and Barriers to Practice
Professional Organizations
Resources for Learning: Texts and Equipment
Female Reproductive Anatomy and Physiology
Human Sexuality

**1b. Prenatal Care, Part I / *67.5 contact hours***

Hygiene for the Midwife
The Female Pelvis, Pelvimetry
Impacts of Sexual and Other Forms of Abuse
Diversity Awareness
Initial Interview
Medical/Health History
Risk Assessment
Routine Maternal Assessments per Trimester
Teratogens in Pregnancy
Genetic Screening
Routine Labs and Tests in Pregnancy

**1c. Prenatal Care, Part II / *67.5 contact hours***

Fetal Development
Leopold's Maneuvers/Abdominal Palpation
Fundal Height Assessment
Routine Fetal Assessments
Nutrition
Nutritional Counseling
Herbs in Pregnancy
Psycho-social Issues in Pregnancy
The Role of Intuition in Caregiving
Home Visits (frequency and purpose)
Preparation for Homebirth

**1d. Complications of Pregnancy / *67.5 contact hours***

Hyperemesis Gravidarium
Nutritional Anemias
Miscarriage/Abortion: threatened, spontaneous, incomplete, missed and habitual abortion
Ectopic Pregnancy
Hydatidiform Mole
Pylonephritis (kidney disease)
Placenta Previa
Placental Abruption
Gestational Diabetes
Gestational Hypertension
Pre-eclampsia and Eclampsia
Polyhydramnios
Oligohydramnios
Abnormal Fetal Presentations
Multiple Pregnancy
Prematurity
Postmaturity
Intrauterine Growth Restriction
Uterine Abnormalities
Rh- Sensitization
Sexually Transmitted Infections
HIV/AIDS
TORCH Infections
Hepatitis B, C

*"With each new bit of knowledge, I felt that I was moving deeper and further down a path shrouded with mystery and meaning for me."*

*~ an NMI Student*

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## Heart & Hands Course Work, *continued*

**1e. Labor Facilitation and Assessment / *67.5 contact hours***

Physiology of the Labor Process
Maternal Emotions in Labor
The Role of the Mother's/Birthing Parent's Support Team
Techniques for Facilitating Progress
Plateaus versus Arrests of Progress
Universal Precautions
Nutrition/Hydration in Labor
Routine Maternal Assessments
Technique and Rationale for Internal Exam
Routine Fetal Assessments
Fetal Heart Tone Patterns in Labor

**1f. Normal Delivery & Immediate Care of the Newborn / *67.5 contact hours***

Meconium Staining/Significance and Response
Equipment Used at Births (sterilization and maintenance)
Hand Maneuvers to Assist Birth
Preventing Perineal Tears
Placenta Examination
Maternal Stabilization
Newborn Stabilization
APGAR Scoring
Newborn Exam
Routine Maternal Assessments/Third and Fourth Stages
Routine Fetal Assessments/Immediate Postpartum
Promoting Bonding and Breastfeeding
Postpartum Instructions

*"As I do more, I love it more"*

*~an NMI student*

### 1g. Complications of Labor, Part I / *67.5 contact hours*

Prolonged Labor
Maternal Exhaustion
Cephalopelvic Disproportion
Posterior Arrest
Asynclitism
Maternal Positioning, Rebozo, and Hand Maneuvers to Address Malpresentations
Cesarean Birth and VBAC
Partial Separation of the Placenta/ Third Stage Hemorrhage
Placenta Accreta/Increta/Percreta
Fourth Stage Hemorrhage
Intramuscular Injection
Oxytoxic Medications and Herbs

### 1h. Complications of Labor & Delivery, Part II / *67.5 contact hours*

Fetal Distress
Cord Problems/Prolapsed Cord
Prolonged Rupture of the Membranes
Amniotic Fluid Embolism
Breech Presentation
Shoulder Dystocia
Fetal Anomalies (cleft palate, spina bifida, esophageal atresia, polycystic kidneys, congenital heart defects, trisomies 18 and 21, imperforate anus, hydroencephaly, anencephaly, etc.)
Fetal Demise
Transport to Hospital
Client Advocacy/Informed Consent
Neonatal Testing

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## Heart & Hands Course Work, *continued*

**1i. Postpartum Care and Suturing / *67.5 contact hours***

Routine Maternal Assessments, Day 1, Day 3, Day 7
Routine Newborn Assessments, Day 1, Day 3, Day 7
Maternal Complaints/Complications Postpartum
Newborn Problems/Complications Postpartum
Physiology of Milk Production
Breastfeeding
Postpartum Blues and Depression
Family Dynamics
Perineal/Vaginal Lacerations—Assessment, Repair, Follow-up
Six Weeks' Check-up
Contraceptive Care

**1j. Professional Opportunities & Summary / *22.5 contact hours***

Clinical Training Opportunities
Preparation for Clinical Training/Preparing a Resume
Professional Organizations and Support for Clients
Student Self-Assessment

**1k. Reproductive Health Assessment & Initial Interview, Applied / *67.5 contact hours***

The Midwifery Model of Care, Applied
Initial Reproductive Health Exam
Medical/Health History, Applied
Routine Reproductive Health Assessments
Breast Exam: Rationale and Practice
Bimanual Assessment: Rationale and Practice
Pap Smear and Vaginal/Cervical Cultures
Complications in Reproductive Health Care

**1l. Prenatal Care, Applied / *67.5 contact hours***

Routine Maternal Assessments, Applied
Routine Fetal Assessments, Applied
Charting
Professional Disclosure and Informed Consent
Differential Diagnosis of Prenatal Complications
Professional Collaboration

**1m. Lab Work, Labor and Postpartum Evaluation, Applied / *67.5 contact hours***

Differential Diagnosis of Intrapartum Complications
Differential Diagnosis of Postpartum Complications
Conflict Resolution—Midwife/Client
The Grieving Process, Grief Counseling
Professional Liability
Peer Review
Venipuncture
Student Self-Assessment

*From the anatomy and physiology presented, I fully understand the simplicity and complexity of the journey of pregnant woman to mother, fetus to baby.*

*~ an NMI Student*

# Study Group Course Work

1080 contact hours for completion

## Midwifery Sciences

380 contact hours

**2a. Midwifery Sciences: Social Sciences / *70 contact hours***

- Diversity Awareness
- Female Sexuality
- Grieving
- Physical and Sexual Abuse
- Substance Abuse

**2b. Midwifery Sciences: Physical Science part 1 / *130 contact hours***

- Digestion
- Life Science
- Liver
- Nutrition
- Renal System

**2c. Midwifery Sciences: Physical Science part 2 / *145 contact hours***

- Embryology & Fetal Development
- Fertility and Conception
- Fetal Heart Rate Patterns
- Fetal/Newborn Circulation
- Genetic & Prenatal Screening
- Placenta

**2d. Midwifery Sciences: Pharmacology for Midwives / *35 contact hours***

## Midwifery Care & Practice

400 contact hours

**2e. Midwifery Care & Practice Part 1: Midwifery Practice / *85 contact hours***

- Birth Bag and Set Up
- Charting & Practice Guidelines
- Homeopathic Remedies
- Transporting

**2f. Midwifery Care & Practice Part 2: Prenatal Midwifery Care / *65 contact hours***

- General Pregnancy and Post Partum Ailments
- Physical Assessment
- Prenatal Lab Work & Assessment

**2g. Midwifery Care & Practice Part 3: Midwifery Care at Labor & Birth / *110 contact hours***

- First Stage
- Second Stage
- Ruptured Membranes
- Third Stage

**2h. Midwifery Care & Practice Part 4: Midwifery Care Postpartum / *140 contact hours***

- Suturing
- Postpartum Care
- Breast Feeding
- Well Woman Care

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## Study Group Course Work, *continued*

### Appropriate Intervention in Midwifery Care

300 contact hours

**2i. Appropriate Intervention in Midwifery Care Part 1: Pregnancy & Labor / *160 contact hours***

- Hypertension
- Pre-Eclampsia
- Urinary Tract Infection
- Gestational Diabetes
- Herpes
- Ectopic Pregnancy
- Preterm Labor
- Uterine Size and EDD Discrepancy
- Post Dates Management & Post Maturity
- Stillbirth and Miscarriage

**2j. Appropriate Intervention in Midwifery Care Part 2: Labor & Birth / *70 contact hours***

- Artificial Rupture of Membranes
- Breech and Twins
- Cesarean and VBAC
- Meconium
- OP, Brow & Face Presentations
- Shoulder Dystocia

**2k. Appropriate Intervention in Midwifery Care Part 3: Postpartum / *70 contact hours***

- Hemorrhage
- Jaundice
- Newborn Apnea, Hypoxia & Respiratory Distress
- Postpartum Depression

*"It helps to know that this path will get me where I want to be, in a competent and focused way."*

*~ an NMI Student*

## Clinical Instruction: Apprenticeship/Preceptorship

Knowledge and skills gained in the didactic/course work portion of the program prepare students for active participation at the onset of the apprenticeship experience. Students are responsible for selecting and securing their preceptorship. They may interview with potential preceptors at any time, and may choose to work with any midwife meeting the criteria for precepting faculty. Preceptors occasionally contact the program seeking new students; such opportunities are made available to NMI students. Every effort will be made to link students with appropriate precepting sites: however, most midwives prefer to get to know a student before considering a working relationship. Thus it is the responsibility of students to select and secure their apprenticeships.

While students are not required to enter the program having already secured an apprenticeship, NMI maintains a minimum timeline for clinical experience requirements:

> **Within 36 months** of initial enrollment: student must secure an apprenticeship
>
> **Within 42 months** of initial enrollment: student must begin filing documentation of non-primary experience
>
> **Within 60 months** of initial enrollment: student must begin filing documentation of Supervised Primary Care

Many students are anxious about finding an apprenticeship. Although there are no guarantees, one of the best ways to begin is to train and work as a doula. Precepting midwives want to know that an apprentice can handle the logistics of being on call and can be counted on in the challenging circumstances of hospital transport. Getting involved with other birth professionals by attending local meetings and volunteering to help with community events or political organizing is also important. Precepting midwives are usually more comfortable taking apprentices who are already known and respected by their peers and colleagues.

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## Clinical Instruction: Apprenticeship/Preceptorship, *continued*

As precepting midwives observe and document increasing skill in their apprentices, they are expected to respond by making additional responsibilities and practice opportunities available. Through a joint process of preceptor and self evaluation, students document their accomplishments and progress at their own pace towards meeting NMI program objectives and mastering MANA core competencies.

Apprenticeships are generally based in homebirth or birth center practices. Students can also expect to attend hospital births in the event of transport, which gives them opportunity to learn about and observe obstetrical standards of practice. Students are required to attend a minimum of 2 planned hospital births, either as an observer, student assistant under preceptor supervision, or student primary midwife under preceptor supervision. These planned hospital births are not transports, but may follow a prenatal transfer of care. Additionally, during the course of training within a preceptor's practice, students will likely have opportunity to consult with other health care providers if complications develop in caregiving or questions arise concerning a mother/gestational parent's health status. Students may also have opportunity to accompany their precepting midwife to peer review sessions, and so may confer with other midwives in the community on practical and professional issues.

*"This course was one of birthing myself as a midwife...*
*I remind myself that I am in the early stages of labor, and*
*I must be patient and sensitive to tune in to the pace at*
*which this birthing wants to happen."*

*~ an NMI Student*

## Clinical requirements NMI students must meet for graduation:

Functioning in **any role** (observer, doula, family member, friend, beginning apprentice):

10 Observe Births

Functioning in the role of **student-assistant midwife under preceptor supervision**:

20 Assist Births
22 Assist Prenatal exams
3 Assist Initial exams
20 Assist Newborn exams
10 Assist Postpartum exams

Functioning in the role of **student-primary midwife under preceptor supervision**:

25 Births attended
75 Prenatal exams
20 Initial exams
20 Newborn exams
40 Postpartum exams within the first five days of birth
40 Postpartum exams/family planning/gyn visits

Of the 25 required Student-Primary under Supervision births, 10 must be with clients for whom the apprentice provided **Continuity of Care**, with at least:

- 1 prenatal exam in a student-primary or student-assisting role; and birth.

Of the 25 required Student-Primary under Preceptor Supervision births, an additional 5 must be with clients for whom the apprentice provided **Full Continuity of Care**, with at least:

- 5 prenatal visits spanning two trimesters;
- Birth;
- 1 newborn exam performed within 12 hours of the birth, and;
- 2 postpartum exams occurring between 24 hours and 6 weeks following the birth.

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**Clinical requirements NMI students must meet for graduation,** *continued*

- All Student-Assist prenatal exams, newborn exams, and postpartum exams must be completed before beginning the same categories of clinicals as student-primary midwife under preceptor supervision.
- 18 Student-Assist births must be completed before beginning Student-Primary under Preceptor Supervision births, or more at the discretion of the supervising preceptor.
- A minimum of 5 home births must be attended in any role.
- A minimum of 2 planned hospital births must be attended in any role.
- Transports to the hospital from an out-of-hospital setting are limited to 3 out of the 25 Student-Primary under Preceptor Supervision births: the first 20 Student-Primary under Preceptor Supervision births may include 2 transports, and the remaining 5 Student-Primary under Preceptor Supervision births may include 1 transport.
- 10 out-of-hospital Student-Primary under Preceptor Supervision births must occur within the last 3 years.
- All required minimum clinical experience must occur within the last 10 years.
- A minimum of 10 of the 25 Student-Primary Under Preceptor Supervision births must be attended in the US or Canada and must occur in out-of-hospital settings.
- NARM requires that the clinical component of a student's midwifery education must be at least two years in duration. California Midwifery Practice Act requires for licensure: a program that is 84 semester units in length, with half of the program consisting of clinical practice (84 semester units equates to 3780 total contact hours, with half being 1890 clinical contact hours.) NMI requires a minimum student enrollment period of twelve months, provided that the student meets the NARM two-year clinical timeframe stated above.

These clinical experiences are sufficient to meet NARM certification standards for entry-level midwifery practice, California licensing requirements as well as the licensing requirements of many states.

Although students are encouraged to seek continuity of training by working primarily with one preceptor, a student may have any number of qualified preceptors. Students attending births with a new preceptor and with prior birth experience sufficient to begin student-primary care under preceptor supervision may be required to attend births as an observer or assistant before beginning student-primary care under preceptor supervision.

Current NMI forms require preceptor signatures for each exam and birth.

Students are required to use client codes (not names) on all experience documentation. Clinical experience documentation with client names will be returned to the student for resubmission.

NMI's Batch Summary forms are confirmation that each student is aware of the documentation in that specific batch. The Batch Summary is not intended to document the running total of previous batches. The student, not the preceptor, signs Batch Summary forms. Preceptor signatures are required on the forms that itemize each clinical experience with client codes.

Students are required to submit documentation for the experience completed during each quarter by the end of that quarter.

# Appointment of Faculty

Faculty are recruited, appointed, and promoted without discrimination in regard to sex, gender identity, race, color, marital status, ethnic origin, religion, age, sexual orientation, or disability.

All faculty are asked to complete the Annual NMI Program Review, circulated by online survey by May 5th each year.

## Faculty are required to:

1) Agree to uphold NMI program objectives, the Philosophy and Purpose Statement, and the Mission Statement;
2) Demonstrate an effective teaching style, incorporating student input and feedback;
3) Work cooperatively with other faculty;
4) Maintain updated course content meeting current program objectives;
5) Complete cultural sensitivity/diversity training or course work;
6) Evaluate student progress according to the required schedule;
7) Complete and document 30 hours of continuing education every three years (consistent with NARM CEU policy);
8) Maintain a professional ethic (as defined by the MANA Statement of Values and Ethics) upholding student confidentiality at all times, (see Appendix);
9) Agree to participate in conflict resolution, utilizing the program's Grievance Mechanism as necessary;
10) Respond appropriately to the suggestions arising from the annual NMI program review.

## Precepting Faculty are additionally required* to:

11) Be in active midwifery practice in an out-of-hospital setting;

12) Be certified or licensed by a mechanism recognized in their jurisdiction, or maintain the CPM credential where midwifery is not regulated and not prohibited by enforcement of existing law;
13) Periodically attend peer review. Preceptors are encouraged to include students in routine peer review, if acceptable within the local midwifery community. If an instructor possesses less than these qualifications*, that individual must be responsible to a qualified faculty member. All faculty are strongly encouraged to be NARM Certified.

## Faculty Rights and Responsibilities

Course work faculty are responsible for receiving and reviewing course work in a timely fashion, and for maintaining contact with students on a regular basis. Course work faculty are also responsible for making updates to course content, texts, and materials in keeping with current standards of practice. On the basis of module-to-module feedback, review at course completion, and annual review, they are expected to incorporate student input in course revisions.

Precepting faculty maintain or participate in primary midwifery practices, provide prenatal, intrapartum, postpartum, and reproductive health family planning care. Upholding: 1) NMI program objectives; 2) the Midwifery Model of Care; 3) professional standards of practice; and 4) the MANA Statement of Values and Ethics. Precepting midwives attend clients in the out-of-hospital setting of their choice. Students are introduced to their preceptor's clients as members of the care team, but clients must be fully informed of the student's status and must give consent for the student's participation in their care. The precepting midwife's first responsibility is to uphold parameters of safety while providing quality care and continuity to clients; within that context, the student shall be given every opportunity to acquire clinical experience and skill required for program completion.

*Continued on the next page*

## Faculty Rights and Responsibilities, *continued*

Once a preceptor and student agree to work together, they complete and sign the NMI Apprentice/Preceptor Work Agreement and Informed Consent Worksheet. This document must include the following information regarding preceptor's practice:

- *philosophy*
- *experience and training*
- *certification or licensure status*
- *malpractice insurance status*
- *numbers of clients both for the previous year and current year*
- *number of students the preceptor has trained*
- *number of students the preceptor takes into the practice at a time (with breakdown of learning opportunities for each student)*

The Informed Consent Worksheet may also include a list of the apprentice's expectations of training; however, it is the precepting midwife's responsibility to formulate and file this document. The preceptor/student relationship is formalized when this document has been signed and a copy is filed with the NMI office. The preceptor may then invoice NMI for an honorarium total of $3400 per student (within requirements for each experience category: up to 10 observe births @ $10 each; up to 55 assist exams and 195 supervised primary care exams @ $10 each; up to 20 assist births @ $15 each; and up to 25 supervised primary care births @ $20 each).

Precepting faculty are also responsible for updating their teaching methods and clinical practice in keeping with current standards of care. On the basis of student evaluation and NMI annual review, they are also expected to incorporate student input in their method and style of precepting.

All faculty are responsible for documenting continuing education consistent with current NARM requirements (as of 3/2016, 30 contact hours of continuing education every three years).

Faculty are also encouraged to serve on midwifery boards and actively participate in professional organizations such as CAM, MANA, NARM, MEAC and ACNM, as a means of keeping program curriculum current. We strongly encourage faculty to participate in community education by:

- *lecturing at local universities and community colleges on midwifery, childbirth and related subjects;*
- *providing in-service training at local hospitals and EMS services;*
- *teaching childbirth classes to expectant parents and leading support groups for pregnant women and pregnant people, and new parents;*
- *making presentations to the aspiring midwifery community at state and local midwifery meetings.*

Program flexibility allows both faculty and students to attend midwifery conferences and board meetings.

Faculty are also responsible for participation in annual program review, completing the online survey each year that is initiated by May 5th (International Midwives Day). Incorporating student input, faculty are asked to make recommendations on admissions policy, curriculum revision, references, methods of student assessment, the advisability and selection of new faculty, teaching methodologies and effectiveness, administrative performance and facilities, fees, resources and services.

Existing faculty will have the first option of teaching new course work or new subject matter within existing course work, and will be considered for advancement before new faculty are sought.

## Faculty Evaluation of Students

Each faculty member maintains evaluation records for their students, regularly updating administration on student progress.

In Heart & Hands Course Work, students' written assignments, research, and post-tests are evaluated for accuracy and completeness. Inaccurate or incomplete work will be returned for student to correct and resubmit. In Study Group Course Work, student evaluation is based on written assignments, self-assessment processes, self-tests, and development of practice guidelines and client resources for use in future practice. Students must demonstrate a working comprehension and accomplishment of the learning objectives in each course work module, and all assignments must be satisfactorily completed. Inaccurate or incomplete work will be returned for student to correct and resubmit.

*"I'm comfortable working at my own pace, whether it's tackling a lot if that feels right, or slowing down when that's appropriate."*

*~ an NMI Student*

During clinical training, preceptor and student jointly evaluate student progress regarding skills successfully acquired and those requiring further development. Students and preceptors meet to present and discuss their evaluations on the following schedule: at the close of the initial three month period, and then every three months UNTIL the student has begun student-primary care under preceptor supervision. Once the student has begun student-primary care under preceptor supervision, these evaluations occur after every five births.

Faculty are encouraged to suggest revisions in mechanisms for evaluating students when completing the annual NMI program review, provided as an online survey each year by May 5th (International Midwives Day).

## Student Evaluation of Self and Faculty

As stated in NMI program objectives, it is our intention to teach students to take responsibility for themselves both personally and professionally, and to support them in forming healthy, egalitarian relationships with instructors, preceptors, clients, fellow students, and other professional colleagues. Central to accomplishing these objectives is student evaluation of self and faculty.

Students submit evaluations upon completion of both Heart & Hands and Study Group Course Work, which include self-assessment of didactic, clinical, and personal/interpersonal growth, as well as course critiques and suggestions for improving curriculum. In addition, students are given opportunity to comment on learning activities and resources at the end of each module they complete.

Apprenticing students submit self and preceptor evaluations on the following schedule: at the close of the initial three month period, and then every three months UNTIL the student has begun student-primary care under preceptor supervision. Once the student has begun student-primary care under preceptor supervision, these evaluations occur after every five births.

Student evaluation of faculty is integral to assessing faculty performance and facilitating an egalitarian learning experience and working relationship. Faculty are expected to demonstrate responsiveness to the feedback and individual learning needs of their students. Should a serious disagreement develop between a student and instructor, both will participate in conflict resolution, either through mediation or the program's Grievance Mechanism.

## Satisfactory Academic & Clinical Progress Policy

NMI's Satisfactory Academic and Clinical Progress policy specifies minimum course work progress and includes a schedule for filing experience documentation during midwifery training. Minimum timeline requirements for clinical training are also mandated.

Without measurable progress toward graduation, NMI does not allow a student to remain in the program. Completed course work, experience documentation and student/preceptor evaluations demonstrate student progress.

## Satisfactory Clinical Progress Policy

NMI mandates for Student Progress include clinical training and experience. Precepting faculty must submit clinical evaluations of students according to the following schedule: at the close of the initial three month period, and then every three months UNTIL the student has begun student-primary care under preceptor supervision. Once the student has begun student-primary care under preceptor supervision, these evaluations occur after every five births. Should student progress be less than satisfactory, preceptor and/or student may seek advice from the administration, or the administration may, at their discretion, make recommendations to preceptor and/or student.

Each quarterly cycle of experience documentation is **due within two weeks of the end of the quarter**. If clinical experience documentation is not received by this time for a period of two quarters, student is **suspended**. Reinstatement after suspension must occur within the next three quarters and requires a fee of $250, and completion of all delinquent paperwork, or student is dismissed from the program.

NMI enforces a minimum timeline for clinical experience requirements. **Suspension** occurs if a student does not meet the minimum timeline: **Within 36 months of initial enrollment** (within 3 years), students must provide a completed work agreement with a preceptor with the intention to begin preceptorship within the next 6 months.

Student documentation of non-primary experience must begin **within 42 months of initial enrollment** (within 3.5 years).

Student documentation of Preceptor Supervised Student-Primary Care must begin **within 60 months of initial enrollment** (within 5 years).

## Satisfactory Academic Progress Policy

Every effort will be made to assist students in successfully completing coursework. Students must complete at least 2 modules per quarter. Without minimum academic progress for a period of two quarters, student is suspended. Reinstatement after suspension must occur within the next three quarters and requires a fee of $250 and completion of at least 3 modules, or student is dismissed from the program. Students in full time apprenticeships or other clinical training (with mandatory experience filed) may waive submitting coursework for up to 2.5 years, but must then complete modules at a rate of 3 per quarter or request a formal leave of absence.

## Student Records

Student records are confidential; however, all students are entitled to full disclosure of their didactic and clinical records. Students have access to these records through the administration; requests will be met within five working days. Instructors maintain student transcript information and provide course work transcripts and letters of reference on request. Student/Preceptor documentation is kept on file in the NMI office, and an updated record is provided as confirmation of receipt of these documents. Student transcripts are available on request from the NMI office.

Students sign a release in the NMI Enrollment Agreement, granting NMI access to student/graduate NARM test scores and CPM/application status.

Rosters of student and graduate contact information are made available to other students and graduates unless NMI is notified in writing that a student will not allow this.

## NMI Annual Program Review - May 5th

*Honoring International Midwives Day.*

NMI marks May 5th, International Midwives Day, by annually polling students, graduates and faculty in preparation for curriculum revisions and with regard to various aspects of the program. Online surveys are sent to invite comment from all parties regarding aspects of program performance:

- curriculum content
- structure
- reference resources
- admissions process
- mechanisms of evaluating student progress
- methods of informing students of their progress
- program resources
- student services
- facilities/other services
- clinical sites
- library
- administrative facilities
- equipment and supplies

Survey results are distributed to academic faculty and Program Directors (with a copy kept on file in the NMI office). After receiving the survey results, each party is asked to make proposals to Program Directors specific to their own area of responsibility and that of related parties.

*"Helping a new family with such a sacred event makes me feel blessed."*

*~ an NMI Student*

These proposals are discussed between academic faculty, administrative staff and program directors, and are addressed using a consensus process.

If proposals are made regarding precepting faculty, new policy must be in alignment with NARM requirements. Decisions regarding changes in preceptor policies are made by Program Directors in accordance with NMI philosophy and policies and procedures, with particular sensitivity to the effect such changes may have on the preceptor/student relationship. Students and precepting faculty are invited to give comment in response to any new policy. If student or preceptor feedback justifies policy adjustment, Program Directors and Program Administrators make such changes through consensus. Changes to existing policy may be assigned a timeline for development and implementation, the length of which will be suggested by Program Directors with input from Program Administrators.

*"I am inspired enough by the quality of work that I'll be doing that I'm even forgetting to be overwhelmed!"*

*~ an NMI Student*

At the time of annual review, instructors discuss specific feedback and make plans for curriculum revision. Topics for discussion include selection and purchasing of textbooks and resources, and the content and format of course work. Program Directors and administrative staff may also be involved in these discussions. If areas of weakness are identified, a timeline and details for improvement are established with input from the instructor and Program Directors.

Annual academic faculty review, Program Director review, and administrative staff review occurs during the 4th Quarter each year in order to allow time for May 5th Annual Review results to be received and distributed.

## Student Resources/Student Life

Students are invited to participate in NMI's weekly virtual NMI Study Forum meetings hosted by NMI Course Work Instructors. Participants share information and resources during these student-driven weekly study sessions using an online video conferencing platform.

Students also may participate in NMI's closed Facebook group for enrolled students and graduates. This lively discussion board is a place for students and graduates to interact with other students, graduates, and NMI Course Work instructors and staff, as well as to share resources, discuss course work, network, and more.

Students are encouraged to participate in professional and consumer midwifery and birth organizations at the state, regional, and national level. For listings, contact MANA. (See Appendix for contact information.) For example, students in California can access local chapters of the California Association of Midwives that host regular meetings and social events for practicing and aspiring midwives. In addition, local childbirth and parenting resource centers can help students link with community based classes on birth-related topics, investigate part-time employment in the birth community, access childcare, utilize lending libraries, and find support in the area from others who share their interests and concerns. Upon request, students will be assisted in identifying these resources in their own community.

Students are also welcome to access the program's video and audio lending library and list of online resources.

Students share in virtually every aspect of program development, and are encouraged to participate in the annual program review. This review (of admissions, curriculum revision, references, methods of student assessment, the advisability and selection of new faculty, teaching methodologies and effectiveness, administrative performance and facilities, fees, resources and services) is circulated through online survey by May 5th (International Midwives Day).

## Student Services

NMI administrative staff and program instructors provide the following services upon request:

- access to the NMI student Facebook group, weekly virtual Study Forum, and Student Section of the NMI website
- roster of student and graduate contact information
- electronic course work modules
- references for students during preceptor interviews
- updated transcripts
- loans from the audio and DVD library
- web site links and contact information for midwifery organizations and learning resources
- informal meetings when attending conferences
- email and phone contact for questions
- tuition payment plans (limited)
- options for leave of absence

*"I like the flexibility of a modular format"*

*~ an NMI Student*

## Program Facilities, Equipment, Supplies

NMI is a correspondence program; there are no classrooms. Correspondence education affords students the opportunity to complete program requirements in their own communities. Students must be prepared to purchase or arrange access to the textbooks and resources required for completion of course work and training. See Additional Expenses.

The NMI office is located in rural Vermont; it is not a public facility. The office houses student and program files, computers, office equipment and supplies. The NMI office is staffed by the Program Administrator, Associate Administrator, and office support staff.

NMI maintains paper and electronic student files. Back-up electronic files are maintained off site.

## Admissions

Qualified applicants will be admitted without discrimination in regard to sex, gender identity, race, color, marital status, ethnic origin, religion, age, sexual orientation, or disability.

Students must have a high school diploma or equivalent. Students self-select, based on their own assessment of suitability for correspondence learning and the program in general. All applicants are assisted in their enrollment decision through a series of phone conversations with administrative staff, who advise the applicant of the risks, benefits, and demands of correspondence learning, as well as the risks, benefits, and demands of midwifery practice. NMI students are responsible for securing their own preceptorship, and the rationale for this is discussed at length, as well as strategies for establishing this working relationship.

*"I am but a small player on a big, big stage."*

*~ an NMI Student*

If an applicant is concerned about their ability to perform the responsibilities of midwifery education, training and practice, they are encouraged to attend births as a labor support person, and to participate in Heart & Hands Course Work prior to enrollment. Sample modules are made available to all potential applicants.

Students accepted for enrollment must be able to meet the physical and emotional requirements of the academic and clinical course work, and will be required to perform the tasks and uphold the responsibilities particular to midwifery training and practice. For students with dis/ability concerns, NMI offers the flexibility of self paced learning and correspondence education.

Each state regulates the profession of midwifery in its own way. Educational requirements vary, and licensing or certification may or may not be required—applicants must research guidelines in their anticipated state of practice before deciding to enroll. For more information, contact your state midwifery organization, MANA, or NARM. (See contact information in appendix.)

## How To File An Application

Upon receipt of your application, NMI staff will contact you by e-mail to schedule a phone interview to answer any questions you may have, provide further detail regarding program policies, and to discuss details for completing the enrollment process. Complete and submit the Student Application for Enrollment form with a $30 application fee. Upon acceptance to the program, tuition fees are due.

All incoming students are advised to carefully review the forms in their forms book packet, and to consult the Schedule For Filing Forms regarding student responsibilities for filing. Students must also obtain a NARM certification application. The NARM application is available through narm.org.

## Advanced Placement

Previous completion of Heart & Hands Course Work and/or prior birth experience that can be adequately documented transfer with the student upon enrollment. At the preceptor's discretion, students with prior birth experience sufficient to begin student-primary care under preceptor supervision may be required to attend births as an observer or assistant before beginning student-primary care under preceptor supervision.

NMI course work is specific to the Midwives Model of Care, weaving core sciences into the curriculum. Students with prior study in anatomy, physiology, microbiology, or pharmacology do not receive advanced placement, but will find that the NMI curriculum provides excellent review and integration of these subjects.

## New Student Orientation

Initial course work assignments involve identifying community resources for learning and support, including libraries, childbirth resource centers, parenting/postpartum services, and local midwifery organizations. Students are also provided with a list of online resources and textbooks.

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**New Student Orientation,** *continued*

Study Group Course Work includes suggestions for establishing local study groups, and guidelines on how to involve midwife facilitators.

Students are expected to have access to core textbooks. See *Additional Expenses*.

Participation in the NMI student Facebook group and weekly virtual Study Forum sessions is voluntary but strongly encouraged. Enrolled students also gain access to a students-only password protected section of the NMI website where video and audio resources, writable versions of NMI forms, and course work resources are available.

## Tuition and Fees

The NMI application fee is $30.

Tuition and fees for our program total $17,000. NMI's last fee increase occurred in 2013, the first increase in over ten years.

Students enrolling with a payment plan must make monthly payments, may make payments ahead, or may pay their balance at any time. NMI does not charge interest for the payment plan, but late payment penalties and a reinstatement fee are specified.

The following payment plan is available:

| | |
|---|---|
| • Minimum down payment upon enrollment | $5000 |
| • Payments during months 1-12 of enrollment | $500 |
| • Payments during months 13-24 of enrollment | $250 |
| • Payments during months 25-36 of enrollment | $250 |
| Total tuition and fees with payment plan | $17,000 |

All payments are made directly to National Midwifery Institute, Inc.

# Tuition Policy

Payment of all program fees must be completed prior to graduation from the program. During a payment plan, tuition may be paid ahead or in full at any time.

## Tuition Penalties and Reinstatement

Program fees past due 30 days will be assigned a $15 late fee for each month that payment is delayed. If fees remain unpaid an additional five months after maximum $90 late penalty is assigned, the student will be suspended from the program. Program instructors and preceptors are notified and students may not continue to submit course work or experience documentation. Transcript records reflect student work during the time in which the tuition was paid and current. Students wishing to be reinstated must make arrangements to resume regular payments, pay the accumulated $90 in penalties, and pay a reinstatement fee of $250.

If a student wishes to remain in tuition-suspension beyond five months, NMI requires the student to sign and return a Continued Enrollment After Suspension (CEAS) Agreement and provide monthly CEAS payments of $25 each. Mandatory CEAS payments must be received within 30 days of the end of each month, or the $15 late penalty raises that month's CEAS payment to $40. After 90 days of unpaid CEAS payments and with the additional penalties totaling $120, if fees remain unpaid the student is dismissed. Reinstating enrollment and avoiding dismissal requires payment of all unpaid fees ($90 for the initial late fees prior to suspensions, all unpaid CEAS fees, $250 reinstatement fee, and returning to regular tuition payments).

Re-enrollment following dismissal is at the discretion of Program Directors, dependent on payment of all previously delinquent fees and the reinstatement fee of $500. MEAC policy for re-enrollment after dismissal requires NMI to count the student as "new" and student is responsible for the current tuition rate. Re-enrollment after dismissal requires a minimum monthly payment

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of $250 until tuition is paid in full. If a student has remaining first year tuition payments, monthly payments of $500 are required until the tuition schedule shifts to $250 monthly. All fees and tuition must be paid in full prior to graduation. Clinical experience requirements for graduation must be current according to the terms described by NARM.

## Payment Plan & Refund Policy

The initial down payment is nonrefundable. Students who make monthly tuition payments are confirming their intent to continue in the program. Tuition and fees are nonrefundable, unless paid ahead of schedule. NMI reserves $3400 of each student's tuition for honorarium payment to preceptors. If a student withdraws from the program after tuition has been paid in full, the unused portion of the preceptor fees is refunded within 60 days. There is no payment plan fee.

## Financial Aid

Title IV funding is currently not available for students in correspondence-only programs.

## Additional Expenses

In addition to program fees, students should expect to incur related expenses.

- All students should expect to have phone, IT, internet, photocopying and mailing expenses associated with course work completion and program participation. Pager and/or cell phone will probably be required during apprenticeship.
- Textbook costs (approximately $500 to $1000, or more if a student is building a library for future client use) are not included in course work fees.

• Training in adult CPR (required for NARM certification and licensure) costs between $50 and $100; Neonatal Resuscitation training (required for NARM certification and licensure) can be as much as $200.

• Students applying to take the NARM exam will need a NARM certification application, which can be purchased in hard copy from the NARM website ($50, as of May 2016—see contact information in Appendix). The pdf form of NARM application and Candidate Information Booklet (CIB) are also available as free downloads from the NARM website—see contact information in Appendix.

• Students applying to take the NARM exam are required to pay a NARM certification application fee ($1000, as of May 2016—see contact information in Appendix). In addition, the computer testing site requires a fee ($120 as of May 2016).

• Some states require apprentices or midwives in training to register with a licensing agency. Fees for this vary.

• During apprenticeship, students must also expect to build their durable equipment supply for future midwifery practice. Stethoscope, blood pressure cuff, fetoscope and basic delivery and suturing instruments cost approximately $350. A doppler fetoscope costs $700 or more. An oxygen tank and regulator valve may cost $300 or more. Herbal and homeopathic remedies, if desired, usually cost between $7 and $15 each.

• Professional periodicals cost between $35 and $100 annually.

• Memberships in the Midwives' Alliance of North America (MANA) and the California Association of Midwives (CAM) or other state and professional midwifery organizations cost between $35 and $100 each. Student rates may be available.

• Upon completion of the program, application fees for state licensure, certification or registration vary but start at $250. Renewal of these credentials is due every two or three years, with continuing education requirements specific to each state.

## Additional Costs for Preceptorship

An approved NMI preceptor may invoice the program for a total honorarium of $3400 per student (limited to the minimum requirements for each experience category: up to 10 observe births @ $10 each; up to 55 student-assist exams and 195 preceptor supervised student-primary care exams @ $10 each; up to 20 student-assist births @ $15 each; and up to 25 preceptor supervised student-primary care births @ $20 each). NMI holds this amount in reserve from the student's tuition.

Most preceptors realize adequate exchange with an apprentice via assistance with the practice and payments from NMI. However, it is possible that a preceptor will charge a student additional fees. Students are responsible for this as a separate agreement; NMI limits payment to preceptors as described above. If a preceptor requires additional fees, that independent agreement with the student disqualifies the preceptor from also invoicing NMI for the preceptor honorarium amounts.

*"I have tuned in to and learned to trust my intuition as an underpinning (not just a tool) of midwifery care."*

*~ an NMI Student*

# National Midwifery Institute Quarters

During work with preceptors, documentation of training and evaluations of self and preceptor are completed for each quarterly cycle. Students file each cycle of documentation within the quarter or the following two-week grace period. Students are encouraged to plan ahead and have documentation ready to send in the final weeks of each quarter.

**1st Quarter:**
January – February – March (grace period ends April 15*)

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**2nd Quarter:**
April – May – June (grace period ends July 15*)

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**3rd Quarter:**
July – August – September (grace period ends October 15*)

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**4th Quarter:**
October – November – December (grace period ends January 15*)

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*The extra two weeks past the end of the quarter is a grace period to allow postal mail to arrive.

## Academic Calendar

NMI offers open enrollment year-round. Students may complete the program and graduate at any time. Students complete course work at their own pace while meeting or exceeding NMI's minimum academic progress policies, and submit work to course work instructors throughout the year. Documentation of clinical training is submitted to the NMI office by the end of each quarter of active apprenticeship and received by the NMI administrative staff.

The NMI office is open Monday through Friday. During busy office times, appointments are available for phone consultations and may be arranged by email or by leaving a phone message. NMI office hours may be reduced when other schools in Vermont are closed for break:

- last week of December
- third week of February
- last week of April
- July 1-September 1
- The NMI office is closed on national holidays.

Instructors maintain professional responsibilities in the greater midwifery community: serving on advisory or executive boards, teaching at conferences, doing research or technical writing. Instructors notify students if they will be unavailable due to personal or professional commitments.

## State and National Midwifery Credentials

North American Registry of Midwives (NARM) provides midwifery certification for out-of-hospital birth practitioners. Certified Professional Midwife (CPM) is the credential administered by NARM. The final step in the certification process is the NARM Written Examination. NARM works with midwives to assure that the CPM credential and examination reflect current midwifery knowledge and practice.

At least twenty-eight states currently regulate midwifery as a profession separate from nursing. With the exception of New York, all of these states license or certify midwives by using either the NARM CPM credential or the NARM CPM Written Examination (visit http://narm.org/state-organizations/state-info/ and click on "Legal Status of Direct Entry Midwifery" to compare the legal status of midwives in states).

## Graduation Requirements, Licensing and Certification

Students graduate from NMI upon successful completion of all requisite course work and clinical requirements. All student fees must be paid in full, with all completed program documents on file.

Upon completion of our program, students wishing to pursue the NARM Certified Professional Midwife credential (CPM) will qualify under the MEAC Schools application route (see www.narm.org for details).

NMI graduates qualify for California midwifery licensure by applying to the Medical Board of California and passing the NARM Written Examination. Applicants may sit the NARM Written Examination at any of the NARM regional testing sites (see www.narm.org for the list of testing sites and testing information).

NMI graduates who pass the NARM Written Examination qualify for licensure or certification in many states. Licensing or certification applications are made separately, with regulations specific to each state.

The NARM Written Examination is computer-based and the test is given year-round. Candidates will schedule their preferred test date directly with the testing company once their NARM application process has been completed to the stage of testing. For more information, visit narm.org. NARM applicants are responsible for the application and testing site fees, $1000 to NARM and $120 to the testing company for use of the computer testing site.

# NMI Challenge Program for California Midwifery Licensure

The 1993 California Midwifery Practice Act provided legal allowance for a challenge mechanism to midwifery licensure. National Midwifery Institute was granted medical board approval for a proposal to administer the NMI Challenge Program for California Midwifery Licensure. From 2006 through 2014, National Midwifery Institute provided the Challenge Program for over fifty CPMs who successfully completed licensure in California. The NMI Challenge was suspended due to state legislative changes. Program Directors anticipate completion of a revised proposal for the NMI Challenge Program for California Midwifery Licensure, to be submitted to the Medical Board of California in 2016.

The 2006 NMI Challenge Program for California Midwifery Licensure included the following requirements, which are in alignment with the CA Midwifery Practice Act and will also be included in future proposals:

- At least half of all experience had to occur within five years preceding application to NMI Challenge Program for Midwifery Licensure.
- Students pursuing the Challenge Program were required to apply and qualify for NARM CPM certification, including NARM experience requirements and skills assessment. Application to NARM and related fees were the responsibility of the student.
- In addition to NARM experience requirements, students were required to complete the experience requirements identified in the CA Midwifery Practice Act. Both NARM and CA experience requirements are included in NMI graduation requirements. Students who earned their NARM CPM credential prior to enrolling with NMI were also required to demonstrate completion of NMI clinical experience requirements.

- All students who pursued the NMI Challenge Program for California Midwifery Licensure were required to have their clinical experience documentation verified by a licensed physician/surgeon and a licensed midwife or certified nurse-midwife. Students were required to document their experience on forms provided by NMI. Students were responsible for making arrangements with verifiers. Verification is documented and submitted to NMI. Verifiers were provided a stipend for their services to students of NMI.
- Students qualified to take the NMI Challenge Program Written Examination upon successful completion of NMI clinical experience requirements, verification of clinical experience, and NARM Skills Assessments.
- Midwives completing the NMI Challenge Program qualified for the California licensing exam, aka NARM exam.

*"I am open to being wrong and to changing my mind. I am growing as a student every day. I feel I know the most about birth when I acknowledge that it is not up to me."*

*~ an NMI Student*

# Co-Founders of National Midwifery Institute

***Elizabeth Davis*** has been a midwife, women's health care specialist, educator and consultant since 1977. She holds a degree in Holistic Maternity Care from Antioch University, and has been certified by the North American Registry of Midwives since 1992. She served as a representative to the Midwives Alliance of North America for five years, and as president of the Midwifery Education Accreditation Council. She was instrumental in passing midwifery legislation in California, and spearheaded the development of the NARM Certification Task Force to create the CPM credential. Her books, translated into many languages, include the classic *Heart & Hands: A Midwife's Guide to Pregnancy and Birth* (now in its 5th edition); *Orgasmic Birth: Your Guide to a Safe, Satisfying and Pleasurable Birth Experience; The Rhythms of Women's Desire: How Female Sexuality Unfolds at Every Stage of Life;* and *The Women's Wheel of Life.* Internationally active in women's reproductive rights, she travels and lectures widely on midwifery, sexuality, and other birth-related topics. In 2015, she received a Lifetime Achievement Award from Midwifery Today. She lives in Sebastopol, California, and is the mother of three children. See her website at www.elizabethdavis.com

***Shannon Anton*** has been a women's health care advocate since 1978, and was certified as a massage therapist in 1988. She is an apprentice-trained midwife, certified in 1992 by the California Association of Midwives and the North American Registry of Midwives in 1995. She piloted the initial California Midwifery Licensing Challenge Mechanism and earned California midwifery license number five. She served the CAM Board as regional representative, certification administrator and treasurer for the legislative committee. She was CAM representative to the NARM Certification Task Force during the consensus-based creation of the CPM credential. She was nominated to the NARM Board in 1993 and currently serves as NARM Director of Accountability. She attended US MERA 2014 & 2015 meetings and serves on the US MERA Equity Task Force.

She was a founding member of the Bay Area Homebirth Collective in San Francisco and former co-owner of Medea Books. Now administrator of National Midwifery Institute, Inc., she and her life partner live in rural Vermont.

**Elizabeth Davis and Shannon Anton**
*were honored by California Association of Midwives'*
**2004 Brazen Woman Award**

**Elizabeth Davis**
*was honored by Midwifery Today's*
**2015 Lifetime Achievement Award**


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*Our work continues in thoughtful memorial to*

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**Marsden Wagner**
MD, perinatologist, perinatal epidemiologist, and outspoken midwifery supporter

*and to our ancestors,*
*midwives who names we may never know*
*but whose knowledge and skills we are grateful for today.*

# Appendix

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MANA Documents
MEAC Documents
NMI Policies

# Midwives Model of Care

The Midwives Model of Care is based on the fact that pregnancy and birth are normal life processes.

**The Midwives Model of Care includes:**

- monitoring the physical and social well-being of the mother throughout the childbearing cycle;
- providing the mother with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support;
- minimizing technical interventions; and
- identifying and referring women who require obstetrical attention. The application of this woman-centered model of care has been proven to reduce the incidence of birth injury, trauma and cesarean section. Copyright 1996-2001, Midwifery Task Force, Inc. All rights reserved.



The Midwifery Model of Care statement is circulated by Citizens for Midwifery:

**Citizens for Midwifery,** PO Box 82227, Athens, GA 30608-2227 **www.cfmidwifery.org** 1-888-236-4880

## Supporting Healthy and Normal Physiologic Childbirth: A Consensus Statement by ACNM, MANA, and NACPM*

In 1996, the World Health Organization called for the elimination of unnecessary intervention in childbirth,[1] yet currently there are few resources to assist maternity care providers in achieving this goal. The purpose of this consensus statement is to explicitly identify key benchmarks of safe, healthy, and normal physiologic childbirth. This statement will assist maternity care providers, women, policymakers, and payers to protect, promote, and support human childbearing physiology and to avoid overuse of interventions, thus achieving better care, better health, and lower costs.

This consensus statement represents the work of a task force comprised of representatives from three U.S. midwifery organizations whose members are experts on supporting women's innate capacities to birth, and was externally reviewed by maternity care organizations and leaders. The specific aims of the consensus statement are to

- Provide a succinct definition of normal physiologic birth;
- Identify measurable benchmarks to describe optimal processes and outcomes reflective of normal physiologic birth;
- Identify factors that facilitate or disrupt normal physiologic birth based on the best available evidence;
- Create a template for system changes through clinical practice, education, research, and health policy; and
- Ultimately improve the health of mothers and infants, while avoiding unnecessary and costly interventions.

This statement is placed in the context of the current, widespread application of technological interventions that lack scientific evidence to a primarily healthy birthing population.[2] The use of obstetric interventions in labor and birth has become the norm in the United States. More than half of all pregnant women receive synthetic oxytocin to induce or augment labor,[3] which demands additional interventions to monitor, prevent, or treat side effects. Nationally, one third of women deliver their babies via cesarean,[4] a major abdominal surgery with potential for serious short- and long-term health consequences. For the mothers these consequences include, but are not limited to, postoperative infections, chronic pain, future cesarean births, and placental complications that can lead to hemorrhage, hysterectomy, and rarely, death.[5,6] Infant risks include respiratory distress,[7] and in subsequent pregnancies maternal risks include increased likelihood of preterm birth and associated morbidity and mortality. [8–,12] Regardless of intervention or outcome, childbearing care perceived by the woman as disrespectful or traumatic is more likely to be associated with maternal psychological morbidity and potential for disrupted mother-infant attachment.[13–,16]

### DEFINING THE NORMAL PHYSIOLOGY OF CHILDBIRTH

This statement is grounded in scientific evidence and based on definitions drawn from the 2012 version of the Oxford English Dictionary, in which "normal" refers to typical or usual—a standard, and "physiology" refers to the functional processes of an organism, organ, or system. Thus, normal human physiology provides a framework to understand the optimal functioning of childbirth. For the purposes of this statement, birth includes the three stages of labor, the newborn transition, and the first hour after birth.

A normal physiologic labor and birth is one that is powered by the innate human capacity of the woman and fetus. This birth is more likely to be safe and healthy because there is no unnecessary intervention that disrupts normal physiologic processes.[17] Some women and/or fetuses will develop complications that warrant medical attention to assure safe and healthy outcomes. However, supporting the normal physiologic processes of labor and birth, even in the presence of such complications, has the potential to enhance best outcomes for the mother and infant.[18–,21]

**Normal physiologic childbirth is characterized by spontaneous onset and progression of labor;**

- includes biological and psychological conditions that promote effective labor;
- results in the vaginal birth of the infant and placenta;
- results in physiological blood loss;[22]
- facilitates optimal newborn transition through skin-to-skin contact and keeping the mother and infant together during the postpartum period; and
- supports early initiation of breastfeeding.[1]

**The following factors disrupt normal physiologic childbirth:**

- induction or augmentation of labor;[23–25]
- an unsupportive environment, i.e., bright lights, cold room, lack of privacy, multiple providers, lack of supportive companions, etc.;[26,27]
- time constraints, including those driven by institutional policy and/or staffing;[28]
- nutritional deprivation, e.g., food and drink;[29]
- opiates, regional analgesia, or general anesthesia;[30,31]
- episiotomy;[32,33]
- operative vaginal (vacuum, forceps) or abdominal (cesarean) birth;[6,34]
- immediate cord clamping;[35–37]
- separation of mother and infant;[38] and/or
- any situation in which the mother feels threatened or unsupported.[39]

**THE MECHANISMS AND OUTCOMES OF PHYSIOLOGIC CHILDBIRTH**

Normal physiologic labor and birth has positive short- and long-term health implications for the mother and infant. Optimal physiologic function of the neuroendocrine system enhances the release of endogenous oxytocin and beneficial catecholamines in response to stress.[40,41] These hormones promote effective labor patterns and protective physiologic responses, including enhanced endorphin levels, facilitation of cardio-respiratory transition and thermoregulation of the newborn, successful lactation, and enhanced bonding behavior between the mother and infant.[38,42–44] When there is optimal physiologic functioning, women are less likely to require interventions to artificially augment labor, which can potentially interfere with their ability to cope with pain.[44–47] When labor progresses spontaneously there is a reduced likelihood of fetal compromise or need for instrumental/surgical intervention.[48]

For most women, the short-term benefits of normal physiologic birth include emerging from childbirth feeling physically and emotionally healthy and powerful as mothers. Their infants will benefit from the ability of their mothers to respond to their needs and from the lack of exposure to medications that can affect neurological behavior. Long-term outcomes include beneficial effects for the woman's physical and mental health and capacity to mother, enhanced infant growth and development, and potentially diminished incidence of chronic disease.[49–56] Together, these outcomes are beneficial to the family and society through enhanced family functioning and cost effective care. Importantly, a focus on these aspects of normal physiologic birth will help to change the current discourse on childbirth as an illness state where authority resides external to the woman to one of wellness in which women and clinicians share decisions and accountability.[57]

**FACTORS THAT INFLUENCE NORMAL PHYSIOLOGIC CHILDBIRTH**

**There are multiple factors that influence the ability of a woman to give birth without intervention. These include the following:**

**For the woman:**

- Her individual health status and physical fitness;
- Autonomy and self-determination in childbirth;[58]
- Personal knowledge and confidence about birth, including cultural beliefs, norms, and practices and education about the value of normal physiologic birth;[59]
- Fully informed, shared decision-making; and
- Access to health care systems, settings, and providers supportive of and skilled in normal physiologic birth.60

**For the clinician:**

- Education, knowledge, competence, skill, and confidence in supporting physiologic labor and birth, including helping women cope with pain;
- Commitment to working with women through education to enhance their confidence in birth and diminish their fear of the process;
- Commitment to shared decision making; and
- Working within an infrastructure supportive of normal physiologic birth.[60]

*Continued on the next page*

**For the birth setting and environment:**

- Access to midwifery care for each woman;[18]
- Adequate time for shared decision making with freedom from coercion;
- No inductions or augmentations of labor without an evidence-based clinical indication;[24]
- Encouragement of nourishment (food and drink) during labor as the woman desires;[61]
- Freedom of movement in labor and the woman's choice of birth position;
- Intermittent auscultation of heart tones during labor unless continuous electronic monitoring is clinically indicated;[62]
- Maternity care providers skilled in non-pharmacologic methods for coping with labor pain for all women;[63]
- Care that supports each woman's comfort, dignity, and privacy; and
- Respect for each woman's cultural needs.

**RECOMMENDATIONS FOR POLICY, EDUCATION, AND RESEARCH TO PROMOTE NORMAL PHYSIOLOGIC CHILDBIRTH INCLUDE, BUT ARE NOT LIMITED TO, THE FOLLOWING:**

- Introduction of policies into hospital settings to support normal physiologic birth;
- Comprehensive examination and dissemination of the evidence and care practices supportive of normal physiologic birth;
- Midwifery care as a key strategy to support normal physiologic birth;
- Increasing the midwife workforce and enhancing regulations and funding strategies to support their practice;
- Competency-based, inter-disciplinary education programming for maternity health care clinicians and students on the application of care that promotes normal physiologic birth and (see the Normal Birth Summit Statement)
- Development of a future research agenda on short and long-term effects of normal physiologic birth.[2,64]

*Approved by the Boards of Directors of ACNM, MANA, and NACPM, April 2012*
*Released May 14, 2012*

**Footnotes**

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***Note.** ACNM = American College of Nurse-Midwives, http://www.midwife.org/; MANA = Midwives Alliance of North America, http://mana.org/; NACPM = National Association of Certified Professional Midwives, http://www.nacpm.org/. This document is intended for health care professionals and policymakers. A companion document for consumers is in development.

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**REFERENCES**


1. World Health Organization Care in Normal Birth: A Practical Guide. World Health Organization; 1996
2. Sakala C, Corry MP Evidence-based maternity care: what it is and what it can achieve. New York, NY: Milbank Memorial Fund; 2008
3. Declercq ER, Sakala C, Corry MP, et al. Listening to mothers II: Report of the Second National U.S. Survey of Women's Childbearing Experiences. New York, NY: Childbirth Connection; 2006
4. Martin JA, Hamilton BE, Ventura SJ, et al. Births: preliminary data for 2010. Natl Vital Stat Rep. 2011;60(2):1–25 [PubMed]
5. Guise JM, Eden K, Emeis C, et al. Vaginal birth after cesarean: new insights. Evidence report/technology assessment no.191. Rockville, MD: Agencyfor Healthcare Research and Quality; 2010 [PMC free article] [PubMed]
6. Koroukian SM Relative risk of postpartum complications in the Ohio Medicaid population: vaginal versus cesarean delivery. Med Care Res Rev. 2004;61(2):203–224 [PubMed]
7. Hansen AK, Wisborg K, Uldbjerg N, et al. Elective caesarean section and respiratory morbidity in the term and near-term neonate. Acta Obstet Gynecol Scand. 2007;86(4):389–394 [PubMed]
8. Bager P, Wohlfahrt J, Westergaard T Caesarean delivery and risk of atopy and allergic disease: meta-analyses. Clin Exp Allergy. 2008;38(4):634–642 [PubMed]
9. Galyean AM, Lagrew DC, Bush MC, et al. Previous cesarean section and the risk of postpartum maternal complications and adverse neonatal outcomes in future pregnancies. J Perinatol. 2009;29(11):726–730 [PubMed]
10. Kennare R, Tucker G, Heard A, et al. Risks of adverse outcomes in the next birth after a first cesarean delivery. Obstet Gynecol. 2007; 109(2, pt 1):270–276 [PubMed]

11. Osborne C, Ecker JL, Gauvreau K, et al. First birth cesarean and risk of antepartum fetal death in a subsequent pregnancy. J Mid wifery Womens Health. 2012;57(1):12–17 10.1111/j.1542-2011.2011.00142.x; 10.1111/j.1542-2011.2011.00142.x [PubMed]
12. Richter R, Bergmann RL, Dudenhausen JW Previous caesarean or vaginal delivery: which mode is a greater risk of perinatal death at the second delivery? Eur J Obstet Gynecol Reprod Biol. 2006;132(1):51–7 [PubMed]
13. Beck CT Birth trauma: in the eye of the beholder. Nurs Res. 2004;53(1):28–35 [PubMed]
14. Beck CT, Watson S The impact of birth trauma on breastfeeding: a tale of two pathways. Nurs Res. 2008;57(4):228–236 [PubMed]
15. Beck CT The anniversary of birth trauma: failure to rescue. Nurs Res. 2006;55(6):381–390 [PubMed]
16. Beck CT Post-traumatic stress disorder due to childbirth: the aftermath. Nurs Res. 2004;53(4):216–224 [PubMed]
17. Romano AM, Lothian JA Promoting, protecting, and supporting normal birth: a look at the evidence. J Obstet Gynecol Neonatal Nurs. 2008;37(1):94–105 10.1111/j.1552-6909.2007.00210.x [PubMed]
18. Hatem M, Sandall J, Devane D, et al. Midwife-led versus other models of care for childbearing women. Cochrane Database Syst Rev. 2008;(4):CD004667 [PubMed]
19. Cragin L, Kennedy HP Linking obstetric and midwifery practice with optimal outcomes. J Obstet Gynecol Neonatal Nurs. 2006;35(6):779–785 [PubMed]
20. Murphy PA, Fullerton JT Development of the optimality index as a new approach to evaluating outcomes of maternity care. J Obstet Gynecol Neonatal Nurs. 2006;35(6):770–778 [PubMed]
21. Low LK, Seng JS, Miller JM Use of the optimality index—United States in perinatal clinical research: a validation study. J Midwifery Womens Health. 2008;53(4):302–309 [PubMed]
22. Dixon L, Fullerton JT, Begley C, et al. Systematic review: the clinical effectiveness of physiological (expectant) management of the third stage of labor following a physiological labor and birth. Int J Childbirth. 2011;1(3):179–195
23. Clark SL, Simpson KR, Knox GE, et al. Oxytocin: new perspectives on an old drug. Am J Obstet Gynecol. 2009;200(1):35, e1,–35 e6 [PubMed]
24. Mozurkewich E, Chilimigras JL, Berman DR, et al. Methods of induction of labour: a systematic review. BMC Pregnancy Childbirth. 2011;11(84):1–19 [PMC free article] [PubMed]
25. Smyth RM, Alldred SK, Markham C Amniotomy for shortening spontaneous labour. Cochrane Database Syst Rev. 2007;(4):CD006167 [PubMed]
26. Hodnett ED, Downe S, Walsh D, et al. Alternative versus conventional institutional settings for birth. Cochrane Database Syst Rev. 2010;(9):CD000012 [PubMed]
27. Hodnett ED, Gates S, Hofmeyr GJ, et al. Continuous support for women during childbirth. Cochrane Database Syst Rev. 2011;(2):CD003766 [PubMed]
28. Zhang J, Troendle J, Reddy UM, et al. Contemporary cesarean delivery practice in the United States. Am J Obstet Gynecol. 2010;203(4):326, e1,–326 e10 10.1016/j.ajog.2010.06.058 [PMC free article] [PubMed]
29. Singata M, Tranmer J, Gyte GM Restricting oral fluid and food intake during labour. Cochrane Database Syst Rev. 2010;(1):CD003930 [PMC free article] [PubMed]
30. Bricker L, Lavender T Parenteral opioids for labor pain relief: a systematic review. Am J Obstet Gynecol. 2002;186(suppl 5):S94–109 [PubMed]
31. Anim-Somuah M, Smyth RM, Jones L Epidural versus non-epidural or no analgesia in labour. Cochrane Database Syst Rev. 2011;(12):CD000331 [PubMed]
32. Carroli G, Mignini L Episiotomy for vaginal birth. Cochrane Database Syst Rev. 2009;(1):CD000081 [PMC free article] [PubMed]
33. Viswanathan M, Hartmann K, Palmieri R, et al. The Use of Episiotomy in Obstetrical Care: A Systematic Review. Evidence reports/ technology assessments, No. 112. Rockville, MD: Agency for Healthcare Research and Quality; 2005
34. Demissie K, Rhoads GG, Smulian JC, et al. Operative vaginal delivery and neonatal and infant adverse outcomes: population based retrospective analysis. BMJ. 2004;329(7456):24–29 [PMC free article] [PubMed]
35. Hutton EK, Hassan ES Late vs early clamping of the umbilical cord in full-term neonates: systematic review and meta-analysis of controlled trials. JAMA. 2007;297(11):1241–1252 [PubMed]
36. Erickson-Owens DA, Mercer JS, Oh W Umbilical cord milking in term infants delivered by cesarean section: a randomized controlled trial [published online ahead of print November 17, 2011]. J Perinatol. 10.1038/jp.2011.159 [PubMed]
37. Mercer JS, Vohr BR, Erickson-Owens DA, et al. Seven-month developmental outcomes of very low birth weight infants enrolled in a randomized controlled trial of delayed versus immediate cord clamping. J Perinatol. 2010;30(1):11–16 [PMC free article] [PubMed]
38. Moore E, Anderson G, Bergman N Early skin-to-skin contact for mothers and their healthy newborn infants. Cochrane Database Syst Rev. 2007;(3):CD003519 [PubMed]
39. Beck CT Birth trauma and its sequelae. J Trauma Dissociation . 2009;10(2):189–203 [PubMed]

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40. Bacigalupo G, Riese S, Rosendahl H, et al. Quantitative relationships between pain intensities during labor and beta-endorphin and cortisol concentrations in plasma decline of the hormone concentrations in the early postpartum period. J Perinat Med. 1990;18(4):289–296 [PubMed]
41. Hoffman DI, Abboud TK, Haase HR, et al. Plasma beta-endorphin concentrations prior to and during pregnancy, in labor, and after delivery. Am J Obstet Gynecol. 1984;150(5, pt 1):492–496 [PubMed]
42. Fourer M Creating birth space to enable undisturbed birth. In Fahy K, Fourer M, Hastie C, eds Birth Territory and Midwifery Guardianship. Theory for Practice, Education and Research. New York, NY: Elsevier; 2008:57–77
43. Unväs-Moberg K The Oxytocin Factor. Tapping the Hormone of Calm, Love, and Healing. Cambridge, MA: Da Capo Press; 2003
44. Taylor S, Klein L, Lewis B, et al. Biobehavioural responses to stress in females: tend- and-befriend, not fight-or-flight. Psychological Rev. 2000;107:411–429 [PubMed]
45. Neal JL, Lowe NK, Patrick TE, et al. What is the slowest-yet-normal cervical dilation rate among nulliparous women with spontaneous labor onset? J Obstet Gynecol Neonatal Nurs. 2010;39(4):361–369 [PMC free article] [PubMed]
46. Lowe NK The nature of labor pain. Am J Obstet Gynecol. 2002;186(5 suppl Nature):S16–S24 [PubMed]
47. Simkin P, Bolding A Update on nonpharmacologic approaches to relieve labor pain and prevent suffering. J Midwifery Womens Health. 2004;49:489–504 [PubMed]
48. Dunne C, Da Silva O, Schmidt G, et al. Outcomes of elective labour induction and elective caesarean section in low-risk pregnancies between 37 and 41 weeks' gestation. JOGC. 2009;31(12):1124–1130 [PubMed]
49. Cardwell CR, Stene LC, Joner G, et al. Caesarean section is associated with an increased risk of childhood-onset type 1 diabetes mellitus: a meta-analysis of observational studies. Diabetologia. 2008;51:726–735 [PubMed]
50. Schlinzig T, Johansson S, Gunnar A, et al. Epigenetic modulation at birth—altered DNA-methylation in white blood cells after caesarean section. Acta Paediatr. 2009;98:1096–1099 [PubMed]
51. Toyokawa S, Uddin M, Koenen KC, et al. How does the social environment "get into the mind"? Epigenetics at the intersection of social and psychiatric epidemiology. Soc Sci Med. 2012;74:67–74 [PMC free article] [PubMed]
52. Heim C, Binder EB Current research trends in early life stress and depression: review of human studies on sensitive periods, gene-environment interactions, and epigenetics. Exp Neurol. 2012;233(1):102–111 [PubMed]
53. Maghzi AH, Etemadifar M, Heshmat-Ghahdarijani K, et al. Delivery may increase the risk of multiple sclerosis. Mult Scler. 2012;18(4):468–471 [PubMed]
54. Xu XF, Du LZ Epigenetics in neonatal diseases. Chin Med J. 2010;123(20):2948–2954 [PubMed]
55. Hyde M, Mostyn A, Modi N, et al. The health implications of birth by caesarean section. Biol Rev. 2012;87(1), 229–243. [PubMed]
56. Kapellou O Effect of caesarean section on brain maturation. Acta Paediatr. 2011;100(11):1416–1422 [PubMed]
57. Kennedy HP, Nardini K, McLeod-Waldo R, et al. Top-selling childbirth advice books: a discourse analysis. Birth. 2009;36(4):318–324 [PubMed]
58. Klein MC, Liston R, Fraser WD Attitudes of the new generation of Canadian obstetricians: how do they differ from their predecessors? Birth. 2011;38(2):1–11 [PubMed]
59. van der Hulst LAM, Van Teijlingen ER, Bonsel GK Does a pregnant woman's intended place of birth influence her attitudes toward and occurrence of obstetric interventions? Birth. 2004;31(1):28–33 [PubMed]
60. Kennedy HP, Grant J, Walton C, et al. Normalizing birth in England: a qualitative study. J Midwifery Womens Health. 2010;55(3): 262–269 [PubMed]
61. American College of Nurse-Midwives Providing oral nutrition to women in labor. Clinical bulletin. http://www.midwife.org/siteFiles/education/Oral_Nutrition_to_Women_in_Labor_5_08.pdf Published March, 2008. Accessed May 4, 2012.
62. American College of Nurse-Midwives Intermittent auscultation for intrapartum fetal heart rate surveillance. Clinical bulletin. http://onlinelibrary.wiley.com/doi/10.1016/j.jmwh.2007.03.021/abstract?userIsAuthenticated=true&deniedAccessCustomisedMessage=Published March, 2007. Accessed May 4, 2012.
63. Simkin PP, O'Hara M Nonpharmacologic relief of pain during labor: systematic reviews of five methods. Am J Obstet Gynecol. 2002;186(5 suppl Nature):S131–S159 [PubMed]
64. Childbirth Connection Blueprint for action: steps toward a high-quality, high-value maternity care system. http://transform.childbirthconnection.org/blueprint/ Accessed May 4, 2012.

*"This course has done so much to fortify my confidence in midwifery as my life's pursuit."*

*~ an NMI Student*

**Current MANA Standards and Qualifications Statement**

# MANA Standards and Qualifications for the Art and Practice of Midwifery

The midwife practices in accord with the MANA Standards and Qualifications for the Art and Practice of Midwifery and the MANA Statement of Values and Ethics, and demonstrates the clinical skills and judgments described in the MANA Core Competencies for Midwifery Practice.

**1. Skills:** Necessary skills of a practicing midwife include the ability to:

- Provide continuity of care to the woman and her newborn during the maternity cycle. Care may continue throughout the woman's entire life cycle. The midwife recognizes that childbearing is a woman's experience and encourages the active involvement of her self-defined family system.
- Identify, assess and provide care during the antepartal, intrapartal, postpartal and newborn periods. She may also provide well woman and newborn care.
- Maintain proficiency in life-saving measures by regular review and practice
- Deal with emergency situations appropriately
- Use judgment, skill and intuition in competent assessment and response.

**2. Appropriate Equipment and Treatment:** Midwives carry and maintain equipment to assess and provide care for the well-woman, the mother, the fetus, and the newborn; to maintain clean and/or aseptic technique; and to treat conditions including, but not limited to, hemorrhage, lacerations, and cardio-respiratory distress. This may include the use of non-pharmaceutical agents, pharmaceutical agents, and equipment for suturing and intravenous therapy.

**3. Records:** Midwives keep accurate records of care for each woman and newborn in their practice. Records shall reflect current standards in midwifery charting, and shall be held confidential (except as legally required). Records shall be provided to the woman on request. The midwife maintains confidentiality in all verbal and written communications regarding women in her care.

**4. Data Collection:** It is highly recommended that midwives collect data for their practice on a regular basis and that this be done prospectively, following the protocol developed by the MANA Division of Research. Data collected by the midwife shall be used to inform and improve her practice.

**5. Compliance:** Midwives will inform and assist parents regarding public health requirements of the jurisdiction in which the midwifery service is provided.

**6. Medical Consultation, Collaboration, and Referral:** All midwives recognize that there are certain conditions for which medical consultations are advisable. The midwife shall make a reasonable attempt to assure that her client has access to consultation, collaboration, and/or referral to a medical care system when indicated.

**7. Screening:** Midwives respect the woman's right to self-determination. Midwives assess and inform each woman regarding her health and well-being relevant to the appropriateness of midwifery services. It is the right and responsibility of the midwife to refuse or discontinue services in certain circumstances. Appropriate referrals are made in the interest of the mother or baby's well-being or when the required or requested care is outside the midwife's personal scope of practice as described in her practice guidelines.

**8. Informed Choice:** Each midwife will present accurate information about herself and her services, including but not limited to:

- her education in midwifery
- her experience level in midwifery
- her practice guidelines
- her financial charges for services
- the services she does and does not provide
- her expectations of the pregnant woman and the woman's self-defined family system.

The midwife recognizes that the woman is the primary decision maker in all matters regarding her own health care and that of her infant.
The midwife respects the woman's right to decline treatments or procedures, and properly documents these choices. The midwife clearly states and documents when a woman's choices fall outside the midwife's practice guidelines.

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**9. Continuing Education:** Midwives will update their knowledge and skills on a regular basis.

**10. Peer Review:** Midwifery practice includes an on-going process of case review with peers.

**11. Practice Guidelines:** Each midwife will develop practice guidelines for her services that are in agreement with the MANA Standards and Qualifications for the Art and Practice of Midwifery, the MANA Statement of Values and Ethics, and the MANA Core Competencies for Midwifery Practice, in keeping with her level of expertise.

**12. Expanded Scope of Practice:** The midwife may expand her scope of practice beyond the MANA Core Competencies to incorporate new procedures that improve care for women and babies consistent with the midwifery model of care. Her practice must reflect knowledge of the new procedure, including risks, benefits, screening criteria, and identification and management of potential complications.

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**REFERENCES:**

The following sources were utilized for reference: Essential documents of the National Association of Certified Professional Midwives 2004, American College of Nurse-Midwives documents and standards for the Practice of Midwifery revised March 2003; ICM membership and joint study on maternity; FIGO, WHO, etc. revised 1972; New Mexico regulations for the practice of lay midwifery, revised 1982; North West Coalition of Midwives Standards for Safety and Competency in Midwifery; Varney, Helen, Nurse-Midwifery, Blackwell Scientific Pub., Boston, MA 1980.

*"The fact that there wasn't a teacher 'breathing down my neck' to get my homework done has given me a good picture of my own commitment—where I lack and where I succeed."*

*~ an NMI Student*

# MANA Statement of Values and Ethics

## Ethics in Midwifery Guide Good Decision Making

The practice of midwifery is infused with values that guide the way midwives provide care to women, infants and families. Ethics is a necessary component of midwifery care and requires midwives to make ethical decision on a daily basis regardless of settings in which they provide services, such as clinics, homes, hospitals and birth centers.

The Midwives Alliance Statement of Values and Ethics was written and adopted by the MANA Board of Directors in 1997, and revised and adopted in August 2012.

## MANA Statement of Values and Ethics

The Statement of Values and Ethics of the Midwives Alliance of North America (MANA) is a critical reflection of moral issues as they pertain to maternal and child health. It is intended to provide guidance for professional conduct in the practice of midwifery, as well as influence MANA's organizational policies, thereby promoting high quality care for childbearing families.

## Statement of Values

Since what we value infuses and informs our ethical decisions and actions, the Midwives Alliance of North America affirms:

**I. Woman as a Unique Individual**

A. We value each woman as a strong, creative, unique individual with life-giving powers.
B. We value each woman's right to a supportive caregiver appropriate to her needs and respectful of her belief system.
C. We value a woman's right to access resources in order to achieve health, happiness and personal growth according to her needs, perceptions and goals.
D. We value a woman as autonomous and competent to make decisions regarding all aspects of her life.
E. We value the empowerment of a woman during the processes of pregnancy, birth, breastfeeding, mother–infant attachment and parenting.

**II. Mother and Baby as Whole**

A. We value the mother and her baby as an inseparable and interdependent whole and acknowledge that each woman and baby have parameters of well-being unique to themselves.
B. We value the physical, psychosocial and spiritual health, well-being and safety of every mother and baby.
C. We value the mother as the direct care provider for her unborn child.
D. We value the process of labor and birth as a rite of passage with mother and baby as equal participants.
E. We value the sentient and sensitive nature of the newborn and affirm every baby's right to a caring and loving birth without separation from mother and family.
F. We value breastfeeding as the ideal way to nourish and nurture the newborn.

**III. The Nature of Birth**

A. We value the essential mystery of birth.
B. We value pregnancy and birth as natural, physiologic and holistic processes that technology will never supplant.
C. We value the integrity of a woman's body, the inherent rhythm of each woman's labor and the right of each mother and baby to be supported in their efforts to achieve a natural, spontaneous vaginal birth.
D. We value birth as a personal, intimate, internal, sexual and social experience to be shared in the environment and with the attendants a woman chooses.
E. We value the right of a woman and her partner to determine the most healing course of action when difficult situations arise.
F. We value the art of letting go and acknowledge death and loss as possible outcomes of pregnancy and birth.

**IV. The Art of Midwifery:**

A. We value our right to practice the art of midwifery, an ancient vocation of women.
B. We value multiple routes of midwifery education and the essential importance of apprenticeship training.
C. We value the wisdom of midwifery, an expertise that incorporates theoretical and embodied knowledge, clinical skills, deep listening, intuitive judgment, spiritual awareness and personal experience.

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**MANA Statement of Values and Ethics,** *continued*

D. We value the art of nurturing the inherent normalcy of pregnancy and birth as expressions of wellness in a healthy woman.
E. We value continuity of care throughout the childbearing year.
F. We value birth with a midwife in any setting that a woman chooses.
G. We value homebirth with a midwife as a wise and safe choice for healthy families.
H. We value caring for a woman to the best of our ability without prejudice with regards to age, race, ethnicity, religion, education, culture, sexual orientation, gender identification, physical abilities or socioeconomic background.
I. We value the art of empowering women, supporting each to birth unhindered and confident in her natural abilities.
J. We value the acquisition and use of skills that identify and guide a complicated pregnancy or birth to move toward greater well-being and be brought to the most healing conclusion possible.
K. We value standing up for what we believe in the face of social pressure and political oppression.

**V. Woman as Mother:**

A. We value a mother's intuitive knowledge and innate ability to nurture herself, her unborn baby and her newborn baby.
B. We value the power and beauty of a woman's body as it grows in pregnancy and a woman's strength in labor and birth.
C. We value pregnancy and birth as processes that have lifelong impact on a woman's self-esteem, her health, her ability to nurture and her personal growth.
D. We value the capacity of partners, family and community to support a woman in all aspects of pregnancy, birth and mothering and to provide a safe environment for mother and baby.

**VI. The Nature of Relationship:**

A. We value an egalitarian relationship between a woman and her midwife.
B. We value the quality, integrity and uniqueness of our interactions, which inform our choices and decisions.
C. We value mutual trust, honesty and respect.
D. We value a woman's right to privacy, and we honor the confidentiality of all personal interactions and health records.
E. We value direct access to information that is readily understood by all.
F. We value personal responsibility and the right of a woman to make decisions regarding what she deems best for herself, her baby and her family, using both informed consent and informed refusal.
G. We value our relationship to a process that is larger than ourselves, recognizing that birth is something we can seek to learn from and to know, but cannot control.
H. We value humility and the recognition of our own limitations.
I. We value sharing information and understanding about birth experiences, skills and knowledge.
J. We value a supportive midwifery community as an essential place of learning.
K. We value diversity among midwives that broadens our collective resources and challenges us to work toward greater understanding.
L. We value collaboration between a midwife and other health-care practitioners as essential to providing a family with resources to make responsible and informed choices.
M. We value the right and responsibility of both a midwife and a woman to discontinue care when insurmountable obstacles develop that compromise communication, mutual trust or joint decision making.
N. We value the responsibility of a midwife to consult with other health-care practitioners when appropriate and refer or transfer care when necessary.

**VII. Cultural Sensitivity, Competency and Humility**

A. We value cultural sensitivity, competency and humility as critical skills for the midwife to master in an increasingly multicultural society.
B. We value cultural sensitivity—a midwife's awareness of and ability to honor differences between people and the cultural values of the women she serves.
C. We value the importance of cultural competency in addressing the social and economic barriers to access to care for vulnerable, underserved and marginalized women, thereby improving maternal and infant health and the well-being of families.
D. We value cultural humility as a lifelong process of self-reflection and self-critique in order to develop a respectful partnership with each woman.*

***Section VII is derived from Melanie Tervalon and Jann Murray-Garcia, "Cultural Humility versus Cultural Competency: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education," Journal of Health Care for the Poor and Underserved 9 (May 1998): 117–25.**

**Statement of Ethics**

Our values inform and inspire midwifery practice in our hearts and minds. Acting ethically is an expression of our values within the context of our individual, geographic, religious, cultural, ethnic, political, educational and personal backgrounds and in our relationships with others. As we seek to respond in the moment to each situation we face, we call upon ethical principles of human interaction as follows:

- Beneficence—to act so as to benefit others
- Nonmaleficence—to avoid causing harm
- Confidentiality—to honor others' privacy and keep personal interactions confidential
- Justice—to treat people respectfully and equitably
- Autonomy—to respect an individual's rights to self-determination and freedom to make decisions that affect his or her life.

The equality and mutuality of the relationship between midwife and client create a foundation uniquely suited to integrate these principles. As midwives, we seek to benefit women and babies in our care. Mutual trust and respect are critical to the success of a relationship that requires joint decision making at every level. Moral integrity, truthfulness and adequate information enable all participants to judge together the best course of action in varied situations.

Judgments are fundamentally based on awareness and understanding of ourselves and others. They grow out of our own sense of moral integrity, which is born within the heart of each individual. Becoming self-aware and increasing understanding are ongoing processes that must be nurtured as a function of personal and professional growth. MANA's affirmation of individual moral integrity and recognition of the complexity of life events bring us to an understanding that there cannot possibly be one right answer for all situations. Since the outcome of pregnancy is ultimately unknown and is always unknowable, it is inevitable that in certain circumstances our best decisions in the moment will lead to consequences we could not foresee.

We recognize the limitations of traditional codes of ethics that present a list of rules to be followed. Therefore, a midwife must develop a moral compass to guide practice in diverse situations that arise from the uniqueness of pregnancy and birth as well as the relationship between midwives and birthing women. This approach affirms the mystery and potential for transformation present in every experience and fosters truly diverse practice. Midwifery care is woman-led care with informed choice and a clear set of values at its core. Decision making is a shared responsibility with the goals of healthy women and babies and of gentle, empowering births with a focus on individual and family needs and concerns. Ultimately, it is at the heart of midwifery practice to honor and respect the decisions women make about their pregnancies and births based on their knowledge and belief about what is best for themselves and their babies.

There are both individual and social implications to any decision-making process. Our decisions may be impacted by the oppressive rules and practices of a society that is often hostile to homebirth, midwives and midwifery clients. Our actual choices may be limited by the medical, legal, political, economic, cultural or social climate in which we function. The more our values conflict with those of the dominant culture, the greater the threat to the integrity of our own values, and the greater the risk that our actions may lead to professional repercussions or legal reprisal. In such conditions we may be unable to make peace with any course of action or may feel conflicted about a choice already made. The community of women, both midwives and those we serve, may provide a fruitful resource for continued moral support and guidance.

In summary, acting ethically requires us to define our values, respond to the communities of families, midwives and cultures in which we find ourselves, act in accord with our values to the best of our ability as the situation demands, and engage in ongoing self-examination, evaluation, peer review and professional growth. By carefully describing the multifaceted aspects of what we value and defining the elements of moral integrity and decision making, we have created a framework for ethical behavior in midwifery practice. We welcome an open and ongoing articulation of values and ethics and the evolution of this document.

# MANA Core Competencies for Midwifery Practice

**MANA Core Competencies are Essential for High Quality Midwifery Care**

The Midwives Alliance Core Competencies establish the essential knowledge, clinical skills and critical thinking necessary for entry-level practice for direct-entry midwifery in the United States. The Certified Professional Midwife (CPM) is based on the MANA Core Competencies.

The MANA Core Competencies were written and adopted by the MANA Board of Directors on October 3,1994, and revised and adopted on August 4, 2011 and again in December 2014.

National Midwifery Institute, Inc. instructors developed course work in 1995 to reflect the 1994 MANA Core Competencies and the NARM Job Analysis documents from 1995, 2001, and 2010. Below are the 1994 MANA Core Competencies:

**GUIDING PRINCIPLES OF PRACTICE:**
**The midwife provides care according to the following principles:**

A. Midwives work in partnership with women and their chosen support community throughout the caregiving relationship.
B. Midwives respect the dignity, rights and the ability of the women they serve to act responsibly throughout the care-giving relationship.
C. Midwives work as autonomous practitioners, collaborating with other health and social service providers when necessary.
D. Midwives understand that physical, emotional, psycho-social and spiritual factors synergistically comprise the health of individuals and affect the childbearing process.
E. Midwives understand that female physiology and childbearing are normal processes, and work to optimize the well-being of mothers and their developing babies as the foundation of care-giving.
F. Midwives understand that the childbearing experience is primarily a personal, social and community event.
G. Midwives recognize that a woman is the only direct care provider for herself and her unborn baby; thus the most important determinant of a healthy pregnancy is the mother herself.
H. Midwives recognize the empowerment inherent in the childbearing experience and strive to support women to make informed decisions and take responsibility for their own well-being.
I. Midwives strive to ensure vaginal birth and provide guidance and support when appropriate to facilitate the spontaneous processes of pregnancy, labor and birth, utilizing medical intervention only as necessary.
J. Midwives synthesize clinical observations, theoretical knowledge, intuitive assessment and spiritual awareness as components of a competent decision making process.
K. Midwives value continuity of care throughout the childbearing cycle and strive to maintain continuous care within realistic limits.
L. Midwives understand that the parameters of "normal" vary widely and recognize that each pregnancy and birth are unique.

**GENERAL KNOWLEDGE AND SKILLS:**

I. The midwife provides care incorporating certain concepts, skills and knowledge from a variety of health and social sciences, including but not limited to:

A. Communication, counseling and teaching skills.
B. Human anatomy and physiology relevant to childbearing.
C. Community standards of care for women and their developing infants during the childbearing cycle, including midwifery and bio-technical medical standards and the rationale for and limitations of such standards.
D. Health and social resources in her community.
E. Significance of and methods for documentation of care through the childbearing cycle.
F. Informed decision making.
G. The principles and appropriate application of clean and aseptic technique and universal precautions.
H. Human sexuality, including indications of common problems and indications for counseling.
I. Ethical considerations relevant to reproductive health.
J. The grieving process.
K. Knowledge of cultural variations.
L. Knowledge of common medical terms.
M. The ability to develop, implement and evaluate an individualized plan for midwifery care.
N. Woman-centered care, including the relationship between the mother, infant and their larger support community.
O. Knowledge of various health care modalities1 as they apply to the childbearing cycle.

**CARE DURING PREGNANCY:**

II. The midwife provides health care, support and information to women throughout pregnancy. She determines the need for consultation or referral as appropriate. The midwife uses a foundation of knowledge and/or skill which includes the following:

A. Identification, evaluation and support of maternal and fetal well-being throughout the process of pregnancy.
B. Education and counseling for the childbearing cycle.
C. Preexisting conditions in a woman's health history which are likely to influence her wellbeing when she becomes pregnant.
D. Nutritional requirements of pregnant women and methods of nutritional assessment and counseling.
E. Changes in emotional, psycho-social and sexual variations that may occur during pregnancy.
F. Environmental and occupational hazards for pregnant women.
G. Methods of diagnosing pregnancy.
H. Basic understanding of genetic factors which may indicate the need for counseling, testing or referral.
I. Basic understanding of the growth and development of the unborn baby.
J. Indications for, and the risks and benefits of bio-technical screening methods and diagnostic tests used during pregnancy.
K. Anatomy, physiology and evaluation of the soft and bony structure of the pelvis.
L. Palpation skills for evaluation of the fetus and uterus.
M. The causes, assessment and treatment of the common discomforts of pregnancy.
N. Identification of, implications of and appropriate treatment for various infections, disease conditions and other problems which may affect pregnancy.
O. Special needs of the Rh- woman.

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**CARE DURING LABOR, BIRTH AND IMMEDIATELY THEREAFTER:**

III. The midwife provides health care, support and information to women throughout labor, birth and the hours immediately thereafter. She determines the need for consultation or referral as appropriate. The midwife uses a foundation of knowledge and/or skill which includes the following:

A. The normal processes of labor and birth.
B. Parameters and methods for evaluating maternal and fetal well-being during labor, birth and immediately thereafter, including relevant historical data.
C. Assessment of the birthing environment, assuring that it is clean, safe and supportive, and that appropriate equipment and supplies are on hand.
D. Emotional responses and their impact during labor, birth and immediately thereafter.
E. Comfort and support measures during labor, birth and immediately thereafter.
F. Fetal and maternal anatomy and their interactions as relevant to assessing fetal position and progress of labor.
G. Techniques to assist and support the spontaneous vaginal birth of the baby and placenta.
H. Fluid and nutritional requirements during labor, birth and immediately thereafter.
I. Assessment of and support for maternal rest and sleep as appropriate during the process of labor, birth and immediately thereafter.
J. Causes of, evaluation of and appropriate treatment for variations which occur during the course of labor, birth and immediately thereafter.
K. Emergency measures and transport procedures for critical problems arising during labor, birth or immediately thereafter.
L. Understanding of and appropriate support of the newborn's transition during the first minutes and hours following birth.
M. Familiarity with current bio-technical interventions and technologies which may be commonly used in a medical setting.
N. Evaluation and care of the perineum and surrounding tissues.

**POSTPARTUM CARE:**

IV. The midwife provides health care, support and information to women throughout the postpartum period. She determines the need for consultation or referral as appropriate. The midwife uses a foundation of knowledge and/or skill which includes but is not limited to the following:

A. Anatomy and physiology of the mother during the postpartum period.
B. Lactation support and appropriate breast care including evaluation of, identification of and treatment for problems with nursing.

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**1** *Health care modalities include but are not limited to such practices as bio-technical medicine, homeopathy, naturopathy, herbology, Chinese medicine, chiropractic, etc.*

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## MANA Core Competencies for Midwifery Practice, *continued*

C. Parameters of and methods for evaluating and promoting maternal well-being during the postpartum period.
D. Causes of, evaluation of and treatment for maternal discomforts during the postpartum period.
E. Emotional, psycho-social and sexual variations during the postpartum period.
F. Maternal nutritional requirements during the postpartum period including methods of nutritional evaluation and counseling.
G. Causes of, evaluation of and treatment for problems arising during the postpartum period.
H. Support, information and referral for family planning methods as the individual woman desires.

**NEWBORN CARE:**

V. The entry-level midwife provides health care to the newborn during the postpartum period and support and information to parents regarding newborn care. She determines the need for consultation or referral as appropriate. The midwife uses a foundation of knowledge and/or skill which includes the following:

A. Anatomy, physiology and support of the newborn's adjustment during the first days and weeks of life.
B. Parameters and methods for evaluating newborn wellness including relevant historical data and gestational age.
C. Nutritional needs of the newborn.
D. Community standards and state laws regarding indications for, administration of and the risks and benefits of prophylactic bio-technical treatments and screening tests commonly used during the neonatal period.
E. Causes of, assessment of, appropriate treatment and emergency measures for newborn problems and abnormalities.

**PROFESSIONAL, LEGAL AND OTHER ASPECTS:**

VI. The entry-level midwife assumes responsibility for practicing in accord with the principles outlined in this document. The midwife uses a foundation of knowledge and/or skill which includes the following:

A. MANA's documents concerning the art and practice of Midwifery.
B. The purpose and goal of MANA and local (state and provincial) midwifery associations.
C. The principles of data collection as relevant to midwifery practice.
D. Laws governing the practice of midwifery in her local jurisdiction.
E. Various sites, styles and modes of practice within the larger midwifery community.
F. A basic understanding of maternal/child health care delivery systems in her local jurisdiction.
G. Awareness of the need for midwives to share their knowledge and experience.

**WELL-WOMAN CARE AND FAMILY PLANNING:**

VII. Depending upon education and training, the entry-level midwife may provide family planning and well-woman care. The practicing midwife may also choose to meet the following core competencies with additional training. In either case, the midwife provides care, support and information to women regarding their overall reproductive health, using a foundation of knowledge and/or skill which includes the following:

A. Understanding of the normal life cycle of women.
B. Evaluation of the woman's well-being including relevant historical data.
C. Causes of, evaluation of and treatments for problems associated with he female reproductive system and breasts.
D. Information on, provision of or referral for various methods of contraception.
E. Issues involved in decision-making regarding unwanted pregnancies and resources for counseling and referral.

*"I love getting the chance to witness people's transformations, and I love it when I can do something helpful."*

*~ an NMI Student*

# Midwifery Education Accreditation Council

## Philosophy on Midwifery Education

As an accrediting body for direct-entry midwifery educational programs, the Midwifery Education Accreditation Council plays an essential role in the development and support of the profession by requiring educators to follow a path of continual growth and improvement in the delivery of midwifery education. This is achieved by supporting the development and accountability of high-quality educational programs built on evidence-based and current best-practice research. MEAC views accountability as a necessary and positive component of professional midwifery, and we embrace our role as accreditors in this process.

MEAC sets standards for midwifery education while encouraging heterogeneity in the educational models used and the individuals served. The tension between upholding objective standards and maintaining a rich variety of options for students is a challenge we gratefully accept.

We uphold the principles of inclusivity, non-discrimination, and diversity with regard to gender identity, race, marital status, ethnic origin, creed, age, sexual orientation, or disability in our board composition and in our support of varied educational models. MEAC standards for accreditation encourage broad student and faculty recruitment among our member schools.

MEAC values competency-based educational programs that train midwives to serve culturally, socially, and economically diverse women and families inclusive of gender identity, race, marital status, ethnic origin, creed, age, sexual orientation, and disability. We believe the following to be integral to that goal:

- Mastery of core competencies is not defined by the length of time spent in the educational process but should meet an international standard of midwifery education.

- Mastery of core competencies can be accomplished through various educational routes including conventional classroom format, distance learning, and clinical placement.

We believe in the Midwives Model of Care, not only as the form of care provided by midwives to their clients but also as a standard for our work of accreditation. This value leads us to strive toward respectful, fair, individualized, responsive and transparent interactions among those with whom we work.

We aspire to be a source of positive influence in healthcare by collaborating with midwifery and other professional organizations. We believe in the midwifery educator's ability to effect change in the maternity care system by making the Midwives Model of Care more accessible to all women through the training of skilled midwives and their integration as primary providers in women's health.

*Adopted on January 13, 2013*

# Midwifery Education Accreditation Council Mission Statement

## MEAC's Mission and Purpose

The Midwifery Education Accreditation Council's mission is to promote excellence in midwifery education through accreditation. It creates standards and criteria for the education of midwives. MEAC standards incorporate the nationally recognized core competencies and guiding principles set by the Midwives Alliance of North America (MANA), The International Confederation of Midwives (ICM), and the requirements for national certification of the North American Registry of Midwives (NARM). MEAC's accreditation criteria for midwifery education programs reflect the unique components and philosophy of the Midwives Model of Care.

The purpose of MEAC is to establish standards for the education of competent midwives, and to provide a process for self-evaluation and peer evaluation for diverse educational programs. MEAC is a non-profit organization approved by the U.S. Secretary of Education as a nationally recognized accrediting agency.

## History of MEAC

The Midwifery Education Accreditation Council (MEAC) was formed in 1991 by the National Coalition of Midwifery Educators as a not-for-profit organization. MEAC's standards for accreditation were developed by expert midwifery educators from a variety of midwifery educational programs in the United States. MEAC is a membership organization comprised of institutions and programs accredited by MEAC.

# NMI Policy – *Disciplinary Policies/Conflict Resolution*

We intend that disagreements among students, faculty and administration be worked out by frank and respectful discussion, or by informal mediation via other faculty members. Failing this, student, faculty or administration grievances are heard through the program's Grievance Mechanism.

## Grievance Mechanism

A written complaint is required to initiate the Grievance Mechanism. All parties named in the grievance are required to participate in the process of resolution. Once a written complaint has been registered, the parties named in the complaint are notified. The parties exercise a mandatory one-week cooling-off period, during which time they do not work together. This keeps disagreements within the program and upholds client well being.
The Grievance Mechanism is enacted at the end of the cooling-off period. Each party may bring an advocate/support person. The Grievance Mechanism is facilitated by two individuals who may be: members of the faculty; members of the administration; members of the Advisory Board, or; outside community members agreed upon by all parties.

All parties present agree to uphold confidentiality of the proceedings. Parties are reminded that the nature of the Grievance Mechanism is educational and constructive, not punitive.

The complaint is read aloud. A history of the grievance is reviewed, including all pertinent communications and attempts to reconcile differences prior to the written complaint. All parties present their statements, and the facilitators ask questions. The facilitators then work with the parties to reach resolution. If resolution cannot be reached, the facilitators will privately discuss the grievance and make a decision. The program's Philosophy and Purpose Statement, MANA's Values and Ethics Statement and, in the case of preceptor/student disagreement, their Informed Consent document, shall provide the context for all decision making.

Outcomes are limited to the following:

1) Resolution is reached during the session and parties resume their work together;
2) Resolution is not reached and the facilitators make one or more of the following recommendations:
    a) The facilitators will speak privately to each party and make another effort at reconciliation;
    b) Professional outside mediation between parties is required;
    c) Parties agree to disagree. In the case of student-faculty grievance, another instructor or precepting site for the student may be sought;
    d) in the case of a seriously offensive incident, facilitators convene a meeting of the faculty and Advisory Board, and that body decides through consensus further appropriate action.

The outcome of all written complaints and resolutions shall be kept in a separate administration file. Copies of individual complaint records shall be included in the personal files of both parties. The details and outcome of all complaints shall remain confidential. Students will not be discriminated against as a consequence of making a complaint. If a faculty member refuses participation in the Grievance Mechanism, that member may be barred from future program participation.

In case of criminal activity, the student will be advised to file a complaint with the proper authorities. In case of harassment, the student will have the option of utilizing the Grievance Mechanism.

## MEAC Grievance Policy

MEAC encourages parties to pursue informal grievance mediation attempts with each other, or with MEAC staff or Board members, to attempt to resolve grievances informally before commencing a formal written complaint process with MEAC. If those attempts fail, MEAC will review complaints received against an institution or program if it is in writing and complies with the guidelines set forth in the Accreditation Handbook, Section G III(P):

## Complaints against an Institution/Program

1. MEAC will review in a timely, fair and equitable manner any complaint it receives against an accredited institution or program in accordance with these procedures and will take follow-up action as appropriate based on the results of its review. MEAC encourages parties to pursue informal grievance mediation attempts with each other, or with MEAC staff or Board members, to attempt to resolve grievances informally before commencing a formal written complaint process with MEAC.
2. Contents of a complaint:
    **The complaint shall be submitted in writing and dated by the Complainant and shall include:**
    a. A statement clearly identifying the submitted materials as a written complaint, and
    b. identification of the accredited institution or program against which the complaint is being filed, and

c. a concise statement of the specific activities or conduct that constitute the basis of the complaint, and
d. an explanation of why such activities or conduct violate a specific MEAC standard, benchmark or policy (MEAC standards, benchmarks, and policies can be found at http://meacschools.org/wp-content/uploads/2013/10/2013-Section- B- Institition-Standards-v.2-Accreditation-Handbook.pdf), and
e. a description of the steps already taken to resolve the problem, and
f. a description of what Complainant requests of MEAC to resolve the grievance, and
g. the name and contact information for the person making the complaint or a statement indicating the complaint is being made anonymously. If the complaint is being made anonymously, MEAC still requires a mailing address so that requests for additional information can be made. Every effort will be made to keep the Complainant's identity and mailing address confidential.
If the written complaint does not contain the required information listed above, the MEAC Executive Director will notify the Complainant, and request additional information. The Complainant has 30 business days to respond with additional information; if additional information is not provided within 30 business days the complaint will be considered inactive, and MEAC will take no further action unless the Complainant submits the requested information and a letter requesting that the complaint review re-commence.
The Executive Director will review the complaint information, including any additional information requested by MEAC, and determine if the complaint is within the scope of the MEAC standards or policies. If the Executive Director determines that the written complaint does not contain the required information listed above, the complaint is outside the scope of MEAC standards or policies, the MEAC Executive Director will notify the Complainant and the MEAC Board President and enclose a copy of this policy. If the written complaint is found to be within the scope of MEAC standards or policies, the following procedures will commence:

3. Process for handling complaints
a. Within 15 business days of receipt by the MEAC office of a written complaint that includes all of the required components, or submission of additional information by the Complainant as requested by MEAC to complete a complaint, a copy of the complaint and a letter requesting a response to the complaint will be forwarded via certified mail to the institution/program against which the complaint has been filed.
b. The Complainant will receive written notification from MEAC within 15 fifteen business days that the complaint has been received and processed for resolution.
c. The institution/program (the Respondent) will then have a maximum of 30 business days from the date of the letter from MEAC to respond to MEAC in writing to the complaint. MEAC will request the Respondent to provide documentation and/or evidence relevant to the complaint sufficient to permit evaluation of its merits.
d. Whenever a complaint indicates that the school may be in violation of accrediting standards or requirements, the matter may be forwarded to the MEAC Board of Directors for independent consideration or for consideration in conjunction with any other accreditation matter pending before the Board.
e.T he MEAC President shall appoint a member of the Board of Directors who shall not have a conflict of interest nor shall have been directly involved in the circumstances giving rise to the complaint to serve as chairperson of an Investigative Committee (the "Investigative Committee") to investigate the activities or conduct under complaint.
f. Should the MEAC President be named in the complaint, the Investigative Committee Chairperson will be appointed by an uninvolved member of the MEAC Executive Committee.
g. Within 30 business days, the Chairperson of the Investigative Committee shall appoint at least one additional member of the Investigative Committee who is a current or former member of the MEAC Board of Directors or a current or former Accreditation Review Committee Member, excluding any current or former members with conflicts of interest or who may have participated directly or indirectly in the complaint under review. A public member must participate in either the Investigative Committee or the Executive Committee, the body that will render the complaint review decision. Within ten business days of appointing the Investigative Committee members, the Chairperson of the Committee shall notify the Respondent of the names of the members of the Investigative Committee.
h. The Chairperson of the Investigative Committee shall notify the Complainant in writing that the Respondent has been advised of the nature of the complaint and that an investigation of the charge is pending in accordance with these procedures. The notification will include the address to which any additional information in support of the complaint may be sent and the deadline for the submission of any such additional material.
i. The Investigative Committee will review the documentation provided by the Complainant and the Respondent and create a report analyzing this documentation, including how each area of the complaint reflects compliance or non-compliance with MEAC standards, benchmarks, or policies by the Respondent. The report will also identify areas where the Respondent complied with MEAC standards, benchmarks, or policies. Where areas of inadequacy or weakness in policy, action or response by the Respondent occurred that require feedback and/or remediation, the Committee may make a recommendation for resolution of the complaint. This resolution may include:
    i. a follow-up complaint report submitted by the Respondent addressing changes to inadequate areas or weaknesses identified in the investigation, or
    ii. action regarding the accreditation or pre-accreditation status of the institution or program, including interim report(s), show cause action, or revocation of pre-accreditation or accreditation status.

*Continued on the next page*

j. The Investigative Committee shall complete the investigation within 90 business days after its formation or such other time as determined by the MEAC President. The MEAC President and the Investigative Committee Chairperson shall determine whether and for how long an extension of the 90 business-day timeline should be granted if the Respondent requests an extension of the deadline.

k. The Chairperson of the Investigative Committee shall send the Investigative Committee's report and recommendations to the Executive Committee in advance of the Executive Committee's next available scheduled meeting and present the Committee's findings at that meeting.

l. The Executive Committee will consider the Investigative Committee's recommendations and determine whether the Executive Committee requires any additional information to render a decision. If no further information is required, the Executive Committee will determine whether the complaint is valid, and if so, what actions are needed to achieve resolution. MEAC may request that the Respondent submit a follow-up report describing how Respondent will address inadequacies and weaknesses, or MEAC may take actions regarding the accreditation or pre-accreditation status of the institution or program, ranging from requiring Interim Report(s) to initiating a Show Cause Action to revoking pre- accreditation or accreditation status.

m. If more than half the Executive Committee has conflicts of interests with the complaint under review, then the consideration of the complaint will be considered by the full MEAC Board, excluding those with conflicts of interest.

4. Resolution of the complaint:

a. If the Executive Committee decides to require the Respondent to prepare a follow-up report addressing weaknesses or areas of inadequacy, the Respondent's response will be considered by the Investigative Committee. The Investigative Committee will provide an analysis of the Respondent's response and either make recommendations for further action or recommend that the complaint be declared resolved. The Executive Committee will consider the Investigative Committee's analysis and recommendations and make the final decision on whether further action is required by the Respondent or if resolution of the complaint has been achieved.

b.If the Executive Committee decides to require an Interim Report(s) or initiate a Show Cause action in response to the complaint review, then these will be referred to an Accreditation Review Committee and will follow MEAC's policies and procedures for Interim Reports and Show Cause Actions.

c. If the Executive Committee's complaint review decision includes a mix of weaknesses or inadequacies and items requiring Interim Reports or a Show Cause Action, then all items will be referred to an Accreditation Review Committee and will follow MEAC's policies and procedures for Interim Reports and Show Cause Actions.

d. The President or Executive Director will notify in writing the Complainant and Respondent of the findings of the complaint review and any decisions by the MEAC Executive Committee or Board regarding actions to be taken by the Respondent.

e. The Respondent may request an appeal hearing to dispute the findings or MEAC's decision regarding actions to resolve the complaint. If the Respondent does not request a hearing within 30 business days from the date of the Complaint Findings letter, MEAC will consider the complaint review closed.

f. The Complainant may also request a hearing if the resolution has failed to satisfy the Complainant or if the Complainant wishes to pursue the matter further. If the Complainant does not communicate in writing to within 30 business days from the date of the Complaint Findings letter, MEAC will consider the complaint review closed.

g. If the Complainant and Respondent accept that the complaint review has been resolved, the MEAC Board President will provide written confirmation of closure to both parties.

h. A hearing in accordance with MEAC's due process procedures will be arranged if further recourse is required and/or if the situation warrants such action.

i. The MEAC President shall present a synopsis of the processing and outcome of complaints and investigations to the MEAC Board at the next regularly scheduled Board meeting following final resolution.

## NMI Policy – *Length of Program and Student Leave of Absence*

National Midwifery Institute was founded on the ideal of providing students with a flexible, self-paced study and training program. NMI program directors recognize that adult learners have adult lives and responsibilities. NMI's minimum mandatory enrollment period is one (1) year. Beyond the NMI mandatory minimum requirement of one-year enrollment, total length of enrollment necessary for graduation is affected by advance placement, full time or part time study, access to clinical training and experience, and leaves of absence. Students have up to seven (7) years to complete the program, with leaves of absence reviewed on a case-by-case basis. Leaves of absence do not extend the seven year time frame for program completion.

Students may request a formal leave of absence for health or family needs, with a maximum length of one year. Requests must be in writing. To be granted a leave of absence, the student must be in compliance with NMI's Satisfactory Academic and Clinical Progress Policies, and tuition payments must be current. Tuition payments and requirements for academic and clinical progress compliance resume once the student's leave of absence expires. Students may be granted multiple 1-year leaves of absence over the course of their enrollment with NMI, but multiple leaves must be separated by at least one full quarter of active program participation including compliance with tuition, academic and clinical progress policies. It is the student's responsibility to maintain contact with NMI and keep all contact information current. Students have been granted leave for personal and family transitions such as pregnancy, newborn care, parenting concerns, long distance relocation, the death of a parent, illness and injury.

## NMI Policy – *Full and Part Time Students*

A full time student works at least 25 hours per week on meeting clinical and academic program requirements. A full time student could finish the program in thirty-six months, or three years.

Regardless of full or part time effort, the amount of course work and required clinical training remains the same, as does the cost of tuition ($17,000).

## NMI Policy – *Satisfactory Academic and Clinical Progress*

National Midwifery Institute's Satisfactory Academic & Clinical Progress policy specifies minimum course work progress and includes a schedule for filing experience documentation during midwifery training. Minimum timeline requirements for clinical training are also mandated.

Without measurable progress toward graduation, NMI does not allow a student to remain in the program. Completed course work, experience documentation and student/preceptor evaluations demonstrate student progress.

### Lack of Satisfactory Academic Progress (SAP)

NMI policy for Satisfactory Academic Progress (SAP) is based on the concept of 65 modules spread over 7 years. Students must show minimum progress by completing at least 2 academic modules per quarter. A student may work ahead of the minimum schedule and then take a break from course work, but must ultimately maintain minimum progress. Without minimum academic progress for a period of two quarters, student is suspended. Students in full time apprenticeships or other clinical training (with mandatory experience filed) may waive submitting coursework for up to 2.5 years, but must then complete modules at a rate of 3 per quarter or request a formal leave of absence. Reinstatement after suspension must occur within the next three quarters and requires a fee of $250 and completion of at least 3 modules, or student is dismissed from the program.

### Lack of Satisfactory Clinical Progress (SCP)

Each quarterly cycle of experience documentation is due within two weeks of the end of the quarter. If clinical experience documentation is not received by this time for a period of two quarters, student is suspended. Reinstatement after suspension must occur within the next three quarters and requires a fee of $250, and completion of all delinquent paperwork, or student is dismissed from the program

**Lack of clinical training by 3.5 and 5-year marks**

NMI enforces a minimum timeline for clinical experience requirements. Suspension occurs* if a student does not meet the minimum timeline:

**Within 36 months (3 years) of initial enrollment,** students must provide a completed work agreement with a preceptor with the intention to begin preceptorship within the next 6 months. Lack of a qualifying work agreement within 36 months of initial enrollment results in immediate suspension.

**Within 42 months (3.5 years) of initial enrollment,** student documentation of non-primary experience must begin. Lack of qualifying non-primary experience within 42 months of initial enrollment results in immediate suspension.

**Within 60 months (5 years) of initial enrollment,** student documentation of Supervised Primary Care with a preceptor must begin. Lack of qualifying supervised primary care experience within 60 months of initial enrollment results in immediate suspension.

Reinstatement after suspension for lack of required clinical experience must occur within one year and requires a Student/Preceptor Work Agreement or confirmed agreement with a clinical site/preceptor, and a fee of $250, or student is dismissed from the program.

***Under MEAC policy, suspensions do not lengthen enrollment requirements for the 36-42-60-month Student Clinical Progress timeline; missing the 36-42- or 60-month deadlines for initiating categories of experience documentation results in suspension without benefit of a grace period. Reinstatement from suspension for missing a 36-42-or 60-month deadline must occur within the next year and requires a Student/Preceptor Work Agreement or confirmed agreement with a clinical site/preceptor, and reinstatement fee of $250. Dismissal occurs without timely reinstatement.**

**A student who is on time with 36- 42- and 60- month requirements and suspended for missing documentation of experience must return from suspension (complete the missing documentation and pay $250 reinstatement fee) within the next three quarters or be dismissed from the program.**

## NMI Policy – *Reinstatement After Dismissal*

After dismissal, students are reinstated only by permission of Program Directors, and by submitting a fee of $500 and all paperwork past due at the time of suspension, as well as any paperwork/forms necessary for reinstatement. Reinstated students are counted as new enrollments, and must comply with all current NMI policies in effect at the time of reinstatement including current tuition and fee schedule and NARM eligibility requirements.

## NMI Policy – *Graduation Requirements*

In order to graduate from National Midwifery Institute, students are required to:

- Complete all 10 Beginning/Intermediate and 3 Advanced Heart & Hands modules
- Complete all 52 Study Group Course Work modules, including practice guidelines
- Complete the minimum clinical experience requirements for NMI graduation. Original forms must be on file prior to graduation if student has sent copies only.
- During apprenticeship and Observe and Assist experience, file preceptor/student reviews after every 3 months. For specific forms filing schedule, please reference Schedule for Filing Forms on page 1 of NMI forms book
- During apprenticeship and Supervised Primary Care, file Preceptor Evaluation/Student Self-Assessment of Midwifery Skills form after every 5 births. For specific forms filing schedule, please reference Schedule for Filing Forms on page 1 of your NMI forms book.
- Achieve competent demonstration of content of NARM Skills List (preceptor rates student with 4's on all skills included in Preceptor Evaluation/ Student Self-Assessment of Midwifery Skills form).
- Provide evidence of current CPR (adult and infant) and Neonatal Resuscitation certification
- Submit Skills Requiring a Second Signature form (located in NMI forms book).
- Submit Heart & Hands and Study Group Course Work Instructor Evaluations after completing each set of course work
- Submit at least 3 Study Group Module Evaluation Sheets (forms sent to students when corrected coursework is returned).
- Pay all tuition and fees in full.

## Dismissing a Student from the Program

A student may be dismissed from the program for the following reasons:

- Fees are delinquent (See Tuition Penalties and Reinstatement);
- Lack of participation in course work or clinical training, or failing to meet parameters specifically set for progress within the program; (See Satisfactory Academic & Clinical Progress Policies)
- Student moves and cannot be located;
- Refusal to participate in the program's Grievance Mechanism;
- Unprofessional conduct
- Illegal activity

When appropriate, attempts are made by program administration to resolve the problem. If the concern is not resolved, the student is notified of the dismissal in writing. Returned mail is held in the student's file.

## Withdrawing from the Program

A student may withdraw from the program by notifying the NMI office in writing. Withdrawing students are held to their financial agreement with NMI; refunds are limited to program policy. Withdrawing students are asked to complete a questionnaire and/or exit interview.

## Contingency Plan

Should termination of the program be necessary, National Midwifery Institute, Inc., has the following contingency plan:

- National Midwifery Institute, Inc., accounts will hold in reserve an amount sufficient to print materials, mail and otherwise notify students should termination of the program be necessary. Fees paid ahead of schedule are refundable. Course work fees are non-refundable; students who have paid for course work yet to be completed will be given the opportunity to finish that course work with the respective instructor. Preceptor fees in excess of work already completed will be refunded.
- Students of the National Midwifery Institute, Inc., will receive transcripts of the work they have completed, including estimated hours for completed modules within partially completed Heart & Hands or Study Group Course Work.
- Students will be provided with references and referrals to other midwifery programs. National Midwifery Institute, Inc., will encourage participating preceptors to link to other programs so that current students may continue their training.

*"I am even more impressed with the modules than I expected to be"*

*~an NMI student*

# NMI Curriculum Matched to MANA Core Competencies

## Heart & Hands Course Work

**810 hours of study**

**1a. Orientation to Midwifery / *45 contact hours***

History of Midwifery
The Three Paradigms of Healthcare
Clinical Training Options and Barriers to Practice
Professional Organizations
Resources for Learning: Texts and Equipment
Female Reproductive Anatomy and Physiology
Human Sexuality

**MANA Core Competencies addressed in 1a:**
**GENERAL KNOWLEDGE AND SKILLS:**
I. A., D.
**PROFESSIONAL, LEGAL AND OTHER ASPECTS:**
VI. A., B., D., E., F.

**1b. Prenatal Care, Part I / *67.5 contact hours***

Hygiene for the Midwife
The Female Pelvis, Pelvimetry
Impacts of Sexual and Other Forms of Abuse
Diversity Awareness
Initial Interview
Medical/Health History
Risk Assessment
Routine Maternal Assessments per Trimester
Teratogens in Pregnancy
Genetic Screening
Routine Labs and Tests in Pregnancy

**MANA Core Competencies addressed in 1b:**
**KNOWLEDGE AND SKILLS:**
I. B., C., E., F., G., H., I., N.
**CARE DURING PREGNANCY:**
II. A., B., C., E., F., G., H., J., K., N., O.

**1c. Prenatal Care, Part II / *67.5 contact hours***

Fetal Development
Leopold's Maneuvers/Abdominal Palpation
Fundal Height Assessment
Routine Fetal Assessments
Nutrition
Nutritional Counseling
Herbs in Pregnancy
Psycho-social Issues in Pregnancy
The Role of Intuition in Caregiving
Home Visits (frequency and purpose)
Preparation for Homebirth

**MANA Core Competencies addressed in 1c:**
**GENERAL KNOWLEDGE AND SKILLS:**
I. B., C., D., H., L., N.
**CARE DURING PREGNANCY:**
II. B., D., I., J., L., M., N.

**1d. Complications of Pregnancy / *67.5 contact hours***

Hyperemesis Gravidarium
Nutritional Anemias
Miscarriage/Abortion: threatened, spontaneous, incomplete, missed and habitual abortion
Ectopic Pregnancy
Hydatidiform Mole
Pylonephritis (kidney disease)
Placenta Previa
Placental Abruption
Gestational Diabetes
Gestational Hypertension
Pre-eclampsia and Eclampsia
Polyhydramnios
Oligohydramnios
Abnormal Fetal Presentations
Multiple Pregnancy
Prematurity
Postmaturity
Intrauterine Growth Restriction
Uterine Abnormalities
Rh- Sensitization
Sexually Transmitted Infections
HIV/AIDS
TORCH Infections
Hepatitis B, C

**MANA Core Competencies addressed in 1d:**
**GENERAL KNOWLEDGE AND SKILLS:**
I. B., C.
**CARE DURING PREGNANCY:**
II. A., J., N., O.

**1e. Labor Facilitation and Assessment / *67.5 contact hours***

Physiology of the Labor Process
Maternal Emotions in Labor
The Role of the Mother's/Birthing Parent's Support Team
Techniques for Facilitating Progress
Plateaus versus Arrests of Progress
Universal Precautions
Nutrition/Hydration in Labor

Routine Maternal Assessments
Technique and Rationale for Internal Exam
Routine Fetal Assessments
Fetal Heart Tone Patterns in Labor

**MANA Core Competencies addressed in 1e:**
**GENERAL KNOWLEDGE AND SKILLS:**
I. B, C., E., G., H., N.
**CARE DURING LABOR, BIRTH AND IMMEDIATELY THEREAFTER:**
III. A., B., C., D., E., F., H., I., J., M.

**1f. Normal Delivery & Immediate Care of the Newborn / *67.5 contact hours***

Meconium Staining/Significance and Response
Equipment Used at Births (sterilization and maintenance)
Hand Maneuvers to Assist Birth
Preventing Perineal Tears
Placenta Examination
Maternal Stabilization
Newborn Stabilization
APGAR Scoring
Newborn Exam
Routine Maternal Assessments/Third and Fourth Stages
Routine Fetal Assessments/Immediate Postpartum
Promoting Bonding and Breastfeeding
Postpartum Instructions

**MANA Core Competencies addressed in 1f:**
**GENERAL KNOWLEDGE AND SKILLS:**
I. B., C., D., H., N.
**CARE DURING LABOR, BIRTH AND IMMEDIATELY THEREAFTER:**
III. B., G., H., I., J., K., L., M.

**1g. Complications of Labor, Part I / *67.5 contact hours***

Prolonged Labor
Maternal Exhaustion
Cephalopelvic Disproportion
Posterior Arrest
Asynclitism
Maternal Positioning, Rebozo, and Hand Maneuvers to Address Malpresentations
Cesarean Birth and VBAC
Partial Separation of the Placenta/ Third Stage Hemorrhage
Placenta Accreta/Increta/Percreta
Fourth Stage Hemorrhage
Intramuscular Injection
Oxytoxic Medications and Herbs

**MANA Core Competencies addressed in 1g:**
**GENERAL KNOWLEDGE AND SKILLS:**
I. B., C., N.
**CARE DURING LABOR, BIRTH AND IMMEDIATELY THEREAFTER:**
III. J., K., M.

**1h. Complications of Labor and Delivery, Part II / *67.5 contact hours***

Fetal Distress
Cord Problems/Prolapsed Cord
Prolonged Rupture of the Membranes
Amniotic Fluid Embolism
Breech Presentation
Shoulder Dystocia
Fetal Anomalies (cleft palate, spina bifida, esophageal atresia, polycystic kidneys, congenital heart defects, trisomies 18 and 21, imperforate anus, hydroencephaly, anencephaly, etc.)
Fetal Demise
Transport to Hospital
Client Advocacy/Informed Consent
Neonatal Testing

**MANA Core Competencies addressed in 1h:**
**GENERAL KNOWLEDGE AND SKILLS:**
I. B., C., D., E., F., I., J., N.
**CARE DURING PREGNANCY:**
II. E. Changes in emotional, psycho-social and sexual variations that may occur during pregnancy.
**CARE DURING LABOR, BIRTH AND IMMEDIATELY THEREAFTER:**
III. J., K., M.
**POSTPARTUM CARE:**
IV. E. Emotional, psycho-social and sexual variations during the post partum period.
**NEWBORN CARE:**
V. B., D., E.
**WELL-WOMAN CARE AND FAMILY PLANNING:**
VII. A. Understanding of the normal life cycle of women.

**1i. Postpartum Care and Suturing / *67.5 contact hours***

Routine Maternal Assessments, Day 1, Day 3, Day 7
Routine Newborn Assessments, Day 1, Day 3, Day 7
Maternal Complaints/Complications Postpartum
Newborn Problems/Complications Postpartum
Physiology of Milk Production
Breastfeeding
Postpartum Blues and Depression
Family Dynamics
Perineal/Vaginal Lacerations—Assessment, Repair, Follow-up
Six Weeks' Check-up
Contraceptive Care

**MANA Core Competencies addressed in 1i:**
**GENERAL KNOWLEDGE AND SKILLS:**
I. A., B., C., N.
**CARE DURING LABOR, BIRTH AND IMMEDIATELY THEREAFTER:**
III. B.
**POSTPARTUM CARE:**
IV. A., B., C., D., E., F., G., H.

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**NEWBORN CARE:**
V. A., B., C., D., E.
**WELL-WOMAN CARE AND FAMILY PLANNING:**
VII. D. Information on, provision of or referral for various methods of contraception.

**1j. Professional Opportunities & Summary / *22.5 contact hours***

Clinical Training Opportunities
Preparation for Clinical Training/Preparing a Resume
Professional Organizations and Support for Clients
Student Self-Assessment

**MANA Core Competencies addressed in 1j:**
**1. GENERAL KNOWLEDGE AND SKILLS:**
I. B., D., N.
**CARE DURING LABOR, BIRTH AND IMMEDIATELY THEREAFTER:**
III. N.
**PROFESSIONAL, LEGAL AND OTHER ASPECTS:**
VI. E., F.

**1k. Well-Woman Assessment & Initial Interview, Applied / *67.5 contact hours***

The Midwifery Model of Care, Applied
Initial Reproductive Health Exam
Medical/Health History, Applied
Routine Reproductive Health Assessments
Breast Exam: Rationale and Practice
Bimanual Assessment: Rationale and Practice
Pap Smear and Vaginal/Cervical Cultures
Complications in Reproductive Health Care

**MANA Core Competencies addressed in 1k:**
**GENERAL KNOWLEDGE AND SKILLS:**
I. A., B., C., D., N.
**WELL-WOMAN CARE AND FAMILY PLANNING:**
VII. A., B., C., E.

**1l. Prenatal Care, Applied / *67.5 contact hours***

Routine Maternal Assessments, Applied
Routine Fetal Assessments, Applied
Charting
Professional Disclosure and Informed Consent
Differential Diagnosis of Prenatal Complications
Professional Collaboration

**MANA Core Competencies addressed in 1l:**
**GENERAL KNOWLEDGE AND SKILLS:**
I. A., C., D., E., F., M., N.
**CARE DURING PREGNANCY:**
II. E.
**PROFESSIONAL, LEGAL AND OTHER ASPECTS:**
VI. C.

**1m. Lab Work, Labor and Postpartum Evaluation, Applied / *67.5 contact hours***

Differential Diagnosis of Intrapartum Complications
Differential Diagnosis of Postpartum Complications
Conflict Resolution—Midwife/Client
The Grieving Process, Grief Counseling
Professional Liability
Peer Review
Venipuncture
Student Self-Assessment

**MANA Core Competencies addressed in 1m:**
**GENERAL KNOWLEDGE AND SKILLS:**
I. D., J., K., N.
**PROFESSIONAL, LEGAL AND OTHER ASPECTS:**
VI. E., F.

*"Thank you for your care and commitment to teaching us with integrity and holism."*

*~ an NMI Student*

# NMI Curriculum Matched to MANA Core Competencies

## Study Group Course Work

**1080 hours of study**

### Midwifery Sciences

380 contact hours

**2a. Midwifery Sciences: Social Sciences / *70 contact hours***

Diversity Awareness
Female Sexuality
Grieving
Physical and Sexual Abuse
Substance Abuse

**MANA Core Competencies addressed in 2a:**
**GENERAL KNOWLEDGE AND SKILLS:**
I. A., B., D., H., I. , J., K., M., N.
**CARE DURING PREGNANCY:**
II. A., B., E., G., K.
**CARE DURING LABOR, BIRTH AND IMMEDIATELY THEREAFTER:**
III. D., J., N.
**POSTPARTUM CARE:**
IV. A., C., D., E., G., H.
**NEWBORN CARE:**
V. B.
**PROFESSIONAL, LEGAL AND OTHER ASPECTS:**
VI. D., F.
**WELL-WOMAN CARE AND FAMILY PLANNING:**
VII. A., B., D., E.

**2b. Midwifery Sciences: Physical Science part 1 /*130 contact hours***

Digestion
Life Science
Liver
Nutrition
Renal System

**MANA Core Competencies addressed in 2b:**
**GENERAL KNOWLEDGE AND SKILLS:**
I. , B., E., L.
**CARE DURING PREGNANCY:**
II. A., D.
**CARE DURING LABOR, BIRTH AND IMMEDIATELY THEREAFTER:**
III. L.
**NEWBORN CARE:**
V. A.
**PROFESSIONAL, LEGAL AND OTHER ASPECTS:**
VI. F.
**WELL-WOMAN CARE AND FAMILY PLANNING:**
VII. B.

**2c. Midwifery Sciences: Physical Science part 2 / *145 contact hours***

Embryology & Fetal Development
Fertility and Conception
Fetal Heart Rate Patterns
Fetal/Newborn Circulation
Genetic & Prenatal Screening
Placenta

**MANA Core Competencies addressed in 2c:**
**GENERAL KNOWLEDGE AND SKILLS:**
I. A., B., C., D., E., F., H., I., J., K., L., M., N.
**CARE DURING PREGNANCY:**
II. A., B., C., D., E., F., G., H., I., J., L., N.
**CARE DURING LABOR, BIRTH AND IMMEDIATELY THEREAFTER:**
III. B., J., K., L., M.
**POSTPARTUM CARE:**
IV. A., C., D., E., G., H.
**NEWBORN CARE:**
V. E.
**PROFESSIONAL, LEGAL AND OTHER ASPECTS:**
VI. F.
**WELL-WOMAN CARE AND FAMILY PLANNING:**
VII. A., B., C., D.

**2d. Midwifery Sciences: Pharmacology for Midwives / *35 contact hours***

**MANA Core Competencies addressed in 2d:**
**GENERAL KNOWLEDGE AND SKILLS:**
I. C., D., E., F., G., L., O.
**CARE DURING PREGNANCY:**
II. B., C., I., M., N., O.
**CARE DURING LABOR, BIRTH AND IMMEDIATELY THEREAFTER:**
III. B., C., E., H., J., K., M.
**POSTPARTUM CARE:**
IV. B., D., G.
**NEWBORN CARE:**
V. D., E.
**PROFESSIONAL, LEGAL AND OTHER ASPECTS:**
VI. D.

*Continued on the next page*

## Midwifery Care & Practice
400 contact hours

**2e. Midwifery Care & Practice Part 1: Midwifery Practice / *85 contact hours***

Birth Bag and Set Up
Charting & Practice Guidelines
Homeopathic Remedies
Transporting

**MANA Core Competencies addressed in 2e:**
**GENERAL KNOWLEDGE AND SKILLS:**
I. A., C., D., E., F., G., J., L., M., O.
**CARE DURING PREGNANCY:**
II. A., C., O.
**CARE DURING LABOR, BIRTH AND IMMEDIATELY THEREAFTER:**
III. B., C., D., G., J., K., L., M.
**POSTPARTUM CARE:**
IV. A., B., C., D., E., G.
**NEWBORN CARE:**
V. A., B., E.
**PROFESSIONAL, LEGAL AND OTHER ASPECTS:**
VI. A., B., C., D., F.
**PROFESSIONAL, LEGAL AND OTHER ASPECTS:**
VI. E.
**WELL-WOMAN CARE AND FAMILY PLANNING:**
VII. B., C., E.

**2f. Midwifery Care & Practice Part 2: Prenatal Midwifery Care / *65 contact hours***

General Pregnancy and Post Partum Ailments
Physical Assessment
Prenatal Lab Work & Assessment

**MANA Core Competencies addressed in 2f:**
**GENERAL KNOWLEDGE AND SKILLS:**
I. A., B., C., D., E., F., G., H., I., L., M., O.
**CARE DURING PREGNANCY:**
II. A., C., D., E., G., I., J., K., L., M., N., O.
**CARE DURING LABOR, BIRTH AND IMMEDIATELY THEREAFTER:**
III. A., B., E., F., H., I., J., K., L., M., N.
**POSTPARTUM CARE:**
IV. A., B., C., D., F., G.
**NEWBORN CARE:**
V. A., B., C., D., E.
**PROFESSIONAL, LEGAL AND OTHER ASPECTS:**
VI. F.
**WELL-WOMAN CARE AND FAMILY PLANNING:**
VII. A., B., C., E.

**2g. Midwifery Care & Practice Part 3: Midwifery Care at Labor & Birth / *110 contact hours***

First Stage
Second Stage
Ruptured Membranes
Third Stage

**MANA Core Competencies addressed in 2g:**
**KNOWLEDGE AND SKILLS:**
I. A., B., C., E., F., G., H., L., M. , O.
**CARE DURING PREGNANCY:**
II. B., L.
**CARE DURING LABOR, BIRTH AND IMMEDIATELY THEREAFTER:**
III. A., B., D., E., F., G., H., I., J., K., L., M., N.
**POSTPARTUM CARE:**
IV. C.
**NEWBORN CARE:**
V. B., E.
**PROFESSIONAL, LEGAL AND OTHER ASPECTS:**
VI. F.

**2h Midwifery Care & Practice Part 4: Midwifery Care Postpartum / *140 contact hours***

Suturing
Postpartum Care
Breast Feeding
Well Woman Care

**MANA Core Competencies addressed in 2h:**
**GENERAL KNOWLEDGE AND SKILLS:**
I. A., B., C., D., E., F., G., H., I., J., K., L., M., N., O.
**CARE DURING PREGNANCY:**
II. B., C., K.
**CARE DURING LABOR, BIRTH AND IMMEDIATELY THEREAFTER:**
III. A., B., D., E., H., I., J., K., L., M., N.
**POSTPARTUM CARE:**
IV. A., B., C., D., E., F., G., H.
**NEWBORN CARE:**
V. A., B., C., E.
**PROFESSIONAL, LEGAL AND OTHER ASPECTS:**
VI. F.
**WELL-WOMAN CARE AND FAMILY PLANNING:**
VII. A., C., D., E.

## Appropriate Intervention in Midwifery Care
300 contact hours

**2i. Appropriate Intervention in Midwifery Care Part 1: Pregnancy & Labor / *160 contact hours***

Hypertension
Pre-Eclampsia

Urinary Tract Infection
Gestational Diabetes
Herpes
Ectopic Pregnancy
Preterm Labor
Uterine Size and EDD Discrepancy
Post Dates Management & Post Maturity
Stillbirth and Miscarriage

**MANA Core Competencies addressed in 2i:**
**GENERAL KNOWLEDGE AND SKILLS:**
I. A., B., C., D., E., F., H., I., J., L., M., N., O.
**CARE DURING PREGNANCY:**
II. A., C., D., F., G., J., L., N., O.
**CARE DURING LABOR, BIRTH AND IMMEDIATELY THEREAFTER:**
III. B., J., K., L., M.
**POSTPARTUM CARE:**
IV. A., C., E.
**NEWBORN CARE:**
V. A., B., C., E.
**PROFESSIONAL, LEGAL AND OTHER ASPECTS:**
VI. F.
**WELL-WOMAN CARE AND FAMILY PLANNING:**
VII. B. Evaluation of the woman's well-being including relevant historical data.

**2j. Appropriate Intervention in Midwifery Care Part 2: Labor & Birth / *70 contact hours***
Artificial Rupture of Membranes
Breech and Twins
Cesarean and VBAC
Meconium
OP, Brow & Face Presentations
Shoulder Dystocia

**MANA Core Competencies addressed in 2j:**
**GENERAL KNOWLEDGE AND SKILLS:**
I. A., B., C., E., F., G., H., I., J., K., L., M., N.
**CARE DURING PREGNANCY:**
II. A., C., J., K., L.
**CARE DURING LABOR, BIRTH AND IMMEDIATELY THEREAFTER:**
III. B., F., J., K., L., M.
**POSTPARTUM CARE:**
IV. A., B., C., D., E., G.
**NEWBORN CARE:**
V. A., B., D., E.
**PROFESSIONAL, LEGAL AND OTHER ASPECTS:**
VI. F.

**2k. Appropriate Intervention in Midwifery Care Part 3: Postpartum / *70 contact hours***
Hemorrhage
Jaundice
Newborn Apnea, Hypoxia & Respiratory Distress
Postpartum Depression

**MANA Core Competencies addressed in 2k:**
**GENERAL KNOWLEDGE AND SKILLS:**
I. A., B., C., E., G., H, L., M., N., O.
**CARE DURING PREGNANCY:**
II. O. Special needs of the Rh- woman.
**CARE DURING LABOR, BIRTH AND IMMEDIATELY THEREAFTER:**
III. B., D., I., J., K., L., M.
**POSTPARTUM CARE:**
IV. A., B., C., D., E., G.
**NEWBORN CARE:**
V. A., B., C., E.
**PROFESSIONAL, LEGAL AND OTHER ASPECTS:**
VI. F.
**WELL-WOMAN CARE AND FAMILY PLANNING:**
VII. B.

*"I love watching families become strong child advocates."*

*~an NMI student*

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**2016 update:** National Midwifery Institute, Inc. is currently revising program course work to match recent expansions to the accreditation standard MEAC Curriculum Checklist of Essential Competencies. Upon completion of NMI module revisions, content details will be cross-referenced and posted.

# Contact Information

**North American Registry of Midwives General Information**
888-84-BIRTH (2-4784) or 770-381-9051
5257 Rosestone Dr.
Lilburn, GA 30047
info@narm.org
**www.narm.org**

**NARM Applications**
888-426-1280 or 931-964-4234
P. O. Box 420
Summertown, TN 38483
applications@narm.org

**Midwifery Education Accreditation Council**
MEAC phone 360-466-2080
850 Mt. Pleasant Ave.
Ann Arbor, MI 48103
info@meacschools.org
**www.meacschools.org**

**Midwives Alliance of North America**
MANA phone 888-923-MANA (6262)
PO Box 373
Montvale, NJ 07645
contact@mana.org
**www.mana.org**

**California Association of Midwives**
P. O. Box 586
Coarsegold, CA 93614
info@californiamidwives.org
**www.californiamidwives.org**

**Citizens for Midwifery**
CfM phone 888-236-4880
P. O. Box 82227
Athens, GA 30608
**www.cfmidwifery.org**

*"Thank you for your care*
*and commitment to teaching us*
*with integrity and holism."*

*~an NMI Student*