New Mexico Midwives Association: Practice Guidelines

2019 Edition
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INTRODUCTION

This manual was first written many years ago by pioneering midwives in the state of New Mexico. These midwives envisioned a time where the art and science of midwives practice would become a socially and legally sanctioned profession building on the socially accepted practice from the traditional midwives already practicing in the state. Through the formalization of midwifery practice guidelines, they were able to take a giant step in the direction of that vision. As midwifery is still working toward its necessary place within the health care profession, its practice and accessibility are even more essential to the liberation and freedom of women, and of all peoples. These updated practice guidelines could not exist without the struggles and vision of those midwives, as well as the traditional midwives who paved the way for midwifery in New Mexico.

Through this most recent revision process, the New Mexico Midwives Association (NMMA), through the NMMA Council (see NMMA bylaws for definition of Board, available by contacting NMMA through http://www.newmexicomidwifery.org/), and the New Mexico Department of Health Licensed Midwifery Advisory Board (hereafter referred to as the LM Advisory Board) approved these updated practice guidelines based on research and the most up-to-date, evidence-based practices. This revision is a reflection of the hunger for knowledge, growth, education, as well as profound continued respect for the heart and soul of midwifery—trusting human birth.

Our intention is to represent both the art and science of midwifery in these practice guidelines. They reflect a philosophy allowing for the personalization of care and creativity of each midwife. We have also been conscientiously determined to represent the way midwives actually practice, encompassing our commitment to our clients and ourselves. The continued creation of these practice guidelines has been a meaningful group endeavor, which helped us discover and record our own abundance of wisdom and knowledge. May these practice guidelines serve as a rich resource for the holistic care we provide women and families.

One major change to this edition of the practice guidelines is the inclusion of qualifications and curriculum criteria for required classes: IV certification, transport class (for state licensed apprentices), and the pharmacology course. Other changes include significant updates to many sections and the addition of other sections based on current best practices.

These practice guidelines include eleven sections: general midwifery information; education, apprenticeship, and licensure requirements; business practices; well-woman care; antepartum care; intrapartum care; third-stage care; postpartum care for the mother; newborn care; and appendices. Midwives licensed as LMs by the state of New Mexico are the providers whose practice is guided by these guidelines. New Mexico LMs who practice outside of New Mexico are encouraged to use these guidelines as well as to follow the laws of the jurisdiction they practice in.

Please note that there are many topics that can be included in more than one section. We have made every effort to place overlapping guidelines in the section where the situation may first occur. For example, placenta previa is an antenatal and an intrapartum topic; therefore it appears in the antepartum section. All sexually transmitted infections are in the well-woman section.
Where treatment differs for pregnant women, this is noted accordingly. The phrase “natural therapies” is used throughout the practice guidelines. These therapies are not detailed, as each midwife has many alternative health care modalities she uses (e.g., herbs, oils, homeopathic, emotional, and spiritual).

NMMA would like to acknowledge that in writing the practice guidelines, we understand that not all people who become pregnant identify as women or as mothers. We wish to hold in respect and acknowledgement all those people who become pregnant and give birth. This document uses female gender as default language out of an understanding that women as a group have not yet been fully actualized in their human rights and societal place. This language is used with the intention of elevating women and recognizing that, by and large, it is women who carry the burden of oppression in pregnancy and in birth. This language is chosen to elevate one oppressed population, but not to devalue or make invisible another. Please keep in mind as you read through this document that there are many circumstances in which this gendered language may not serve midwives or midwifery clients in giving the best, most appropriate care.
PROCESS FOR PRACTICE GUIDELINE REVISIONS

It is understood that practice guidelines should be developed in coordination with evidence, and that in order to continue to serve women and families well, these practice guidelines will need to be reviewed, updated, and periodically revised. The practice guidelines shall have an official and complete review approximately every 3 to 5 years with the understanding that as new evidence becomes available in any given section, it may be submitted immediately for revision of the guidelines. The next revision process is scheduled to commence between the years of 2020 and 2022.

A. The LM Advisory Board will initiate the process by advising the NMMA Council to begin reviewing the practice guidelines for revisions.

B. The NMMA Board will request that its membership, as individuals and/or in committee(s), review the practice guidelines and propose necessary revisions.
   a. Revisions from NMMA membership shall be submitted to the NMMA Board with supporting documentation.
   b. Submitted proposed revisions to the practice guidelines shall be reviewed by the NMMA Board.
      i. If not substantive, the revisions can be presented for approval at the subsequent quarterly meeting of the LM Advisory Board for approval.
      ii. If the changes are substantive:
          1. A review and revision of the practice guidelines will be completed by the NMMA Board and presented to NMMA members for approval.
          2. Following approval by the NMMA Board after consultation with the membership, the revised practice guidelines shall be presented at the subsequent quarterly meeting of the LM Advisory Board for approval.

C. The LM Advisory Board must approve by consensus the revisions to the practice guidelines submitted by NMMA.
   a. If approved, the revised practice guidelines will be sent to the Department of Health Maternal Health Program Manager.
   b. If not approved, the revisions will be sent back to NMMA with detailed objections. The revision process can begin again or be abandoned at this point.

D. The Department of Health Maternal Health Program Manager gives final approval of the revised practice guidelines.
   a. If approved:
      i. Notice shall be given to the NMMA of approval.
      ii. The practice guidelines shall be updated in all printed and online materials.
      iii. The Program Manager or NMMA Board shall inform all LMs on the state’s roster of the revision.
iv. A review of the state’s Licensed Midwife test must take place to ensure that test questions and answers are up-to-date and not in conflict with the updated guidelines.

b. If not approved, the objections will be outlined and submitted for review and redress to the LM Advisory Board and NMMA.

E. Any grammatical errors may be brought to the immediate attention of the NMMA Board and be changed without process.

a. Updated version will be forwarded to Department of Health Program Manager to make online changes.

Forward suggested changes to:
New Mexico Midwives Association
c/o Co-chair
P.O. Box 40647
Albuquerque, NM 87196
nmmidwives@gmail.com
PART I: GENERAL MIDWIFERY INFORMATION
STATEMENT OF PHILOSOPHY

The midwives’ model of care is based on the fact that pregnancy and birth are normal life processes.

A. The midwives’ model of care includes:
   1. Monitoring the physical, psychological, and social wellbeing of the mother throughout the childbearing cycle;
   2. Providing the mother with individualized education, counseling, and prenatal care, continuous assistance during labor and birth, and postpartum support;
   3. Minimizing technological interventions; and
   4. Identifying and referring women who require medical attention.

B. As midwives, we believe the practice of midwifery to be distinct from the practice of medicine. We base our profession on a model of care, which believes:
   1. Each woman is unique and her care should be tailored to meet her individual needs;
   2. Attending to a woman's emotional and spiritual needs is as important as providing adequate medical care;
   3. Midwives are trained by other midwives, whether that training takes place in schools or through apprenticeships;
   4. Midwives maintain a professional attitude and practice, which promote collegial and respectful relationships among all health care providers;
   5. The relationship between midwife and client is collaborative;
   6. Midwives support the inter-relationship of midwifery and communities; and
   7. Midwives promote the awareness of the connection between the health of women, babies, and families; the environment; communities, and nations of the world.
NEW MEXICO LICENSED MIDIVES SCOPE OF PRACTICE

Providers who are licensed by the state of New Mexico as Licensed Midwives (LMs) are autonomous practitioners who provide well-woman, antepartum, intrapartum, postpartum, and newborn care. LMs practice both the art and science of midwifery in caring for families who want a midwifery model for their care. LMs offer holistic care that encompasses the needs of the well-woman, including the specific needs of the adolescent, antepartum, intrapartum, postpartum, and peri- and post-menopausal woman. LMs provide holistic woman- and family-centered care and attend their clients in all settings.

The New Mexico Midwives Association adapted the Midwives Alliance of North America (MANA) “Core Competencies for Basic Midwifery Practice” as the “Standards and Core Competencies of Practice for Licensed Midwives in New Mexico” (see Appendix A; also available at https://www.newmexicomidwifery.org/midwife-resources). LMs perform skills and procedures necessary to provide safe care for clients. These skills and procedures are defined by the North American Registry of Midwives, MANA, the World Health Organization, and New Mexico Department of Health.

LMs follow evidence-based standards of care that are rooted in a midwifery model of normal physiologic pregnancy and birth. Standards of care evolve based on changing community standards, national and international principles, new research, and recommendations by experts in the field. As independent practitioners, LMs work in collaboration with the entire health care network to provide care for clients, including, but not limited to, ordering lab work, ultrasounds, non-stress tests, biophysical profiles, newborn screenings, obtaining consultation for medication and follow-up care for clients and their infants, and insurance billing (see also New Mexico Department of Health Rule, Licensed Midwives, 16.11.3 NMAC; also referred to as the “LM Rule” in this document) in Appendix B; also available at http://164.64.110.134/parts/title16/16.011.0003.html). LMs use appropriate resources for referrals to meet psychosocial, medical, economic, cultural, or family needs.

More specifically, the midwife’s care includes:

A. ANTEPARTUM, INTRAPARTUM, AND POSTPARTUM CARE
   1. Elicit an accurate medical history, identifying risk factors
   2. Perform appropriate physical examinations
   3. Perform complete pelvic examinations, including bimanual and speculum examination, collection of laboratory, specimens, and clinical pelvimetry as indicated
   4. Diagnose minor conditions, such as uncomplicated upper respiratory infection, asymptomatic bacteriuria, or cystitis, and refer for treatment and/or consult
   5. Identify abnormal conditions and consult with physician, CNM, or APRN (as appropriate)
   6. Provide individual and group counseling and teaching
   7. Provide education for clients such as nutrition, childbirth, informed consent, newborn feeding, parenting skills, and child development
   8. Confirmation of pregnancy
   9. Perform routine antepartum laboratory work and order ultrasound as needed
   10. Manage intrapartum and postpartum course
New Mexico Licensed Midwives Scope of Practice

a. Evaluate labor
b. Confirm rupture of membranes
c. Perform pelvic and cervical examinations
d. Assess the status of the woman/fetus during labor
e. Perform amniotomy as needed
f. Catheterize as needed
g. Initiate intravenous therapy as needed
h. Administer local anesthesia as needed
i. Perform and repair laceration and/or episiotomy as needed
j. Facilitate birth of infant and placenta
k. Administer anti-hemorrhagic medications as needed
l. Utilize natural therapies as needed
m. Facilitate family participation and bonding
n. Give woman and family postpartum instructions
o. Provide routine follow up of mother and newborn during the postpartum period
p. Manage common problems of the immediate postpartum period

11. Manage any complications of childbirth and transfer as needed
12. Support breastfeeding and its common problems
13. Perform final examination at completion of postpartum period
14. Provide family planning and sexual counseling
15. Provide community resources and referrals
16. In special situations, the midwife may manage, in collaboration with the appropriate care providers, care of a woman who develops complications in cases that are appropriate to the skills and knowledge of the particular midwife
17. Consult and refer as appropriate to other health care professionals

B. PEDIATRIC CARE

1. Manage care of the normal newborn up to 6 weeks
   a. Provide routine follow-up for the newborn
   b. Obtain an accurate history of the labor and birth
   c. Perform physical assessment, including gestational age assessment, of the healthy newborn
d. Identify deviations from normal in the newborn
e. Obtain labs as needed
f. Offer routine prophylaxis for the newborn's eyes
g. Offer anti-hemorrhagic prophylaxis for the newborn
h. Offer newborn metabolic and critical congenital heart defect (CCHD) screenings and perform or refer for hearing screening
   (a) If client consents, the midwife must fax CCHD results and hearing screen referral to the Department of Health point person (see Appendices C and D).
   (b) If client declines the Newborn Screen (NBS), hearing screen, or CCHD screen, the midwife must fax the signed “Newborn Screening Test Refusal” to the Department of Health point person (see Appendix E).
i. File a birth certificate and, as requested by parents, a social security number and paternity statement as needed with Vital Records
2. Manage emergency resuscitation
3. Provide guidance and counseling to parents regarding issues such as early childcare, feeding, safety, etc.
4. Midwives will recommend consultation with a family physician, pediatrician, or other health care provider as needed; after 6 weeks of life, will recommend transfer of care to appropriate provider

C. WELL-WOMAN CARE
1. Provide periodic screening, preventative, and gynecologic care
   a. Perform physical examinations, history, and obtain appropriate lab work
   b. Perform breast examinations, including instructions for self-examination by the client
   c. Perform pelvic examinations and collect appropriate laboratory specimens
   d. Diagnose and treat common gynecological problems
   e. Educate and counsel on family planning issues and unexpected pregnancy
   f. Fit diaphragms as trained, per “Mechanism for Expansion of Practice” in Part II; note diaphragms are not part of the formulary, and a prescription is needed to obtain one
   g. Consult or refer for abnormal conditions that arise
   h. Develop a comprehensive plan of care on issues such as nutrition, exercise, family violence, relaxation, emotional health, and spiritual health
   i. Implement treatment for women and for other family members or sexual partners as appropriate
   j. Provide needed counseling and/or teaching
2. Consult and refer as necessary to other health care professionals
PART I: GENERAL MIDWIFERY INFORMATION

MIDWIFE AND CLIENT RIGHTS AND RESPONSIBILITIES

Midwives and their clients share in both the joys and the responsibility of antepartum, intrapartum, postpartum, and well-woman care. A birth at home or in a birth center setting requires a high level of self-awareness, respect, and responsibility on the part of the mother, her family and/or support system, and the midwife. Clients and midwives also have rights in the hospital care system.

A. CLIENT RIGHTS
An ethical midwife will respect the personal rights of her clients, including the right to:
1. Be treated with respect, dignity, and without prejudice;
2. Informed consent concerning her care and to have access to relevant information upon which to base decisions;
3. Freedom from coercion in decision making;
4. To accept or decline treatment;
5. Full disclosure of the costs of her care;
6. To know who will participate in her care and to obtain additional consultation of her choice;
7. Not be abandoned, neglected, or discharged from care without an opportunity to find other care or have appropriate closure;
8. Privacy as detailed by HIPAA, except where this right is preempted by law;
9. Timely access to her midwifery records.

B. MIDWIFE RIGHTS
A midwife recognizes the importance of respect for her own rights as care provider, including the right to:
1. Refuse care to clients with whom no midwife/client relationship has been established;
2. Discharge clients from her care, provided adequate referral to other care is established;
3. Receive honest, relevant information from clients upon which to base care; and
4. Receive reasonable compensation for services rendered.

C. CLIENT RESPONSIBILITY
A thorough commitment from the client and her family is necessary to ensure the safety and well-being of mother and infant. Most parents seeking to birth at home or in a birth center accept responsibility for their health and will share information with their provider(s) about changes and matters that may affect their pregnancy and birth. Maintaining communication is important to be able to respond appropriately to the particular needs a client may have during this special time of life.

A client will:
1. Care for her physical, emotional, and spiritual health to the best of her ability;
2. Make a commitment to learn about her body, the antepartum changes that occur, the birth process, the postpartum period, and throughout her life cycle;
3. Work with the midwife to change or improve nutrition, health, and environment as needed;
4. Consider additional screening and tests or other health care provider visits as needed;
5. Communicate any concerns or changes that affect any aspect of her care to her provider(s);
6. Respect appointment schedule, changing times only when necessary and with suitable notification;
7. Discuss, sign, and abide by a financial agreement; and
8. Agree to a transport or transfer of care if necessary, after all aspects of care have been considered and discussed.

D. MIDWIFE RESPONSIBILITY
A midwife recognizes certain responsibilities, including:
1. Respecting the normal birth process;
2. Honoring confidentiality of information and details of the client's condition;
3. Providing complete, accurate, and relevant information to the client (and obtain a signed consent) so she can make informed choices regarding her health care;
4. Remaining responsible for the client when referring to another health care provider, until she is either discharged or formally transferred;
5. Developing and utilizing a safe and efficient mechanism for consultation, collaboration and referral;
6. Continuing professional development through ongoing evaluation of knowledge and skills and continuing education, including study of subjects relevant to midwifery practice;
7. Knowing and complying with all legal requirements related to midwifery practice within the state of New Mexico;
8. Maintaining accountability for all midwifery care delivered under her supervision (Assignment and delegation of duties to other midwives or apprentices should be equal to their educational preparation and demonstrated proficiency.);
9. Accurately documenting the client's history, condition, physical progress, and other vital information obtained during client care;
10. Filing quarterly reports with the Public Health Division Maternal Health Program office of the Department of Health;
11. Participating in Peer Review as a reviewer and/or a reviewee;
12. Being informed about and implementing safety and infection control methods for the protection of mothers, babies and their families as well as of the midwife, her family, other clients, and staff; and
13. Obtaining a signed authorization (when necessary) to release midwifery and medical records for the purpose of insurance reimbursement, medical consultation or referral, or for the woman's own records.
DETERMINING APPROPRIATE CLIENT CARE PROVIDER

The following is a list of conditions, which require primary care by a physician or nurse-midwife, or factors, which require consultation, referral, or transfer of care. Maternal (and fetal) factors and conditions are listed first, followed by newborn factors and conditions. Refer to the specific guidelines for more detailed information for each condition or factor, as well as the transfer of care guidelines in Part III: Business Practices.

A. CONDITIONS THAT REQUIRE PRIMARY CARE BY A PHYSICIAN OR NURSE-MIDWIFE

1. Chronic Medical Conditions
   a. Cardiac disease (Class II or greater)
   b. Diabetes Mellitus (DM) Type I
   c. Diabetes Mellitus Type II not well controlled on diet (consultation required otherwise, see Antepartum Factors in Conditions That Require Consultation)
   d. Hemoglobinopathies (carrier or disease, not trait)
   e. Renal disease (chronic, diagnosed; not UTIs)
   f. History of pulmonary embolism or deep vein thrombosis
   g. Current chronic condition not well controlled: hyperthyroidism, seizures, lupus
   h. Active tuberculosis
   i. Active syphilis infection
   j. Active gonorrhea infection at onset of labor
   k. Positive HIV status or AIDS
   l. Any other condition at midwife’s discretion

2. Current Antepartum Conditions
   a. Ectopic pregnancy or hydatidiform mole/molar pregnancy (suspected or confirmed)
   b. Preeclampsia with or without severe features, HELLP syndrome, eclampsia
   c. Placenta previa at onset of labor
   d. Placental abruption
   e. Primary genital/anal herpes simplex infection in the third trimester
   f. Active genital/anal herpes simplex outbreak at onset of labor or at ROM
   g. Positive Zika infection
   h. Gestational diabetes not controlled by diet (consultation required otherwise, see Antepartum Factors in Conditions That Require Consultation)
   i. Preterm labor or preterm premature rupture of membranes (PPROM) defined as <37 weeks gestation per verified EDD by LMP date, ultrasound assessment, and/or physical exam
   j. Fetus in any presentation other than vertex at onset of labor
   k. Signs and symptoms of uterine rupture
   l. Multiple gestation
   m. Any other condition at midwife’s discretion

3. Previous Obstetrical History
   a. Previous Rh sensitization
   b. Previous cesarean with vertical uterine incision, inverted T uterine incision, or extension of the incision into the contractile portion of the uterus
c. Previous cesarean birth less than 18 months prior to EDD of current pregnancy
d. Two or more cesareans
e. Any other condition at midwife’s discretion

4. Intrapartum
   a. Prolonged rupture of membranes (> 24 hours) with no progress of labor
   b. Placental abruption, if birth is not imminent
   c. Severe bleeding prior to or during birth
   d. Signs and symptoms of maternal infection
   e. Maternal fever of 100.4° F for over 4 hours
   f. Severe headache, visual disturbances, epigastric pain
   g. Maternal respiratory distress
   h. Significant meconium stained fluid when birth is not imminent
   i. Cord prolapse when birth is not imminent
   j. Persistent or recurrent fetal heart tones below 100 or above 160 or late decelerations when birth is not imminent, or other non-reassuring fetal heart rate patterns
   k. Signs and symptoms of uterine rupture
   l. Mother desires consult or transfer
   m. Any other factor at midwife’s discretion

B. CONDITIONS THAT REQUIRE CONSULTATION

1. Antepartum Factors
   a. History of seizure disorder not on medication
   b. Chronic hypertension
   c. Gestational hypertension
   d. Diabetes Mellitus Type II that is well controlled by diet
   e. Gestational diabetes controlled by diet (transfer required otherwise, see Current Antepartum Conditions in Conditions That Require Primary Care By A Physician or Nurse-midwife)
   f. Thrombophlebitis
   g. Thrombocytopenia
   h. Maternal anemia (Hgb <10, Hct <30%) unresponsive to treatment
   i. Vomiting unresponsive to treatment
   j. Persistent fever (unresponsive to treatment)
   k. Serious maternal viral/bacterial infection at term unresponsive to treatment
   l. Maternal rubella infection contracted in first or second trimester
   m. Positive for Hepatitis B or C; severe symptoms of Hepatitis A
   n. Primary genital herpes simplex infection (except in third trimester which necessitates a transfer)
   o. UTI unresponsive to treatment
   p. Adnexal mass or uterine fibroid
   q. Positive and identifiable antibody screen
   r. Oligohydramnios (documented)
   s. Polyhydramnios (documented)
   t. Continued vaginal bleeding before onset of labor with or without pain
Determining Appropriate Client Care Provider

u. Intrauterine growth restriction (IUGR), documented or suspected (size less than dates)
v. Post dates >42 weeks gestation (verified EDD by dates, ultrasound assessment and/or physical exam)
w. Signs of fetal distress or demise
x. Teratogenic exposure
y. Current severe psychiatric condition requiring medication within a 6-month period prior to pregnancy
z. Current drug or alcohol substance use disorder
aa. History of uterine surgery other than cesarean section
bb. History of uterine inversion
cc. Any other condition at midwife’s discretion

2. Intrapartum Factors
   a. Mother desires consult or transfer
   b. Any other factor at midwife’s discretion

3. Fetal Factors
   a. Two-vessel umbilical cord
   b. Documented fetal anomaly
   c. Any other factor at midwife’s discretion

C. POSTPARTUM FACTORS THAT REQUIRE IMMEDIATE TRANSFER
   1. Maternal hemorrhage not responsive to interventions
   2. Third or fourth degree perineal laceration
   3. Signs of infection not responsive to treatment
   4. Retained placenta
   5. Placenta accreta
   6. Hematoma increasing in size or pain
   7. Uterine inversion or prolapse
   8. Any other factor at midwife’s discretion

D. NEWBORN FACTORS THAT REQUIRE IMMEDIATE TRANSFER
   1. Neonatal distress not responsive to interventions
   2. Seizures
   3. Any other factor at midwife’s discretion

E. NEWBORN FACTORS THAT REQUIRE CONSULTATION
   1. Fails to urinate or move bowels within 24 hours
   2. Low birth weight (less than 2500 g)
   3. Obvious anomaly or injury
   4. Respiratory distress or abnormal respiratory patterns
   5. Cardiac irregularities
   6. Prolonged pale, cyanotic, or gray color
   7. Abnormal cry
   8. Jaundice within 24 hours of birth
   9. Hyperbilirubinemia
   10. Lethargy
11. Edema
12. Signs of hypoglycemia
13. Abnormal facial structure
14. Abnormal body temperature
15. Poor feeding
16. Maternal hepatitis B or C infection
17. Any other factor at midwife’s discretion
EVENTS THAT REQUIRE REPORTING TO THE DEPARTMENT OF HEALTH

Licensed midwives practicing in New Mexico are required to report and submit for review any cases that fall into the event categories listed within this section. The listed events trigger a required case review process by the New Mexico Department of Health’s Maternal Health Program. It is the midwife’s responsibility to report and provide any required documentation for all reportable cases of any client for whom the midwife provided care for during the perinatal period, whether the client’s care was transferred or not. The outcomes of case review are confidential and not available in the public domain unless an action is taken against a midwife’s license, in which case only the action against the license is in the public domain.

A. IMMEDIATE REPORTING REQUIRED FOR MORTALITY EVENTS
   1. Maternal death within 42 days of delivery (during 6 week postpartum period)
   2. Neonatal death within 28 days of birth
   3. IUFD or stillborn at 20 weeks gestation or more, or, if gestational age is unknown, when the fetus weighs greater than or equal to 350 grams
   4. Immediate reporting is defined as within 48 hours of the event per the LM Rule, 16.11.3.12(I) NMAC (see Appendix B), “The licensed midwife must report within 48 hours to the Division any neonatal or maternal mortality in patients for whom she has cared in the perinatal period”

B. REPORTABLE EVENT REPORTING PROCESS
   1. Per above requirements for reporting timeframe, LM should contact the DOH Maternal Health Program by email or phone call.
   2. LMs will be asked to provide:
      a. Name and date of birth of the client, date of incident including delivery and/or death, and any hospitals or outside entities involved in the care of the client
      b. Any and all client records for the case
   3. DOH will be responsible for requesting records from hospitals or other applicable entities (i.e. Office of Medical Investigator).
   4. All cases will be reviewed by the Department.
      a. If no input from the LM Advisory Board is needed, the case will be closed, and the LM will be notified via a USPS-posted letter
      b. If further input is needed, the case will be brought to the LM Advisory Board to be heard by the Department and Board in a closed session format at a regularly scheduled or special meeting
      c. Disciplinary action and proceedings will be conducted according to the LM Rule, 16.11.3.9 NMAC "Disciplinary Action" (see Appendix B)
CLIENT EDUCATION

Education is an essential part of midwifery practice. The midwife is a supportive teacher and guide promoting an understanding of physical, emotional, and social changes brought about throughout the cycles of a woman’s life. The midwife encourages her client's involvement in her own health care.

Education during antepartum and well-woman care are based on models of self-care, which can include natural therapies. Education may include the explanation of changes and needs related to general wellbeing, pregnancy and childbirth, anticipatory guidance, short-term counseling, crisis intervention, and referral to other services. Women and families who take responsibility for their part in improving health and experience through pregnancies, births, and well-woman cycles participate in a process that supports truly preventive health care.

It is impossible to write a single plan of client education, because real learning requires that each client be assessed individually for her educational needs. Tailoring education to client interests and needs follows the principles of personalized midwifery care. Educational content will evolve as new information, along with continued experience, becomes available to the midwife.

The following components should be part of client education:

A. Nutrition: antepartum, postpartum, during lactation, and well-woman
B. Exercise and activity
C. Sexuality antepartum, early postpartum, well-woman, and perimenopausal and postmenopausal periods of life
D. Fertility counseling, family planning, contraception care
E. Options for unplanned pregnancy
F. Lifestyle and environmental hazards present in the home and workplace
G. Automobile safety information for pregnant women and infants
   1. Pregnant women should wear their seat belts; the lap belt is placed below the enlarged abdomen and the shoulder harness should be worn
   2. Infants should always be transported in a car seat placed in the back seat rearward facing at least until the child is two years of age
H. Family relationships, dysfunction, violence
I. Recommended vaccination schedule
J. Child development and family integration
K. Routine well-woman schedule
L. Well-woman testing and screening
M. Prenatal visit schedule
N. Maternal antepartum changes and common experiences/discomforts
O. Fetal development
P. Routine and special antepartum and newborn testing and screening
Q. Normal physiology of labor, birth, postpartum, and newborn
R. Preparation for giving birth in the selected birth site, including maternal comfort measures and sibling preparation
S. Essentials of newborn care
T. Danger signs in the antepartum and intrapartum periods, and in the newborn
U. Complications of antepartum, intrapartum, birth, postpartum, and newborn periods
V. Emergency plans/transport planning
W. Breastfeeding and bonding
X. Loss and grief
As independent health care practitioners, licensed midwives may procure, carry, and administer the approved formulary medications as needed for safe practice. Licensed midwives (LMs) may also carry and administer additional medications as ordered by a provider with prescriptive authority. For updated information regarding procurement and administrative authority, contact the Department of Health Maternal Health Program.

The table below shows the approved drugs—and their respective indications, doses, routes of administration, and durations of treatment—that it is best practice for LMs to carry and be prepared to administer if needed. LMs are advised to assess for client medication allergies prior to administration of drug(s).

<table>
<thead>
<tr>
<th>Drug</th>
<th>Indication</th>
<th>Dose</th>
<th>Route of Administration</th>
<th>Duration of Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxygen</td>
<td>Maternal/Fetal distress</td>
<td>0.5 L/min increased as needed to max</td>
<td>Mask or bag and mask</td>
<td>Until stabilization is achieved or transfer of care is complete; refer to “Oxygen in Labor” in Part VI</td>
</tr>
<tr>
<td></td>
<td>Neonatal resuscitation</td>
<td>10-15L/min Amount as needed per NRP guidelines</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxytocin</td>
<td>Active management of third stage</td>
<td>10 units</td>
<td>IM</td>
<td>Immediately postpartum or with delivery of anterior shoulder</td>
</tr>
<tr>
<td>(Pitocin)</td>
<td></td>
<td>20 units in 1 L NS or LR; Initial bolus rate (500-1000 ml/hour) for 30 minutes followed by a maintenance rate of 125 ml/hour for the next 3.5 hours</td>
<td>IV infusion</td>
<td></td>
</tr>
<tr>
<td>Oxytocin</td>
<td>Postpartum hemorrhage</td>
<td>10 units</td>
<td>IM</td>
<td>Until stabilization is achieved or transfer of care is complete</td>
</tr>
<tr>
<td>(Pitocin)</td>
<td></td>
<td>Add 10-40 units; not to exceed 40 units; to 1000 mL of NS or LR and infuse at necessary rate to control uterine atony</td>
<td>IV infusion</td>
<td></td>
</tr>
<tr>
<td>Misoprostol¹</td>
<td>Postpartum hemorrhage</td>
<td>600 mcg (sublingual) and max 800) mcg (rectal or buccal)</td>
<td>Rectal or sublingual</td>
<td>Until stabilization is achieved or transfer of care is complete</td>
</tr>
<tr>
<td>Drug</td>
<td>Indication</td>
<td>Dose</td>
<td>Route of Administration</td>
<td>Duration of Treatment</td>
</tr>
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</tr>
<tr>
<td>Methylergonovine (Methergine)</td>
<td>Postpartum hemorrhage</td>
<td>0.2 mg max 0.6 mg (3 doses)</td>
<td>IM or orally</td>
<td>Single dose; may be repeated every 6 hours up to a max of 3 doses; contraindicated in hypertension and before delivery of the placenta</td>
</tr>
<tr>
<td>Lidocaine HCl 1%</td>
<td>Local anesthetic for use during postpartum repair of lacerations or episiotomy</td>
<td>Maximum &lt;25mL; Use as needed</td>
<td>Percutaneous infiltration only</td>
<td>Completion of repair</td>
</tr>
<tr>
<td>Lidocaine 2% gel</td>
<td>Local anesthetic for use during postpartum repair of lacerations or episiotomy</td>
<td>Maximum 600 mg in 12 hours; Use as needed</td>
<td>Topical</td>
<td>Completion of repair</td>
</tr>
<tr>
<td>Penicillin G²</td>
<td>Group B Strep Prophylaxis only</td>
<td>5 million units initial dose, then 2.5 million units q 4 hours until birth</td>
<td>IV in ≥ 100 mL LR, NS or D5LR</td>
<td>Prophylactic treatment through end of delivery</td>
</tr>
<tr>
<td>Ampicillin Sodium³</td>
<td>Group B Strep Prophylaxis only</td>
<td>2g initial dose, then 1g q 4 hours until birth</td>
<td>IV in ≥ 100 mL NS</td>
<td>Prophylactic treatment through end of delivery</td>
</tr>
<tr>
<td>Cefazolin Sodium⁴</td>
<td>Group B Strep Prophylaxis only</td>
<td>2g initial dose, then 1g q 8 hours until birth</td>
<td>IV in ≥ 100 mL LR, NS or D5LR</td>
<td>Prophylactic treatment through end of delivery</td>
</tr>
<tr>
<td>Clindamycin Phosphate⁵</td>
<td>Group B Strep Prophylaxis only, if sensitive to clindamycin AND erythromycin</td>
<td>900 mg q 8 hours</td>
<td>IV in ≥ 100 mL LR or NS</td>
<td>Prophylactic treatment through end of delivery</td>
</tr>
<tr>
<td>Epinephrine HCl 1:1000 (Epipen)</td>
<td>Maternal treatment or post-exposure prevention of severe allergic reactions</td>
<td>0.3 mL pre-metered dose max of 3 doses</td>
<td>As directed</td>
<td>Max of 3 doses q 5 minutes or until EMS arrives; Administer first dose then immediately request EMS</td>
</tr>
<tr>
<td>Diphenhydramine</td>
<td>Treatment or post-exposure prevention of allergic reactions</td>
<td>25 mg- 50 mg</td>
<td>Orally</td>
<td>As needed; Not to be used in place of Epinephrine</td>
</tr>
<tr>
<td>Lactated Ringer (LR)</td>
<td>To achieve maternal stabilization or hydration</td>
<td>Appropriate volume to treat to client’s condition</td>
<td>IV catheter</td>
<td>Until stabilization is achieved or transfer to a hospital is complete</td>
</tr>
<tr>
<td>Drug</td>
<td>Indication</td>
<td>Dose</td>
<td>Route of Administration</td>
<td>Duration of Treatment</td>
</tr>
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<td>-------------------------------------------</td>
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</tr>
<tr>
<td>5% Dextrose in Lactated Ringer’s solution (D5LR)</td>
<td>To achieve maternal stabilization</td>
<td>Appropriate volume to treat to client’s condition</td>
<td>IV catheter</td>
<td>Until stabilization is achieved or transfer to a hospital is complete</td>
</tr>
<tr>
<td>0.9% Sodium Chloride (NS)</td>
<td>To achieve maternal stabilization or hydration</td>
<td>Appropriate volume to treat to client’s condition</td>
<td>IV catheter</td>
<td>Through end of delivery</td>
</tr>
<tr>
<td>Sterile H2O</td>
<td>Relief of back labor</td>
<td>0.1-0.5 cc at the 4 corners of the sacrum, should be administered rapidly, one after another, over a 30 to 90 second total period</td>
<td>Subdermal, using TB syringe and needle, into appropriate points in a woman’s back</td>
<td>Duration of pain relief is 2-4 hours</td>
</tr>
<tr>
<td>Inactive Influenza Vaccine</td>
<td>Prevent flu, make flu less severe if client is symptomatic or tests positive to flu, and to keep from spreading flu to family/others</td>
<td>0.5 mL</td>
<td>IM</td>
<td>Given as single dose to adult during influenza season (usually October-May); can be given every season; can be given in any trimester</td>
</tr>
<tr>
<td>Diphtheria, Tetanus, and Pertussis Vaccine (Tdap)</td>
<td>Administered to pregnant woman to protect her newborn baby against pertussis</td>
<td>0.5 mL</td>
<td>IM</td>
<td>Pregnant women should receive a single dose of Tdap during every pregnancy, preferably at 27 through 36 weeks gestation. Tdap is recommended in the immediate postpartum period for new mothers who have not received Tdap during the pregnancy or whose vaccination status is unknown.</td>
</tr>
<tr>
<td>Drug</td>
<td>Indication</td>
<td>Dose</td>
<td>Route of Administration</td>
<td>Duration of Treatment</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-----------------------------------------------------------------------------</td>
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<td>-------------------------</td>
<td>---------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Rh(D) Immune Globulin</td>
<td>Prevention of Rh(D) sensitization in Rh(D) negative women</td>
<td>300mcg</td>
<td>IM</td>
<td>Rh(D) negative, antibody negative women within 72 hours of spontaneous bleeding or abdominal trauma or prophylactically in the 2nd trimester or after birth (before 72 hours have passed) with Rh positive infant</td>
</tr>
<tr>
<td>Hepatitis B Immune Globulin (HBIG)</td>
<td>Postexposure prophylaxis for infants exposed to hepatitis B (i.e. mother is hepatitis B positive)</td>
<td>0.5 ml</td>
<td>IM</td>
<td>Should be administered to infant after physiologic stabilization of the infant and preferably within 12 hours of birth</td>
</tr>
<tr>
<td>Hepatitis B Vaccine</td>
<td>Prevention of hepatitis B infection in all infants; postexposure prophylaxis for infants exposed to hepatitis B (i.e. mother is hepatitis B positive)</td>
<td>0.5 ml of vaccine (10 ug) each</td>
<td>IM</td>
<td>The 1st dose should be given to infant within 1 day of birth and may be given concurrently with HBIG but at a separate site; the 2nd and 3rd doses should be given at 1 month and 6 months, respectively, after the 1st dose; these can be administered by pediatric care provider</td>
</tr>
<tr>
<td>Phylloquinone (Vitamin K1)</td>
<td>Prophylaxis for Vitamin K deficiency bleeding</td>
<td>1 mg</td>
<td>IM</td>
<td>1 dose to infant postpartum</td>
</tr>
<tr>
<td>0.5% Erythromycin Ophthalmic Ointment</td>
<td>Prophylaxis of Neonatal Ophthalmia</td>
<td>1 cm ribbon in each eye</td>
<td>Topical</td>
<td>1 dose to infant postpartum</td>
</tr>
<tr>
<td>Various Sutures</td>
<td>Repair of lacerations or episiotomy</td>
<td></td>
<td></td>
<td>As needed</td>
</tr>
</tbody>
</table>
1 Appropriate off label use
2 Recommended antibiotic for prophylactic treatment of GBS as appropriate for client
3 Alternative antibiotic for prophylactic treatment of GBS as appropriate for client
4 Recommended antibiotic for prophylactic treatment of GBS for clients with penicillin allergy with low risk for anaphylaxis
5 Recommended antibiotic for prophylactic treatment of GBS for clients with penicillin allergy with high risk for anaphylaxis
PROCESS FOR FORMULARY REVISIONS

It is understood that a formulary will evolve over time given new research, drugs, and availability and shortages of listed medications. For this reason, formulary changes are expected and accepted for consideration through the following process. For more information or to contact NMMA regarding the formulary status or revisions, visit http://www.newmexicomidwifery.org/.

A. Any proposed changes are formally requested through the NMMA and are reviewed by the NMMA Board.
B. If approved, proposed changes are forwarded to the Department of Health Maternal Health Program Manager for review at the next quarterly LM Advisory Board meeting.
C. Upon approval from the LM Advisory Board, the proposed changes are forwarded to the Department of Health for departmental review.
D. After final approval for the proposed change to the formulary by the LM Advisory Board and the Department, the approved changes will be integrated into these practice guidelines without need for secondary approval by the LM Advisory Board.
E. With any change to the Approved Formulary, any NMMA pharmacology course(s) will be required to resubmit an application for course approval through the NMMA Continuing Education Unit (CEU) process and review for inclusion of additional competencies.
SAFE STORAGE, TRANSPORTATION, AND DISPOSAL OF FORMULARY

A. STORING FORMULARY DRUGS
A licensed midwife must store all formulary drugs in secure areas suitable for preventing unauthorized access and for ensuring a proper environment for the preservation of the drugs.
1. Licensed midwives may carry formulary drugs to the home setting while providing care within the course and scope of the practice of midwifery.
2. The licensed midwife must promptly return the formulary drugs to the secure area when the licensed midwife has finished using them for patient care.

B. DISPOSING OF FORMULARY DRUGS
A licensed midwife must dispose of formulary drugs using means that are reasonably calculated to guard against unauthorized access and harmful excretion of the drugs into the environment. The means that may be used include, without limitation:
1. Transferring the drugs to an authorized collector for disposal; U.S. Drug Enforcement Agency (DEA) authorized collectors safely and securely collect and dispose of pharmaceuticals containing controlled substances and other medicines (see DEA website for disposal information);
2. Medicine take-back programs are a good way to safely dispose of most types of unneeded medicines. The DEA periodically hosts National Prescription Drug Take-Back events where collection sites are set up in communities nationwide for safe disposal of prescription drugs;
3. Removing the drugs from their original containers, mixing them with an undesirable substance such as coffee grounds or kitty litter, putting them in impermeable, non-descript containers such as empty cans or sealable bags, and throwing the containers in the trash; or
4. Flushing the drugs down the toilet if the accompanying patient information instructs that it is safe to do so.
SAFETY AND INFECTION CONTROL

The Occupational Safety and Health Administration (OSHA) publishes rules and guidelines which, if followed, will assist in maintaining safety in the work environment, including protection from blood-borne pathogens and toxic chemicals. Midwives in New Mexico are required to comply with OSHA standards, which are accessible in full through http://www.osha.gov.

Individual midwifery practice requirements include:

A. Written exposure control plan, including but not limited to:
   1. Exposure determination
   2. Methods of implementation
      a. Standard precautions
         (a) Hand-washing and cleanup facilities
         (b) Cleanup activities
         (c) Engineering control equipment
         (d) Personal protective equipment
         (e) Appropriate transportation and handling of blood, hazardous waste, and infectious wastes
         (f) Labeling
      b. Training
      c. Record keeping

B. Fire safety requirements in a birth center or midwives’ office, including but not limited to:
   1. Fire extinguishers
   2. Plan of building and exit routes labeled
   3. Written plan in case of fire
   4. Practice fire drills

C. Disaster plan (may adopt your community's disaster plan)

D. Safeguarding client personal information, including but not limited to:
   1. Confidentiality of client records and informed consent
      a. Keep records in office in locked, fire-proof file cabinet
      b. Obtain release for chart
      c. Secure Health Insurance Portability and Accountability Act (HIPAA) protected client information as informed in the individual midwife’s HIPAA written policy
      d. If using electronic health records (EHR), the system must be in compliance with current HIPAA guidelines.
SEXUALLY TRANSMITTED INFECTIONS PREVENTION

Midwives as health care providers have a role in the prevention and control of sexually transmitted infections (STIs). In addition to interrupting transmission by referring for treatment those with STIs, midwives should provide client education and counseling and may participate in identifying and/or referring infected partners. Each LM needs to be familiar with and comply with local infection reporting regulations and requirements. In New Mexico, public health authorities should be notified as appropriate per the NM Department of Health regulations governing the control of disease and conditions of public health significance (see NMAC 7.4.3 and Appendix F for a list of reportable diseases and conditions in the state of New Mexico).

Prevention and control of STIs are based on four concepts:
1. Education on means of reducing risk of transmission
2. Detection of asymptomatic individuals and those who are symptomatic but unlikely to seek treatment services
3. Effective diagnosis and treatment
4. Evaluation, treatment, and counseling of sex partners

Effective evaluation of a client's risk of STIs requires that accurate and complete information be elicited from the client. When risks have been identified, then appropriate prevention messages can be delivered. Counseling skills of respect, compassion, and a non-judgmental attitude are essential to the effective delivery of prevention information. Prevention messages should be tailored to the client, with consideration given to her individual needs and risks. For more information, see “Safer Sex Practices” in Part IV: Well-Woman Care.
PART II: EDUCATION REQUIREMENTS FOR APPRENTICESHIP, LICENSURE, AND LICENSE RENEWAL
MIDWIFERY INSTRUCTOR/PRECEPTOR REGISTRATION

In the state of New Mexico, LMs wishing to teach the art and skills of midwifery to an apprentice or student midwife are required to register with the Department of Health to become an Approved Preceptor pursuant to the LM Rule (see Appendix B). Preceptor registration is achieved according to the requirements below.

A. Submit the following forms with the proof or documentation requested to the Maternal Health Program
   1. “Application for Midwifery Instructor/Preceptor” form (available at https://nmhealth.org/publication/view/form/1728/)
   2. “Student/Instructor Relationship” form, signed and notarized (available at https://nmhealth.org/publication/view/form/1730/)

B. Preceptors are encouraged to register as a NARM Registered Preceptor in addition to registering with the DOH (see http://narm.org/preceptors/)
   Rationale: Registering as a NARM preceptor helps protect students who may not finish the New Mexico licensure process.
MECHANISM FOR EXPANSION OF PRACTICE

The LM may expand her scope of practice beyond the Licensed Midwife Scope of Practice (see Part I) and Core Competencies (see Appendix A) to incorporate new procedures that improve care for women and their families, consistent with the midwifery model of care and NMAC 16.11.3.12. The midwife’s practice should reflect knowledge of the new procedure including risks, benefits, screening criteria, and identification and management of potential complications. The following requirements must be followed for the new or expanded procedure to be incorporated in the New Mexico Licensed Midwife’s practice. This guideline is adapted from the Midwives Alliance of North America’s “Standards and Qualifications for the Art and Practice of Midwifery”.

A. IDENTIFY THE NEED FOR A NEW PROCEDURE
   Take into consideration:
   1. Consumer demand
   2. Standards for safe practice
   3. Availability of qualified professionals who provide the procedure

B. LEGALITY: Ensure that there are no institutional, state, or federal statutes, regulations, or bylaws that would constrain the midwife from incorporating the procedure into practice

C. TRAINING AND DOCUMENTATION: Maintain documentation of the process used to achieve the necessary knowledge, skills, and ongoing competency of the expanded or new procedures, for example maintain documentation of supervised clinical and/or didactic training specific to the new skill/procedure

D. COMPETENCY: Demonstrate knowledge and competency of the new procedure by writing and maintaining a practice guideline for the procedure (if one does not already exist in this document), including:
   1. Definition
   2. Etiology
   3. Signs and symptoms
   4. Management
   5. Identification and management of complications
   6. Mechanism for obtaining medical consultation, collaboration, referral, and transport as related to this procedure
   7. Informed decision making handout for clients to sign which should include
      a. Risks
      b. Benefits
      c. Client selection criteria
   8. Outline how competency will be maintained
   9. Report any incurred complications to the NMDOH Maternal Health Program
   10. Process to evaluate outcomes (e.g., include in midwife’s peer review cases)
Licensed midwives licensed by the state of New Mexico are required to certify in intravenous (IV) therapy with each license renewal. Class requirements are based on the North American Registry of Midwives (NARM) skills.

A. CERTIFICATION CAN BE ACHIEVED IN THE FOLLOWING WAYS
   1. Taking a course approved by the education committee of the NMMA;
   2. Working as a health care practitioner who starts and maintains IVs on a daily basis through other employment for at least three months during the previous two years (e.g., RNs, EMTs);
   3. Taking a course through another nationally or state-recognized organization (e.g., EMT, community college, National College of Midwifery, MANA conference program); or
   4. Other avenues, as approved by the NMDOH, on an individual basis.

B. COURSE REQUIREMENTS
   1. It is recommended that a class meet a continuing education unit (CEU) approval process
   2. IV therapy CEUs cannot be included in the 30 CEUs required for license renewal as a New Mexico Licensed Midwife
   3. The course instructor may be any person who is licensed to administer IVs and who can demonstrate sufficient and ongoing experience
   4. Didactic portion of the course must include instruction in all intravenous formulary medications approved for use by these Guidelines.

C. NECESSARY COMPONENTS OF CERTIFICATION IN IV THERAPY
   1. Uses of IV therapy in midwifery care
   2. Different IV fluids and their uses
   3. Drip rates and their rationales
   4. Basic anatomy and physiology of the vasculature
   5. Initiation and maintenance of an IV line
      a. Administration of IV fluids, including drip rate control
      b. Changing and discontinuing an IV line
      c. Attaching a saline lock
      d. Complications and troubleshooting the IV line
   6. Administration of IV medications, including antibiotics and Pitocin
   7. Practical skills evaluation, including:
      a. Successful initiation of an IV line (while a model is acceptable, the NMMA encourages LMs to successfully start an intravenous catheter on a volunteer at least once every two years)
      b. Administration of IV fluids
      c. Changing and discontinuing an IV line
      d. Attaching a saline lock
      e. Adding medication to an IV line
PHARMACOLOGY COURSE REQUIREMENT

Licensed midwives (LMs) carry and administer an approved formulary of dangerous drugs and devices as part of safe practice (see “Licensed Midwife Formulary” in Part 1). LMs should complete a 4-hour NMMA pharmacology course for CEUs, or an equivalent course, every 2 years. Proof of a 4-hour pharmacology course should be submitted with the initial license application and subsequent license renewal applications.
TRANSPORT CLASS QUALIFICATIONS AND CURRICULUM CRITERIA

Successful completion of a class on managing emergency transport is required for completion of the state apprenticeship process.

A. INSTRUCTOR QUALIFICATIONS
   1. Instructor must be a provider with demonstrated sufficient and ongoing experience transporting or receiving obstetrical emergencies
   2. The NMMA encourages apprentices and practicing midwives to seek training opportunities taught by multidisciplinary instructors

B. CURRICULUM REQUIREMENTS.
   1. Review practice guidelines for clinical scenarios which require transport to a medical facility
   2. Specifically discuss etiology and management detailed in “Emergency Transport” in Part VI
   3. Review current evidence and guidelines around transport criteria
   4. Participants should have written documentation of appropriate phone numbers (e.g., EMS, hospital) for their local area of practice
   5. Review “Best Practice Guidelines for Transfer from Planned Home Birth to Hospital” (see Appendix G)

C. ENDORSEMENT
   The NMMA has endorsed the Home Birth Summit’s “Best Practice Guidelines for Transfer from Planned Home Birth to Hospital” (see Appendix G)
PART III: BUSINESS PRACTICE
FINANCIAL CONTRACT

A financial contract between midwife and client is mandatory and is part of the informed consent that a licensed midwife must obtain, as is stated in NMAC 16.11.3.12.E. Financial contracts provide the best means to prevent financial misunderstandings and redress issues. A financial contract for midwifery care should include the following:

A. TOTAL FEE AND PAYMENT
   1. Include an explanation of what this fee includes and may exclude
   2. Detailed schedule of payments, clearly stating the date the full fee is due

B. REFUNDABILITY
   Clearly state if any of the fee is non-refundable, and which portion of the fee may be refundable and under what circumstances

C. DISCONTINUATION OF CARE POLICY
   Detail discontinuation of client care and client/midwife relationship policy; see “Transfer of Care or Discontinuation of Client/Midwife Relationship” and “Transfer of Non-compliant Client” in this Part III

D. MEDICAL INSURANCE POLICY
   Detail how insurance reimbursement is handled
MEDIATION

This mediation guideline provides general information regarding the activity of mediation. This guideline does not constitute legal advice.

In any relationship, disagreements may arise. If unresolved, disagreements can become problematic for individuals, professionals, clients, and the community. Disputes may arise between individual midwives, between midwives and clients, between midwives and student midwives, and between committees and groups. These issues and concerns can ultimately harm not only the individuals involved, but also the whole of the midwifery and birth communities. Mediation is a mature, healthful, and positive way of dealing with disputes. This process is created for building integrity, self-development, confidence, and a strong midwifery community. The mediation process is one of growth, reclamation of power, and mutual resolution; it should not be and is not reprimanding or punitive.

If disagreement or dispute occurs, individuals must attempt to deal with those concerns with each party involved. Each party should put forth efforts to resolve concerns and responses by other parties in writing. If parties are unwilling or unable to resolve issues, consider a confidential mediation process. Mediation can help develop a better understanding of issues and relationships in a neutral setting. The mediation process is detailed below.

A. Mediation is a voluntary, confidential method of working through concerns or issues of two or more parties with an outside, uninvolved, third party. It involves listening to and striving to understand each other’s concerns. This is essentially done with cooperation, trust, and a collaborative decision making process. The purpose of this process is to work constructively to:
   1. Define the problem
   2. Improve situations
   3. Create better working relationships
   4. Resolve differences
   5. Resolve legal issues, breech of contracts, wrong doings, etc.

B. Failure in this process can be due to being locked in adversarial positions or negative and abusive patterns. Completion of mediation may be completed in one meeting, but may require up to two or more meetings.

C. A mediator is a facilitator, not an advocate or counselor. They will assist in negotiating changes or resolutions that are mutually acceptable. A mediator can be chosen in two ways:
   1. Another midwife, association, or community member trained for this purpose (not personally involved with negotiating parties)
   2. A paid professional mediator

D. Steps to initiate mediation
   1. One or both parties approach mediator via phone, letter, or in person.
   2. Mediator will approach second party via phone, letter, or in person to explain mediation concerns and request voluntary participation.
Mediation

a. If one party is in disagreement with a mediation process, then mediator will do all possible to elicit voluntary participation.
b. If second party will not agree to voluntary participation, mediation is not an option.
   (a) Redefine severity of issues
   (b) Determine importance of resolving issues
   (c) If still feel resolution is necessary, see “if agreements unsuccessful” section below
c. Initial interview set up
d. Voluntary participation by all parties confirmed
e. Mediation process explained to all parties

E. Mediation process
   1. Joint session with all parties, [each] session following this agenda:
      a. Introductions
      b. Mediation process reviewed
      c. Ground rules explained
      d. All parties agree to participate
      e. Define the issues:
         (a) Each party makes opening remarks about how each perceives the issues
         (b) Each party describes the situation from her point of view
         (c) Mediator helps involved persons identify all issues they need to resolve in order to improve and/or clarify areas of differences
   2. Processing the issues: Each party has a private session with mediator
      a. Mediator helps each party clarify and simplify individual needs
      b. Mediator attempts to clarify understanding of other party’s feelings and point of view
      c. Mediator helps create a clearer understanding of the similarities and differences in their views, and concerns, which will be helpful for resolution and/or positive changes
      d. Identify possible alternatives to resolve the issues
   3. Resolving the issues: In a joint session,
      a. Each party presents suggestions for solutions to issues
         (a) Prioritize issues (e.g., most to least urgent; easiest to most difficult)
         (b) Summarize issues and negotiations
      b. Explore areas of compromise
      c. Make decisions about specific points in agreement, duties, obligations, and expectations
   4. Making an agreement
      a. Restate verbally all points of agreement
      b. Put into writing agreement in detail
      c. All parties, including mediator, sign a written agreement, and each receive copies (verbal acknowledgement of agreements may be acceptable to all parties for simple issues)
      d. Schedule future review if indicated
      e. Congratulate all parties on their participation and work accomplished
5. Agreements unacceptable or unsuccessful
   a. Consider another mode of resolution
      (a) Professional mediation
      (b) Co-mediation
      (c) Counseling
      (d) Bring issues to NMMA
      (e) Bring issues to LM Advisory Board
   b. Do nothing else
   c. Consider legal options
TRANSFER OF CARE OR DISCONTINUATION OF CLIENT/MIDWIFE RELATIONSHIP FOR THE NON-ADHERANT CLIENT

For the midwife, the primary goal in any course of care is to have a healthy, safe outcome. This is true whether her practice setting is at home, in a birth center, or in a hospital. There are times when the out-of-hospital setting is no longer safe or desirable and transfer of care is appropriate. These times can occur during the antepartum, intrapartum, postpartum, or interconception periods. Reasons for transfer can be psychosocial or physiological. In any event, it is the legal and ethical obligation of the midwife to transfer or discontinue care in a sensitive, respectful, and efficient manner.

"Risking a client out" is not an easy task. When transfer of care occurs, every effort must be made to assist the woman in locating a suitable health care provider. Upon consent, all pertinent records should be given to the woman or to the new provider in a timely manner to facilitate and promote continuous care. If the transfer occurs intrapartum, the midwife should accompany the client to the hospital and remain with her until the case is transferred or resolved, as appropriate. These practice guidelines provide a detailed list of when transfers of care and consultation for care should occur.

On occasion, it is also necessary to discontinue a client/midwife relationship for other pertinent reasons. Some indications from the client are:

1. Irresponsibility, unwillingness to change habits
2. Lack of compliance within necessary time frame
3. Dishonesty, intentional breach of contract
4. Unstable or dangerous home environment
5. Immaturity, questionable emotional status
6. Refusal to agree to necessary specified testing, emergency medical care, or transport
7. Unresolved conflicts or personality differences between client and midwife
8. Not honoring financial contract/commitment

The midwife is not ethically, morally, or legally bound to keep a client if it is not in the best interest of both parties. This is a difficult decision to make and should be done with integrity.

In the event of discontinuation or transfer of care, the midwife should:

1. Set a date
2. Notify the client in person if possible and/or send notification by certified mail
3. Document in chart
4. Provide woman with referrals to other care providers
5. Upon written consent, mail a certified letter including a copy of client’s chart to client and/or to the new health care provider in a timely manner
6. Settle payments from client for services rendered to date, referring to the financial contract between client and midwife, and providing reimbursement if applicable

Midwifery care is known as "the extra mile" care. Time and effort spent with a client is meant to support the client’s awareness of herself as a woman and mother. It is difficult to let go of a
relationship. However, a midwife must remember that the purpose of these boundaries is for the safety and protection of all involved.
TRANSFER OF CARE DURING LABOR FOR THE NON-ADHERANT CLIENT

Perhaps the most difficult situation a midwife and client can face is when they are at an impasse on the appropriate level or setting of care during active labor. This particular situation is challenging for the midwife because it can put her at odds with legal and licensing restrictions, her personal ethics, expose her to increased legal and civil risks, and bring into question both within the midwifery and client communities her commitment to the legal and professional standards set forth in this document.

It is the hope and expectation of the midwifery community that a trusting relationship between the midwife and her client be established during the course of her prenatal care so that this type of situation is rarely, if ever, seen during the entire career of a midwife. It is expected that the client understand and respect the boundaries the midwife must work within both because of the legal restrictions placed on her through licensing but also through professional standards of practice as well as a midwife’s own individual ethical and moral bounds.

However, in the event that such a situation arises that a midwife feels a transfer of care to another facility becomes medically or legally necessary during active labor and a client refuses the following guideline has been written to help the midwife and client navigate this situation.

Please note that should this situation come to the attention of the LM Advisory Board or the NMDOH, regardless of a positive or negative outcome, this guideline does not provide protection from adverse outcomes to the LM.

1. The LM should consider having a client sign a contract at the time initial hiring contract is signed that states: “You hereby acknowledge that if your medical condition escalates to a level above the scope of practice of the LM, the LM will call EMS, and you will agree to a transfer of care; should you refuse to transfer by EMS to a hospital or other provider, you assume the risk of any medical outcome resulting from a medical condition that you have been advised is above the scope of practice of the LM, and acknowledge that the LM may only provide care to you within the scope of her practice.”

2. The midwife is responsible for helping the woman understand the risks involved, documenting the discussion, and having the client sign a document, if possible, to verify the discussion.
   a. Notify the client in writing the reason you, the LM, believe a transfer of care is medically and/or legally necessary
   b. Have the client state in her own words verbally but preferably in her own writing and primary language the reason why she is declining a transfer
   c. If possible have a member of the birth team, non-family member or family member (order is in preference of signature) witness these interactions and sign any statements provided to the client with the date and time the discussion took place

3. The midwife should also alert the hospital that is the most likely to receive the client of the situation and that she is doing what she can to get the woman’s permission to transfer care.
4. The midwife should call EMS, state that you have an emergency situation and go through standard procedure per EMS
Transfer of Care During Labor for the Non-adherent Client

   a. Stay with the client until EMS arrives
   b. If the client refuses to transfer with EMS, have the EMS sign, date, and time the LM’s chart to document refusal

5. Having taken these measures, the midwife should stay with the client and, while continuing to encourage her to transfer, provide midwifery and emergency care to the best of her ability.
PART IV: WELL-WOMAN CARE
WELL-WOMAN CARE SCHEDULE

Midwives independently assume responsibility for the care of the woman seeking gynecological and well-woman care.

A. INITIAL EVALUATION
   1. History taking
      a. Family history
         (a) Cardiac disease and hypertension
         (b) Diabetes
         (c) Cancers: breast, colon, ovarian, etc.
         (d) Thyroid abnormalities
         (e) Alcohol and drug use
         (f) Mental illness
         (g) Congenital abnormalities
         (h) History of twins
      b. Lifestyle history
         (a) Smoking
         (b) Alcohol and drug use
         (c) Diet and or eating disorders
         (d) Exercise, sleep patterns, stress management
         (e) Support systems
         (f) Family violence, sexual assault
         (g) Work
      c. Menstrual history
         (a) Age at menarche
         (b) Frequency, duration, amount, character
         (c) Dysmenorrhea
         (d) Abnormal uterine bleeding
         (e) History of toxic shock syndrome
         (f) Premenstrual syndrome
         (g) Perimenopausal symptoms
      d. General health
         (a) Acute
         (b) Chronic
      e. Sexual history
         (a) Age of onset
         (b) Nature
         (c) Frequency
         (d) Date of last intercourse
         (e) Type(s) of intercourse
         (f) Satisfaction
         (g) Problems and concerns
         (h) Bleeding and pain
         (i) Number of partners currently, over lifetime
         (j) Risk for STI
         (k) History of abuse
f. Family planning
   (a) Present method
      (i) Type
      (ii) Satisfaction
      (iii) Side effects
      (iv) Consistency of use
      (v) Length of time used
   (b) Previous methods
      (i) Types
      (ii) Duration of use for each
      (iii) Side effects
      (iv) Reasons for discontinuing
      (v) Compliance
   (c) Fertility goals

2. Physical Examination as indicated
   a. Complete physical exam for risk screening
   b. Review of systems
   c. Breast examination
   d. Pelvic examination
e. Rectal exam
3. Laboratory work as indicated
   a. Collection of blood for relevant tests, such as
      (a) CBC
      (b) Type and Rh, antibody screen
      (c) Hepatitis B and C
      (d) HIV
      (e) Thyroid, FSH, or other hormonal levels
      (f) Cholesterol
      (g) HgbA1c
   b. Collection of gynecological specimens, such as:
      (a) Cervical Cancer Screening (Papanicolaou test, ThinPrep)
      (b) Gonorrhea
      (c) Chlamydia
      (d) Viral and bacterial cultures
   c. Collection of other appropriate specimens, including those needed from partners or family members, such as:
      (a) Throat
      (b) Urine
   d. Collection of specimens for microscopic examination
   e. Pregnancy testing
   f. TB skin testing

B. ASSESSMENT: Data interpretation and problem identification
   1. Rule out presence of current gynecological disorders
      a. Tumors/masses of the reproductive system
      b. Lesions of the reproductive system
      c. Infestations
      d. Fistulas
      e. Uterine anomalies
      f. Pelvic relaxation
      g. Vaginal foreign body
      h. Polyps/cysts
      i. Other disorders
      j. Gynecologic infections, such as:
         i. Candida
         ii. Chlamydia
         iii. Trichomoniasis
         iv. Syphilis
         v. HPV
         vi. Herpes
         vii. Gonorrhea
         viii. Bacterial vaginosis
   2. Rule out presence of other infectious disease processes:
      a. UTI
      b. TB
Well-Woman Care Schedule

c. HIV
d. Upper respiratory infections
e. Other viral and/or bacterial infections
3. Anticipate potential problems which may be precipitated by present problems
4. Determine need for consult/referral
5. Evaluate need for immediate intervention, consultation, or referral

C. MANAGEMENT
1. Develop comprehensive plan of care
   a. Teach and counsel for health enhancement, such as:
      (a) Nutrition and exercise
      (b) Gynecologic disorders
      (c) Breast health/monthly exam
      (d) Contraception
      (e) Conception
      (f) Decision-making about unplanned and/or unwanted pregnancy
      (g) Psychosocial issues
      (h) Current condition and plan of care
      (i) Natural therapies
      (j) Conditions relative to general health
   b. Treat current condition(s)
   c. Provide referrals to community, social services, and other practitioners
   d. See “Determining Appropriate Client Care Provider” in Part I to confirm or rule out need to transfer or consult
2. Implement plan of care
   a. Follow through with protocols for treatment of current condition
   b. Use natural treatment as indicated
   c. Schedule follow-up to re-evaluate condition, treatment, and need for referral at appropriate intervals
3. Special considerations for the interconceptional (6 weeks postpartum to next pregnancy and beyond) and postpartum client
   a. Reintegration into the work force
   b. Increased nutritional needs due to breastfeeding
   c. Psychosocial adjustments to new roles
   d. Trouble obtaining enough rest and exercise
   e. Trouble making sexual readjustment
   f. Addressing and supporting fertility goals, including seeking contraceptive education/products
ABNORMAL UTERINE BLEEDING

A. DEFINITION
Abnormal uterine bleeding (AUB) refers to bleeding that is excessive or occurs outside of normal cyclic menstruation.

B. ETIOLOGY
1. Profound alteration in ovarian rhythm
2. Surface lesion
3. Benign or malignant growth with ulceration
4. Abortion
5. Ectopic pregnancy
6. Placenta previa
7. Endocrine disorders
8. Uterine anomalies
9. Local injury or foreign bodies
10. Displacements
11. Infection
12. Subinvolution
13. Birth control
14. Perimenopause
15. Unknown
16. Coagulation disorders (e.g., Von Willebrand’s)

C. SIGNS AND SYMPTOMS
1. Acyclical uterine bleeding
2. Irregular uterine bleeding
3. Continuous uterine bleeding

D. MANAGEMENT
1. Confirm source and type of bleeding
   a. Rule out abnormal bleeding due to contraceptive method
   b. Rule out bleeding from cervix and lower genital tract
   c. Rule out bleeding from anus and urethra
   d. Rule out pregnancy, including ectopic and molar, and miscarriage
   e. Rule out cysts, fibroids, endometriosis, or other benign or malignant growths
   f. May be a functional disturbance which resolves spontaneously
   g. Rule out cancer
2. Keep chart or record of all bleeding during 3-4 months
3. Look for history of hemorrhagic tendency, nose bleeds, bruising, etc.
4. Perform complete physical exam
5. Consider labs/testing, as appropriate
   a. HCG
   b. CBC
   c. Endocrine tests (i.e., TSH, prolactin)
   d. Coagulation tests
   e. Tests for cervicitis
f. Papanicolaou test, if appropriate timing per “Cervical Cancer Screening”
6. Consider ultrasound
7. Nature of cause will determine management
8. Offer referrals to other health care providers (e.g., for endometrial biopsy)
   a. Endometrial biopsy is indicated for all postmenopausal bleeding and some
      abnormal bleeding during reproductive years
9. Consider natural therapies
ADNEXAL MASS

A. DEFINITION
A growth, or neoplasm, of ovarian, fallopian tube, or uterine connective tissue.

Adnexal masses can be functional or pathological and are often discovered incidentally. Masses are most often benign and appear to be very common in asymptomatic and symptomatic women of all ages, including fetuses, infants, and prepubescent girls. Types of common adnexal masses include follicular cyst, hemorrhagic cyst, corpus luteum cyst, dermoid cyst, ectopic pregnancy, abscess, endometrioma, polycystic ovary, and benign or malignant tumor. Functional and benign masses appear to resolve in less than three menstrual cycles, but can take much longer to resolve.

B. SIGNS AND SYMPTOMS
1. General
   a. Unilateral or bilateral pelvic pain
   b. Urinary symptoms (difficulty, pain with, urgency, or frequency)
   c. Swelling, heaviness, bloating, low back pain
   d. Pain with intercourse, defecation, or menstruation
2. If torsion or rupture
   a. Signs and symptoms of shock
   b. Acute, severe abdominal pain, may be intermittent
3. Bimanual exam
   a. Palpation of adnexal mass or enlargement, usually unilateral
   b. Possibly tender to palpation

C. MANAGEMENT
1. Labs to consider
   a. Transvaginal ultrasound to determine size, appearance, differential diagnosis
   b. Urine: Beta-human chorionic gonadotropin (βhCG) to check for pregnancy
2. Premenopause
   a. Bimanual exam for size, consistency, location, mobility, and tenderness
   b. Ultrasound for size and sonographic characteristics
      (a) If simple and less than 3 cm in diameter, no follow-up is needed
      (b) For asymptomatic simple cyst that are 5 to 7 cm, yearly ultrasound recommended
      (c) If greater in size than 7 cm, consult for management
   c. Provide for symptomatic relief
   d. Consider natural therapies
   e. If leiomyoma is confirmed or suspected, see “Uterine Fibroids” in Part IV
   f. If ectopic pregnancy is confirmed or suspected, consultation is required; see also “Ectopic Pregnancy” in Part V and “Determining Appropriate Client Care Provider” in Part I
   g. Consider referral if painful, infection is present, or concern for malignancy
3. Antepartum
Adnexal Mass

a. If ectopic pregnancy is diagnosed or suspected, consultation is required; see also “Ectopic Pregnancy” in Part V and “Determining Appropriate Client Care Provider” in Part I.
b. Consultation for antepartum clients with adnexal masses or uterine fibroids is required; see “Determining Appropriate Client Care Provider” in Part I. Prepare client for possible transfer if painful, infection is present, there is concern for malignancy, or there is concern for obstruction of the birth canal.
c. Adnexal masses discovered incidentally antepartum can sometimes be followed expectantly depending on size and characteristics. Cysts found in first trimester that are simple, asymptomatic, and less than 5 cm will often resolve by the second trimester.
d. Torsion is a complication risk for persistent masses in antepartum

4. Postmenopause
   a. Much greater likelihood of malignancy
   b. Consider referral for diagnosis and treatment

5. Pediatric cases (infants and premenarchal girls)
   a. Much greater likelihood of malignancy with larger masses (greater than 10 cm or causing marked increase in abdominal girth) being more likely to be malignant
   b. Refer for diagnosis and treatment
AMENORRHEA

A. DEFINITION
Absence of menstruation. Amenorrhea is a normal state of prepubescent, pregnant, lactating, and postmenopausal women, but can be a symptom of pathology in reproductive-aged women who are otherwise not pregnant, lactating, or postmenopausal.

B. TYPES
1. Primary amenorrhea: Has never had a menstrual period by the age of 14-16, with or without signs of puberty
2. Secondary amenorrhea: Absence of menstrual periods for 3 months in a woman who previously had regular periods or for 12 months in a woman who previously had irregular periods
3. Cryptomenorrhea (false or hidden): When the menstrual flow is obstructed at level of the cervix, vagina, or vulva
4. True amenorrhea due to pathological or physiological causes

C. ETIOLOGY
1. Physiological
   a. Normal until menarche; usually menses is established by age 16-18
   b. Pregnancy
   c. Lactation
   d. Menopause
2. Pharmacological
   a. Sex hormones
   b. Long acting hormonal birth control (e.g., medroxyprogesterone (Depo-Provera), IUD)
   c. Drugs that affect dopamine
   d. Cancer/Chemotherapy drugs
3. Pathological
   a. Disturbances of the hypothalamus
      (a) Cerebral cortex influences
      (b) Disease or injury in the region of the midbrain
      (c) Drugs
      (d) Eating disorder
      (e) Infections
      (f) Irradiation
   b. Pituitary
      (a) Tumors in or near pituitary gland
      (b) Disease or injury
   c. Ovarian
      (a) Autoimmune disorders
      (b) Continuous production of estrogen and progesterone
      (c) Genetic abnormality
      (d) Metabolic disorders
      (e) Overproduction of androgens
      (f) Polycystic ovary syndrome
(g) Underproduction of estrogen and progesterone
(h) Viral infections

4. Structural
   a. Congenitally absent or malformed uterus or vagina
   b. Uterus removed
   c. Uterus underdeveloped
   d. Uterus damaged
   e. Imperforate hymen

5. Other endocrine diseases
   a. Thyroid
   b. Pancreas
   c. Adrenal cortex
   d. Hormonal changes due to tumor activity

6. General constitutional upset and disease
   a. Any acute illness
   b. Chronic diseases
   c. Hermaphroditism

7. Nutrition
   a. Malabsorption syndromes
   b. Starvation
   c. Anorexia nervosa/bulimia
   d. Obesity

8. Environmental
   a. Climate
   b. Occupation
   c. Living conditions
   d. Worry
   e. Overexertion/exercise
   f. Stress/abuse

9. Psychological imbalances

D. SIGNS AND SYMPTOMS
   1. No menstruation
   2. May have pain
   3. Headache
   4. Weight loss or gain
   5. Vision changes
   6. Lack of breast development
   7. Milky discharge from breast
   8. Other chronic health concerns

E. MANAGEMENT
   1. Exclude
      a. Pregnancy
      b. Systemic disease
      c. Gross endocrine dysfunction
d. Cryptomenorrhea

e. Galactorrhea

f. Polycystic ovaries

2. If before menarche:
   a. Rule out pregnancy and other physiologic causes
   b. Counsel on management
      (a) Nutrition
      (b) Exercise
      (c) Stress
   c. Suggest waiting until 16-18 years of age

3. Primary or secondary amenorrhea
   a. Perform full clinical history and examination
   b. Pregnancy test
   c. Rule out
      (a) Pituitary tumor
      (b) Glycosuria
      (c) Hormonal malfunctions
      (d) Chromosomal abnormalities
      (e) Streak gonads, testes, small ovarian tumors, polycystic ovaries
   d. Consider the following labs
      (a) CBC/UA/serum chemistry
      (b) FSH, LH, DHEAS, E2, Progesterone
      (c) Chromosome evaluation
      (d) Prolactin
      (e) Testosterone
      (f) Thyroid panel
      (g) Androgens
      (h) Hormone challenge test
      (i) Genetic screening for permutation of FMR1 gene (Fragile X)
   e. Consider referral for:
      (a) Ultrasound
      (b) CT Scan
      (c) MRI
      (d) Hysteroscopy
   f. Consider referral to other health care professionals
   g. Consider natural therapies

4. If possibly menopausal, see “Menopause” in Part IV
ANAPHYLAXIS

A. DEFINITION
An acute, rapidly progressing, life-threatening allergic reaction affecting multiple body systems resulting from exposure (ingested, inhaled, injected, or absorbed) to an agent, such as insect sting, medication, or other physical factor.

B. ETIOLOGY
1. Antepartum
   a. Foods
      (a) Common: shellfish, peanuts, eggs, fish, milk, and tree nuts
      (b) Herbs (as tea, tincture, or in formula)
      (c) Stinging insect venoms (hymenoptera stings—all stinging insects belong to the order Hymenoptera, i.e., bees, wasps, yellow jackets, hornets, and ants)
   b. Medications
      (a) Most common
         (i) Antibiotics
         (ii) NSAIDs (i.e., aspirin and other nonsteroidal anti-inflammatories)
      (b) Other medications
         (i) IV iron
         (ii) IV B1, B6, and B12 (used for treatment of hyperemesis gravidarum in some countries)
      (c) Foreign serum (antepartum Rh IgG, i.e., RhoGAM)
   c. Other
      (a) Environmental exposure/chemical substances
      (b) Immunizations (i.e., allergy to vaccine ingredients)
2. Intrapartum
   a. Antibiotics; most common are penicillin and other antibiotics for prevention of neonatal GBS infection
   b. Natural rubber latex (NRL)
   c. Anti-hemorrhagic medications (e.g., Pitocin, Methergine)
   d. Antiseptics
      (a) Iodine (i.e., Betadine)
      (b) Chlorhexidine (i.e., Hibiclens)
   e. Local anesthetics (e.g., Lidocaine, Xylocaine)
   f. Blood products (e.g., Rh IgG)
   g. Herbs (e.g., tea, tincture, sitz bath preparations)

C. SIGNS AND SYMPTOMS
1. May occur within seconds, minutes, or hours of exposure
2. Dermatologic (subcutaneous and mucosa)
   a. Subjective
      (a) Itching
      (b) Preorbital itching
      (c) Itching or swelling of lips, tongue, palate, uvula, palms, soles
      (d) Metallic taste in mouth
b. Objective
   (a) Classic manifestation of urticaria (hives), anywhere on the body
   (b) Angioedema
   (c) Generalized whole body erythema
   (d) Conjunctival erythema
   (e) Morbilliform rash, piloerection
3. Respiratory
   a. Subjective
      (a) Nasal itching
      (b) Congestion
      (c) Severe air hunger
      (d) Throat itching, tightness
      (e) Chest tightness
   b. Objective
      (a) Severe swelling of tongue and lips
      (b) Tachypnea, increased respiratory rate, SOB
      (c) Stridor
      (d) Dysphonia
      (e) Rhinorrhea
      (f) Dry staccato cough
      (g) Cyanosis
      (h) Respiratory arrest
4. Gastrointestinal
   a. Subjective
      (a) Abdominal pain
      (b) Dysphagia
      (c) Nausea
      (d) Bloating
      (e) Cramps
   b. Objective
      (a) Vomiting (stringy mucous)
      (b) Diarrhea
      (c) Abdominal distention
5. Cardiovascular system
   a. Subjective
      (a) Chest pain, palpitations
      (b) Weakness
      (c) Dizziness
      (d) Feeling faint
   b. Objective
      (a) Hypotension
      (b) Tachycardia/Bradycaardia (less common), other dysrhythmias
      (c) Incontinence
      (d) Cardiac arrest/cardiovascular collapse
      (e) Shock
6. Central nervous system
Anaphylaxis

a. Subjective
   (a) Feeling of impending doom
   (b) Headache (before epinephrine)
   (c) Dizziness
   (d) Confusion
   (e) Tunnel vision
b. Objective
   (a) Altered or depressed level of consciousness; may be agitated and/or combative
   (b) Loss of consciousness
   (c) Uneasiness and confusion

7. Symptoms related to pregnancy
   a. Increased itching of vulvar/vaginal regions
   b. Uterine cramps
   c. Low back pain
   d. Fetal distress
   e. Preterm labor

D. MANAGEMENT
1. Activate emergency medical system (EMS)
2. Remove the trigger, if possible
3. Assess circulation, airway, breathing, and mental status
4. Be prepared to maintain an airway
5. In cases of systemic reaction/anaphylaxis
   a. Immediately administer aqueous epinephrine per “Licensed Midwifery Formulary” in Part I
   b. Anaphylaxis is a serious allergic or hypersensitivity reaction that is rapid in onset and may cause death
   c. Give high-flow supplemental oxygen
   d. Position patient on left side and elevate lower extremities, keep warm
   e. Start IV of Normal Saline; use large bore catheters in cases of circulatory collapse
6. Monitor throughout management:
   a. Maternal heart rate
   b. Blood pressure
   c. Maternal pulse
   d. Maternal oxygenation by pulse oximetry (if available)
   e. Fetal heart rate
7. When indicated, perform CPR with continuous chest compressions and rescue breathing until transfer completed

E. PREVENTION
1. Note abnormal reaction to drugs, anesthetics, food, etc. prominently in the chart
2. Recommend avoidance of offending trigger
3. Before administering any medication, supplement, or herb, ask again about previous allergic reactions
ANEMIA

A. DEFINITION
Anemia is a condition in which blood has a lower than normal number of red blood cells or red blood cells have a lower concentration of hemoglobin.

B. TYPES OF ANEMIA
1. Normal physiologic anemia of pregnancy
2. Iron deficiency anemia (nutritional)
3. Megaloblastic anemia (folic acid deficiency)
4. Anemia resulting from blood loss
5. Anemia associated with infection
6. Acquired hemolytic anemia (toxic or congenital conditions, enzyme deficiency)
7. Aplastic or hypoplastic anemia (deficient cell-formation in bone marrow)
8. Sickle cell disease (crescent and sickle shaped red blood cells; more common in those of African descent)
9. Thalassemia (hemoglobin synthesis deficiency; more common in those of African or Mediterranean descent)
10. Pernicious anemia (B12 deficiency)

C. PREDISPOSING FACTORS
1. History of anemia
2. Prior or current inadequate diet
   a. Hyperemesis
   b. Low food resources
   c. Specialized diet
   d. Eating disorders
   e. Pica
   f. Other
3. History of closely spaced pregnancies
4. Pregnancy, especially between 28-32 weeks gestation
5. Current lactation
6. History of heavy menses, other heavy blood loss, or chronic long term blood loss
7. Inherited (e.g., sickle cell anemia)
8. Infection

D. SIGNS AND SYMPTOMS
1. Fatigue, weakness, malaise, drowsiness
2. Dizziness
3. Dyspnea
4. Skin pallor
5. Headaches
6. Sore or ulcerated tongue
7. Poor appetite, nausea, vomiting
8. Pica
9. Pallor (conjunctiva, nail beds, mucous membranes)
10. Heart murmur, tachycardia, or palpitations
11. Increased pain perception
12. Insomnia
13. Lab values indicating anemia
   a. Mild: Hct 30%-35%, Hgb greater than 10 gr/dl and less than 12 gr/dl
   b. Severe: Hct less than 30%, Hgb less than or equal to 10 gr/dl

E. MANAGEMENT
1. Mild
   a. Diet history and nutritional counseling with emphasis on iron rich foods, increased protein and fluid intake
   b. Suggest iron supplementation with 500 mg Vitamin C, buffered or sustained release, and avoid taking with calcium
   c. Consider folic acid supplementation as indicated
   d. Consider natural therapies
   e. Consider repeating labs in one month
   f. If unresponsive to iron therapy, see below for management of severe anemia
2. Severe
   a. Careful diet history with nutritional counseling in foods rich in protein, iron, and B12
   b. Consider supplemental iron with buffered or time release Vitamin C
   c. Consider additional lab evaluations
      (a) CBC with morphology
      (b) Total iron and TIBC (total iron-binding capacity)
      (c) Stool for parasites and their ova
      (d) Sickle cell prep
      (e) Serum iron, folate, and B12 levels
      (f) Reticulocyte count
   d. If unresolved and client in late pregnancy, consult
3. Maternal anemia (Hgb less than 10, Hct less than 30%) in antepartum clients unresponsive to treatment requires consultation; see “Determining Appropriate Client Care Provider” in Part I
BACTERIAL VAGINOSIS

A. DEFINITION
   A vaginal infection caused by an imbalance or overgrowth of one or more types of gram negative bacteria (e.g., *Hemophilus vaginalis*, *Gardnerella vaginalis*, and *Corynebacterium vaginale*) or other causative agents (e.g., *Mycoplasma*). It is characterized by a malodorous vaginal discharge, with occasional irritation and itching, but may be asymptomatic. In the antepartum period, bacterial vaginosis has been associated with adverse outcomes (e.g., premature rupture of membranes, preterm labor, preterm birth, endometritis, and post-operative wound infections).

B. ETIOLOGY
   1. Regarded as overgrowth of normal flora
   2. Not considered an STI, but it is associated with sex, and condoms may decrease risk of recurrent infection
   3. Times of stress and changes in diet or environment can precipitate an onset of symptoms requiring treatment

C. SIGNS AND SYMPTOMS
   1. Many infected women are asymptomatic
   2. Symptomatic infection:
      a. Increased chalky or gray-green vaginal discharge
      b. Discharge has offensive "fishy" odor
      c. Speculum exam reveals mild to moderate amounts of white or gray-green discharge
      d. Cervix and vagina do not usually appear irritated
      e. Palpation of pelvic organs should not elicit pain or tenderness
   3. Saline wet mount reveals "clue cells"
   4. KOH prep reveals positive "whiff test" or fishy odor present when 10% KOH is added to slide
   5. Elevated pH of vaginal discharge greater than 4.5

D. MANAGEMENT
   1. Suggest natural therapies for symptom relief
   2. Complete labs as appropriate
      a. Wet mount to rule out trichomoniasis
      b. Cervical cancer screen, gonorrhea, chlamydia screening
      c. Urinalysis to rule out increased bacteria
      d. Vaginal pathogens panel by DNA probe test detects and identifies all of the following: *Candida*, bacterial vaginosis, and *Trichomonas vaginalis*
   3. Client education
      a. Limiting sexual partners
      b. Sexual partners may need treatment for persistent infections
      c. Teach good perineal hygiene, including not douching
      d. Prevention and transmission of causative organism(s)
      e. Good nutrition and stress management
f. Pros and cons of antibiotic use; including that if history of preterm birth, treating with oral antibiotics may decrease risk of recurrent preterm birth
4. Consider follow-up to evaluate effectiveness of treatments
5. Arrange consult as appropriate
BARTHOLOMITIS

A. DEFINITION
Inflammation and enlargement of Bartholin's ducts and glands, leading to cyst formation which can become secondarily infected. Occasionally the infection persists in a chronic form with periodic exacerbations and abscess formation. The gland can become permanently enlarged/fibrotic and can be felt as a hard, tender lump.

B. ETIOLOGY
1. Commonly occur following vulvovaginal surgery
2. May be caused by gonococcal infection
3. Other causes
   a. Escherichia coli
   b. Staphylococcus spp.
   c. Streptococcus faecalis
   d. Trichomonas vaginalis
   e. Other pyogenic organisms
   f. Episiotomy or laceration may involve the Bartholin's gland

C. SIGNS AND SYMPTOMS
1. Local discomfort
2. Dyspareunia
3. Severe pain or heat in the presence of abscess
4. Tender swelling beneath the posterior part of the labium majus extending inward to the base of the labium minus
5. Overlying skin may be reddened
6. Surrounding tissues may be indurated and/or edematous
7. The position of the swelling is diagnostic

D. MANAGEMENT
1. Test for gonorrhea and/or other STIs
2. Bed rest
3. Sitz baths
4. Consider natural therapies
5. Pain relief measures
6. Consult if not responsive
7. If abscess formation is certain, consult for treatment
CANDIDIASIS INFECTION

A. DEFINITION
Fungal infection of tissue by *Candida albicans*, which may be asymptomatic.

B. ETIOLOGY
1. pH changes due to pregnancy
2. Diabetes
3. Use of antibiotics
4. High progestin levels, due to use of birth control pills, etc.
5. Diet high in simple sugars
6. Stress, fatigue
7. Sexual contact with infected partner
8. Tight/synthetic underwear
9. Compromised immune system

C. POSSIBLE LOCATIONS OF INFECTION
1. Urogenital area
2. Nipples of breastfeeding mothers
3. Any skin area chronically moist and lacking air circulation
4. May become systemic

D. SIGNS AND SYMPTOMS
1. Thick, white, cottage cheese-like vaginal discharge seen by client or on speculum exam
2. Itching and burning of the affected tissue
3. Painful intercourse
4. Burning upon urination
5. Yeasty odor
6. Red, inflamed, sore, scaly, and/or itchy tissue
7. Bimanual exam should not elicit pain and tenderness in uncomplicated vaginitis

E. MANAGEMENT
1. Educate about hygiene and nutritional causes
2. Consider saline wet mount to rule out *Trichomonas*
3. KOH wet mount of discharge shows presence of spores and hyphae
4. Consider labs to rule out other infections
5. Vaginal pathogens panel by DNA probe, test detects and identifies: *Candida*, bacterial vaginosis, and *Trichomonas vaginalis*
6. Consider urinalysis to rule out UTI, glycosuria, increased bacteria
7. Consider natural therapies
8. Consider over-the-counter antifungal, topical preparations
9. If no improvement after above treatments, consult

F. PREVENTIVE ADVICE
1. Eliminate simple sugars and improve quality of diet
2. Consider increasing probiotics and fermented foods in diet
3. Consider other natural remedies
4. Maintain good personal hygiene
   a. Thorough hand washing
   b. Wipe perineum front to back
   c. Daily bathing
   d. Frequent cleansing of perineum
   e. Use clean, unused wash cloths and towels when cleaning the vulva
   f. Frequent changing of sweaty, wet garments
   g. Use of high temperature in washing clothing
   h. Dry clothing that touches affected area in sunlight or on high temperature
5. Avoid chemical irritants
   a. Feminine deodorant sprays
   b. Scented toilet paper
   c. Perfumed soaps
   d. Perfumed douches
   e. Scented sanitary pads and tampons
6. Wear only cotton underwear
7. Avoid tight-fitting clothes, girdles, pantyhose
8. Go without underwear whenever possible
9. Advise sexual partner to avoid direct contact with infected areas until infection is resolved
10. Explain possible relationship between Candida infection and life stress, consider teaching or referring for stress management
11. For postpartum/lactating women: explain relationship of Candida for lactating woman, thrush development in the newborn, and preventive measures
CERVICAL CANCER SCREENING

A. DEFINITION
Screening women through cellular sampling that can reveal cancerous, pre-cancerous, and infectious conditions of the cervix and vagina.

B. METHODS OF SCREENING
1. Papanicolaou (Pap), or cytology, test
   a. Conventional: Consists of scraping the outermost layer of cervical and vaginal cells with a cytology brush (or q-tip in antepartum period), and wooden spatula. These cells are then smeared on a slide, fixed with a cytology solution for analysis.
   b. Liquid Based (e.g., ThinPrep): Consists of circular brushing of the outermost layer of cells. These cells are then rinsed in a collection solution and sent to the lab for dispersal onto a slide for analysis.

2. HPV co-test: HPV and cytology tests administered together. Use of an FDA-approved test that is also well validated is recommended to avoid excessively high false-positive rates. Use of laboratory-developed tests (LDTs) are not recommended.

C. SCHEDULING
1. Well-woman care
   a. As of 2013, cervical cancer screening recommendations have changed. According to American Society for Colposcopy and Cervical Pathology (ASCCP) it is no longer recommended that women of any age in the general population undergo annual testing, but to follow screening intervals based on age and clinical history.
   b. Screening for women less than age 21 is not recommended, regardless of sexual activity or other risk factors.
   c. Women ages 21-29 are recommended to receive screening every 3 years. A cytology test is sufficient for screening; HPV co-testing is not recommended for women less than age 30. HPV reflex testing for ASCUS is recommended in women age 25-29 and acceptable in women ages 21-24.
   d. Women ages 30-65 should receive screening every 5 years with the HPV co-test (preferred). Cytology alone every 3 years is acceptable. HPV testing alone is not recommended in most circumstances.
   e. Women over age 65
      (a) Can be exited from screening with adequate screening history (3 negative HPV co-tests in the past 10 years)
      (b) Those with a history of CIN2 or CIN2+ diagnosis should continue routine screening for at least 20 years.
   f. After a hysterectomy: Screening is not recommended for women without a cervix who do not have a history of CIN2 or CIN2+ diagnosis in the past 20 years and without a history of cervical cancer ever.
   g. HPV Vaccinated: Follow age-specific recommendations for screening intervals for the general population.

2. Women who may benefit from alternative or more intensive screening
   a. History of cervical cancer
   b. DES exposure in utero
   c. Immune compromised (e.g., infected with HIV)
3. Pregnant women
   a. Cervical cancer screening is not recommended for all pregnant women unless a woman is due for screening following the Well-Woman Care Schedule above
   b. If screening is done, a cytology test alone is recommended using a cytobrush or comparable combination broom
   c. However, there is an increased risk of getting an inadequate specimen antepartum due to normal cervical changes (in particular, the endocervical component or squamocolumnar junction, which is the area for testing for cervical cancer, may not be identifiable antepartum)
   d. Be sure to notify the lab that the client is pregnant as cytology specimens are more difficult to interpret antepartum
   e. If an abnormal screening is obtained and colposcopy is desired, referral for colposcopy can be made, and colposcopy can be performed
   f. Mode of delivery for women diagnosed with CIN1, CIN2, or CIN3 lesions should be based on obstetric indications and not lesion status

4. Postpartum women
   a. Cervical cancer screening is not recommended in all postpartum women unless a woman would be due for screening based on current guidelines
   b. Screening can be done at the 6 to 8 weeks postpartum appointment if no endocervical component was identified in the pregnancy screening
   c. Follow-up screening for women who received antepartum screening should follow current guidelines; see Results section below

D. RESULTS
1. Adenocarcinoma in-situ (AIS): A malignant tumor arising from glandular epithelial tissue; may become cancer if not treated
2. Atypical glandular cells (AGC):
   a. Glandular cells produce mucus and grow in the opening of the cervix and within the uterus
   b. Some abnormal glandular cells found
3. Atypical glandular cells of undetermined significance (AGC-US):
   a. Glandular cells produce mucus and grow in the opening of the cervix and within the uterus
   b. Some abnormal glandular cells found, but it is unclear if these cells are cancerous
4. Atypical squamous cells:
   a. Cannot Exclude High-grade SIL (ASC-H)
   b. Some abnormal squamous cells found that may be high-grade squamous intraepithelial lesion, although it is not certain.
5. Atypical squamous cells of undetermined significance (ASC-US):
   a. Most common abnormal Pap test finding
   b. Condition where some cells are abnormal, but is unclear if these are caused by HPV
   c. Other causes can be irritation, infections, yeast infection, polyps or cysts that are benign and hormonal changes; the potential growth development is unclear
6. Cytology negative, but HPV positive:
Cervical Cancer Screening

a. Indicates no abnormal cells and shows positive for HPV a common name for a group of related viruses that may result in the presence of dysplasia or warts on the woman's cervix, vagina or vulva
b. More than 70 different known forms of this virus exist
c. Presence of HPV may cause no symptoms
7. Cytology negative for intraepithelial lesion or malignancy (NILM): A classification assigned by a cytotechnologist that indicates no abnormal results
8. Cytology negative for intraepithelial lesion or malignancy (NILM), but endocervical/transitional zone (EC/TZ) absent/insufficient: Indicates no abnormal results, but test sample had absent or insufficient Endocervical/Transformational Zone (T-Zone) cells
9. High-grade squamous intraepithelial lesion (HSIL)/grade 2 cervical intraepithelial neoplasia (CIN2)/grade 3 cervical intraepithelial neoplasia (CIN3):
   a. Moderate dysplasia
   b. A condition characterized by a number of dysplastic cells; these changes are caused by HPV
   c. These cells are precancerous and, if not removed, may progress to invasive cancer
10. Low-grade squamous intraepithelial lesion (LSIL)/grade 1 cervical intraepithelial neoplasia (CIN1):
    a. Mild dysplasia, a condition characterized by abnormal cells which can be caused by infections or healing from a minor injury
    b. Sometimes no cause can be identified
    c. Usually caused by HPV infection
11. Squamous cell carcinoma/adenocarcinoma: Cervical cancer cells
12. Squamous intraepithelial lesion (SIL):
    a. Encompasses all epithelial abnormalities that are precursors to invasive squamous cell carcinoma
    b. SIL is a perversion of squamous cell maturation and differentiation. The squamous cell covering of the cervix is replaced by primitive columnar cell epithelium with non-differentiated growth and maturation. The disease begins at the squamocolumnar junction in the epithelium of the transformation zone. The degree of severity is judged by the proportion of epithelial thickness with deranged maturation. It is a continuum of abnormality from mild to moderate to severe to carcinoma in situ. Carcinoma in situ represents a full thickness of abnormal cells with no differentiation or maturation.
13. Unsatisfactory cytology: A sample that cannot be accurately screened due to a lack of sufficient endocervical cells, or obscuring from lubricants, excessive discharge, blood, or inflammation

E. RISK FACTORS FOR DEVELOPING CERVICAL CANCER
1. Human papilloma virus infections from ~15 high risk genotypes, especially HPV 16 and 18, that are persistent for 1 or 2 years strongly predict cervical intraepithelial neoplasia grade 3 or higher (CIN3, CIN 3+) precancerous lesions. These lesions are the required precursors to most cervical cancer as currently understood.
2. Compromised immune status
3. Multiple sexual partners
4. Low socioeconomic status
5. Poor access to medical care (reduced opportunity for screening)
6. African American and Latina
7. "High risk" sexual partner
8. DES exposure (larger T-zone); not proven

F. SIGNS AND SYMPTOMS OF CERVICAL CANCER
1. May be asymptomatic
2. Increased discharge; may be normal-appearing, mucopurulent, or blood-stained
3. Contact bleeding (e.g., with coitus or defecation)
4. Infertility
5. Backache
6. Pelvic discomfort
7. Bright red area continuous with endocervix with clearly defined outer edge visualized
8. Abnormal Pap smear or ThinPrep results: Pap smears have a 10%-30% false negative for SIL; Thin Preps improve on Pap smear accuracy
   (a) Sampling errors account for 60%
   (b) Screening errors for 40%
   (c) Up to 50% of invasive cancer may be erroneously read as "atypical," "inflammatory," or "unsatisfactory"

G. THE BETHESDA SYSTEM
1. Each Pap smear should indicate
   a. Specimen type
      (a) Conventional smear (Pap smear)
      (b) Liquid-based prep
      (c) Other (HPV)
   b. Statement on adequacy of specimen
      (a) Satisfactory for evaluation, describes presence or absence of EC/TZ component and any other quality indicators (e.g., partially obscuring blood, inflammation)
      (b) Unsatisfactory
         (i) Specimen rejected/not processed (specified reason)
         (ii) Specimen processed and examined, but unsatisfactory for evaluation of epithelial abnormality because of (specified reason)
   c. General categorization of the diagnosis
      (a) Negative for intraepithelial lesion or malignancy
         (i) Organisms
            (1) *Trichomonas vaginalis*
            (2) Fungal organisms morphologically consistent with *Candida* spp.
            (3) Shift in flora suggestive of BV
            (4) Bacteria morphologically consistent with *Actinomyces* spp.
            (5) Cellular changes consistent with herpes simplex virus
         (b) Other non-neoplastic findings
            (i) Reactive cellular changes associated with: inflammation, radiation, IUD
            (ii) Glandular cells status post hysterectomy
(iii) Atrophy

d. Other
   (i) Endometrial cells

e. Epithelial cell abnormalities
   (i) Squamous cell
      (1) Atypical squamous cells
          a. Of undetermined significance (ASC-US)
          b. Cannot exclude HSIL (ASC-H)
      (2) Low grade squamous intraepithelial lesion (LSIL)
          a. Encompasses HPV/mild dysplasia/CIN 1
      (3) High grade squamous intraepithelial lesion (HSIL)
          a. Encompasses moderate and severe dysplasia, CIS; CIN 2 and CIN 3
          b. With features suspicious/not for invasion
      (4) Squamous cell carcinoma
   (ii) Glandular cell
      (1) Atypical glandular cells (AGC)
      (2) Endocervical adenocarcinoma in situ (AIS)
      (3) Adenocarcinoma
          a. Endocervical
          b. Endometrial
          c. Extrauterine
          d. Not otherwise specified (NOS)
   f. Other malignant neoplasms

H. MANAGEMENT

1. Educate as to risk factors and possible management
2. Follow the algorithm/management guidelines published by the ASCCP (most updated version as of this revision is August 2014)
3. Refer as appropriate for colposcopy
4. SIL in pregnancy: Pregnancy should not delay or alter the evaluation of an abnormal cervix with regard to the use of cytology alone versus cytology with colposcopy and directed biopsies, however please note the following
   a. Endocervical curettage is never performed antepartum
   b. Biopsies are entirely acceptable and safe; however, due to the increase in bleeding, these are kept to a minimum
   c. Procedures of the cervix are rarely done while a woman is pregnant
   d. Timing of repeat Pap will be determined after colposcopy or referred provider recommendation
5. Consider natural therapies; does not exclude referral as appropriate per guidelines
6. Comply with local infection reporting regulations and requirements; see NMAC 7.4.3 and Appendix F for reporting procedures and a list of reportable diseases and conditions in the state of New Mexico
CERVICITIS

A. DEFINITION
   Inflammation of the cervix characterized by irritation or erosion of the cervical surface.

B. ETIOLOGY
   Due to vaginal or cervical infections, cervical lacerations, instrumentation, foreign objects, and malignancy. If untreated, cervicitis can lead to ascending infections and problems in conceiving or antepartum. Cervicitis can be caused by such organisms as *Chlamydia*, *Neisseria gonorrhoea*, *Trichomonas*, herpes simplex virus, *Staphylococcus*, *Streptococcus*, bacterial vaginosis, *Enterococcus*.

C. SIGNS AND SYMPTOMS
   1. May be asymptomatic
   2. Irritating/purulent vaginal discharge
   3. Pelvic inflammatory disease
   4. Dyspareunia
   5. Spotting after sexual intercourse or douching
   6. Dysuria
   7. Pelvic pain
   8. Fever
   9. Nausea
   10. Pelvic exam
       a. Cervix edematous, red, and friable
       b. Mucopurulent discharge
       c. May be Nabothian cysts on cervix
       d. Bimanual exam should not elicit pain and tenderness
   11. Cervical cancer screening with atypia, infection, or mild dysplasia
   12. Positive culture for atypical organism
   13. KOH and saline wet mount positive

D. MANAGEMENT
   1. Remove irritants/treat symptom
   2. Consider labs
      a. Gonorrhea, chlamydia, herpes cultures
      b. KOH and saline wet mount
      c. Cervical cancer screening if appropriate timing per “Cervical Cancer Screening” in Part IV
   3. If infection present, treat as appropriate or refer
   4. If cervix erosion recurrent and severe, or if positive cervical cancer screen, refer for further diagnostics (i.e., colposcopy, biopsy)
   5. Consider natural therapies
   6. If cultures test positive for sexually transmitted infection, offer partner expedited treatment as appropriate.
   7. Educate client
      a. Causes of cervicitis
      b. Prevention of vaginal infections (e.g., good genital hygiene, sexual education)
Cervicitis

c. Importance of regular cervical cancer screenings
d. Pelvic rest while treating
e. Discuss pregnancy-related risks
8. Follow-up depends on severity of condition
CHANCROID

A. DEFINITION
Chancroid is a specific infection caused only by the bacteria *Haemophilus ducreyi* and is spread through unprotected sexual contact.

B. ETIOLOGY
Prevalent in Latin America, Africa, and Southwest Asia; few cases are diagnosed in the US per year. According to the CDC there were no reported cases in New Mexico from 2008-2012.

C. SIGNS AND SYMPTOMS
1. Small bumps appear on genitals within 1-14 days after contracting
2. Bumps will become an ulcer within 24 hours
3. Ulcer
   a. 1/8-2 inches in size
   b. Painful
   c. Soft
   d. Sharply defined irregular borders
   e. Base that is covered with a gray or yellowish-gray material
   f. Base bleeds easily if banged or scraped
4. Enlarged inguinal lymph nodes; 50% of these will become abscessed
5. May appear like sore of primary syphilis
6. Dyspareunia
7. Dysuria
8. Common locations
   a. Women
      (a) Labia majora
      (b) “Kissing ulcers”: Ulcers on opposite surface of the labia
      (c) Labia minora
      (d) Perineum
      (e) Inner thighs
   b. Men
      (a) Foreskin
      (b) Coronal ridge
      (c) Shaft of penis
      (d) Head of penis
      (e) Urethral opening
      (f) Scrotum

D. MANAGEMENT
1. WHO and CDC suggest a probable positive diagnosis if the client has all of the following criteria:
   a. One or more painful genital ulcers
   b. No evidence of syphilis by darkfield examination of ulcer exudate OR negative results on serologic testing greater than 7 days after ulcer onset
   c. Negative on testing for herpes simplex virus
Chancroid

d. Clinical presentation consistent with chancroid
2. A definitive diagnosis requires culture, but culture of *H. ducreyi* is unreliable, insensitive, and uses a special medium that is not widely available
3. No blood test for chancroid
4. Refer for antibiotic treatment
5. Test for syphilis, HIV, and genital herpes
6. Possible complications can include
   a. Urethral fistulas
   b. Scars on foreskin of uncircumcised males
7. Comply with local infection reporting regulations and requirements; see NMAC 7.4.3 and Appendix F for reporting procedures and a list of reportable diseases and conditions in the state of New Mexico
A. DEFINITION
   A sexually transmitted infection, caused by *Chlamydia trachomatis* infection, often asymptomatic, may be characterized by inflammation of the cervix resulting in a mucopurulent vaginal discharge.

B. ETIOLOGY
   Transmitted through unprotected sexual activity. Transmitted to newborns through current maternal infection during vaginal birth.

C. SEQUELAE
   1. Well-woman (and antepartum)
      a. Pelvic inflammatory disease
      b. Salpingitis
      c. Endocervicitis
      d. Cystitis
      e. Infertility
   2. Antepartum
      a. Above sequelae
      b. Ectopic pregnancy
      c. Premature rupture of membranes
      d. Preterm labor and birth
      e. Postpartum infection
   3. Newborn
      a. May result in chlamydia ophthalmic infection in the newborn which can result in neonatal blindness
      b. May result in newborn chlamydial pneumonia, onset from 1 to 3 months

D. SIGNS AND SYMPTOMS
   1. Often asymptomatic
   2. Purulent vaginal discharge
   3. Abdominal or low back pain
   4. Pain or bleeding during or after sex
   5. Dysuria
   6. Temperature normal to moderately elevated (98–101° F)
   7. Speculum exam: Mucopurulent discharge at cervical os, cervix edematous and friable
   8. Positive chlamydia test
   9. More than 10 WBCs per high-power field seen on wet prep slide

E. MANAGEMENT
   1. Obtain chlamydia and gonorrhea culture or PCR, and other testing to rule out other infections (chlamydia frequently coexists with gonorrhea)
   2. Consider cervical cancer screen if correct timing as indicated per “Cervical Cancer Screening” in this Part IV
   3. Refer for antibiotic therapy
   4. Counsel client about the importance of finishing the entire course of antibiotics
5. Refer all sexual partners for treatment
6. Counsel on the use of condoms and safer sex practices until the infection has cleared
7. Consider follow-up to include repeat chlamydia test of cure (TOC) with PCR should be done three or more weeks after treatment
8. Pregnant patients should be retested again in three months (for reinfection) and possibly in the third trimester
9. Provide educational material
10. Consider natural therapies
11. Counsel for decreased immunity to other STIs
12. Comply with local infection reporting regulations and requirements; see NMAC 7.4.3 and Appendix F for reporting procedures and a list of reportable diseases and conditions in the state of New Mexico
EATING DISORDERS

A. DEFINITION
Eating disorders are psychological illnesses defined by abnormal eating habits that may involve either insufficient or excessive food intake to the detriment of a client’s physical, emotional, and/or mental health.

B. TYPES
1. Bulimia nervosa
2. Anorexia nervosa
   a. Restricting type
      (i) Calories
      (ii) Exercise
   b. Binge/purge type
3. Orthorexia nervosa
4. Binge eating disorder
5. Pica
6. Other eating disorders

C. ETIOLOGY
1. Psychological factors
   a. Low self-esteem
   b. Feelings of inadequacy
   c. Lack of control in life
   d. Depression
   e. Anxiety
   f. Anger
   g. Stress
   h. Loneliness
2. Interpersonal factors
   a. Troubled personal relationships
   b. Difficulty expressing emotions
   c. History of being bullied about size or weight
   d. History of physical and/or sexual abuse
3. Social factors
   a. Cultural pressures
   b. Narrow definitions of beauty
   c. Stress related to racial, ethnic, size/weight discrimination

D. SIGNS AND SYMPTOMS
1. Bulimia nervosa
   a. Frequent episodes of consuming very large amounts of food followed by behaviors to prevent weight gain, such as self-induced vomiting
   b. Feeling of being out of control during episodes
   c. Self-esteem overly related to body image
2. Anorexia nervosa
   a. Restricting type
(i) Inadequate food intake leading to a weight that is too low
(ii) Intense fear of weight gain
(iii) Obsession with weight and persistent behavior to prevent weight gain
(iv) Self-esteem overly related to body image
(v) Inability to appreciate the severity of the situation
(vi) Inability to perceive accurate self-image

b. Binge/purge type: Involves all of the above with binge eating and/or purging behaviors during last three months

3. Orthorexia nervosa
   a. Orthorexia nervosa is not currently recognized as a clinical diagnosis in the DSM-5, but many people struggle with symptoms associated with this term
   b. Those who have an “unhealthy obsession” with otherwise healthy eating may be suffering from “orthorexia nervosa,” a term which literally means “fixation on righteous eating”

4. Binge eating disorder
   a. Frequent episodes of consuming very large amounts of food even when full (i.e., gorging) and eating fast each time
   b. Feeling of being out of control during episodes
   c. Feelings of strong shame and/or guilt regarding the binge eating

E. MANAGEMENT
   1. Refer client to appropriate provider for treatment options
   2. Refer if weight gain in antepartum period is not adequate
   3. Consider if weight checks are conducive to appropriate and supportive care
   4. Possible treatment options
      a. Antidepressants
      b. Cognitive behavior therapy
      c. Family therapy
      d. Hypnotherapy
      e. Interpersonal therapy
      f. Nutritional therapy
      g. Psychotherapy
      h. Telephone therapy
   5. Access National Eating Disorders Association (NEDA) confidential, toll-free hotline at 1-800-931-2237 or information available at www.nationaleatingdisorders.org
ENDOMETRIOSIS

A. DEFINITION
A proliferation of endometrium in any site other than the uterine mucosa itself, often manifesting by multiple and scattered lesions. It occurs in two forms: in the uterine wall and on extra-uterine organs and tissues. Endometriosis typically proliferates when the ovaries are active and atrophies after menopause. Both glands and stroma must be present in the lesion to justify the designation.

B. ETIOLOGY
Unknown, but theories include:
1. Retrograde menstruation theory: Endometrial cells are pushed backward through fallopian tubes into abdomen
2. Embryonic tissue theory: Endometrial tissue was present abnormally when woman was an embryo and becomes active later in reproductive life
3. Genetic Theory: Endometriosis may be hereditary
4. Lymphatic distribution theory: Endometrial material gets distributed throughout the body via the lymphatic system
5. Immune system dysfunction: Endometriosis may be classified as part of a larger immune system disorder
6. Environmental influences: Toxins in the environment, which affect reproductive hormones and immune system response, may contribute to the development of endometriosis
7. Surgical scar implantation: Endometrial cells implanting in surgical scar site

C. SIGNS AND SYMPTOMS
1. Pelvic pain
   a. Just before or with menstruation
   b. During ovulation
   c. In the bowel during menstruation
   d. When urinating
   e. During or after intercourse
   f. In the lower back region
2. Diarrhea
3. Constipation
4. Abdominal bloating
5. Heavy periods
6. Irregular bleeding
7. Constant tiredness
8. Pain increases over time and can become debilitating

D. DIAGNOSIS
Definite diagnosis is only possible with the direct observation of the misplaced endometrium, which can be done only with laparoscopy. Sometimes tissue samples are taken to confirm diagnosis.

E. MANAGEMENT
1. Consider natural treatments
2. Consider stress reduction techniques
3. Consider consult with physician
4. Treatments may include:
   a. Allopathic over-the-counter medicine
   b. Medical treatment: Hormonal treatments generally attempt to inhibit ovulation and thereby control the production of estrogen
   c. Surgical treatment
      (a) Endometriosis can be removed by excision, laser ablation, vaporization, or coagulation
      (b) Surgery can usually be performed on an outpatient basis by laparoscopy
      (c) While surgery is not considered to be a cure, it may provide extended pain relief
      (d) Uterine surgery other than cesarean section requires consultation for antepartum clients; see “Determining Appropriate Client Care Provider” in Part I
FERTILITY COUNSELING

Fertility counseling is an opportunity to support the empowerment of clients in making individual, intentional choices around their fertility goals with an understanding and hopefully a growing awareness of their own health and wellbeing.

A. INTAKE
   1. Follow normal history and intake process as in “Well-Woman Care Schedule”
   2. Assist client in exploring and understanding their current and future fertility goals

B. FERTILITY GOALS AND OPTIONS
   1. Education about pregnancy prevention or avoidance
      a. Abstinence
      b. Fertility awareness-based methods
         (a) Natural Family Planning methods (e.g., Ovulation Method, Billings Ovulation Method, Marquette Method, Sympto-thermal Method)
         (b) Fertility Awareness Method
         (c) Standard Days Method
         (d) Lactation amenorrhea method
      c. Barrier methods
         (a) Condoms, male and female
         (b) Cervical cap
         (c) Diaphragm
         (d) Chemical barriers such as spermicidal foams, creams, jellies, suppositories, film
      d. Hormonal methods
         (a) Pills
         (b) Patch
         (c) Cervical ring
         (d) Injectables
         (e) Emergency contraception
         (f) Others as they become available
      e. Long-term reversible contraceptives (LARC)
         (a) Intrauterine devices (IUD)
            (a) Hormonal (Mirena, Skyla, Lilletta)
            (b) Non-hormonal (Paragard)
         (b) Implants (Nexplanon)
      f. Permanent Sterilization
         (a) Vasectomy
         (b) Tubal ligation (immediate postpartum or laparoscopic interval)
         (c) Hysterectomy
         (d) Essure (limited availability)
   2. Education about Emergency Contraception
      a. Emergency contraceptive pills (ECPs; Plan B One Step, Ella)
      b. Copper IUD (Paragard)
   3. Pregnancy promotion
      a. Preconception counseling
Fertility Counseling

(a) Nutrition evaluation
(b) Recommend folic acid supplementation
(c) Assess lifestyle risks
(d) Screen for chronic medical conditions
(e) Assess vaccination status

b. Fertility awareness-based methods
c. Medical methods (i.e., Assisted Reproductive Technology methods)

4. Pregnancy termination
   a. Educate on options for termination including medication or surgical abortion
      (based on gestational age and/or preference)
   b. Refer

C. COUNSELING AND TEACHING
   1. How the body works: female and male reproductive systems
   2. Individual and couple fertility
   3. General health: physical, nutritional, emotional, spiritual
   4. Sexual health
      a. Emotions and sexuality
      b. Educational preparation, parenting classes, contraception education
   5. Pregnancy avoidance or promotion methods
      a. Comparative effectiveness of each method
      b. Proper use of client’s chosen method(s)
      c. Contraindications, possible side effects of chosen method(s) and others as indicated by client’s interest

D. MANAGEMENT
   1. Facilitate client in obtaining preferred method and ensure client receives appropriate education in preferred method
   2. Consult or refer if necessary
   3. Obtain appropriate labs
   4. Follow-up
      a. Discuss effectiveness and satisfaction
         (a) Side effects
         (b) Problems
         (c) Other
      b. Obtain labs as necessary
   5. Access more information through the Reproductive Health Access Project (http://www.reproductiveaccess.org/) and the Association of Reproductive Health Professionals (http://www.arhp.org/)
GONORRHEA

A. DEFINITION
A contagious sexually transmitted infection caused by *Neisseria gonorrhea*, a gram negative bacterium, most commonly causing an inflammation of the mucous membrane lining of the genital organs.

B. ETIOLOGY
Transmitted through unprotected sexual activity.

C. SEQUELAE
1. Pelvic inflammatory disease
2. Can cause neonatal blindness as a result of being contracted while passing through the infected vaginal canal during birth
3. Can be spread to other mucous membranes by other sexual activity

D. SIGNS AND SYMPTOMS
1. May be asymptomatic
2. Urinary frequency
3. Dysuria
4. Involuntary loss of urine
5. Reddened, irritated, itchy genitalia
6. Anorectal discomfort or burning
7. Abdominal pain or cramping
8. Sore throat (after orogenital contact)
9. Purulent greenish-yellow discharge
10. Possible swelling of Bartholin's glands
11. Edema, redness, excoriation of the vulva
12. Genital or throat culture positive for *N gonorrhea*

E. MANAGEMENT
1. Well-woman clients:
   a. Obtain gonorrhea and chlamydia cultures (i.e., PCR)
   b. Consider
      (a) Testing to rule out other STIs
      (b) Gram stain
   c. Consult for treatment
   d. Comply with local infection reporting regulations and requirements; see NMAC 7.4.3 and Appendix F for reporting procedures and a list of reportable diseases and conditions in the state of New Mexico
   e. Provide education and referral for partners
   f. Advise client that treatment is required for all sexual contacts
   g. Advise use of condoms and safer sex practices until all post-treatment tests are negative
   h. Instruct client in methods for prevention of spreading infection
   i. Consider natural therapies
j. Consider follow-up to include repeat gonorrhea test of cure (TOC) via culture (preferred) as early as 14 days after treatment is complete

2. Antepartum clients
   a. Follow management guidelines above for well-woman clients
   b. Retest again in 3 months (for reinfection) and possibly in third trimester
   c. Active gonorrhea infection at the onset of labor requires transfer of care; see “Determining Appropriate Client Care Provider” in Part I
HEPATITIS A

A. DEFINITION
A liver infection caused by a virus that is transmitted through contaminated food and water or through sexual activity. Shedding of the virus in the stool can begin up to two weeks before onset of clinical symptoms and usually persists for about two weeks after onset of symptoms. Children and people with weak immune systems may be contagious for up to six months. An acute illness, usually resolves without treatment. Symptoms persist 10 to 15 days and usually resolve by 1 to 2 months.

B. SYMPTOMS
1. Nausea
2. Fatigue
3. Jaundice
4. Loss of appetite
5. Flu-like symptoms
6. Onset often with marked vomiting, abdominal pain, and fever
7. May be subclinical

C. DIAGNOSIS: Hepatitis panel to determine virus type

D. MANAGEMENT
1. All clients:
   a. Educate clients as to transmission risks including hygiene, water, and food preparation, especially while traveling
   b. Educate about possible prevention and treatment options, including hepatitis A vaccine
2. All clients positive for hepatitis A:
   a. If infection is active, consider natural therapies for symptoms relief (be sure to avoid any hepatotoxic herbs or remedies)
   b. Consider labs to rule out other hepatic conditions
   c. Consider consult if symptoms are severe (consult required for antepartum clients, see below)
   d. If acute, comply with local infection reporting regulations and requirements; see NMAC 7.4.3 and Appendix F for reporting procedures and a list of reportable diseases and conditions in the state of New Mexico
3. Antepartum clients positive for hepatitis A:
   a. Educate on risks of preterm labor if acute, severe infection in third trimester
   b. Antepartum management focuses on relief of symptoms
   c. There is no evidence that hepatitis A causes birth defects or is transmitted from the mother to fetus
   d. Consultation is required if symptoms are severe in an antepartum client in any trimester; see “Determining Appropriate Client Care Provider” in Part I)
HEPATITIS B

A. DEFINITION
A virus that can be transmitted by contact with infected blood and body fluids, such as through unprotected sex; sharing needles, toothbrushes, or other blood-contaminated personal items; poor infection control in the medical setting; or from mother to infant during birth. Hepatitis B is NOT transmitted through touching, kissing, or casual contact. Incubation is between 1 and 6 months. People infected as adults usually experience acute symptoms and then clear the infection, while people infected in early childhood typically have no symptoms but remain infected for life. Chronic infection can lead to cirrhosis and liver cancer. Most people with chronic hepatitis B are not aware of their infections.

B. SYMPTOMS
1. Most common: no symptoms
2. Acute symptoms: nausea, vomiting, headache, malaise, abdominal pain, jaundice
3. Fulminant illness
   a. Fever
   b. Jaundice
   c. Hepatomegaly
   d. Pain in right flank

C. DIAGNOSIS
1. Routine prenatal screening: hepatitis B surface antigen (HBsAg, not to be confused with hepatitis B surface antibody or HBsAb)
2. For acute illness: hepatitis panel to determine virus type, acute versus chronic

D. MANAGEMENT
1. Liver function labs
2. Educate about risks and transmission
   a. Recommend lifelong abstention from alcohol and hepatotoxic drugs/herbs
   b. Refer household/sexual contacts to public health office for testing, vaccine
3. Consider natural therapies (avoid any hepatotoxic herbs or remedies)
4. Treat for symptom relief
5. Comply with local infection reporting regulations and requirements
   a. see NMAC 7.4.3 and Appendix F for reporting procedures and a list of reportable diseases and conditions in the state of New Mexico
   b. Notify Regional Perinatal Hepatitis B Nurse Coordinator of birth
6. Antepartum clients positive for hepatitis B:
   a. Antepartum clients positive for hepatitis B require consultation; see “Determining Appropriate Client Care Provider” in Part I
   b. For infants born to clients positive for hepatitis B, consultation is required for possible transfer and/or arrangements for appropriate newborn care
      (a) LMs should have arrangements for planned administration of hepatitis B immune globulin (HBIG) and Hepatitis B vaccine for infant by 34 weeks of pregnancy
      (b) HBIG and the Hepatitis B vaccine should be administered within 12 hours of birth, and can be administered by the LM
(c) Options for obtaining HBIG and Hepatitis B vaccine include pediatric provider or Department of Health Regional Perinatal Hepatitis B Nurse Coordinator

c. Note that breastfeeding is safe for babies born to Hepatitis B positive mothers
(a) Reinforce education about nipple care, consider pausing breastfeeding if nipples cracked and bleeding
A. DEFINITION
A virus that lives in blood and body fluids that can be transmitted through unprotected sex, sharing needles, and by maternal fetal transmission. Hepatitis C is most commonly transmitted by contact with infected blood.

B. SYMPTOMS
1. May be asymptomatic until there is evidence of liver damage
2. Flu-like symptoms (nausea, vomiting, headache, malaise)
3. Fulminant illness
   a. Fever
   b. Jaundice
   c. Hepatomegaly
   d. Pain in right flank

C. DIAGNOSIS
1. For acute illness: hepatitis panel to determine virus type, acute versus chronic
2. Screening for patients with risk factors (history of substance use disorder, partner with hepatitis C, elevated liver function tests)
   a. Hepatitis C antibody
   b. If hepatitis C antibody is positive, obtain hepatitis C PCR

D. MANAGEMENT
1. If high-risk for hepatitis, consider repeated hepatitis C antibody testing or hepatitis C PCR
2. All clients positive for hepatitis C:
   a. Educate regarding risks and modes of transmission
   b. Comply with local infection reporting regulations and requirements; see NMAC 7.4.3 and Appendix F for reporting procedures and a list of reportable diseases and conditions in the state of New Mexico
   c. Consider referral for treatment
   d. Educate that relapse is possible
3. Antepartum clients positive for hepatitis C:
   a. As above and
   b. Consultation is required; see “Determining Appropriate Client Care Provider” in Part I
   c. May have elevated risk of gallstones and cholestasis of pregnancy
   d. Treatments are currently contraindicated antepartum and while lactating (developments ongoing)
   e. Risk of vertical transmission to fetus is 4-5%
   f. Consultation is required for infants born to clients positive for hepatitis C to arrange appropriate pediatric screening for vertical transmission; see “Determining Appropriate Client Care Provider” in Part I
   g. Educate client about precautions for breastfeeding and pumping and discarding breast milk in the presence of bleeding or open sores on the nipples
HERPES

A. DEFINITION
An acute and chronic viral infection characterized by thin–walled watery vesicles or blisters primarily seen on the mucous surface of the cervix, vagina, vulva, or perineum, although lesions can be present elsewhere. Most cases of genital herpes are caused by the herpes simplex virus type 2 (HSV-2). Genital lesions can also be caused by HSV-1, normally responsible for oral lesions (cold sores), which may be contracted through oral sex. Herpes can occur as a primary or a recurrent infection. There is no cure for herpes, but symptoms can be alleviated and sometimes prevented with antivirals.

B. ETIOLOGY
Transmitted through direct contact with or without presence of lesion
a. Direct contact as defined by general interactions such as eating from the same utensils, sharing lip balm, or kissing (oral infection)
b. Direct contact by sexual activity

C. SIGNS AND SYMPTOMS OF MATERNAL INFECTION
1. Primary infection
   a. Low grade fever with aching and malaise
   b. Swollen inguinal lymph nodes
   c. Vulva may appear red, edematous and excoriated
   d. Painful, fluid-filled vesicles appear, with evolution to ulcerations
2. Recurrent infection
   a. Prodromal symptoms of burning, tingling, pain at site where lesions will appear
   b. Painful multiple fluid-filled vesicles or ulcerations possibly with exudate
   c. Difficulty in urination
   d. Pain on intercourse
   e. Watery discharge from vesicles
   f. Vaginal bleeding

D. SEQUELAE
1. Fetal
   a. May be transmitted to fetus antepartum
      (a) TORCH sequelae
      (b) Spontaneous abortion
      (c) Fetal death
2. Newborn
   a. Can be transmitted to neonate during vaginal delivery
      (a) Severe central nervous system damage
      (b) Severe ocular damage
      (c) Neonatal death
   b. Signs and symptoms (can occur anytime during the first six weeks of life)
      (a) Skin lesions
      (b) Cough
      (c) Rapid breathing
      (d) Painful breathing
(e) Jaundice
(f) Seizures
(g) Lethargy
(h) Poor feeding
(i) Fever
(j) Irritability
(k) Swollen anterior fontanel
(l) Stiffness in legs
(m) Sepsis

E. MANAGEMENT
1. Take thorough health history including, but not limited to:
   a. Date of initial outbreak
   b. Frequency of outbreaks
   c. Last known outbreak
   d. Location of outbreak
   e. Herpes status of all sexual partners, if known
2. Consider labs
   a. Swab of lesions to identify organism
      (a) Note that often a culture/PCR can be negative and the client may still be positive for HSV
      (b) Best to do swab when lesion is new and open (versus healed over)
   b. Rule out syphilis
   c. Rule out gonorrhea and chlamydia
   d. Can consider blood test (IgG and IgM), although most people will be positive for IgG and clinical significance may be difficult to determine
3. For primary herpes infection
   a. All clients:
      (a) Examine and confirm appearance of lesions
      (b) Suggest comfort measures and offer emotional support
      (c) Educate about measures to decrease risk of transmission to partner and autoinoculation (spreading infection to another area of the body)
      (d) Counsel about diet, supplements, and natural therapies
      (e) Educate about physical, psychosocial, emotional, and stress related causes for recurrence
      (f) Offer referral for anti-viral therapy
   b. Antepartum clients:
      (a) Acute treatment and prophylaxis should be discussed
      (b) Educate client about risks of herpes to the fetus and neonate
      (c) Consultation required with a primary genital herpes infection in the first or second trimester; see “Determining Appropriate Client Care Provider” in Part I
      (d) Primary outbreak of genital/anal herpes simplex infection in the third trimester requires transfer to physician (scheduled cesarean section is recommended to help prevent vertical transmission); see “Determining Appropriate Client Care Provider” in Part I
4. For non-primary infection or outbreak
   a. For all clients:
      (a) Examine and confirm appearance of lesions and offer testing (PCR swab)
      (b) Counsel about comfort measures and offer support
      (c) Educate about measures to decrease risk of transmission to partner and autoinoculation (spreading infection to another area of the body)
      (d) Counsel about diet, supplements, natural remedies to encourage rapid healing
      (e) Educate about physical, psychosocial, and emotional causes for reoccurrence
      (f) Counsel about availability of antiviral medication for suppressive treatment to decrease incidence of recurrence
      (g) Consult for anti-viral therapy
   b. For antepartum and intrapartum clients:
      (a) Antepartum
         (a) Vaginal birth is recommended if no lesions at time of labor
         (b) Educate about cesarean birth if outbreak occurs in labor or shortly before
         (c) Transfer is required in cases of rupture of membranes (ROM), at any gestational age, when lesions are present in the genital/anal area (cesarean birth within 4 hours of ROM is recommended to help prevent vertical transmission); see “Determining Appropriate Client Care Provider” in Part I
      (b) Intrapartum
         (a) Determine if lesions are present with a thorough examination of vulva/perineum/vagina/cervix paying special attention to location of prior outbreaks
         (b) If no lesions present, continue with vaginal birth
         (c) If lesions present:
            1. Note location of lesions
               a. Lesions located in genital/anal area at the onset of labor or at ROM require transfer of care for cesarean (cesarean birth within 4 hours of ROM is recommended to help prevent vertical transmission); see “Determining Appropriate Client Care Provider” in Part I
               b. Lesions located in non-genital/anal area
                  i. Continue with vaginal birth
                  ii. Cover lesions with an occlusive dressing prior to birth
            2. Consult if there is uncertainty regarding whether location of lesion increases risk of transmission
   5. For asymptomatic clients with history of herpetic lesions:
      a. Counsel and educate
         (a) Situations which increase chance of recurrence
         (b) Importance of client discussing signs and symptoms of recurrence with midwife
         (c) Prevention of recurrence:
            (a) Stress management
            (b) Diet and supplements
            (c) Good genital hygiene
Herpes

(d) Natural therapies
(e) Use of condoms and dental dams with sexual partner
b. For antepartum clients, discuss the option of pharmacological prophylaxis at 34-36 weeks
HUMAN IMMUNODEFICIENCY VIRUS (HIV)

A. DEFINITION
A retrovirus, which causes a gradual systemic collapse of the immune system by destroying CD4, or T, cells. The infection may manifest in a variety of ways, and may lead to Acquired Immune Deficiency Syndrome (AIDS). There is no known cure, but antiretroviral therapy can help slow the progression of the disease and reduce the likelihood of transmitting the disease to others.

B. ETIOLOGY
1. Transmitted by sexual contact or through contact with infected blood or bodily fluids
2. Can be passively transmitted to a fetus
3. Infants born to seropositive mothers may become infected
4. HIV can be transmitted through breastfeeding

C. EDUCATION
All clients should be educated regarding HIV/AIDS, including:
1. Modes of transmission of HIV and methods of prevention
2. Risk factors and risk behaviors associated with contracting HIV
3. Information and locations of both confidential and anonymous testing resources, and implications of both positive and negative results

D. HIV TESTING INFORMATION
1. Screening
   a. HIV antibody testing begins with a sensitive screening test such as the enzyme-linked immunosorbent assay (ELISA) or a rapid assay
   b. If positive, a second test, the Western Blot or immunofluorescence assay (IFA), is done to confirm
   c. If positive results are given with both tests, the person is considered HIV positive and capable of transmitting the virus to another person
   d. HIV antibody is detectable in 95% of people within 6 months of infection
      (a) A negative antibody test cannot rule out infection that occurred less than 6 months before the test
      (b) If high-risk behavior or incident has occurred within that time period, a second HIV test should be done 3 to 6 months afterwards
   e. Persons with HIV should be referred for medical and psychosocial evaluation and monitoring services
2. Confidentiality
   a. Well-woman clients
      (a) Testing is voluntary and done with full knowledge and cooperation of the client
      (b) Full pre-test counseling is required by the state of New Mexico’s Human Immunodeficiency Virus Testing Act and includes
         (a) Explanation of the test
         (b) Purpose of testing
         (c) Potential uses, limitations, and meaning of its results
         (c) Anonymous and confidential testing
(a) Anonymous testing
   (i) Client’s name is not attached to the test results and is kept totally anonymous
   (ii) Client will be given an identification number at testing time and results are retrieved by the client based on that identification number
(b) Confidential testing:
   (i) Client’s name is attached to the results
   (ii) The results are kept confidential in the same way as any other medical information, however positive confidential tests are reported to the New Mexico Public Health Department as required by law for follow-up and statistical purposes

b. Antepartum clients
   (a) HIV screening is part of routine antepartum care and is not typically done as an anonymous test, however informed consent is required
   (b) Full pre-test counseling for antepartum clients is not required by the Human Immunodeficiency Virus Act if screening is part of standard testing
   (c) Clients with informed consent who decline HIV screening should sign a waiver (see §24-2B-2, accessible at http://public.nmcompcomm.us/nmnxtadmin/NMPublic.aspx, for required waiver language)

E. MANAGEMENT
1. Negative test result:
   a. Continue care as normal
   b. Discuss risk factors, safer sex practices as part of client education
   c. Recommend retesting as appropriate
2. Positive test result:
   a. All clients
      (a) Verify that all confirmatory tests have been done
      (b) Counsel with client regarding
         (a) Meaning of the results
         (b) Decreasing transmission risks to others
         (c) Possible need of additional testing
         (d) Benefits of locating and counseling the individual who may have transmitted the virus to the client
         (e) Availability of appropriate health care services, including mental health care and social and support services
      (c) Comply with local infection reporting requirements; see NMAC 7.4.3 and Appendix F for reporting procedures and a list of reportable diseases and conditions in the state of New Mexico
      (d) Refer to local facilities for continuing medical care and individual psychosocial counseling; in New Mexico, the HIV Services Program of the DOH is the state service coordinating program
   b. Antepartum clients
      (a) Primary care by physician or CNM is required for clients with positive HIV status or AIDS; see “Determining Appropriate Client Care Provider” in Part I
(b) Discuss all the counseling points above as well as the following
   
   (a) Risks of perinatal transmission
   
   (b) Methods of decreasing risk of perinatal transmission
   
   (c) Risks and benefits of breastfeeding

   (i) WHO recommends exclusive breastfeeding with antiretroviral treatments for HIV-positive mothers or infants (WHO recommendation November 30, 2009)

   (ii) Possible HIV transmission to breastfeeding infant (CDC recommends against HIV-positive mothers breastfeeding their infants)
HUMAN PAPILLOMA VIRUS (HPV) AND GENITAL WARTS

A. DEFINITION
A very common sexually transmitted infection that most sexually active people contract caused by viruses in the human papilloma virus family. Human papilloma virus is now understood to be the primary causative agent of cervical cancer. HPV strains 16 and 18 have been identified to cause cervical cancer and do not cause warts. Other strains of the virus appear as raised cauliflower shaped warts: flat or raised, large or small, grouped or singular. Lesions occur most commonly on the posterior part of the introitus and labia minora. Lesions may also appear or spread to other parts of the vulva, perineum, or anus, and occasionally are seen on the vaginal walls and cervix. HPV can also infect the mouth and throat. The virus can be present in the body without the presence of warts. The body’s immune system can successfully fight off HPV infection in many cases in about two years.

B. ETIOLOGY
1. Sexual contact is the primary mode of transmission
2. HPV is most commonly transmitted through unprotected vaginal or anal sexual contact with an infected partner
3. HPV is less commonly passed through unprotected oral sex

C. SIGNS AND SYMPTOMS
1. Pedunculated, raised fleshy lesions, pink to red in color, moist and soft to palpation
2. Large lesions appear in cauliflower-like masses or clusters
3. Abnormal discharge from vagina with associated infection
4. Positive result for acetic acid solution test

D. MANAGEMENT
1. Consider Papanicolaou test with or without co-testing (depending on age and test results), if appropriate timing per ASCCP Guidelines
   a. See “Cervical Cancer Screening” in Part IV
   b. Culture for suspected secondary infections
   c. Saline and KOH wet preps if vaginal discharge present
2. For client without lesions, but positive for HPV
   a. Follow ASCCP Guidelines for further management
   b. Educate regarding
      (a) Nature of HPV as sexually transmitted
      (b) Use of condoms and other safer sex practices during sexual intercourse to decrease risk of transmission
      (c) Risk of progression to cervical cancer
3. For client with genital warts
   a. All clients
      (a) Educate regarding
         (a) Nature of HPV as sexually transmitted
         (b) Risk of progression to cervical cancer
         (c) Use of condoms and other safer sex practices (see “Safer Sex Practices” in Part IV) during sexual intercourse to decrease risk of transmission
(d) Sexual partner can consider treatment if they have lesions
(e) Good perineal hygiene and sitz baths
(f) Loose clothing and cotton underwear
(g) Psychosocial and sexual issues
(b) Consider treatment, see following

b. Well-woman clients
   (a) Consider consult for topical prescriptions such as topically applied Podophyllin
   (b) Consider consulting for treatment, or referring for treatment or removal (e.g., trichloroacetic acid, cauterization, cryotherapy, laser treatments, possible biopsy)
   (c) Educate regarding HPV vaccination if client is 26 years or younger

c. Antepartum clients
   (a) Podophyllin is contraindicated due to teratogenicity
   (b) HPV vaccination in pregnancy is not recommended by CDC
   (c) Consider consult with other healthcare providers as appropriate
   (d) When lesions are present at birth
      (i) Avoid tearing or cutting lesions, as they may bleed excessively
      (ii) Educate client of risk to newborn for developing vocal cord polyps within 6 months of birth
      (iii) Consider follow-up with pediatrician
PART IV: WELL-WOMAN CARE

INTRAUTERINE INSEMINATION (IUI)

A. DEFINITION
   A procedure whereby washed sperm is placed in the uterus with an IUI catheter to achieve pregnancy.

B. INDICATIONS
   1. Clients wishing to conceive with donor sperm
   2. Clients with fertility concerns (e.g., sperm antibodies)

C. MANAGEMENT
   1. Performed by a trained professional such as a LM (who has received additional documented training per the “Mechanism for Expansion of Practice” guideline), nurse-midwife, physician, or other qualified provider
   2. Complete intake appointment equivalent to “Well-Woman Care Schedule”
   3. Consider lab screening for vaginal infections and STIs
   4. Diagnose ovulation with fertility charting for timing of IUI for conception
   5. Review required consent form for IUI
      a. Consent form should include:
         (a) Risks such as possible perforation of the uterus, bleeding, infection, cramping, incorrect implantation site, missed fertilization due to incorrect timing of procedure, possible health risks associated with receiving donor sperm
         (b) Notification of possible allergens added to sperm if donor sperm coming from a sperm bank
         (c) Information regarding conception rate dependent on number of cycles of IUI completed
         (d) No change in risk of pregnancy and fetal complications from pregnancy obtained through IUI
   6. Use sterile technique
   7. Client education should include:
      a. Normalcy of some cramping and spotting after procedure
      b. Signs and symptoms of
         (a) Anaphylaxis
         (b) Uterine perforation
         (c) Infection
         (d) Conception, pregnancy
   8. Recommend client continue full charting practice of ovulation and menses at least until pregnancy is documented
   9. After 6 completed cycle of IUI trails without achieving pregnancy
      a. Consider referral
      b. Educate about alternative treatments (i.e., fertility medication, IVF) to achieving pregnancy
A. DEFINITION
The natural decline of ovarian function resulting in the eventual cessation of menstrual cycles and fertility that is clinically defined as one year without menstruation since the last menstrual period.

B. ETIOLOGY
1. Menopause generally occurs due to the normal aging process
2. Age of onset dependent on genetic, racial, and health factors, but typically occurs between ages 40–55
3. Women may experience premature or induced menopause due to:
   a. Removal of both ovaries through surgery (bilateral oophorectomy or total hysterectomy with bilateral oophorectomy)
   b. Radiation, chemotherapy
   c. Primary ovarian insufficiency, congenital anomaly
   d. Other health, nutritional, emotional factors

C. SIGNS AND SYMPTOMS
1. Gradual changes in menstrual cycles over several months or years
   a. Reduction in amount and/or duration of menstrual periods
   b. Reduction or increase in cycle frequency with irregular ovulatory events in early perimenopause to longer periods of anovulation in later perimenopause
2. Body changes
   a. Alteration in pituitary, thyroid, and adrenal function
   b. Reduced glandular activity and estrogen leads to:
      (a) Atrophy of genitalia and breasts and may lead to vulvovaginal irritation, burning, itching, vaginal discharge, postcoital bleeding, and dyspareunia
      (b) General body aches and pains
      (c) Drier mucus membranes, skin, and eyes
      (d) Reduced bone density
   c. Change in fat deposition from hips and breasts to shoulders and waist
   d. Hair loss or excessive hair growth (hirsutism)
3. Mood swings, emotional changes, or depression
4. Hot flashes
5. Sleep disturbance

D. SEQUELAE
1. Osteoporosis
2. Cardiovascular problems, including coronary thrombosis
3. Pelvic Organ Prolapse (see “Pelvic Organ Prolapse” in Part IV for more detail)
   a. Bladder
   b. Cervix
   c. Uterus
4. Urinary problems
   a. Incontinence
   b. Reduced bladder capacity
E. MANAGEMENT

1. Encourage client to
   a. Honor her unique self-discovery and aging process
   b. Renew her interest in life and its meaning for her
   c. Be in touch with herself
   d. Nurture healthfully inside and out

2. Obtain accurate history
   a. Medical
   b. Gynecological
   c. Obstetric
   d. Nutrition
   e. Psychosocial

3. Physical exam
   a. Rule out pregnancy
   b. Rule out existing disease on the basis of any complaints

4. Recommended labs and screening as indicated
   a. Consider labs which would address symptoms such as FSH, Estradiol, LH, Prolactin, Thyroid
   b. Ultrasound
   c. Cervical cancer screening (see “Cervical Cancer Screening” in Part IV)

5. Breast exams; includes breast self-awareness and referral for screening mammograms

6. Educate woman about the natural process of menopause

7. Counsel with the woman regarding the possible need for lifestyle changes
   a. General health
      (a) Proper nutrition
      (b) Boosting the immune system
      (c) Exercise, pelvic floor exercise
      (d) Rest and sleep disturbance
      (e) Implement plan for prevention of osteoporosis and other related conditions
   b. Sexual function
      (a) Consider lubricants, technique changes, and novelty during sex
      (b) Enhance relationship and communication with partner
   c. Emotional, spiritual, psychosocial issues; support
   d. Natural therapies
   e. Health measures for exposure to toxins and sun

8. Consider referral for
   a. Bioidentical hormones
   b. Counseling
   c. Sex therapy
   d. Other health care providers and support groups

9. Follow-up: yearly or as indicated
PELVIC INFLAMMATORY DISEASE (PID)

A. DEFINITION
Inflammation of the pelvic cavity involving the fallopian tubes, ovaries, pelvic peritoneum, vascular system, or connective tissue. Infection may involve one structure or the entire pelvis and be acute or chronic. PID usually results from gonorrhea or chlamydia infection.

B. ETIOLOGY
1. Exposure to sexually transmitted infections
2. Recent history of abortion or D&C
3. Uterine or cervical neoplasms
4. History of peritonitis
5. Impaired immunity

C. SEQUELAE
1. Ectopic pregnancy (occurs in 1 in 26 pregnancies after PID)
2. Infertility due to tubal occlusion
3. Chronic pain

D. SIGNS AND SYMPTOMS
1. Acute
   a. Lower abdominal and pelvic pain and cramping, severe, bilateral, non–radiating
   b. Fever, chills, nausea, vomiting, fatigue
   c. Menstrual disturbances: Heavy, foul smelling, prolonged, spotting, or dysmenorrhea
   d. Malodorous, purulent vaginal discharge
   e. Possible back and/or leg pain
2. Chronic
   a. Possibly asymptomatic
   b. Low grade fever
   c. Painful menstruation
   d. Bleeding after intercourse
   e. Low back ache
   f. Dysuria, constipation, tiredness
   g. Mild to moderate dull, intermittent abdominal pain and cramping
3. Vital signs
   a. Fever low-grade to high
   b. Elevated pulse
   c. Respirations normal to elevated
4. Abdominal exam
   a. Severe tenderness in lower quadrants
   b. Adnexal fullness or masses possible
   c. Abdominal rigidity possible
   d. Bowel sounds may be decreased or absent
5. Pelvic exam
   a. Purulent vaginal or cervical discharge
Pelvic Inflammatory Disease (PID)

b. Discharge from urethra or Skene's glands possible
c. Bi-manual exam elicits exquisite tenderness of cervix and uterus; however, when chronic or subacute PID is present, the above symptoms may be absent or minimal during physical exam

E. MANAGEMENT
1. HCG quantitative blood test; consider serial testing to rule out ectopic pregnancy
2. Consider other labs:
   a. Vaginal wet mount or vaginal DNA test
   b. CBC
c. GC/CT and syphilis screens
d. Clean catch urinalysis, especially if dysuria present
e. Cervical cancer screen, if appropriate timing per “Cervical Cancer Screening”
f. Consult for appropriate treatment and/or referral
3. If infection is severe, hospitalization is indicated for immediate and vigorous antibiotic therapy
4. Follow up with retest as indicated
5. Education
   a. Importance of treatment of all sexual partners
   b. Prevention of re-infection: emphasis on good perineal hygiene, avoid use of tampons
c. Abstinence from intercourse for 1 week following treatment; use condoms and other safer sex practices subsequently until cultures are negative
d. Bed rest, good diet, increased fluid intake
e. Possible infertility
6. Provide emotional support
7. Consider natural therapies
8. For antepartum clients, consultation is required in cases of:
   a. Persistent fever at any point antepartum
   b. Serious maternal viral/bacterial infection at term unresponsive to treatment
   c. Refer to “Determining Appropriate Client Care Provider” in Part I
A. DEFINITIONS

1. Uterine prolapse: Downward displacement of the uterus
   a. First degree: Any minor degree of descent with the cervix remaining inside the vagina
   b. Second degree: Cervix protrudes through the vaginal introitus
   c. Third degree: Comprises prolapse of the entire uterus outside the vulva
2. Cystocele: Bulging of the upper (cervical) end of the anterior vaginal wall
   a. First degree: Slight bulging
   b. Second degree: Bulging reaches the vaginal orifice
   c. Third degree: Bulging extends past the introitus
   d. Frequently accompanies uterine prolapse
3. Urethrocele: The distal (vulvar) end of the anterior vaginal wall bulges downward into the vagina and outward toward the introitus.
4. Rectocele: Evidenced by bulging upward at the lower (vulvar) end of the posterior vaginal wall into the vagina and outward toward the introitus; graded in the same manner as a cystocele
5. Enterocele: Prolapse of the upper (cervical) end of the posterior vaginal wall; almost always associated with herniation of the cul-de-sac of Douglas and may contain loops of bowel.

B. SEQUELAE

1. Uterine prolapse can result in
   a. Sexual dissatisfaction
   b. Dyspareunia
   c. Heaviness or dragging sensation in pelvic area
2. Cystocele and urethrocele can cause
   a. Urinary incontinence due to loss of the posterior urethrovesical angle
   b. Urinary frequency
   c. Urinary retention and stasis
   d. Urinary tract infections (UTIs)
   e. Dyspareunia
3. Rectocele and enterocele can cause
   a. Difficulty with bowel elimination
   b. Pelvic discomfort

C. SIGNS AND SYMPTOMS

1. Uterine prolapse
   a. Sensation of heaviness or pulling in pelvis
   b. Tissue protruding from vagina, feeling as if sitting on a small ball, or as if something is falling out of vagina
   c. Incontinence or urinary retention
   d. Trouble having a bowel movement
   e. Low back pain
   f. Sexual concerns, such as a sensation of looseness in the tone of vaginal tissue
   g. Symptoms that are less bothersome in the morning and worsen as the day goes on
2. Cystocele and urethrocele
   a. Stress incontinence
   b. Urinary retention
   c. Urinary tract infections
   d. Presence of relaxation with pelvic examination; bulging vaginal wall through the introitus
   e. Dyspareunia
3. Rectocele and enterocele
   a. Anal incontinence (stool or gas)
   b. Chronic constipation
   c. Inability to completely empty rectum
   d. Pain with bowel movement
   e. Dyspareunia
   f. Presence of relaxation with pelvic examination; bulging vaginal wall through the introitus
4. Minor degrees may be asymptomatic

D. MANAGEMENT
   1. Education as to the causes, physiology, and consequences one can expect from pelvic organ prolapse
   2. Evaluate for pelvic muscle prolapse antepartum as indicated, at well-woman exams, and at the six week postpartum visit
   3. Prevention is best (e.g., work with the laboring woman to prevent prolonged second stage and avoid prolonged forceful breath-holding pushing)
   4. Encourage pelvic floor exercises
   5. Consider the use of natural remedies to strengthen and tone tissues
   6. Teach the woman how to splint (digitally hold back) a rectocele
   7. Use of a ring pessary for urinary incontinence
   8. Refer for consultation or possible surgical repair if serious symptomatic prolapse or with hernia with an enterocele; an enterocele should be differentiated from a rectocele as it is a more serious condition.
   9. Schedule follow-up
   10. Consider a pelvic physical therapy referral
PREMENSTRUAL SYNDROME

A. DEFINITION
Premenstrual syndrome (PMS) is a common cyclical hormonal disorder that may manifest with physical or emotional signs or symptoms. The symptoms usually start 10-14 days before the menstrual flow, worsening until the onset of the flow or shortly thereafter, then gradually lessening. Symptoms range from mild to debilitating and may interfere with daily activities and personal relationships. PMS is followed by a period entirely free of symptoms.

B. ETIOLOGY
1. Approximately 40% of all women suffer from PMS, and 2-3% of these suffer from severe symptoms
2. Associated with maternal history (i.e., client’s mother also experienced PMS)
3. Hormonally related
4. May be related to allergies, vitamin deficiencies
5. More common in relation to other life stresses
6. Increases depending on diet, caffeine intake, hypoglycemia
7. Underweight
8. Overweight
9. Related to lack of exercise
10. Other medical conditions including endocrine disorders, heart disease, hypertension

C. SIGNS AND SYMPTOMS
1. Irritability, anxiety, depression, hostility, mood swings
2. Migraine, headache, dizziness, fainting
3. Boils, acne, allergies, sore throat, joint pain, insomnia
4. Bloating, water retention
5. Weight gain, constipation, cramps, cystitis
6. Backache
7. Breast tenderness
8. Sugar craving
9. Clumsiness, poor coordination, accidents
10. Depression
11. Individual signs and symptoms exist

D. MANAGEMENT
1. Educate as to the possible causes, help identify the symptoms
2. Teach the use of a monthly cycle diary or journal to document feelings, life events, diet, and signs and symptoms
3. Evaluate for depression
4. Provide nutritional counseling
5. Consider natural therapies
6. Offer consult to support groups, community resources
7. Encourage exercise, yoga, etc. as appropriate
8. Follow up at regularly scheduled intervals as appropriate
9. Consider referral as appropriate, including referral for medication/hormonal contraceptive treatment
PART IV: WELL-WOMAN CARE

RELATIONSHIP STRUCTURES

A. DEFINITION
A family is any group of people who live together, share with one another, work together, care and support each other, keep each other safe, and love each other. A family may include people who are not legally or biologically related.

B. DIFFERENT FAMILY STRUCTURES
1. Single parents
2. Blended families: often occur when two people are in a partnership, and one or more of the adults have children from other relationships
3. Heterosexual couples: partnership between a man and a woman
4. Homosexual couples: partnership between two individuals of the same gender
5. Polyamorous families: partnership between more than two individuals
6. Non-monogamous: partnership often between two (or more) individuals in which there is an agreed emotional commitment between partners without the commitment of monogamy between one or more of the partners

C. CONSIDERATIONS FOR CARE
1. Consider asking clients their preferred parenting label
2. Consider studying different relationship structures and their special challenges and increased health risks (if any) associated with them
3. Consider adapting intake, handout, and office materials to represent a wide variety of family types
4. Consider continuing education on barriers to social services and health care access faced by nonconforming families
5. Consider factors related to infant feeding, such as more than one individual nursing their infant
6. Consider the fact that economic and social marginalization increase health risks

D. MANAGEMENT
It is vital for the midwife to be nonjudgmental and to keep an open mind to different family structures. The midwife should strive to understand the effect prejudice, discrimination, and violence has on individuals (adults and children) and their families (both chosen and family of origin). Midwives are encouraged to increase their knowledge and understanding of different family structures through continuing education, training, supervision, and consultation. At a minimum, the midwife should become educated on potential challenges her clients may face simply because of their relationship structure and dynamic.
PART IV: WELL-WOMAN CARE

SAFER SEX PRACTICES

A. DEFINITION
Safer sex practices reduce risk of contracting a sexually transmitted disease.

B. COUNSELING AND RISK ASSESSMENT
1. Midwives often have the unique opportunity to discuss topics of an intimate nature. With this privilege comes the responsibility to be respectful and nonjudgmental.
2. In some cases, the goal of safer-sex education may be to help someone minimize risk to themselves. In other cases, it may be to help someone minimize risk to their partners.
3. Not everyone will open a discussion about safer sex with their midwife.
4. Some clients do not perceive themselves to be at risk or may be too embarrassed to start the conversation.
5. It is incumbent on the midwife to complete a risk assessment as an integral part of the medical history and to educate the client on her and her partner’s risk based on that history and the physical exam.

C. SAFER SEX EQUIPMENT
1. Condoms
   a. Male
   b. Female
2. Dental dams (can be substituted with plastic wrap or cut open condom)
3. Lubrication
   a. Use makes condoms and dams less likely to break
   b. Use only water- or silicone-based lubrication

D. CARE OF SEX TOYS
1. Use with condom
2. Change condom with change of person using toy and from one body opening to another
3. Frequently clean sex toys following manufacturer’s instruction for cleaning
4. Never use breakable household objects as sex toys

E. SEXUAL PRACTICES AND RELATIVE RISK OF STI CONTRACTION
1. No-risk practices
   a. Self-masturbation
   b. Touching, massaging, hugging, caressing
   c. Social (dry) kissing
   d. Any type of sexual intercourse between partners who are certain that they are uninfected
2. Extremely low-risk practices
   a. French (wet) kissing
   b. Mutual masturbation; if no cuts on hands and no ulcers or lesions on genitals of either partner
   c. Vaginal intercourse with a male or female condom; with proper use, including putting latex or polyurethane condom in place before any penetration
d. Fellatio with condom (i.e., latex condom placed on penis before oral contact)  
e. Cunnilingus with dental dam (i.e., latex dam placed over vaginal area before oral contact)  
f. Anilingus or “rimming” with dental dam (i.e., latex dam placed over anus before oral contact)  
g. Contact with urine: only with intact skin, avoiding contact with mouth  
h. Using one's own sex toys without sharing any toys that contact body fluids  

3. Low-risk practices  
a. Fellatio without condom (risk of HIV infection to penetrating partner is extremely low; risk to receptive partner is increased if ejaculation occurs in mouth)  
b. Cunnilingus without a latex dam  
c. Anilingus without a latex dam  
d. Anal intercourse with condom (i.e., proper use of condom, including placing latex condom on penis prior to any penetration and using ample amounts of water-based or nonpetroleum-based lubrication with latex condoms)  
e. Anal or vaginal penetration with the hand with latex gloves  

4. High-risk practices  
a. Vaginal intercourse without a male or female condom  
b. Anal intercourse without a latex condom (highest risk is to the receptive partner)  
c. Anal penetration with the hand (fisting) or other object without use of a latex glove or condom, or fisting followed by unprotected anal intercourse
SYPHILIS

A. DEFINITION AND OVERVIEW
An infectious systemic disease caused by the spirochete Treponema pallidum. The disease is divided into stages determined by clinical findings: primary, secondary, tertiary, latent syphilis: early and late. Early latent syphilis is an infection acquired within the preceding year. Late latent syphilis is all other latent cases or syphilis of unknown duration. It is thought that syphilis is only transmitted in the presence of a lesion. Syphilis infection increases the risk of acquiring HIV infection. Antepartum syphilis infection (see D) and in the neonate (see E) are both covered in this section.

B. ETIOLOGY
1. Thought to be transmitted only by direct sexual contact with a chancre (mucocutaneous syphilitic lesion) present on external genitalia, in the vagina, on the penis, anus, rectum, perineum, or on the lips and in the mouth
2. Acquired congenitally in utero

C. DIAGNOSIS
1. Screen for syphilis
   a. A presumptive diagnosis of syphilis requires use of two tests:
      (a) Nontreponemal test (i.e., Venereal Disease Research Laboratory [VDRL] or Rapid Plasma Reagin [RPR])
      (b) Treponemal test (i.e., fluorescent treponemal antibody absorbed [FTA-ABS] tests, the T pallidum passive particle agglutination [TP-PA] assay, various enzyme immunoassays [EIAs], chemiluminescence immunoassays, immunoblots, or rapid treponemal assays).
   b. Use of only one type of serologic test is insufficient for diagnosis and can result in false-negative results in persons tested during primary syphilis and false-positive results in persons without syphilis
   c. False-positive nontreponemal test results can be associated with various medical conditions and factors unrelated to syphilis, including other infections (e.g., HIV), autoimmune conditions, immunizations, pregnancy, injection-drug use, and older age. Therefore, persons with a reactive nontreponemal test should always receive a treponemal test to confirm the diagnosis of syphilis
2. Darkfield examinations and tests to detect T pallidum directly from lesion exudate or tissue are the definitive methods for diagnosing early syphilis (not commonly used)

D. STAGES WITH SIGNS AND SYMPTOMS
1. Primary Stage: characterized initially in the primary stage by a painless lesion, or chancre of the skin or mucous membranes which can appear within 10 days to 3 months, but usually appears within 2-6 weeks, lasts about 3-6 weeks
   a. May be asymptomatic
   b. Contagious
   c. Lesion or chancre present on the vagina, perineum, cervix, penis, mouth, or anal area where the spirochete enters the body
   d. Lesion or chancre is typically firm, round, and painless, and it may be ulcerated and indurated with purulent discharge
Syphilis

e. Bilateral inguinal lymph nodes enlarged
f. If untreated, one third will progress onto late chronic stage

2. Secondary stage: follows when the primary chancre is healing or several weeks after it has healed typically with a characteristic rash on one or more areas of the body; symptoms can come and go over 1 to 2 years and will heal, but not be cured, without treatment
a. May go unnoticed or rash may resemble those caused by other diseases
b. Contagious only if lesions are present
c. Characteristic rash that usually does not itch: rough, red, or reddish brown spots on both the palms of the hands and the soles of the feet, or rash with a different appearance may appear elsewhere on the body
d. Condylomata lata (flat, wart-like plaques with gray exudate) may be present in warm, moist areas
e. Fever
f. Swollen or enlarged lymph glands
g. Sore throat and hoarseness
h. Patchy hair loss
i. Headaches
j. Weight loss
k. Muscle aches
l. Malaise
m. Possible enlargement of liver and spleen
n. Possible acute arthritis

3. Early Latent and Latent stage: dormant with no symptoms; can persist for years

4. Tertiary stage
a. Heart abnormalities
b. Gummas (soft, tumor-like growth of the tissues (granuloma), gummatous lesions)
c. Tabes dorsalis
d. General paresis

5. Latent stage/infection
a. Lacks clinical manifestations
b. Detected by serologic testing

6. Neurosyphilis
a. Occurs when T pallidum infects the central nervous system at any stage of syphilis
b. Early clinical manifestations usually present within the first few months or years of infection:
   (a) Cranial nerve dysfunction
   (b) Meningitis
   (c) Stroke
   (d) Acute altered mental status
   (e) Auditory abnormalities
   (f) Ophthalmic abnormalities and disease (uveitis, iritis, neuroretinitis, optic neuritis)
c. Late neurologic manifestations usually occur 10-30 years after infection
   (a) Tabes dorsalis
(b) General paresis

E. ANTEPARTUM SYPHILIS INFECTION AND THE FETUS OR NEONATE
   1. Transmission to fetus can be in any stage, even if in latent stage
   2. Possible sequelae include:
      a. Low birth weight infant
      b. Premature birth
      c. Miscarriage
      d.Stillbirth
      e. Neonatal death

F. CONGENITAL SYPHILIS OR SYPHILIS IN THE NEONATE
   a. Neonate may be asymptomatic at birth
   b. Serious health problems may develop in the first few weeks after birth or years later
   c. Symptoms of congenital syphilis can include
      (a) Failure to thrive
      (b) Fever
      (c) Irritability
      (d) No bridged nose (saddle nose) and other bone deformities
      (e) Rash on the mouth, anus, and genitals, rash on the palms and soles of feet
      (f) Watery fluid released from the nose
      (g) Jaundice
      (h) Nerve problems (e.g., blindness, deafness)
      (i) Meningitis

G. MANAGEMENT
   1. Comply with local infection reporting regulations and requirements; see NMAC 7.4.3 and Appendix F for reporting procedures and a list of reportable diseases and conditions in the state of New Mexico
   2. Well-woman clients
      a. Consider other labs
         (a) HIV screening
         (b) Other STI screening
      b. Refer for antibiotic treatment
      c. Stress necessity of treating all sexual contacts for at least the last three months
      d. Instruct client to use condoms and other safer sex practices during intercourse for at least 1 month following treatment
      e. Consider natural therapies (not to be substitute for treatment)
      f. Counsel about hygiene, mode of transmission, sexuality, psychosocial issues
      g. Follow-up should be repeated at 3, 6, and 12 months after treatment until test is nonreactive
   3. Antepartum clients with an active syphilis infection are required to transfer their care to a CNM or a physician for primary care; see “Determining Appropriate Client Care Provider” in Part I
4. Neonates with congenital syphilis or other acquired syphilis infection should receive care from a pediatric infectious-disease specialist
TRANSGENDER AND GENDER NONCONFORMING CLIENTS

A. DEFINITION
Transgender and gender nonconforming individuals are those whose gender identity does not coincide, partially or completely, with their biological sex assignment at birth. Gender identity is not the same as sexuality or sexual orientation; gender-nonconforming people may have a range of sexualities.

B. CONSIDERATIONS FOR CARE
1. With clients
   a. Adapt intake materials to represent gender neutral or gender inclusive language
   b. Ask clients their preferred pronoun and anatomical vocabulary
   c. Understand screening recommendations as it relates to transgender and gender non-conforming clients (e.g., trans-male clients may need to continue being screened for breast and cervical cancer)
   d. Consider and provide as needed education regarding factors related to feeding an infant after chest reconstruction surgery and for trans-feminine parents such as supplementation, milk supply augmentation, and other related infant feeding strategies
2. Other considerations to inform the midwife’s practice
   a. Economic and social marginalization increase health risks for transgender people
   b. Gender identification or history of prior gender affirmation procedures should not directly affect risk status for midwifery care
   c. Continuing education on barriers to healthcare access faced by gender nonconforming people
   d. Study the effects of gender affirmation procedures and therapies on reproductive health status
TRICHOMONIASIS

A. DEFINITION
An infection caused by the anaerobic, flagellated, one-celled protozoan *Trichomonas vaginalis* characterized by itching and inflammation of the vagina, vulva, lower urinary tract, and Skene's glands. Antepartum, trichomoniasis increases risk for preterm delivery, low birth weight, increased mortality.

B. ETIOLOGY
Sexually transmitted

C. SIGNS AND SYMPTOMS
1. May be asymptomatic
2. Strawberry appearance of upper vagina and cervix
3. Copious malodorous frothy, yellowish green discharge
4. Itching and burning
5. Dysuria
6. Dyspareunia
7. Inflamed labia, vulva, and Skene's glands
8. Friable cervix
9. Wet smear using normal saline is positive for mobile *T vaginalis* with a negative whiff test

D. MANAGEMENT
1. For all clients
   a. Offer symptomatic relief measures
   b. Complete labs as appropriate
      (a) Wet mount to rule out bacterial vaginosis
      (a) KOH prep: Positive "whiff test" or fishy odor present when 10% KOH is added to slide to diagnose BV
      (b) DNA probe test panel for vaginal pathogens (test detects and identifies: *Candida*, bacterial vaginosis, and *T vaginalis*)
      (c) Cervical cancer screening, if appropriate per guidelines; see “Cervical Cancer Screening” in Part IV
      (d) Gonorrhea and chlamydia and other STI screening
      (e) Urinalysis to rule out increased bacteria
   c. Follow-up for effectiveness of treatments
   d. Consider natural therapies
   e. Refer as appropriate for treatment
   f. Client education
      (a) Partner needs treatment
      (b) Prevention and transmission of organism
      (c) Good nutrition and stress management
2. Antepartum clients: In addition to the above management steps, consider the following guidelines
   a. Treatment in pregnancy is not contraindicated
b. Treatment can increase risk of preterm delivery and preterm premature rupture of membranes, though the infection itself can increase these risks

c. For asymptomatic pregnant patients, delaying treatment until 36 weeks gestational age may be considered

d. Serious maternal bacterial infection unresponsive to treatment at term requires consultation; see “Determining Appropriate Client Care Provider” in Part I
URINARY TRACT INFECTIONS (UTI)

Discussed in this guideline are common factors resulting in UTI including asymptomatic bacteriuria, cystitis, and pyelonephritis.

Antepartum clients with a UTI unresponsive to treatment requires consultation; see “Determining Appropriate Client Care Provider” in Part I.

ASYMPTOMATIC BACTERIURIA

A. DEFINITION
   Actively multiplying bacteria in the urinary tract without symptoms. Untreated UTI may progress to cystitis or pyelonephritis (see below) and antepartum may lead to preterm labor.

B. ETIOLOGY
   1. Usually caused by ascending gram negative bacteria, most commonly *E coli*
   2. Antepartum UTI may be precipitated by normal physiological changes of pregnancy
   3. Emotional and stress factors contribute to UTIs

C. SIGNS AND SYMPTOMS
   1. Client reports no symptoms; consider routine culture sensitivity, especially in pregnant clients
   2. Urinalysis via clean catch culture may reveal some, all, or none of the following:
      a. 100,000 or more bacteria
      b. Hematuria
      c. Leukocytes
      d. Nitrites
      e. Albumin
      f. High specific gravity
      g. High WBCs, RBCs

D. MANAGEMENT
   1. Consider natural therapies
   2. Increase water intake
   3. Reassess after 7-10 days of treatment or at any time if symptoms appear
   4. Consult as appropriate
   5. Antepartum clients with a UTI unresponsive to treatment require consultation; see “Determining Appropriate Client Care Provider” in Part I
   6. If allopathic treatment given, consider natural remedies to support normal flora
**CYSTITIS**

A. DEFINITION
   Infection confined to the bladder.

B. SIGNS AND SYMPTOMS
   1. Urinary frequency and urgency
   2. Dysuria
   3. Oliguria
   4. Pain after urination
   5. Suprapubic pain
   6. Back pain
   7. Fever
   8. Vomiting
   9. Hot flashes
   10. Urinalysis via clean catch culture may reveal some, all, or none of the following
       a. Colony count of 100,000 or more bacteria
       b. Hematuria
       c. Leukocytes
       d. Nitrites
       e. Albumin
       f. High specific gravity
       g. High WBCs, RBCs, etc.

C. MANAGEMENT
   1. Educate client
      a. Natural therapies
      b. Hydration, at least 4 quarts/day
      c. Good hygiene
      d. Empty bladder before and after intercourse
      e. Provide nutritional counseling
      f. Risk of ascending infection with pyelonephritis or sepsis
      g. Risk of preterm labor
   2. Perform culture and sensitivity as appropriate
   3. Consult for treatment as appropriate
   4. Antepartum clients with a UTI unresponsive to treatment require consultation; see “Determining Appropriate Client Care Provider” in Part I
   5. Follow-up evaluation and repeat urinalysis when treatment completed

**PYELONEPHRITIS**

A. DEFINITION
   Infection of the kidney(s). This is a serious complication as it may lead to septicemia and chronic pyelonephritis, and to premature labor in pregnancy.
B. ETIOLOGY
   1. Ascending bacteria from the bladder
   2. Untreated asymptomatic bacteriuria
   3. Inflammation from renal stones

C. SIGNS AND SYMPTOMS
   1. CVA tenderness, often unilateral (right)
   2. Fever over 100.4° F, chills, hot flashes
   3. Anorexia, nausea, vomiting
   4. Dysuria, urinary frequency and urgency
   5. Hematuria
   6. Elevated WBCs in blood
   7. Bacteria, WBCs, cast in urine

D. PYELONEPHRITIS MAY BE SIGNIFICANTLY ASSOCIATED WITH
   1. Kidney stones
   2. Antepartum placental abruption
   3. Infarcted fibroid
   4. Uterine infection (usually postpartum)
   5. With right-sided kidney infection, rule out appendicitis or biliary colic

E. MANAGEMENT
   1. Rule out above conditions
   2. Consider consultation with physician
   3. Antepartum clients with a UTI unresponsive to treatment require consultation; see “Determining Appropriate Client Care Provider” in Part I
   4. Prepare client for physician’s assessment and probable need for IV therapy, antibiotics, and hospitalization
   5. Consider natural therapies in conjunction with allopathic treatment
UTERINE FIBROIDS

A. DEFINITION
Benign tumor of the uterus composed primarily of smooth muscle and connective tissue. Also referred to as a leiomyomas or myomas.

B. ETIOLOGY
1. Cause unknown
2. Originate in myometrium
3. Usually multiple
4. May be located immediately beneath endometrial or decidual surface of uterine cavity, immediately beneath uterine serosa, or confined to the myometrium
5. Sometimes hormone responsive: known to increase in size with estrogen therapy and during pregnancy, and to decrease in size or disappear following pregnancy and/or menopause

C. SEQUELAE
1. Anemia
2. Infection
3. Intestinal obstruction
4. Genitourinary anomalies (e.g., urethral deviation or compression)
5. Miscarriage
6. Preterm labor
7. Placental abruption
8. Uterine inertia, which may lead to
   a. Obstructed labor
   b. Postpartum hemorrhage
9. Fetal malpresentation
10. Intrauterine growth restriction (IUGR)
11. Obstruction of birth canal
12. Increased risk of cesarean
13. Retained placenta

D. SIGNS AND SYMPTOMS
1. Often asymptomatic
2. Abnormal bleeding
   a. Menorrhagia
   b. Premenstrual spotting
   c. Prolonged light staining after menses
3. Abdominal pain, may radiate to back, lower extremities
4. Heaviness or bearing-down feeling in pelvic area
5. Constipation
6. Urinary retention
7. Intermittent incontinence
8. Serosanguinous vaginal discharge
9. Dyspareunia
10. Infertility
11. Enlarged abdomen
12. Lower extremity edema
13. Normal uterine contour distorted by one or more smooth, spherical, firm masses
14. Fever
15. Vaginal/cervical bleeding
16. Low hematocrit
17. Elevated leukocytes
18. Ultrasound reveals fibroid

E. MANAGEMENT
Usually no treatment required, particularly if asymptomatic or in post-menopausal woman
1. Well-woman clients
   a. Consult with physician for diagnosis, evaluation, treatment
   b. Consider natural therapies
   c. Recommend follow-up every 6 months
2. Antepartum clients
   a. Expectant management usually successful
   b. Myomectomy usually contraindicated
   c. Consider natural treatments
   d. If myomectomy indicated, refer for surgery 5-6 months after delivery
   e. Anticipate
      (a) IUGR; see “Intrauterine Growth Restriction (IUGR) or Small for Gestational Age (SGA)” in Part V
      (b) Fetal malpresentation
      (c) Obstructed labor
      (d) Postpartum hemorrhage; see “Postpartum Hemorrhage (Immediate)” and “Postpartum Hemorrhage (Late)” in Part VIII
   f. Consultation is required in the following cases; see “Determining Appropriate Client Care Provider” in Part I. Prepare client for diagnosis, evaluation, possible collaborative management plan with consulting provider(s).
      (a) Uterine fibroids
      (b) History of uterine surgery other than cesarean section
      (c) IUGR, suspected or documented
VARICOSITIES

A. DEFINITION
   Dilated, tortuous superficial veins most commonly occurring in the legs and vulva, which can be associated with deep vein thrombosis.

B. ETIOLOGY
   1. Heredity
   2. Weakness of veins
   3. Prolonged standing
   4. Increased venous pressure caused by enlarging uterus of pregnancy inhibiting venous return
   5. Relaxation of walls and valves of veins caused by increased antepartum progesterone levels

C. SIGNS AND SYMPTOMS
   1. Often asymptomatic
   2. Pain and/or heaviness in affected area
   3. Edema
   4. Itching
   5. Eczema
   6. Ulceration

D. MANAGEMENT
   1. Avoid restrictive clothing above site of varicosity
   2. Use support hose or elastic bandages to provide support
   3. Avoid prolonged standing
   4. Rest with legs elevated several times a day
   5. Avoid crossing legs while sitting
   6. Maintain good body posture
   7. Exercise regularly
   8. Consider natural therapies
   9. Dietary changes
   10. Be aware of signs and symptoms of deep venous thrombosis
PART V: ANTEPARTUM CARE
PART V: ANTEPARTUM CARE

ANTEPARTUM CARE SCHEDULE

A. INITIAL VISIT
   May include, but is not limited to:
   1. Personal information
   2. Obtain documented and signed informed consent(s)
   3. Obtain medical, obstetrical, family, dietary, mental health, and social history
   4. History of current pregnancy
   5. Determine EDD
   6. Perform physical exam
   7. Obtain appropriate labs as outlined in “Antepartum Testing”
   8. Question and inform clients as to their risks of HIV/AIDS and other STIs and available diagnostic testing
   9. Review recommended vaccination schedule and offer vaccines as appropriate during the pregnancy: influenza vaccine during flu season (generally Oct-May) and Tdap between 27 and 36 weeks gestation
   10. Instruct to avoid environmental and household hazards and exposures such as cat feces, raw meat, x-rays, chemicals, etc.
   11. Instruct to use seatbelt appropriately
   12. Instruct and educate on avoidance of alcohol, cigarettes, and drug exposure
      a. Standardized screening tools are recommended, with referral for treatment if substance use is ongoing
   13. Counseling regarding use of over-the-counter medications and safety in pregnancy
   14. Complete family violence assessment
   15. Educate regarding nutrition and supplements, exercise, childbirth education, and normal antepartum physiological changes
   16. Inform of available community resources
   17. Advise of warning signs of antepartum complications and how and when to contact midwife
   18. Establish prenatal care schedule
   19. Schedule next appointment
   20. Consult “Determining Appropriate Client Care Provider” in Part I to rule out consult or transfer requirements based on client’s history and clinical presentation

B. FOLLOW UP VISITS
   These visits shall include the following:
   1. Obtain maternal vital signs and FHTs
   2. Check for weight gain, presence of edema
   3. Consider dipstick urine for protein and glucose as needed
   4. Perform abdominal palpation for fundal height and fetal position
   5. Perform nutritional assessment and counseling
   6. Answer questions, address concerns
   7. Follow-up for risk factors
   8. Frequency of visits, if everything is normal, is once a month until 28 weeks, every 2 weeks until 36 weeks, and then every week until birth.
   9. Obtain labs as outlined in “Antepartum Testing” section below
   10. Birth preparation visit is scheduled by 37 weeks.
Antepartum Care Schedule

a. Encourage all persons planning to attend birth to be present
b. If homebirth is planned, have visit in the client’s home
c. Allow time for collaboration on a birth plan
d. Assess home environment for preparedness
e. Discuss management and plan for emergencies and/or transport
f. Review when and how to contact midwife
g. Discuss breastfeeding and postpartum care and support
h. Discuss newborn care issues
i. Discuss postpartum contraception plans
ANTEPARTUM TESTING

Midwives believe that women are the primary decision-makers for their own and their babies’ health care. As such, midwives support women’s informed choices regarding decisions to test and receive treatments, or to decline such testing and treatment.

A. STANDARD TESTING
   1. If client declines any standard testing, her midwife must have a signed waiver in client’s chart
   2. Prenatal testing may include the following:
      a. Initial testing
         (a) Blood type, factor, and antibody screen
         (b) Syphilis
         (c) CBC
         (d) Rubella titer
         (e) Hepatitis B
         (f) Glucose screening as indicated; see “Gestational Diabetes Mellitus (GDM)” screening protocol in Part V
         (g) HIV
         (h) Gonorrhea screen
         (i) Chlamydia screen
         (j) Cervical cancer screening
         (k) Genetic screening or testing: advise and inform all clients of available genetic screening and testing options
            (a) Chorionic villi sampling
            (b) Amniocentesis
            (c) First trimester screen: includes nuchal translucency and serum markers
            (d) Cell-free fetal DNA (for at risk clients)
            (e) Maternal multiple marker test (triple or quad screen) at 15-20 weeks
         (l) Carrier testing for genetic diseases (i.e., cystic fibrosis testing)
      b. Subsequent testing
         (a) Diabetes screen at 24-28 weeks
         (b) If Rh-negative, see “Rh Incompatibility” in Part V
         (c) Hemoglobin/hematocrit at 28 and 36 weeks
         (d) GBS screening at 35-37 weeks

B. TESTING TO CONSIDER
   1. Urinalysis
   2. Ultrasound
   3. Other blood tests as indicated (e.g., TSH, varicella titer, toxoplasmosis, tuberculosis)
   4. Genetic screening (see next section)

C. GENETIC SCREENING/TESTING CONSIDERATIONS
   1. It is considered the ethical duty of the LM to provide information about the existence of genetic testing and a referral for genetic testing or to a provider who can provide this referral if the client so desires
2. This information should be part of the informed consent provided to the client stating at a minimum, “Genetic testing and screening exists via blood draw, amniotic fluid sampling, placental sampling, and/or ultrasound. If you would like genetic counseling or any of these tests, a referral for testing or to a provider who can provide a referral will be provided on request.”

D. ULTRASOUND CONSIDERATIONS
1. Considerations for ultrasound include:
   a. Evaluation of fetal growth
   b. Estimation of gestational age for unconfirmed or uncertain dates
   c. Suspected ectopic pregnancy
   d. Suspected hydatidiform mole
   e. Suspected fetal demise
   f. Suspected multiple gestation
   g. Suspected polyhydramnios or oligohydramnios
   h. Suspected abruptio placenta or placenta previa
   i. Vaginal bleeding of unknown origin
   j. Presence of pelvic mass
   k. Questionable fetal presentation
   l. History of previous congenital anomaly
   m. Gestational diabetes
   n. History indicative of risk for congenital anomaly
   o. As part of biophysical profile
   p. Amniotic fluid index (AFI) or largest vertical pocket (LVP)
   q. Client request
2. Refer to individual guidelines for management considerations as applicable to the above considerations and to “Determining Appropriate Client Care Provider” in Part I
3. Consultation is required for the following factors that may be diagnosed or confirmed with ultrasound (see “Determining Appropriate Client Care Provider” in Part I):
   a. Two-vessel umbilical cord
   b. Size less than dates or suspected or documented IUGR
   c. Documented fetal anomaly
   d. Signs of fetal distress or demise
   e. Oligohydramnios (documented)
   f. Polyhydramnios (documented)
   g. Post dates greater than 42 weeks gestation (verified EDD by dates, ultrasound assessment, and/or physical exam)
4. Transfer of care to physician or CNM is required for the following factors that may be diagnosed or confirmed with ultrasound (see “Determining Appropriate Client Care Provider” in Part I):
   a. Ectopic pregnancy
   b. Placenta previa at onset of labor
   c. Placental abruption
   d. Fetus in any presentation other than vertex at onset of labor
   e. Multiple gestation
ANTEPARTUM BLEEDING

This section covers any antepartum bleeding from the urogenital region occurring during pregnancy. It is divided into two parts addressing antepartum bleeding at less than 20 weeks gestation and at greater than 20 weeks gestation.

ANTEPARTUM BLEEDING AT LESS THAN 20 WEEKS GESTATION

A. DEFINITION
   Any bleeding from the urogenital region during the first half of pregnancy.

B. ETIOLOGY
   1. Break-through bleeding due to implantation
   2. Threatened or actual abortion
   3. Cervical lesions
   4. Polyps
   5. Erosion
   6. Carcinoma
   7. Hydatidiform mole
   8. Ectopic pregnancy
   9. Trauma
   10. Recent sexual intercourse
   11. Hemorrhoids
   12. Infection of reproductive tract
   13. Subchorionic hemorrhage
   14. Fibroids

C. SIGNS AND SYMPTOMS
   1. Irregular urogenital spotting or bleeding
   2. Lower abdominal pain, cramping, pelvic tenderness
   3. History or signs of:
      a. Vaginitis
      b. Cervicitis
      c. Ectopic pregnancy
      d. Abnormal cytology
      e. DES exposure
      f. Hemorrhoids
      g. Over-exertion
      h. Recent sexual intercourse
      i. Recent cervical exam including cervical cancer screening
   4. Pelvic exam reveals:
      a. Products of conception or uterine bleeding
      b. Cervical erosion, polyps
      c. Pelvic tenderness
D. MANAGEMENT

1. Assess vital signs, blood loss, and for symptoms of shock
2. Gentle speculum exam/bimanual exam to determine source of bleeding
3. If indicated, culture vaginal/cervical exudate for:
   a. Chlamydia
   b. Gonorrhea
   c. Vaginitis, cervicitis, other infections
   d. Abnormal cervical cancer screen, if indicated per timing recommendation in guidelines; see “Cervical Cancer Screening” in Part IV
4. FHTs or ultrasound is indicated to confirm pregnancy unless other source of bleeding is identified; see “Ectopic Pregnancy” in Part V if an ectopic pregnancy cannot be ruled out
5. Labs to consider:
   a. If intrauterine pregnancy has already been documented, and there is no concern for ectopic pregnancy, can order quantitative HCG and repeat in 48 hours if indicated
   b. CBC
   c. Urine culture
   d. If client is Rh-negative, provide AST screen if more than 6 weeks pregnant, and consider administration of Rh IgG; see “Rh Incompatibility” in Part V for more details
6. If no cervical dilation, products of conception, nor evidence of cervicitis or vaginitis:
   a. Educate/inform client of possible sequelae with bleeding
   b. Consider
      (a) Bed rest
      (b) Pelvic rest
      (c) Alternative treatment/natural remedies
   c. Instruct client to contact midwife if bleeding persists or increases, or if she passes products of conception
   d. Evaluate tissue/clots
7. Transfer is required in cases of documented or suspected ectopic pregnancy or hydatidiform mole/molar pregnancy (if intrauterine pregnancy has not yet been verified by ultrasound or fetal heart tones); see “Determining Appropriate Client Care Provider” in Part I
8. Consultation is required in cases of heavy bleeding with or without severe pain; see “Determining Appropriate Client Care Provider” in Part I
9. For suspected SAB, see “Spontaneous Abortion (Miscarriage)” in this Part V

ANTEPARTUM BLEEDING GREATER THAN 20 WEEKS GESTATION

A. DEFINITION
   Any bleeding from the urogenital region during the second half of pregnancy.

B. ETIOLOGY
1. Abruptio placenta
2. Placenta previa
3. Vasa previa
4. Contractions/onset of labor
5. See the above etiology section of this guideline under “antepartum bleeding less than 20 weeks” for other possible etiologies

C. SIGNS AND SYMPTOMS
   1. Same as first 20 weeks antepartum
   2. History of contractions
   3. Uterine tenderness/pain localized or general
   4. Hypertonic uterus
   5. Absence of FHTs/fetal movement
   6. Evidence of hypovolemic shock

D. MANAGEMENT
   1. Suspected abruption: check vital signs, FHTs, transfer; see “Determining Appropriate Client Care Provider” in Part I
   2. Suspected previa not ruled out by previous ultrasound: avoid vaginal exam and see “Placenta Previa”
   3. Suspected fetal demise: consultation is required; see “Fetal Demise” in this Part V for management and refer to “Determining Appropriate Client Care Provider” in Part I
   4. Evaluate for presence of labor
      a. Labor is present
         (a) Consult and transfer for premature labor if indicated; see “Preterm Labor” and “Determining Appropriate Client Care Provider”
         (b) If term labor, evaluate amount of bleeding; severe bleeding prior to or during birth requires transfer of care, see “Determining Appropriate Client Care Provider” in Part I
         (c) If known previa at onset of labor, transfer; see “Placenta Previa” in Part V and “Determining Appropriate Client Care Provider” in Part I
      b. Labor is not present
         (a) Consultation is required when there is continued vaginal bleeding before onset of labor with or without pain; see “Determining Appropriate Client Care Provider” in Part I
         (b) Consultation is required when there are signs of fetal distress or demise; see “Fetal Distress” in Part VI, “Fetal Demise” in Part V, and “Determining Appropriate Client Care Provider” in Part I
   5. Recommended examinations as indicated:
      a. Cervical exam (contraindicated if known previa)
      b. Ultrasound
      c. Speculum exam
   6. Recommended labs: As indicated, complete labs as above in “Antepartum Bleeding Less Than 20 Weeks”
   7. Recommended treatments:
      a. Treat for hypovolemic shock if indicated
      b. If mother Rh-negative, offer Rh IgG as indicated; see “Rh Incompatibility” in Part V
COMMON ANTEPARTUM DISCOMFORTS

The following discomforts or problems are attributed to the physiological and emotional changes during the first, second, and third trimesters of pregnancy. This section includes guidance for the following topics: Constipation, Heartburn, Hemorrhoids, Insomnia, Leg Cramps, Lower Back Pain, Nausea and Vomiting of Pregnancy, and Round Ligament Pain.

CONSTIPATION

A. DEFINITION
   Dry, difficult bowel movements.

B. ETIOLOGY
   1. Increase in progesterone
   2. Decreased fluid intake
   3. Lack of leafy green vegetables or fiber in diet
   4. Vitamins, iron supplementation, other medications

C. SIGNS AND SYMPTOMS
   1. Difficult, dry, painful, or infrequent bowel movements
   2. Impacted fecal matter

D. MANAGEMENT
   1. Increase clear fluids to 3 quarts daily
   2. Educate about nutrition and exercise
   3. Consider natural therapies

HEARTBURN

A. DEFINITION
   A burning sensation or pain in lower esophagus.

B. ETIOLOGY
   Usually caused by reflux of gastric contents into the lower esophagus due to upward compression and displacement of the stomach by the uterus in combination with relaxation of the lower esophageal sphincter.

C. SIGNS AND SYMPTOMS
   1. A continual burning/pain in throat or upper chest
   2. May be accompanied or followed by nausea and/or vomiting

D. MANAGEMENT
   1. Rule out epigastric pain due to preeclampsia
   2. Frequent small meals
   3. Decrease spicy/greasy foods
4. Avoid eating immediately prior to bedtime and lying down
5. Papaya tablets or digestive enzymes and teas
6. Separate intake of fluids and fruits from meals by 30 minutes
7. Consider other natural therapies
8. Consider over the counter medications

HEMORRHOIDS

A. DEFINITION
   An enlarged vein in the mucous membrane inside or just outside the rectum that causes pain, itching, discomfort, and bleeding.

B. ETIOLOGY
   1. Standing or sitting for long periods
   2. Constipation
   3. Straining with defecation
   4. Pregnancy
   5. Prolonged forceful pushing with second stage of labor
   6. Trauma

C. SIGNS AND SYMPTOMS
   1. Itching
   2. Pain and/or burning
   3. Swelling
   4. Fresh rectal bleeding
   5. Observation of dilated anal veins

D. MANAGEMENT
   1. Prevention
      a. Teach methods for and importance of avoiding constipation
      b. Avoid straining during defecation
      c. Increase fluids and fiber
      d. Careful second stage management
   2. Relief measures may include
      a. Ice packs
      b. Sitz baths
      c. Topical herbal ointments
      d. Witch hazel compresses
      e. Epsom or sea salt compresses
      f. Topical analgesic ointments
      g. Castor oil applied directly
      h. Other natural remedies
      i. Gentle reinserterion of hemorrhoids while exercising the pelvic floor muscles
      j. Pelvic floor exercises
   3. Consult if excessively painful or intractable
INSOMNIA

A. DEFINITION
   Inability to sleep or to remain asleep.

B. ETIOLOGY
   1. Physical
      a. Urinary frequency
      b. Poor venous return
      c. Diet
      d. Hormonal changes
      e. Active fetus
      f. Other pregnancy discomforts
   2. Emotional
      a. Concerns or fears
      b. Anxiety and/or depression

C. MANAGEMENT
   1. Decrease/eliminate caffeine consumption and improve dietary habits
   2. Exercise during the day
   3. Relaxation, deep breathing, naps as necessary
   4. Bathe or shower before bedtime
   5. Hot milk, herbal teas, or other natural therapies
   6. May be a marker for postpartum recurrence of depression among women with previous depression

LEG CRAMPS

A. DEFINITION
   Muscle spasms in legs.

B. ETIOLOGY
   1. Pressure of fetus on vessels/nerves to legs
   2. Abnormal serum calcium, magnesium, or sodium levels
   3. Very cold weather
   4. Muscle tension
   5. Muscle fatigue

C. MANAGEMENT RECOMMENDATIONS
   1. Rule out phlebitis
   2. Review dietary intake of calcium/magnesium
      a. Make appropriate recommendations
      b. Inform client about foods which prevent calcium absorption
   3. Maintain hydration
   4. Teach dorsiflexion and extension exercises
   5. Teach comfort measures
Common Antepartum Discomforts

a. Elevate feet  
b. Keep feet and legs warm  
c. Massage  
6. Avoid long periods of standing or sitting  
7. Consider natural therapies

LOWER BACK PAIN

A. ETIOLOGY
   1. Change in center of gravity
   2. Hormonal changes
   3. May be due to constipation, poor posture, improper lifting, UTI, or labor
   4. Lack of physical movement or exercise

B. MANAGEMENT RECOMMENDATIONS
   1. Rule out UTI or labor
   2. Demonstrate good posture and body mechanics
   3. Exercise (e.g., yoga, pelvic rock)
   4. Apply heat
   5. Massage
   6. Recommend firm mattress
   7. Consider natural therapies

NAUSEA AND VOMITING OF PREGNANCY

A. DEFINITION
   A common condition of early pregnancy characterized by recurrent or persistent nausea, often in the morning, which may result in vomiting, weight loss, anorexia, general weakness, and malaise.

B. ETIOLOGY
   1. Hormonal changes
   2. Dehydration
   3. Hypoglycemia
   4. Emotional factors

C. SEQUELA
   1. Hyperemesis gravidarum

D. SIGNS AND SYMPTOMS
   1. Excessive salivation
   2. Nausea and/or vomiting
   3. Dehydration

E. MANAGEMENT
1. Rule out hyperemesis gravidarum
2. Institute starch-based oral rehydration therapy
3. Check ketones
4. Eat small frequent high-protein, high-carbohydrate, low-fat meals
5. Eat solid food separately from liquids
6. Carbohydrate snack upon waking
7. Consider vitamin B-6 supplementation
8. High-protein snacks before bed
9. Take ginger in various forms such as capsule, tea, candied
10. Consider natural therapies
11. Consider consultation with other health care providers if signs and symptoms are severe
12. Consultation is required if vomiting is unresponsive to treatment; see “Determining Appropriate Care Provider” in Part I

ROUND LIGAMENT PAIN

A. DEFINITION
   A sharp pain or tenderness in lower abdominal quadrants. Pain may radiate.

B. ETIOLOGY
   1. Hormonal changes
   2. Stretching of ligaments

C. MANAGEMENT
   1. Evaluate and correct calcium/magnesium and trace mineral intake
   2. Avoid jerky movements
   3. Gentle stretching, lie on or bend towards painful side
   4. Apply moist heat as necessary
   5. Provide abdominal support when lying down
   6. Demonstrate good posture
ECTOPIC PREGNANCY

A. DEFINITION
Life-threatening implantation of the blastocyst anywhere outside of the uterine cavity including but not limited to the ovaries and fallopian tubes.

B. RISKS
1. Previous ectopic pregnancy
2. Salpingitis: inflammation or infection of fallopian tube
3. Peritubal adhesions
4. Endometriosis
5. Pelvic inflammatory disease
6. Developmental abnormalities of the tube
7. Tumors that distort the tube
8. Previous operations on the tube
9. Multiple previous D&Cs
10. Previous cesarean section(s)
11. Smoking
12. Exposure to DES
13. Contraceptive choice
   a. Current use of IUD
   b. Current or past use of Essure
   c. Tubal ligation or reversal

C. SIGNS AND SYMPTOMS
1. Abdominal and pelvic pain, often mild
2. Exquisite tenderness on bimanual exam and tenderness on motion of the cervix
3. Referred shoulder pain
4. Amenorrhea
5. Vaginal spotting or bleeding and hemorrhage
   a. Concealed
   b. Frank
6. Nausea and vomiting
7. Uterine changes
   a. Uterine growth in first two months parallels normal pregnancy
   b. Uterus may be pushed to one side, rule out bicornuate uterus
   c. Occasional passing of uterine casts with cramping
8. Pelvic mass may be palpated posterior or lateral to the uterus
9. Signs and symptoms of shock
10. Ultrasound positive for fetal growth outside uterine cavity

D. MANAGEMENT
1. If suspicion of ectopic pregnancy, immediate ultrasound is recommended
2. Rule out appendicitis and ovarian cyst
3. Check vital signs and treat for shock if appropriate
4. Transfer of care is required for suspected or diagnosed ectopic (consider immediate transfer of care); see “Determining Appropriate Client Care Provider” in Part I
5. Educate mother about her condition and the possibility of salpingectomy
FETAL DEMISE

A. DEFINITION
Intrauterine death of fetus at 20 weeks gestation or more, or, if gestational age is unknown, when the fetus weighs greater than or equal to 350 grams.

B. SIGNS AND SYMPTOMS
1. No fetal movement
2. Cramping or labor pains
3. Bloody or foul discharge
4. Painful, firm (hard) abdomen
5. No FHTs
6. Lack of or decrease in uterine growth
7. Cessation of maternal weight gain and/or decrease in weight
8. Retrogressive pregnancy changes

C. MANAGEMENT
1. Obtain ultrasound to confirm fetal demise
2. Consultation is required with signs of fetal demise; see “Determining Appropriate Client Care Provider” in Part I
3. Prepare and counsel mother and other family members of risks and emotional factors
4. If appropriate, offer birth at home with spontaneous labor if 2 weeks or less since demise
5. Transfer as appropriate
6. Facilitate private bonding time, burial arrangements, religious, and community support
7. Follow and support with postpartum care; may be longer than the normal 6 week period
8. Refer for genetic and grief counseling and/or support groups
9. Follow state regulations for documentation and reporting of fetal demise; in New Mexico for reporting and documentation requirements, refer to
   a. §24-14-22 NMSA, Reports of spontaneous fetal death (retrievable at http://public.nmcompcomm.us/nmnxtadmin/NMPublic.aspx)
   b. NMAC 7.2.2 (http://164.64.110.134/parts/title07/07.002.0002.html)
10. A certificate of still birth is available on request to New Mexico parents from the New Mexico Vital Records and Health Statistics Bureau; follow the same protocol as for live birth registration (refer to §24-14-22.1 Certificates of still birth and NMAC 7.2.2 above)
FEVER IN PREGNANCY

A. DEFINITION
Maternal oral temperature of 100.4° F (38° C) or greater.

B. ETIOLOGY
1. Viral infection
2. Bacterial infection
3. Protozoal infection
4. Dehydration
5. Heat exhaustion
6. Missed abortion

C. SIGNS AND SYMPTOMS
1. Skin hot to touch
2. Dehydration
3. Poor skin turgor
4. Oliguria
5. Maternal and/or fetal tachycardia
6. Chills

D. MANAGEMENT
1. History and physical
2. Monitor maternal vital signs
3. Monitor fetal heart tones for tachycardia; see “Fetal Distress” in Part VI
4. Lab work appropriate for differential diagnosis
5. Educate client that a fever over 100.4° F in the first trimester may increase fetus’ risk
   of neural tube defects, congenital heart defects, and oral clefts
6. Education for home management of minor illness
7. Consider natural therapies, over the counter medication, and referral for antibiotic
   treatment
8. Consultation antepartum is required in the following cases; see “Determining
   Appropriate Client Care Provider” in Part I:
   a. Persistent fever for any illness
   b. For serious maternal viral/bacterial infection unresponsive to treatment at term
9. Transfer of care is required with maternal fever of 100.4° F or greater for over 4
   hours intrapartum; see “Determining Appropriate Client Care Provider” in Part I
GENETIC COUNSELING

A. DEFINITION
The giving of advice to prospective parents concerning the chances of genetic disorders in future children.

B. INDICATIONS
Including but not limited to:
1. Advanced maternal age
2. Abnormal noninvasive prenatal testing (NIPT) results, including abnormal ultrasound
3. Drug or teratogenic exposures
   a. Alcohol
   b. Cigarettes
   c. Recreational drugs
   d. Hypertensives (e.g., angiotensin converting enzyme inhibitors, thiazides)
   e. Anticoagulants (e.g., warfarin sodium [Coumadin])
   f. Anticonvulsants (e.g., hydantoin, carbamazepine, trimethadione, valproic acid)
   g. Antidepressants (e.g., lithium, tricyclic antidepressants)
   h. Antipsychotics (e.g., phenothiazines)
   i. Retinoids (e.g., isotretinoin, etretinate)
   j. Antibiotics (e.g., tetracyclines, streptomycin)
   k. Antimetabolites
   l. Other medication exposure known or thought to cause harm to fetus
4. Family history of hereditary condition
5. Positive TORCH panel
6. Client desires testing
7. Ethnicity/race

C. MANAGEMENT
1. Educate client about indications
2. Explain timing and procedures, risks versus benefits, probable costs for maternal multiple marker screening such as triple or quadruple screen and other NIPT, chorionic villi sampling, amniocentesis, and ultrasound
3. Can use online risk calculators available at Perinatology.com
4. Consult as indicated; teratogenic exposure is an antepartum factor requiring consultation, see “Determining Appropriate Client Care Provider” in Part I for the full list
GESTATIONAL DIABETES MELLITUS (GDM)

A. DEFINITION
Onset or recognition of carbohydrate intolerance of variable severity during pregnancy.

B. RISK FACTORS FOR GDM
1. BMI greater than 25 kg/m²
2. African American, Latina, Pacific Islanders, and Native American
3. Previous history of GDM
4. Family history of diabetes
5. History of previous infant with macrosomia: birth weight over 4500 g (9.9 lb)
6. Note: these other possible factors can indicate a woman may have type 2 diabetes (but not GDM)
   a. History of unexplained stillbirth
   b. Previous birth of infant with fetal anomalies
   c. Two or more spontaneous abortions

C. MATERNAL SEQUELAE OF GDM
1. Increased chance of macrosomia (birth weight over 4500 g / 9.9 lb), with associated risks increasing significantly if macrosomia present
   a. Shoulder dystocia
   b. Operative birth
   c. Lacerations
   d. Postpartum hemorrhage
2. May also be associated with
   a. Polyhydramnios
   b. More frequent incidence of gestational hypertension
   c. More frequent Candidiasis infection
   d. More frequent UTIs
   e. Increased risk of developing type 2 diabetes in later life

D. FETAL/NEONATAL SEQUELAE OF GDM
1. Macrosomia
2. Hypoglycemia
3. Hypocalcemia
4. The following symptoms are possible with GDM, but are more commonly seen in newborns born to mothers with diabetes mellitus type 2:
   a. Respiratory distress
   b. IUGR
   c. Polycythemia
   d. Hyperbilirubinemia
   e. At higher risk for fetal and neonatal death if GDM is not diet-controlled

E. SIGNS AND SYMPTOMS OF GDM
1. Glycosuria
2. Excessive weight gain
3. Fetus large for gestational age
4. Additional signs and symptoms more commonly associated with diabetes mellitus type 2
   a. Polyuria, polydipsia, polyphagia
   b. Weight loss
   c. Weakness
   d. Poor healing
   e. Blurred vision

F. SCREENING

1. Educate women about GDM screening options
2. Document education and client’s decision regarding screening
3. Consider screening for pre-gestational diabetes in the first trimester for all women; recommend screening for those at risk
   a. Risk factors for diabetes
      (a) History of GDM in last pregnancy
      (b) Increased BMI
      (c) Strong family history of DM
      (d) Abnormal HgbA1C
      (e) Multiple SABs
      (f) Unexplained IUFD
      (g) History of macrosomia in previous infant
      (h) Polyhydramnios in previous pregnancy
      (i) Congenital anomalies in previous pregnancy
      (j) Glucosuria
      (k) History of glucose intolerance / pre-diabetes
   b. First trimester screening
      (a) Hemoglobin A1C (HgbA1C)
         (a) If greater than or equal to 6.5, client is considered to have diabetes mellitus type 2; see “Determining Appropriate Client Care Provider” in Part I for consult or transfer requirements
         (b) If 5.7-6.4, do a fasting glucose if client is 23 weeks gestation or less; otherwise screen for GDM as at 24-28 weeks
         (i) If fasting glucose is less than 92, screen for GDM at 24-28 weeks
         (ii) If fasting glucose is greater than or equal to 92, then woman is considered to have GDM; see Management section below
         (b) A fasting blood glucose of greater than or equal to 125 or random blood glucose of greater than or equal to 200 is also consistent with overt diabetes (diabetes mellitus type 1 or 2; see “Determining Appropriate Client Care Provider” in Part I for consult or transfer requirements)
4. Screening at 24-28 weeks: offer 50 gram glucose challenge, OR 75 gram 2-hour glucose challenge, OR Fasting blood sugar and 2-hour postprandial test
   a. 50 gram glucose challenge with 1-hour blood draw: if blood glucose is greater than or equal to 130, follow with the 3-hour Glucose Tolerance Test (GTT):
      (a) Normal values of the 3-hour GTT
         (a) Fasting: less than 95
         (b) 1 hour: less than 180;
Gestational Diabetes Mellitus (GDM)

(c) 2 hour: less than 155
(d) 3 hour: less than 140
(b) If two of the four blood glucose values or the fasting value alone exceed normal range, the diagnosis of gestational diabetes is confirmed
(c) If one of the 1, 2, or 3 hour blood glucose values is abnormal, diagnosis is glucose intolerance
    (a) Dietary counseling should be given
    (b) Repeat 3 hour glucose test in one month to check for progression to GDM

b. 75 gram 2-hour glucose challenge
(a) Normal values
    (a) Fasting: less than 92
    (b) 1 hour: less than 180
    (c) 2 hour: less than 153
(b) If one value is abnormal, diagnosis of gestational diabetes mellitus is confirmed

c. Fasting blood sugar and 2-hour postprandial test
(a) This form of screening is not evidenced based, but preferable over no screening at all
(b) Normal values
    (a) Fasting: less than 95
    (b) 2 hours postprandial: less than 120
(c) If results are abnormal
    (a) Consider formal screening with 3-hour GTT or 2-hour glucose challenge
    (b) Alternatively client can be diagnosed with GDM if additional screening is declined

G. MANAGEMENT FOR CONFIRMED GDM
1. Antepartum
   a. Nutritional and exercise counseling
   b. Consider natural therapies
   c. Consult with a provider, such as a diabetes educator or nutritionist, who can train the mother in diabetes management and blood glucose monitoring
   d. GDM uncontrolled by diet requires primary care by a physician or CNM; see “Determining Appropriate Client Care Provider” in Part I
   e. GDM controlled by diet (GDM-A1)
      (a) Consultation is required; see “Determining Appropriate Client Care Provider” in Part I
      (b) Fasting goal is less than 95; 2 hour postprandial goal is less than 120
      (c) If blood glucose levels become uncontrollable with dietary and lifestyle changes, transfer to physician or CNM
      (d) Recommend ultrasound at 36-38 weeks for an EFW
      (e) Recommend fetal surveillance at 40 weeks and induction of labor by 41 weeks
      (f) A fetal factor requiring consultation relevant to GDM is IUGR, documented or suspected; see “Determining Appropriate Client Care Provider” in Part I
2. Postpartum Follow-up
   a. Screen for progression to diabetes mellitus type 2
(a) Check fasting glucose at 6 weeks postpartum, OR
(b) HgA1C at 12 weeks postpartum
b. Recommend maternal annual screening for diabetes mellitus type 2
c. Newborn risk factors relevant to GDM requiring consultation include (see “Determining Appropriate Client Care Provider” in Part I)
   (a) Hypoglycemia
   (b) Hyperbilirubinemia
   (c) Respiratory distress or abnormal respiratory patterns
HYPERTENSION IN PREGNANCY

A. DEFINITIONS

1. Chronic hypertension (i.e., pre-existing hypertension)
   a. Systolic blood pressure greater than or equal to 140 mmHg and/or diastolic blood pressure greater than or equal to 90 mmHg
   b. Occurs before 20 weeks of gestation or persisting beyond 12 weeks postpartum

2. Gestational hypertension
   a. Systolic blood pressure greater than or equal to 140 mmHg and/or diastolic blood pressure greater than or equal to 90 mmHg
   b. Elevated on two different occasions, at least 4 hours apart
   c. Occurs after 20 weeks gestation and resolves in the postpartum period
   d. Presents with no proteinuria, other symptoms, or abnormal lab values

3. Preeclampsia without severe features
   a. Systolic blood pressure greater than or equal to 140 mmHg but less than 160 mmHg and/or diastolic blood pressure greater than or equal to 90 mmHg but less than 110 mmHg
   b. Elevated on two different occasions, at least 4 hours apart
   c. Occurs after 20 weeks gestation
   d. Proteinuria (one of the following):
      (a) Protein of 300 mg in a 24 hour urine collection
      (b) Protein/creatinine ratio of 0.3
      (c) Protein 30 mg/dL or 1+ on urine dipstick (using dipsticks for diagnosis is discouraged unless other approaches are not readily available)
   e. No serum lab abnormalities or symptoms

4. Preeclampsia with severe features
   a. Same as preeclampsia without severe features, except one of the following must be present (proteinuria is not required):
      (a) Systolic blood pressure greater than or equal to BP 160 mmHg, measured twice at least 15 min apart
      (b) Diastolic blood pressure greater than or equal to 110 mmHg, measured twice at least 15 min apart
      (c) Thrombocytopenia: platelet count less than 100,000/microliter
      (d) Impaired liver function: AST or ALT twice the normal concentration
      (e) Renal insufficiency: serum creatinine greater than 1.1 mg/dL or doubled from baseline values
      (f) Pulmonary edema
      (g) Symptoms indicating possible cerebral or neurologic involvement: headache or visual changes (e.g., flashing, blurring, visual loss, blindness)

5. Eclampsia
   a. Seizure
   b. Systolic BP greater than or equal to 140 mmHg and/or diastolic BP greater than or equal to 90 mmHg

6. HELLP syndrome
   a. Primarily develops in the third trimester as a result of preeclampsia, but can be diagnosed in women who have not shown any of the typical signs or symptoms of preeclampsia.
b. The underlying mechanism of HELLP includes arterial vasospasms, platelet aggregation, and endothelial damage resulting in tissue hypoxia.

c. Characterized by hemolysis, elevated liver enzymes, low platelet count

B. WOMEN AT INCREASED RISK FOR PREECLAMPSIA
1. Nulliparity
2. Women over 40
3. Multiple gestation
4. Preeclampsia in a prior pregnancy (particularly if with severe features or prior to 32 weeks)
5. Chronic hypertension
6. Chronic renal disease
7. History of thrombophilia
8. Elevated body mass index
9. Diabetes mellitus (Type I or II)
10. In vitro fertilization
11. Family history of preeclampsia
12. Systemic lupus erythematosus

C. SIGNS AND SYMPTOMS OF CONCERN (NOT DIAGNOSTIC)
1. Rise in blood pressure
2. Proteinuria
3. Swelling of hands or face
4. Generalized edema
5. Sudden rapid weight gain
6. Oliguria
7. Neurological sequelae
   a. New onset headache not relieved by medication or other treatment (in particular, frontal and occipital)
   b. Visual disturbances
   c. Hyperreflexia
   d. Clonus
   e. Trembling extremities
8. Epigastric pain
9. Right upper quadrant pain
10. General malaise
11. Nausea and vomiting
12. Abnormal lab values

D. MANAGEMENT
1. Care of women with signs of preeclampsia is usually based on a diagnosis of preeclampsia with or without severe features. However, it is important to note that those with preeclampsia without severe features can progress quickly to having severe features. HELLP Syndrome may appear in women who present with preeclampsia without severe features or who do not have any signs of preeclampsia.
2. Education of all pregnant women, especially those with risk factors listed above
3. Prevention
   a. There is no high quality evidence to support dietary modification in prevention or treatment of hypertensive disorders of pregnancy. However, some midwives recommend the following:
      (a) High protein, high calorie diet
      (b) Calcium rich diet: 1500 mg/day or supplementation of 2 gm of calcium a day
      (c) Magnesium rich diet: 1500 mg/day
      (d) Normal salt intake
      (e) Drink 3 quarts to 1 gallon of water every day
      (f) Exercise at least 30 minutes a day
      (g) Rest and relax at least 2 times a day for an hour
   b. New research shows that baby aspirin (81mg) may prevent preeclampsia in women who have a history of preeclampsia or other risk factors; consider consulting for this option
   c. Consider consulting with a physician or CNM for clients who appear to be borderline for or developing gestational hypertension
4. Gestational hypertension
   a. Consultation is required; see “Determining Appropriate Client Care Provider” in Part I
   b. Educate client on symptoms and danger signs
   c. Increase prenatal visits with at least weekly blood pressure checks
   d. Consider natural therapies
   e. Transfer care if diagnosis made of preeclampsia with or without severe features and/or HELLP
5. Clients presenting with the following require consultation; see “Determining Appropriate Client Care Provider” in Part I
   a. Chronic hypertension
   b. Gestational hypertension
   c. Thrombocytopenia
6. Clients presenting with the following require transfer of care; see “Determining Appropriate Client Care Provider” in Part I
   a. Antepartum transfer to a physician or CNM is required in cases of preeclampsia with or without severe features, HELLP syndrome, eclampsia
   b. Intrapartum transfer of care to a physician or CNM is required when severe headache, visual disturbances, or epigastric pain develop
GROUP B BETA-HEMOLYTIC STREPTOCOCCUS (GBS)

A. DEFINITION
A common bacterium often carried in the intestines or lower genital tract that can be found in a pregnant woman's vagina or rectum. This bacteria is normally found in the vagina and/or rectum of about 20-25% of all healthy, adult women. Women who test positive for GBS are said to be colonized. It is considered part of the normal flora and rarely causes problems in adults. Newborns can be exposed to GBS during passage through the vagina, which can cause a serious illness known as group B strep disease.

B. SEQUELAE
1. Maternal
   a. Premature rupture of membranes
   b. Preterm labor
   c. Possible intrauterine infection and/or inflammation - Triple I (previously referred to as chorioamnionitis)
   d. Postpartum infection in mother
2. Newborn
   a. Most babies who are exposed to GBS will not become infected
   b. Generalized sepsis in newborn that may include pulmonary infection, septicemia, or meningitis

C. RISK FACTORS
1. Preterm birth (born before 37 weeks gestation)
2. Ruptured membranes greater than 18 hours
3. Maternal fever greater than 100.4° F degrees in labor

D. SIGNS AND SYMPTOMS
1. Usually asymptomatic
2. Positive maternal vaginal, urinary, or rectal culture
3. Symptoms of UTI
4. Premature rupture of membranes
5. Premature labor
6. Fever of 100.4° F degrees or higher
7. Intrauterine infection and/or inflammation - Triple I (previously referred to as chorioamnionitis)
8. Early (within first week of life, average 20 hours postpartum) or late (after first week postpartum) onset of neonatal infection

E. MANAGEMENT
1. Provide clients with comprehensive information and informed consent on GBS infection and possible care plans
2. GBS screening and treatment:
   a. Obtain a GBS culture between 35 and 37 weeks; repeat culture after 5 weeks if woman is still pregnant
Group B Beta-Hemolytic Streptococcus (GBS)

(a) Recommend intravenous prophylactic antibiotic treatment in labor to all women who have tested positive according to the CDC protocol (antibiotic treatment prior to labor is not considered effective)
(b) Review possible side effects of antibiotics
(c) Offer alternative treatment/therapies
(d) Do not treat women who test negative

b. If culture is not obtained, offer treatment for those women who present in labor with the following risk factors (according to RCOG Risk Based Protocol) and review possible side effects of antibiotics:
   (a) Women whose membranes have ruptured longer than 18 hours
   (b) Women who have a fever of greater than 100.4°F in labor

3. IV antibiotic treatment for GBS is recommended for women who have:
   a. A child previously affected by GBS disease
   b. Urine culture positive for GBS during this pregnancy (no other cultures needed)

4. Consider natural therapies for prophylaxis and/or treatment

5. Transfer of an intrapartum client is required if signs and symptoms of active infection, maternal fever of 100.4°F for over 4 hours, and other factors are observed; see “Determining Appropriate Client Care Provider” in Part I

6. Neonatal and newborn factors that may indicate infection requiring consultation or transfer of care to pediatrician, physician, nurse practitioner, or physician assistant
   a. Infants who becomes seriously ill in the first 48 hours should be considered for possible GBS sepsis
   b. Infants presenting with seizures require immediate transfer; see “Determining Appropriate Client Care Provider” in Part I
   c. Respiratory distress; consultation is required; see “Determining Appropriate Client Care Provider” in Part I
      (a) Tachypnea
      (b) Grunting
      (c) Nasal flaring
      (d) Retractions
      (e) Cyanosis
   d. Poor feeding; consultation is required; see “Determining Appropriate Client Care Provider” in Part I
   e. Lethargy; consultation is required; see “Determining Appropriate Client Care Provider” in Part I
   f. Vomiting
   g. High or low temperature; abnormal body temperature requires consultation, see “Determining Appropriate Client Care Provider” in Part I
   h. High pitched cry; abnormal cry requires consultation, see “Determining Appropriate Client Care Provider” in Part I
HYPEREMESIS GRAVIDARUM

A. DEFINITION
   Excessive nausea and vomiting during pregnancy.

B. RISK FACTORS
   1. Multiple pregnancy due to increased HCG levels
   2. Female fetus
   3. Family history
   4. Occurrence in previous pregnancy
   5. Hyperthyroidism
   6. Low vitamin B levels
   7. Molar pregnancy due to increased HCG levels
   8. Low socioeconomic status
   9. Substance abuse
   10. Psychological factors including anxiety

C. SIGNS AND SYMPTOMS
   1. Nausea and aversion to food unresponsive to treatment for morning sickness
   2. Sensitivity to odors
   3. Excessive vomiting unresponsive to treatment for morning sickness
   4. Oliguria
   5. Weakness and fatigue
   6. Ketonuria greater than 1+
   7. Weight loss or failure to gain weight
   8. Dehydration evidenced by:
      a. Decreased skin turgor
      b. Dry mucous membranes
      c. Fruity odor of ketones on breath
      d. Rapid pulse
      e. Decreased urine output
   9. Blood pressure significantly below baseline
   10. Serum electrolyte analysis indicates electrolyte imbalance
   11. CBC indicates hemoconcentration

D. MANAGEMENT
   1. Educate client about high risk of venous thromboembolism including pulmonary embolism
   2. Consider rehydration strategies
      a. Oral electrolyte replacement
      b. IV rehydration; see “Intravenous (IV) Therapy” in Part VI
      c. Hydrating enema
   3. Institute starch-based oral rehydration therapy
   4. Consider
      a. Natural therapies
      b. Over-the-counter doxylamine pyridoxine (Unisom) and vitamin B6
   5. Provide nutritional counseling and emotional support
6. Consult if unresponsive to treatment
7. Transfer is required in cases of documented or suspected ectopic pregnancy or hydatidiform mole/molar pregnancy; see “Determining Appropriate Client Care Provider” in Part I
INTRAUTERINE GROWTH RESTRICTION (IUGR) OR SMALL FOR GESTATIONAL AGE (SGA)

A. DEFINITION
1. IUGR: Intrauterine growth restriction is a pathological condition indicating intrauterine impaired growth with a fetal weight that is below the 10th percentile for gestational age as determined through an ultrasound
2. IUGR is an intrauterine diagnosis and SGA is a neonatal diagnosis
3. Symmetrical IUGR is EFW and HC less than 10%
4. Asymmetrical IUGR is EFW less than 10% with sparing of the head circumference (i.e., a normal finding)

B. RISK FACTORS
1. Pre-pregnancy weight of less than 90 pounds
2. Poor nutrition, anorexia, bulimia
3. Poor maternal weight gain
4. Family history of small babies
5. Previous history of IUGR or SGA infant
6. Multiple gestation
7. Genetic abnormalities
8. Infection (TORCH)
9. Anemia
10. Diabetes
11. Vascular disease
12. Heart disease
13. Preeclampsia
14. Renal disease
15. Smoking
16. Drug use
17. Alcohol abuse
18. History of chronic illness, including viral disease

C. SIGNS AND SYMPTOMS
1. Prenatal assessment shows size-date discrepancy
2. Fundal height lags 3 cm or more behind gestational age
3. Estimated fetal weight inappropriately low
4. When evaluating for growth, consider:
   a. Documentation and accuracy of EDD
   b. Maternal height, weight, and body build
   c. Estimated fetal weight, presentation, position, and station of presenting part
   d. Number of different examiners

D. DIAGNOSIS
1. Refer for ultrasound to make diagnosis: diagnosis made with ultrasound report showing fetal growth in 10th percentile or less

E. MANAGEMENT
1. Consultation is required for the following factors; see “Determining Appropriate Client Care Provider” in Part I for the full list
   a. Documented or suspected IUGR
   b. Current drug or alcohol substance use disorder
2. Consider collaborating with a physician or CNM; recommendations may include
   a. Serial ultrasounds and Doppler studies
   b. Testing to rule out underlying infection, anomalies, and obstetric and medical diseases which cause utero-placental insufficiency and result in IUGR
   c. Fetal testing (non-stress tests, BPPs) to confirm fetal health
   d. Induction of labor for diagnosed IUGR, abnormal Doppler studies, and/or non-reassuring fetal surveillance
3. Provide client with
   a. Nutritional assessment and counseling
   b. Educational and emotional support
   c. Preparation for a hospital birth with possible induction of labor and cesarean birth if fetus does not tolerate labor
4. Encourage client to take periods of rest in left lateral position throughout the day to improve blood flow
SPONTANEOUS ABORTION (MISCARRIAGE)

A. DEFINITION
A pregnancy loss involving a non-viable embryo or fetus which dies before 20 weeks gestation. Spontaneous abortion (SAB) or miscarriage can be characterized as:
1. Complete: embryo or fetus and placenta spontaneously birth within a short time frame
2. Incomplete: either all or part of the embryo, fetus, and placenta do not birth within a short time period, but bleeding has occurred
3. Missed: embryo, fetus, and placenta do not birth and no bleeding has occurred; ultrasound shows non-viable conceptus in the uterus

B. ETIOLOGY
1. Embryonic/Fetal
   a. Chromosomal abnormality
   b. Disease of the fertilized ovum
   c. Poor implantation
2. Maternal
   a. Acute diseases
   b. Chronic disorders such as renal disease
   c. Street drugs
   d. Teratogenic exposure
   e. Developmental defects such as bicornuate uterus
   f. Myomas
   g. Cervical insufficiency
   h. Trauma
   i. Hormonal imbalances
      (a) Corpus luteum insufficiency
      (b) Progesterone insufficiency
3. Unknown

C. SIGNS AND SYMPTOMS
1. Decreasing HCG levels
2. Vaginal bleeding, passage of tissue, or loss of fluid
3. Lack of fetal movement
4. Lack of fetal heart tones
5. Lack of uterine growth
6. Pain
   a. Cramping
   b. Palpation of contractions
7. Dilation of cervix
8. Retrograde pregnancy signs and symptoms

D. MANAGEMENT
1. Rule out:
   a. Placenta previa
   b. Placental abruption
   c. Cervical polyps
Spontaneous Abortion (Miscarriage)

d. Ectopic pregnancy
e. Hydatidiform mole
f. UTI

2. Consider quantitative HCG and additional blood workup

3. If client is Rh-negative, consider prophylactic Rh IgG and refer to “Rh Incompatibility” in Part V for other management considerations

4. Consider follow-up ultrasound and labs as indicated

5. Consider natural therapies

6. Educate client about options for management depending on type of SAB, which may include:
   a. Expectant management (consider consultation regarding length of time to “watch and wait”)
   b. Medical management:
      (a) Medication given intravaginally or buccally to encourage client’s body to complete the process
      (b) D&C to surgically complete the process

7. Consider consult or transfer of client with incomplete SAB, especially if vital signs are unstable, bleeding is excessive, or client desires medical management

8. Consultation is required with known teratogenic exposure; see “Determining Appropriate Client Care Provider” in Part I
PART V: ANTEPARTUM CARE

MULTIPLE PREGNANCY

A. DEFINITION
   Presence of two or more fetuses.

B. PREDISPOSING FACTORS
   1. Maternal family history of twins
   2. Previous history of fraternal twins
   3. Grand multiparity
   4. Age greater than 35
   5. Racial predisposition
      a. More common among women of African descent
      b. Less common among women of Hispanic and Asian descent
   6. History of fertility therapy
   7. Discontinuation of hormonal contraception within two months of conception

C. SIGNS AND SYMPTOMS
   1. Maternal perception of excessive movement or excessive size
   2. Exacerbated signs and symptoms of pregnancy
   3. Accelerated growth usually occurring at 20-24 weeks; fundal height consistently greater than dates following this growth
   4. Large, globular uterus
   5. Abdominal palpation reveals three or more large parts and/or multiple small parts
   6. Auscultation of two distinct heartbeats differing by 10 bpm or more
   7. Ultrasound reveals multiple pregnancy

D. MANAGEMENT
   1. Multiple gestation requires primary care by a physician or CNM; see “Determining Appropriate Client Care Provider” in Part I
   2. Offer education regarding
      a. Nutritional counseling
      b. Relief of discomforts
      c. Possible fetal/maternal risks
         (a) Discordance (discrepancy in the size of the fetuses)
         (b) Polyhydramnios
         (c) Malpresentation
         (d) Preeclampsia
         (e) Anemia
         (f) SGA fetuses
         (g) Premature labor
      d. Counsel regarding psychosocial factors
      e. Preparation for labor, birth, parenting
PART V: ANTEPARTUM CARE

NON-VERTEX PRESENTATION

A. DEFINITION
A fetal position, where the crown of the fetus is not the presenting part; includes breech and transverse presentations.

B. ETIOLOGY
1. Polyhydramnios
2. Fibroids in lower uterine segment
3. Abnormal pelvic/uterine shape or formation (including uterine septum)
4. Placenta previa
5. Short cord or cord entanglement
6. Multiple pregnancy
7. Grand multiparity
8. Pendulous abdomen
9. Rectus diastasis
10. Fetal congenital malformations
   a. Hydrocephalus
   b. Anencephaly
   c. Meningomyelocele
   d. Other congenital anomalies

C. SIGNS AND SYMPTOMS
1. Mother reports
   a. "Ball" up high or on one side
   b. Kicking at or below pubis
   c. Hiccoughs above umbilicus
   d. Extreme shortness of breath
   e. Rib pain
2. Severe heartburn
3. Leopold's maneuvers or vaginal exam reveal head not in pelvis
4. Heart tones may be heard best at level of umbilicus or higher with fetoscope or Doppler
5. Ultrasound screening reveals or confirms non-vertex presentation

D. MANAGEMENT
1. Before 32 weeks: no intervention necessary
2. After 32 weeks, consider:
   a. Pelvic tilt exercises, 15 minutes 2 to 3 times a day
   b. Visualization, hypnosis, other natural remedies
   c. In the presence of a lax abdominal wall or pendulous abdomen, try abdominal binder
   d. Referral for acupuncture, chiropractor, massage, or other natural therapies
3. After 36 weeks, consider consulting with physician or other healthcare provider trained to perform versions for external version and plan
4. If non-vertex position persists or there are contraindications to external version:
   a. Educate client about benefits and risks of vaginal birth versus cesarean birth
b. Arrange for transfer of care to physician
5. Fetal presentation other than vertex at the onset of labor requires transfer of care; see “Determining Appropriate Client Care Provider” in Part I
PART V: ANTEPARTUM CARE

ORAL HEALTH

A. DEFINITION
State of being free from chronic oral pain, malfunction, and illness such as periodontal disease and dental caries.

B. ETIOLOGY
1. Increased acidity in oral cavity from reflux and emesis
2. Hormone relaxin loosens teeth
3. Oral flora shifts due to increased acidity and causes a decrease in immune response

C. MANAGEMENT
1. Considerations
   a. Bleeding gums are common in pregnancy, but are not considered a normal finding and should be cause for inspection and considered referral
   b. While an increase in preterm labor and preeclampsia are associated with oral disease, it is believed these adverse effects of oral disease are due to systemic inflammations present at the time of conception
2. Recommendations
   a. Visual exam of oral cavity
   b. Brushing and flossing after each meal
   c. Chlorhexidine 0.12% mouth wash (Chlorhexidine gluconate oral rinse)
      (a) Swish for 30 secs, spit when complete
      (b) Discontinue in two weeks or if brown spots appear
      (c) Chlorhexidine is a pregnancy category B teratogen and should only be used if clearly indicated
      (d) Consultation is required in cases of teratogenic exposure; see “Determining Appropriate Client Care Provider” in Part I
   d. Chewing xylitol gum (xylitol must be first ingredient) after meals for at least 5 minutes 3-5 times per day
3. Refer to dentist if suspect dental caries and/or gingivitis
PLACENTA PREVIA

A. DEFINITION
Placenta located over the internal cervical os. Varying degrees have been recognized:
1. Total previa: The placenta completely covers the internal os.
2. Marginal previa: Edge of the placenta is at the margin of the internal os.
3. Low-lying placenta: Placenta implanted in lower uterine segment at least 2cm from the internal os at term. A low-lying placenta may become partial previa as dilation increases as evidenced by frank bleeding.
4. Vasa previa: Fetal vessels transverse the membranes in the lower uterine segment and cover the cervical os.

B. ETIOLOGY
1. Grand multiparity
2. Maternal age over 35
3. Prior cesarean birth, abortion, D&C, or other uterine surgery
4. History of pelvic inflammatory disease
5. Cigarette smoking
6. History of a previous previa

C. SIGNS AND SYMPTOMS
1. Painless, bright red bleeding from the vagina
   a. Usually occurring near the end of the second trimester or after
   b. Quantity may vary from slight to profuse hemorrhage
2. Ultrasound showing placenta located over or near the internal cervical os

D. MANAGEMENT
1. Before 28 weeks of pregnancy, no bleeding:
   a. Repeat ultrasound at 34 weeks
   b. Educate about risks
2. After 34 weeks, if diagnosed by ultrasound, no bleeding:
   a. Educate about:
      (a) Birth options, probable need for cesarean depending on grade of previa
      (b) Risks, bleeding
      (c) Need for pelvic rest (i.e., nothing in the vagina)
   b. Co-manage prenatal care as appropriate
   c. Transfer of care is required at onset of labor with placenta previa; see “Determining Appropriate Client Care Provider” in Part I
3. Previa suspected due to bleeding:
   a. Avoid vaginal exams as this can lead to uncontrollable hemorrhage
   b. Treat for shock as indicated
   c. Consultation is required for continued vaginal bleeding before onset of labor with or without pain; see “Determining Appropriate Client Care Provider” in Part I
   d. Transfer of care is required intrapartum with severe bleeding prior to or during birth; see “Determining Appropriate Client Care Provider” in Part I
4. Consultation is required with history of uterine surgery other than cesarean section; see “Determining Appropriate Client Care Provider” in Part I
PART V: ANTEPARTUM CARE

POST DATES PREGNANCY

A. DEFINITION
   Pregnancy prolonged beyond 42 weeks gestation with verified EDD by dates, ultrasound assessment, and/or physical exam.

B. ETIOLOGY
   1. Personal and/or familial history of prolonged pregnancies
   2. Psychosocial factors
   3. Unknown or miscalculated dates

C. SIGNS AND SYMPTOMS
   1. Lack of maternal signs of impending labor
   2. Changes in frequency and strength of fetal movements

D. MANAGEMENT
   1. Review and evaluate documentation of EDD
      a. Menstrual history
      b. Review date, regularity, and duration of LMP, LNMP
      c. History of sexual activity and conception
      d. Contraceptive history
      e. First signs of pregnancy (e.g., breast tenderness, morning sickness)
      f. Fundal height corresponding with dates through pregnancy
      g. Date and type of positive pregnancy test
      h. Date FHTs first heard with Doppler and/or fetoscope
      i. Quickening
      j. Uterine size at first pelvic exam
      k. Ultrasound results, if any
   2. Create plan of care for week 41-42
      a. Educate client regarding
         (a) Normalcy of birthing within two weeks after EDD
         (b) Risk factors of post dates pregnancy
      b. Assess and address client’s needs
         (a) Psychosocial issues
         (b) Preparedness for birth
      c. Consider
         (a) Daily fetal kick counts until birth
         (b) Natural therapies to promote labor
      d. Clinical care considerations
         (a) Assess amniotic fluid
         (b) NST, AFI, or BPP
         (c) Membrane sweeping/stripping
   3. Consultation is required for post term gestation greater than 42 weeks; see “Determining Appropriate Client Care Provider” in Part I
   4. Transfer care as appropriate
PRETERM LABOR

A. DEFINITION
   Labor before 37 weeks gestation.

B. ETIOLOGY
   1. Premature rupture of the membranes
      a. Possible infection
      b. Malpresentation
      c. Multiple pregnancy
      d. Family history of prematurity
      e. Unknown causes
   2. Spontaneous preterm labor with membranes intact
      a. Cervical insufficiency
      b. Uterine abnormalities
      c. Fetal anomalies
      d. Multiple gestation
      e. Extraterine infection
         (a) Appendicitis
         (b) Peritonitis
         (c) Pyelonephritis
         (d) Pneumonia
         (e) Others
      f. Maternal trauma
      g. Autoimmune diseases
      h. Gestational hypertension
      i. Severe maternal illness
      j. Unexplained hydramnios
      k. Maternal vaginal infections
      l. Dehydration
   3. Complications of pregnancy which may necessitate preterm delivery
      a. Preeclampsia with severe features
      b. Severe diabetes
      c. Fetal growth restriction
      d. Abruptio placenta

C. SIGNS AND SYMPTOMS
   1. Contractions with progressive cervical changes
   2. Amniotic fluid leakage
   3. Vaginal bleeding

D. MANAGEMENT
   1. Re-evaluate history, including early pregnancy symptoms in current pregnancy, EDD, and physical evaluation
   2. Complete maternal and fetal evaluation
a. Rule out fetal distress; consultation required if there are signs of fetal distress, see “Fetal Distress” in Part VI and “Determining Appropriate Client Care Provider” in Part I

b. Rule out maternal infection

3. Recommend pelvic rest

4. If membranes ruptured, transfer; see “Determining Appropriate Client Care Provider” in Part I

5. If membranes intact with contractions
   a. Determine if contractions are causing progressive cervical changes
   b. Hydrate mother
   c. Utilize natural therapies to stop contractions
   d. Transfer of care is required with premature labor; see “Determining Appropriate Client Care Provider” in Part I

6. Educate mother about prematurity

7. Consider standard GBS swab; note that a rapid GBS swab should not be done if client is less than 37 weeks
PRETERM PREMATURE RUPTURE OF MEMBRANES (PPROM)

A. DEFINITION
   Rupture of membranes before 37 weeks gestation.

B. ETIOLOGY
   1. Multiple gestation
   2. Malpresentation
   3. Infection
   4. Unknown reasons

C. SIGNS AND SYMPTOMS
   1. Leaking amniotic fluid
   2. Pooling in posterior vaginal vault observed during sterile speculum exam
   3. Fluid nitrazine positive
   4. Fluid positive for ferning

D. MANAGEMENT
   1. Re-evaluate history and EDD
   2. Examinations
      a. No digital exam, but consider gentle sterile speculum exam to confirm ROM, rule out prolapsed cord, and observe for dilation
      b. Check FHTs
      c. Obtain maternal vital signs
      d. Assess for contractions
   3. Transfer of care for preterm labor, PPROM, or cord prolapse when birth is not imminent is required; see “Preterm Labor” in this Part for management if applicable and “Determining Appropriate Client Care Provider” in Part I
   4. Consider
      a. Group B Strep culture (rapid GBS swab is not appropriate before 37 weeks)
      b. Consider advising on natural therapies to prevent infection
   5. Inform parents of potential risks
RH INCOMPATIBILITY

A. DEFINITION
A condition that can occur when a woman with Rh-negative blood type is exposed to Rh-positive blood cells. It generally occurs antepartum when a woman with Rh-negative blood type is exposed to Rh-positive fetal blood cells, but can also occur if she receives a blood transfusion of Rh-positive blood. Women who are Rh-positive will not experience Rh incompatibility, even if exposed to Rh-negative blood cells.

B. ETIOLOGY OF SENSITIZATION
1. Antepartum, intrapartum, or postpartum sensitization routes:
   a. Amniocentesis, cordocentesis, or chorionic villus sampling
   b. Ectopic pregnancy
   c. Spontaneous or induced abortion or miscarriage
   d. Abdominal or pelvic trauma causing fetomaternal hemorrhage
   e. Placental abruption
   f. Placenta previa
   g. Failure to administer Rh IgG (Rh immunoglobulin G; e.g., RhoGAM) as indicated or inadequate dosage administered for volume of fetomaternal hemorrhage
2. Previous blood transfusion with Rh-positive blood

C. SEQUELAE
1. Maternal production of Rh IgG antibodies that persist for life and may freely cross into fetal circulation through the placenta during current or future pregnancies
2. Fetal alloimmune-induced hemolytic anemia with risk of hydrops fetalis
3. Spontaneous abortion
4. Mild jaundice to extreme pallor and anemia to death in the newborn

D. MANAGEMENT FOR PREVENTION
In each section below, documentation is essential to ensure client education and informed decision making has taken place and is documented in client’s chart.
1. Spontaneous or induced abortion
   a. After spontaneous or induced abortion if 6 weeks LMP or further, client should be offered Rh IgG
   b. Client education regarding Rh factor, how sensitization may occur, future pregnancies, and possible need for future fetal and neonatal transfusions
   c. Antibody screen can be offered before Rh IgG is administered
2. Antepartum
   a. Client education regarding Rh factor, how sensitization may occur, future pregnancies, and possible need for future fetal and neonatal transfusions
   b. Screen for antibodies (AST screen) initially in the first trimester and at 28 weeks
      (a) AST screen negative for antibodies:
         (a) Educate client regarding administration of antepartum Rh IgG at 28 weeks
         (b) Administer Rh IgG with client consent
         (c) Monitor for adverse reaction which may include headache, chills, and anaphylactic shock
         (d) If Rh IgG declined, client signs waiver and AST is repeated at 36 weeks
(b) AST screen positive for antibodies (assuming not from Rh IgG) requires consultation; see “Determining Appropriate Client Care Provider” in Part I

c. If maternal abdominal trauma or vaginal bleeding in pregnancy, recommend antepartum Rh IgG

d. A client with previous Rh sensitization requires primary care from a physician or CNM; see “Determining Appropriate Client Care Provider” in Part I

3. Immediate postpartum

a. Client education regarding Rh factor, how sensitization may occur, future pregnancies, and possible need for future fetal and neonatal transfusions

b. Obtain cord blood at birth to determine infant’s blood type

(a) If infant is Rh-negative, administration of Rh IgG is not necessary for client

(b) If infant is Rh-positive

   (a) Obtain client's consent to receive Rh IgG or sign waiver of refusal after full discussion of benefits and risks

   (b) If consent is obtained, ensure mother receives Rh IgG within 72 hours of birth

      (i) Consider ordering Rh IgG workup to determine Rh IgG postpartum dose

      (ii) Monitor for adverse reaction which may include headache, chills, and anaphylactic shock

c. Consider direct Coombs test for the infant

   (a) A positive direct Coombs test result confirms diagnosis of antibody-induced hemolysis, and suggests the presence of ABO or Rh incompatibility

   (b) If direct Coombs is positive, recommend maternal antibody screen (if not already known/done) for the purpose of identifying antibody type

   (c) Consult for infant care or transfer, especially if:

      (a) There is early onset of neonatal jaundice

      (b) Client has positive antibody screen

      (c) Client has Rh negative blood type

d. Neonatal distress not responsive to interventions requires immediate transfer of care; see “Determining Appropriate Client Care Provider” in Part I

e. Newborns presenting with any of the following require consultation; see “Determining Appropriate Client Care Provider” in Part I

   (a) Obvious anomaly or injury

   (b) Respiratory distress or abnormal respiratory patterns

   (c) Cardiac irregularities

   (d) Prolonged pale, cyanotic, or gray color

   (e) Jaundice within 24 hours of birth

   (f) Edema

   (g) Hyperbilirubinemia
PART V: ANTEPARTUM CARE

RUBELLA NON-IMMUNE BLOOD STATUS

A. DEFINITION
A woman who does not have antibodies for, and is therefore not immune to, rubella (German measles).

B. SEQUELAE
1. Maternal antenatal rubella infection
2. Congenital rubella syndrome (CRS)
   a. Most common CRS congenital birth defects:
      (a) Deafness
      (b) Cataracts
      (c) Heart defects
      (d) Intellectual disabilities
      (e) Liver and spleen damage
      (f) Low birth weight
      (g) Skin rash at birth
   b. Less common CRS complications:
      (a) Glaucoma
      (b) Brain damage
      (c) Thyroid and other hormone problems
      (d) Inflammation of the lungs

C. MANAGEMENT
1. Educate woman of implications of contracting rubella during early pregnancy
2. Antepartum vaccination is not recommended
3. Discuss risks and benefits of postpartum vaccine administration
4. Advise client to make arrangements for postpartum immunization as desired
5. If rubella infection is contracted in first or second trimester, consultation is required; see “Determining Appropriate Client Care Provider” in Part I
6. Low birth weight (less than 2500 g) is a newborn risk factor requiring consultation; see “Determining Appropriate Client Care Provider” in Part I for the full list
TRIAL OF LABOR AFTER CESAREAN AND VAGINAL BIRTH AFTER CESAREAN

A. DEFINITION
A trial of labor after cesarean delivery (TOLAC) is the attempt to have a vaginal birth after cesarean (VBAC) delivery.

B. RISKS OF TOLAC
1. Repeat cesarean delivery, elective or emergent
2. Uterine rupture

C. MATERNAL SEQUELAE
1. Pelvic floor injury
2. Accreta in future pregnancies
3. Uterine rupture
   a. Hysterectomy
   b. Hemorrhage
   c. Transfusion
   d. Maternal mortality

D. FETAL/NEONATAL SEQUELAE
1. Hemorrhage
2. Hypoxic ischemic encephalopathy
3. Fetal/neonatal mortality
4. Transient tachypnea of the newborn (TTN)

E. SCREENING AND MANAGEMENT OF TOLAC
1. Eligibility for VBAC in a home or birth center setting (see also “Determining Appropriate Client Care Provider” in Part I)
   a. History of only one prior cesarean
   b. Records documenting low transverse uterine incision without extension into the contractile portion of the uterus
   c. Placental location not previa at onset of labor of current pregnancy
   d. Previous cesarean birth at least 18 months prior to EDD of current pregnancy
   e. Client must sign the New Mexico Midwives Association Informed Consent for Out-of-Hospital VBAC (see Appendix H)
   f. History of uterine surgery other than cesarean section requires consultation; see “Determining Appropriate Client Care Provider” in Part I
2. Other eligibility factors the midwife and mother may consider
   a. Birth location provides for a transport time no longer than 30 minutes from problem recognition to arrival at hospital with surgical and pediatric services
   b. Placental location documented by ultrasound to not be previa nor low and anterior
3. Antepartum Care
   a. Review history and records including operative report of previous cesarean birth; document in chart if records unattainable
   b. Document:
      (a) Previous or subsequent vaginal deliveries
      (b) Discussion of risks and benefits of trial of labor and possible alternatives
(c) Provision of relevant information and/or education for the special concerns of TOLAC/VBAC mothers and families; refer to appropriate support groups where available
c. Provide for third trimester ultrasound for documentation of placental location unless previously documented to not be low-anterior nor placenta previa
d. Discuss the potential of an antepartum uterine rupture which can occur, although less frequently than in labor, often late in the third trimester
e. Explain and discuss the “New Mexico Midwives Association Informed Consent for Out-of-Hospital VBAC” (see Appendix H) and obtain appropriate signatures
f. Perform assessment and prenatal work-up as for all clients

4. Intrapartum Care
   a. Clients in labor are monitored as described under “Labor and Birth Care Schedule” in Part VI
      (a) Clients who have never delivered vaginally are assessed in labor by nulliparous criteria (for stages of labor)
      (b) Clients who have delivered vaginally are assessed by multiparous criteria
   b. Consider placement of a saline lock upon confirming active labor
   c. Continually assess for symptoms of uterine rupture

5. Indications for transfer of care
   a. Mother’s request
   b. Midwife’s discretion
   c. Signs and symptoms of uterine rupture
   d. Any other usual indications for transfer; see “Determining Appropriate Client Care Provider” in Part I
A. DEFINITION
Viral blood infection spread by bite of infected mosquito, from pregnant woman to fetus, via sex, or likely but not confirmed via blood transfusion. Information about Zika virus (ZIKV) continues to evolve since this is a newly reported virus; always check with the CDC regarding latest update(s) on Zika.

B. ETIOLOGY
Zika virus infection during pregnancy can cause certain birth defects.

C. DIAGNOSIS
1. Gather detailed history including information about any:
   a. Recent travel
      (a) CDC has up to date information on countries with Zika activity
   b. Signs and symptoms
   c. Sex or sharing of sex toys without a condom with a person who lives in or traveled to an area with Zika
2. Testing
   a. Blood and/or urine test
   b. Refer to DOH for testing information: 505-827-0006

D. SEQUELAE
1. Newborn
   a. Microcephaly
   b. Other severe fetal brain defects
   c. Defects of the eye
   d. Hearing deficits
   e. Impaired growth
2. Maternal
   a. Guillain Barre Syndrome (increased reports)

E. SIGNS AND SYMPTOMS
1. History: Many people infected with Zika virus will not have symptoms or will only have mild symptoms. Symptoms usually occur around 2 weeks after exposure and can last for several days to about a week. Hospitalization is rare, as is death.
2. Presentation:
   a. Fever
   b. Rash
   c. Joint pain
   d. Conjunctivitis
   e. Muscle pain
   f. Headache

F. MANAGEMENT
1. Prevention
   a. Clothing
Zika

(a) Wear long-sleeved shirts and long pants
(b) Treat or buy clothing and gear with permethrin

b. Insect repellent
(a) Always follow the product label instructions and use Environmental Protection Agency-registered insect repellents that
   (a) Are proven safe when used as directed for pregnant and breastfeeding women
   (b) Have one of the following active ingredients:
      (i) DEET
      (ii) Picaridin
      (iii) IR3535
      (iv) Oil of lemon, eucalyptus or para-menthane-diol,
      (v) 2-undecanone
(b) Do not use insect repellents on babies younger than 2 months old
(c) Do not use products containing oil of lemon, eucalyptus or para-menthane-diol on children younger than 3 years old

c. At home
(a) Stay in places with air conditioning and window and door screens to keep mosquitoes outside
(b) Take steps to control mosquitoes inside and outside your home
(c) Mosquito netting can be used to cover babies younger than 2 months old in carriers, strollers, or cribs
(d) Sleep under a mosquito bed net if air conditioned or screened rooms are not available or if sleeping outdoors

d. Sexual transmission: prevent sexual transmission of Zika by using condoms or abstaining from sex

2. All clients: infection is usually mild and self-limited; there is no specific treatment

3. Antepartum clients diagnosed with positive Zika infection
   a. Primary care by a CNM or physician is required; see “Determining Appropriate Client Care Provider” in Part I
   b. Positive infection status must be reported to the state by the midwife; see Notifiable Diseases or Conditions in the State of New Mexico in NMAC 7.4.3, the text of which is available in Appendix F (Please note: At the time of publication, Zika is currently considered by the DOH to be included under the item “other conditions: other illnesses or conditions of public health significance”)

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PART VI: INTRAPARTUM CARE
LABOR AND BIRTH CARE SCHEDULE

A. INITIAL EVALUATION OF LABOR
   1. Review prenatal records for the following:
      a. Age, date of birth
      b. Gravida, parity
      c. Past obstetric history
      d. Obstetric history this pregnancy (e.g., LMP, EDD, gestational age, complications, relevant laboratory tests)
      e. Past medical history
   2. Obtain history of this labor, including:
      a. Signs of labor
      b. Time contractions began
      c. Frequency, strength, and duration of contractions
      d. Any fluid leakage
      e. Fetal activity
      f. History of dietary intake
      g. History of voiding and bowel movement
   3. Maternal condition
      a. Pulse
      b. Blood pressure
      c. Temperature
      d. Abdominal palpation for position
      e. When indicated, urine dipstick and/or ketones
      f. When indicated or desired by client, perform vaginal examination for
         (a) Cervical effacement and dilation
         (b) Status of membranes
         (c) Fetal station, position, and presentation
   4. Fetal heart rate evaluation: establish a baseline by listening to fetal heart tones through at least one contraction
   5. Determine whether to admit to care or not

B. EVALUATION AFTER ADMISSION INTO INTRAPARTUM CONTINUOUS CARE
   1. Continuing evaluation of maternal condition
      a. Vital signs as indicated
      b. Monitor input/output while encouraging hydration and calories
      c. Encourage fluid intake and easily digestible calories particularly in early labor or anytime client desires
      d. General condition
   2. Continuing evaluation of fetal condition
      a. Fetal heart rate and pattern auscultation frequency
         (a) Early labor: At least every hour
         (b) Active labor: Every 15-30 minutes
         (c) Second stage: Every 5-15 minutes
      b. Check FHTs upon:
         (a) Unusual bleeding other than normal show
         (b) Signs and symptoms of abruption
(c) Rupture of membranes
(d) Any other concerning signs and symptoms
(e) Drastic change in labor
(f) For intrapartum VBAC management, see “Trial of Labor After Cesarean and Vaginal Birth After Cesarean” in Part V

3. Continuing evaluation of progress of labor including, but not limited to:
   a. Vaginal exams, as indicated or by client preference
      (a) Dilation
      (b) Effacement
      (c) Station
      (d) Position
   b. Contraction pattern
      (a) Frequency
      (b) Duration
      (c) Intensity

4. Continue screening for normalcy of labor
5. Consider consult if labor does not follow normal parameters
6. Transfer care upon mother’s request, midwife’s discretion, medical necessity, and/or abnormal labor patterns; see “Determining Appropriate Client Care Provider” in Part I for required transfer and consultation factors
ADULT CARDIO-PULMONARY RESUSCITATION (CPR)

A. DEFINITION
Necessary therapy given to an adult in cardiac or respiratory failure, or shock. Resuscitation aims to provide adequate ventilation, oxygenation, and cardiac output to ensure that an appropriate amount of oxygen is delivered to the brain, heart, and other vital organs.

B. ETIOLOGY
1. Unresponsive adult
2. Adult has no respirations and/or no pulse
3. Hypovolemic shock

C. MANAGEMENT
1. Activate EMS
2. Assess the need for rescue breathing or full CPR as appropriate, according to protocol established by the American Red Cross
3. Start IV as indicated and if not alone
4. Transport immediately
5. Maternal respiratory distress requires transfer of care to a physician or CNM; see “Determining Appropriate Client Care Provider” in Part I
AMNIOTOMY OR ARTIFICIAL RUPTURE OF MEMBRANES (AROM)

A. DEFINITION
   Procedure by which the amniotic sac is deliberately ruptured so as to cause the release of amniotic fluid.

B. CRITERIA
   1. Labor pattern is established
   2. Confirmed cephalic presentation, engaged, and well-applied to the cervix

C. INDICATIONS
   1. To augment labor
   2. To increase effective pushing efforts

D. MANAGEMENT
   1. Educate about amniotomy, possible effects on labor, and potential risks to fetus
   2. Use sterile technique
   3. Confirm fetal position including flexion and cervical application
   4. Rupture membranes during contractions to decrease risk of cord prolapse
   5. Leave fingers in vagina to rule out prolapse
   6. Assess fetal heart tones immediately after procedure
   7. Evaluate color and amount of amniotic fluid
   8. Attempt to decrease number of vaginal exams after rupture
   9. Proceed with protocols for prolonged ruptured membranes; see “Prolonged Rupture of Membranes” in Part VI for more details
10. Transfer is required in the following cases; see “Determining Appropriate Client Care Provider” in Part I for the complete list:
   a. Fetal presentations other than vertex
   b. Cord prolapse when birth is not imminent
   c. Prolonged rupture of membranes (greater than 24 hours) with no progress of labor
   d. Significant meconium stained fluid when birth is not imminent
DEHYDRATION IN LABOR

A. DEFINITION
   A condition in which the client exhibits a fluid volume deficit resulting in deterioration in normal maternal vital signs and general condition.

B. ETIOLOGY
   1. Vomiting
   2. Diarrhea
   3. Reduced fluid intake
   4. Diuresis
   5. Diaphoresis

C. SIGNS AND SYMPTOMS
   1. Prolonged latent phase
   2. Fatigue, exhaustion, discouragement
   3. Thirst
   4. Oliguria
   5. Excessive vomiting or diarrhea
   6. Inadequate fluid intake
   7. Increased urinary concentration
   8. Ketonuria
   9. Fruity odor on breath
   10. Tachycardia of client or fetus
   11. Fever
   12. Decreasing tolerance to normal labor sensations

D. MANAGEMENT
   1. Rehydrate orally with electrolyte replacement fluids
   2. Consider natural therapies
   3. If condition is severe or deteriorates, consider starting an IV with Lactated Ringer; see “Licensed Midwife Formulary” in Part I
   4. Reevaluate as needed
   5. If there is no improvement, consult
EMERGENCY TRANSPORT

A. DEFINITION
The emergency transfer of care of the mother/fetus dyad, mother, or the infant when the condition is outside normal parameters, the condition is further complicated by staying home, or a transport to a medical facility is deemed necessary.

Refer to and review Appendix G for NMMA-endorsed best practices regarding transfer from planned home or freestanding birth center birth to hospital. Also see “Determining Appropriate Client Care Provider” in Part I for a list factors for which emergency (i.e. immediate) transport are required.

B. ETIOLOGY
1. Placental
   a. Abruptio placenta
   b. Placenta accreta
   c. Placenta previa
   d. Retained placenta
2. Maternal
   a. Uterine inversion
   b. Uterine rupture
   c. Anaphylaxis
   d. Hypovolemic shock
   e. Postpartum hemorrhage uncontrolled and unresponsive to management
   f. Signs of infection not responsive to treatment
   g. Hematoma increasing in size or pain
   h. Maternal desire
   i. Any other condition at the midwife’s discretion
3. Fetal and neonatal
   a. Prolapsed cord
   b. Fetal distress
   c. Transverse presentation in labor
   d. Breech presentation diagnosed intrapartum if birth is not imminent
   e. Twins diagnosed intrapartum if birth not imminent
   f. Neonatal distress not responsive to resuscitation or treatment efforts
   g. Respiratory distress syndrome
   h. Neonatal seizures
   i. Congenital anomalies, severe
   j. Maternal desire
   k. Any other condition at the midwife’s discretion

C. MANAGEMENT
1. Implement and maintain emergency procedures to stabilize condition of mother and/or infant while initiating and throughout transfer
2. Activate EMS to facilitate transport
3. Notify physician and/or hospital of impending transport and current status of mother/fetus dyad, mother, or infant
4. Accompany mother and/or infant to hospital and continue to provide stabilization procedures as indicated
5. Provide necessary records to admitting hospital personnel and exchange pertinent information leading up to the transport
6. Notify physician and/or hospital if situation resolves and decision is made not to transfer
FETAL DISTRESS

A. DEFINITION
A physiologic response by the fetus to known and unknown fetal, uterine, and placental conditions resulting in pathologic changes in fetal functioning that is detected by auscultation of fetal heart tones or the presence of meconium.

B. ETIOLOGY
1. Maternal conditions such as
   a. Hypertension or hypotension
   b. Anemia
   c. Diabetes
   d. Preeclampsia
   e. Heart conditions
2. Placenta previa
3. Placental abruption
4. Postmaturity syndrome
5. Hypertonic uterus
6. Cord involvement: short, entangled, knotted, nuchal, compression, or prolapse
7. Malposition
8. Prolonged labor or difficult delivery
9. Maternal malnutrition
10. Exposure to toxic substances
11. Substance abuse
12. Intrauterine growth restriction
13. Fetal abnormalities
14. Maternal or fetal infection, including intrauterine infection and/or inflammation - Triple I (previously referred to as chorioamnionitis)
15. Dehydration

C. SIGNS AND SYMPTOMS
1. Mother may report decreased fetal movement
2. Fetal heart rate abnormalities
   a. Bradycardia
   b. Tachycardia, especially if associated with or followed by bradycardia and decreased variability
   c. Progressive decrease in variability
   d. Late decelerations
   e. Significant variable decelerations
3. Meconium stained (thick, particulate) amniotic fluid
4. Excessive fetal movement in association with one of the above findings

D. MANAGEMENT
1. Turn mother to either side and observe FHTs through two contractions to determine if there is a change
2. If client is laboring in or plans to birth in water, check water temperature and adjust as appropriate, consider removing client from water
3. If no change or severity increases, reposition mother and assess FHTs again
4. Perform fetal scalp stimulation for fetal responsiveness; fetal accelerations, either induced or spontaneous, indicate the absence of acidosis
5. If membranes ruptured recently, assess for prolapsed cord; see “Prolapsed Cord” in Part VI
6. Consultation is required when there are signs of fetal distress; see “Determining Appropriate Client Care Provider” in Part I
7. Transport is required if birth is not imminent when there is
   a. Cord prolapse
   b. Significant meconium stained fluid
   c. Persistent or recurrent observations of fetal heart tones are below 100, above 160, late decelerations, or other non-reassuring fetal heart rate patterns
   d. See “Determining Appropriate Client Care Provider” in Part I for the full list
8. If birth is imminent:
   a. Assess need to activate EMS based on estimated EMS arrival time, distance to hospital, estimated time to delivery, length and degree of distress, and requirement to transfer per “Determining Appropriate Client Care Provider” in Part I
   b. If activating EMS, notify facility of incoming transfer and prepare transfer documentation; see “Emergency Transport” in this Part VI
   c. Administer oxygen to the mother
   d. Change mother's position
   e. Expedite birth
   f. Be prepared to resuscitate infant
   g. Reassess need for EMS transport
INTRAVENOUS (IV) THERAPY

A. DEFINITION
   Infusion of liquid substances directly into a vein.

B. FOR DEHYDRATION
   1. See “Dehydration in Labor” in Part VI
   2. Start an IV with 18–20 gauge needle
   3. Use large tubing: 10 gtt or 15 gtt
   4. Prepare to infuse Lactated Ringers or Normal Saline via IV
   5. Administer bolus of 500 cc to 1000 cc
   6. Plan to replace fluid volume equal to estimated fluid volume lost
   7. Titrate drip rate to achieve optimal maternal pulse
   8. Evaluate maternal vital signs every 15 minutes until stable
   9. Auscultate lungs for rales and rhonchi
   10. Monitor IV site
   11. Evaluate urinary output for volume and ketones before discontinuing IV therapy
   12. Encourage drinking fluids as soon as vomiting has stopped
   13. If IV is discontinued before birth, consider using a saline lock to keep IV site open
   14. Continue to evaluate maternal wellbeing and stability
   15. Chart IV initiation, amount of time of infusion, and amount and type(s) of specific substance(s) given

C. FOR POSTPARTUM HEMORRHAGE
   1. See “Postpartum Hemorrhage (Immediate)” and “Postpartum Hemorrhage (Late)” in Part VIII
   2. Start an IV with 16–18 gauge needle
   3. Use large tubing: 10 gtt or 15 gtt
   4. Prepare to infuse Lactated Ringers or Normal Saline via IV
   5. Administer bolus of 500 cc to 1000 cc, re-evaluate vitals to titrate proper drip rate
   6. Titrate drip rate to achieve desired maternal pulse
   7. Monitor maternal vital signs every 5 to 15 minutes until stable
   8. Monitor IV site
   9. Administer fluid volume 1–3 times estimated blood loss volume until normal pulse rate is established
   10. Continue IV therapy until client is stabilized
   11. Administer IV antihemorrhagic medication as appropriate
   12. Chart IV initiation, amount of time of infusion, and amount and type(s) of specific substance(s) given

D. FOR ADMINISTRATION OF INTRAPARTUM ANTIBIOTICS
   1. See guidelines for individual woman’s need (e.g., GBS prophylaxis)
   2. Review client history to rule out history of allergies to medication
   3. Start an IV with 16–20 gauge needle
   4. Use large tubing: 10 gtt or 15 gtt
   5. Prepare to infuse Lactated Ringers or Normal Saline via IV
6. Prepare antibiotic and add it to the bag or hang piggy back to Lactated Ringers or Normal Saline
7. Administer medication at the rate prescribed
8. Monitor client for reaction; see “Anaphylaxis” in Part IV
9. Discontinue or continue therapy as indicated
10. Flush lock with normal saline after administration
11. Document IV initiation, amount of time of infusion, and amount and type(s) of specific substance(s) given

E. TO DISCONTINUE IV
1. For hypovolemia
   a. Re-evaluate maternal condition as appropriate
      (a) If stable:
         (a) Reduce drip rate and re-evaluate maternal pulse
         (b) With continued stability, continue to reduce drip rate
      (b) If unstable:
         (a) Increase drip rate and re-evaluate every five minutes
         (b) With continued instability, consult and transfer/transport
   b. IV may be discontinued when maternal vital signs are stable
2. If medication is administered, discontinue when complete course of medication has been administered
3. Consider leaving saline lock in place
PART VI: INTRAPARTUM CARE

OXYGEN IN LABOR

A. PURPOSE
1. This section outlines procedures for administration of oxygen.
2. Indications for administration of oxygen shall be clearly documented in the client's chart.
3. A midwife is not required to use oxygen.

B. INDICATIONS
1. Deteriorating vital signs
2. Excessive exhaustion, air hunger, faint
3. Over-exertion, excitement, pain, nausea, anxiety
4. Poor venous return, poor color
5. Maternal hemorrhage
6. Maternal shock
7. Prolapsed cord
8. Fetal heart rate irregularities
9. Resuscitation efforts as indicated by American Heart Association Cardiopulmonary Resuscitation guidelines
10. Initial newborn resuscitation (at a rate concurrent with American Academy of Pediatrics Neonatal Resuscitation guidelines)
11. Any reason not listed above to the mother and/or newborn as deemed necessary

C. MANAGEMENT AS INDICATED BY THE CONDITION
1. Administer as appropriate
2. Wean oxygen as appropriate based on improvement of vital signs and stabilization of woman
PLACENTAL ABRUPTION

A. DEFINITION
Premature separation of the normally implanted placenta from the uterine wall with often unknown etiology.

B. ETIOLOGY
1. Maternal age over 35
2. Grand multiparity
3. Premature rupture of membranes
4. Abdominal trauma, including external version
5. Cigarette smoking
6. Alcohol consumption
7. Cocaine and meth-amphetamine use
8. Uterine fibroids
9. Previous placental abruption
10. Gestational hypertension or chronic hypertension
11. Seizures (eclampsia)
12. Sudden decrease in uterine volume
13. Short cord
14. Malnutrition
15. Multiple gestation
16. Polyhydramnios
17. Clotting disorders

C. SEQUELAE
1. Maternal
   a. Hemorrhage
   b. Cesarean birth
   c. Shock
   d. DIC
   e. Organ failure
   f. Hysterectomy, if bleeding cannot be controlled
2. Infant
   a. Premature birth
   b. Oxygen deprivation
   c. Stillbirth

D. SIGNS AND SYMPTOMS
1. Continuous pain in upper portion of uterus
2. Irritable, discordant contractions
3. Concealed or frank bleeding
4. Uterine enlargement, if bleeding is concealed
5. Hypertonic uterus
6. Severe back pain
7. FHTs may be normal
8. FHTs may be abnormal
a. Tachycardia
b. Variable decelerations
c. Late decelerations
d. Lack of variability
9. Decreased or absent fetal movement
10. Maternal shock

E. MANAGEMENT
1. Transfer of care is required for antepartum and intrapartum placental abruption, and when severe bleeding occurs prior to or during birth; see “Determining Appropriate Client Care Provider” in Part I
2. Activate EMS
3. Administer oxygen to mother
4. Treat for shock as indicated
5. Expedite birth of fetus if possible while preparing for neonatal resuscitation
6. If infant born
   a. Expedite birth of placenta
   b. Be prepared for neonatal resuscitation
   c. Be prepared for postpartum hemorrhage; see “Postpartum Hemorrhage (Immediate)” and “Postpartum Hemorrhage (Late)” in Part VIII
7. If birth not imminent, transfer care immediately; see “Determining Appropriate Client Care Provider” in Part I
PART VI: INTRAPARTUM CARE

PROLAPSED CORD

A. DEFINITION
When the fetal umbilical cord comes out of the uterus with or before the presenting part.
Two different presentations exist:
1. Overt cord prolapsed into the vagina or outside the vulva after the membranes have ruptured
2. Occult prolapse with the cord located alongside and often compressed by the presenting part but not within reach during vaginal exam

B. ETIOLOGY
Any condition in which the presenting part does not fit completely into the lower uterine segment.
1. Malpresentation
2. Polyhydramnios
3. Multiparity
4. ROM with high station or unengaged fetal presenting part

C. SIGNS AND SYMPTOMS
1. Cord visualized or palpated
2. FHTs become irregular in combination with periodic episodes of bradycardia of variable duration
3. Severe variable decelerations

D. SEQUELAE
1. Cesarean birth
2. Asphyxia
3. Hypoxic–ischemic encephalopathy
4. Cerebral palsy
5. Stillbirth or neonatal death

E. MANAGEMENT
1. If birth is not imminent, immediate transfer is required; see “Determining Appropriate Client Care Provider” in Part I
   a. Activate EMS
   b. Notify hospital to prepare for cesarean birth
   c. Instruct client to get into knee-chest or Trendelenburg position
   d. Administer oxygen to client
   e. Elevate the presenting part with a gloved hand in the vagina in an effort to release pressure off the cord; continue elevating until delivery
   f. If cord prolapsed outside of the vulva, wrap in a warm sterile moist towel and minimize handling; do not try to push cord back into uterus
   g. Start IV
   h. Transport immediately
2. If birth is imminent, prepare to actively support the newborn’s transition and assess the need to activate EMS
A. DEFINITION
Labor which exhibits no progress for 6 hours after 6 centimeters dilation with
contractions every 2–4 minutes which palpate strong and last 60 seconds or longer. Labor
which exhibits minimal signs of descent through the mid-pelvis and/or pelvic outlet after
complete dilation and active pushing for 3 hours with nulliparous clients and 2 hours for
multiparous clients.

B. ETIOLOGY
1. Malpresentation
2. Labor dysfunction
3. PROM with unripe cervix
4. Cervical dystocia
5. CPD
6. Psychosocial issues
7. High anxiety
8. Dehydration
9. Induced labor
10. Intrauterine infection and/or inflammation - Triple I (previously referred to as
chorioamnionitis)
11. LEEP Procedure or other cervical surgeries that may have caused scar tissue
12. Primiparous
13. Pendulous uterus
14. Cord involvement

C. SEQUELAE
1. Increased risk of cesarean delivery
2. Intrauterine infection and/or inflammation - Triple I (previously referred to as
chorioamnionitis)
3. Higher incidence of NICU admissions

D. SIGNS AND SYMPTOMS
1. Maternal signs of exhaustion
   a. Signs of dehydration
   b. Increased pulse, rising temperature
   c. Restlessness, anxiety, distress, unable to sleep
2. Lack of progress
3. Signs of malposition, such as deflexed head, asynclitic head, or occiput posterior
   position
4. Irregular contraction pattern
5. Caput formation without descent
6. Uterine abnormalities

E. MANAGEMENT
1. Prolonged latent phase in either primigravida or multipara
   a. Assess fetal and maternal conditions
Prolonged Labor

(a) Contractions
   (i) Frequency
   (ii) Duration
   (iii) Intensity
   (iv) Interval
   (v) Changes in pattern
(b) Fetal heart tones
(c) Maternal vital signs
(d) Maternal energy level
(e) Maternal environment
(f) Maternal emotional response to labor
(g) Fetal position, presentation

b. If condition of both mother and fetus is stable, consider the following measures:
   (a) If mother is tired, encourage rest and sleep with natural therapies, hot bath, massage, IV therapy, etc.
   (b) If mother is energetic, encourage augmentation of labor through walking, showering, nipple stimulation, squating, enema, other natural remedies
   (c) Consider position assist

2. Prolonged active labor
   a. Assess maternal and fetal condition
      (a) Unstable condition: transfer care
      (b) Stable condition:
         i. Consider therapeutic measures described above
         ii. If fetal head is engaged and well applied to the cervix, consider artificial rupture of membranes (AROM)
   b. If there is no progress in effacement, dilation, or station after above measures have been employed, obtain consult
   c. Prepare for increased risk of hemorrhage

3. Prolonged second stage
   a. Assess fetal and maternal conditions
   b. If mother and fetus are stable, consider the following:
      (a) Determine fetus's position
         i. If fetus is thought to be asynclitic or posterior, consider fetal position assist
         ii. Ask client to try to push in different positions (e.g., squat, supported squat, hands and knees, toilet sitting)
      (b) Check to make sure bladder is empty; consider catheterization if unable to void
      (c) Have mother rest until contractions resume in strength and frequency
      (d) Augment contractions using nipple stimulation, natural therapies
      (e) Consult physician or midwife if no progress
   c. Transfer care if condition of mother or fetus is unstable
   d. Prepare for increased risk of hemorrhage
A. DEFINITION
Rupture of the chorioamniotic membranes can occur spontaneously (SROM) or artificially (AROM). A gush of fluid or a slow leak of watery discharge may be noticed by the pregnant client. When the rupture of membranes occurs before the onset of labor, it is called premature rupture of membranes (PROM) regardless of gestational age.

Prolonged rupture of membranes is the confirmed rupture of membranes at term that persists for more than 24 hours.

This guideline addresses spontaneous and prolonged ROM. For AROM, see "Amniotomy or Artificial Rupture of Membranes (AROM)" in Part VI for management considerations. For preterm premature rupture of membranes (PPROM), see the guideline in Part V for management considerations.

B. ETIOLOGY
1. Usually unknown
2. Infection
3. Injury
4. Poor nutrition

C. SIGNS AND SYMPTOMS
1. Mother reports gushing or leaking from the vagina
2. Fluid is
   a. Nitrazine positive
   b. Positive for ferning
   c. Observed pooling in the vaginal vault during sterile speculum exam
3. Odor of amniotic fluid

D. MANAGEMENT
1. For ROM with or without labor, but before 24 hours since rupture has elapsed
   a. A sterile speculum exam may be done to verify ROM and/or rule out prolapsed cord
   b. Avoid increasing the risk of infection
      (a) Avoid vaginal exams, at least until active labor is established
      (b) Balance the risk of infection against potential information obtained with a vaginal exam
      (c) See education factors listed below under part h. “educate mother”
   c. Assess FHTs and fetal movement
   d. Evaluate maternal vital signs
   e. Determine gestation; if preterm, see “Preterm Premature Rupture of Membranes (PPROM)” in Part V
   f. Inform parents of potential risks
   g. Confirm vertex position
   h. Educate mother
      (a) Wear clean sanitary pads and change frequently
Rupture of Membranes and Prolonged Rupture

(b) Daily shower
(c) Clean, loose clothing
(d) Complete pelvic rest
(e) Toileting hygiene (i.e., wipe from front to back)
(f) Careful hand washing
(g) Signs and symptoms of infection

i. Instruct mother to
   (a) Check temperature every 4 hours
   (b) Immediately report any change in fluid color or odor, and if fever or illness symptoms develop
   (c) Maintain hydration and nutritional intake

j. Consider
   (a) Natural therapies to prevent infection
   (b) Natural therapies to initiate or augment labor
   (c) Prophylactic antibiotic administration after 18 hours of rupture if unknown GBS status; see “Group B Beta-Hemolytic Streptococcus (GBS)” in Part V

2. Transfer of care is required if
   a. No progress of labor with prolonged rupture of membranes greater than 24 hours
   b. Signs and symptoms of maternal infection develop
   c. Maternal fever of 100.4°F is present for over 4 hours
   d. Cord prolapse when birth is not imminent
   e. See “Determining Appropriate Client Care Provider” in Part I for full list
SHOULDER DYSTOCIA

A. DEFINITION
The birth of the head occurs, but the shoulders cannot be delivered by the usual methods.

B. RISK FACTORS
1. Estimated fetal weight greater than 4000 g (8.5 lb)
2. Marginal pelvis, contracted outlet
3. Previous shoulder dystocia
4. Prolonged second stage and prolonged crowning
5. Maternal diabetes or GDM

C. SIGNS AND SYMPTOMS
1. Retraction of fetal head against perineum, usually after some difficulty with its birth and extension
2. Color of head may darken to deep purple
3. Head fails to restitute spontaneously
4. Normal traction maneuvers and maternal effort fail to affect birth progress
5. No spontaneous birth of shoulders

D. MANAGEMENT
Not necessarily in this order:
1. Once shoulder dystocia is suspected, note time of birth of the head
2. Rule out nuchal cord, compound presentation
3. Change maternal position: Gaskin maneuver (hands and knees), semi-squat, lunge, McRobert’s maneuver (exaggerated lithotomy), standing, standing with one leg up
4. Apply suprapubic pressure
5. If shoulders transverse or AP, rotate to oblique
6. Flex shoulders if extended
7. Attempt delivery of posterior arm
8. Consider episiotomy
9. Consider Woodscrew Maneuvers
10. Break fetal clavicle to deliver posterior shoulder
11. Be prepared for neonatal resuscitation and possible pneumothorax
12. Be prepared for possible postpartum hemorrhage
13. Transport as indicated
14. Mnemonic to remember steps as presented by ALSO
   o H: Ask for help
   o E: Evaluate for episiotomy
   o L: Legs (McRobert’s Maneuver)
   o P: Suprapubic pressure
   o E: Enter (insert fingers for internal maneuvers)
   o R: Rubin I and II Maneuvers, remove posterior arm
   o R: Roll the client (Gaskin Maneuver)
PART VI: INTRAPARTUM CARE

SURPRISE BREECH

A. DEFINITION
   Undiagnosed breech presentation late in labor.

B. SIGNS AND SYMPTOMS
   1. Vaginal exam or visual inspection of perineum reveals fetus’s buttocks, testes, feet or knees
   2. Probable terminal meconium

C. MANAGEMENT
   1. Transport mother to hospital if safe and timely transfer is possible
   2. If birth is imminent:
      a. Activate EMS
      b. Remain calm
      c. Catheterize maternal bladder if necessary
      d. Increase room temperature so that it will be warm when fetus’s body emerges allowing midwife to not be as concerned with cooling of wet infant while waiting for head
      e. Ascertain dilation is complete before commencing with pushing and delivery
      f. Consider performing an episiotomy if birth progress arrests
      g. Be prepared to resuscitate infant

D. METHODS FOR BREECH DELIVERY
   1. Considerations for all delivery methods
      a. Most breech presentations birth in 3–5 minutes once presenting part is crowning (‘rumping’ if it is a frank breech presentation)
      b. Legs and feet are usually born spontaneously; gently disengage if necessary
      c. Unless cord is under tension, there is no value in pulling on the cord
      d. Rotation to the sacrum anterior is necessary for delivery of the head
         (a) Having the fetus facing client’s sacrum, or some variation of this position, is the only position that will allow a breech birth to progress
         (b) If the fetus is facing mother’s pubic bone, it is less likely a spontaneous vaginal birth will occur
      e. Remember: flexion before traction
         (a) Do not put traction on the fetal trunk to hasten delivery because it deflexes the head; provide supra-pubic pressure instead if progress stalls
         (b) Maintain suprapubic pressure to keep head flexed if client is any position other than hands and knees
      f. Infant may need longer to transition, may have low 1 minute APGAR
      g. Delay cord clamping to facilitate better transition to extra-uterine life
      h. Support infant as needed, resuscitate as indicated
      i. Transfer infant as indicated
   2. Hands and Knees (preferred method)
      a. Place mother in hands and knees to optimize fetal descent and optimal fetal cardinal movements
      b. See considerations for all delivery methods above
c. Hands off the breech until the chest is seen
   (a) If chest crease (cleavage) is seen, do not touch—the arms are down and there is no need to assist
   (b) If the chest is smooth, one or both arms are up and management is required
      i. Feel for the arms
      ii. If arms are extended, deliver shoulders by rotating the trunk 180 degrees to release first arm
      iii. Second arm may spontaneously release; if not, rotate the trunk 180 degrees the opposite way to release second arm
      iv. The body should be birthed to the neck, or head may spontaneously birth due to sudden amount of room freed up by birth of arms
   d. Slowly deliver the head; may need to use Louwen Maneuver in conjunction with mother’s pushing efforts

3. Supine
   a. See considerations for all delivery methods above
   b. Hands off the breech until it delivers to the umbilicus
      (a) Wrap the birthed portion of the body in a warm towel
      (a) Maintain suprapubic pressure to keep head flexed
      (b) If necessary, feel for the arms
         i. If present, deliver anterior shoulder first
         ii. Elevate buttocks to deliver the posterior shoulder
         iii. If arms are extended: deliver shoulders by rotating to the anteroposterior position and sweeping down first the anterior arm and then the posterior arm
   c. When hairline appears
      (a) Birth head by flexion
         i. Grasp the feet with one hand
         ii. Elevate the feet through a 180 degree arc until the face is born over the perineum
      (b) Slowly deliver the head
         i. If head has extended, apply suprapubic pressure and proceed with delivery
         ii. If head will not deliver, apply maneuvers to flex the head
SURPRISE TWINS AT BIRTH

A. DEFINITION
   Unexpected birth of previously undetected multiple gestation infants.

B. SIGNS AND SYMPTOMS
   1. After birth of the first infant, the mother feels continued pushing contractions
   2. Multiparous client may feel increased fetal movement in relation to other pregnancies
   3. Fundus measures significantly large for dates
   4. Fetal heart tones can be heard in more than one location, with different heart rates
      with the use of two fetoscopes or Dopplers
   5. Presenting part is at the introitus after the birth of the first baby

C. MANAGEMENT
   1. After birth and as soon as the midwife realizes there is a twin, clamp Baby A’s cord: 
      double clamp the cord and cut in between the clamps to protect both infants from 
      possible exsanguination
   2. Activate EMS as needed
   3. Assess Baby B
      a. FHT
      b. Presentation and position, prior to actual delivery if possible
   4. Consider catheterization
   5. If needed, have an assistant direct the second twin into position abdominally as 
      primary midwife’s vaginal manipulations guide the presenting part into the pelvis
   6. Consider rupturing Baby B’s membranes if still intact once the presenting part is 
      fixed
   7. Encourage the mother to push and conduct the birth as usual, being prepared for 
      a. Breech delivery
      b. Neonatal resuscitation
      c. Postpartum hemorrhage
      d. Normalcy
   8. Identify Baby A from Baby B
      a. Ribbon on cord
      b. Double clamp
      c. Straight versus curved clamp
   9. Consult, transfer, and refer for care as usual; see “Determining Appropriate Client 
      Care Provider” in Part I for any maternal, fetal, or neonatal factors that may require 
      consultation or transfer of care
TIGHT NUCHAL CORD

A. DEFINITION
   Umbilical cord wrapped tightly around infant's neck at birth, potentially inhibiting birth of body and preventing oxygen supply to infant.

B. ETIOLOGY
   Fetal activity resulting in cord being wrapped around neck, possibly more than one time.

C. SIGNS AND SYMPTOMS
   1. Variable decelerations of FHTs during labor
   2. Abrupt change from fetus 'being high' and then suddenly crowning
   3. Slow crowning
   4. Fetus’s head retracting on pelvic floor
   5. Delayed birth of shoulders
   6. Tight cord felt around the neck after birth of head

D. MANAGEMENT
   1. If possible, insert two gloved fingers between cord and fetus's body and encourage mother to push
   2. Somersault baby to birth body
   3. If necessary, take cord over the head
   4. If the above managements are ineffective, birth is stalled due to cord tension preventing descent, or if FHTs or fetal color indicate need for immediate delivery:
      a. Double clamp and cut cord at introitus, unwrap cord from neck
      b. Ask mother to push and assist delivery of shoulders as needed
   5. Assess newborn and anticipate need for resuscitation
PART VI: INTRAPARTUM CARE

URINARY CATHETERIZATION

A. DEFINITION
   Emptying of the bladder by inserting a catheter.

B. INDICATIONS
   1. Avoid further trauma to the bladder during the birth
   2. Decrease the discomfort to the woman during the birth
   3. Allow the head to apply firmly to the cervix
   4. Facilitate descent of the head
   5. To facilitate a prolonged labor
   6. Decrease risk of shoulder dystocia or immediate postpartum hemorrhage
   7. Mother is unable to void postpartum
   8. Facilitate birth of placenta

C. SIGNS AND SYMPTOMS
   1. Suprapubic pain
   2. Inability to void, even with inducements
   3. Enlarged bladder can be felt, or seen bulging above the pubis
   4. Failure of descent of fetal head
   5. Uterus remains large and/or boggy after the birth
   6. Postpartum bleeding is excessive

D. MANAGEMENT
   1. Assess distention of the bladder and when the woman last voided
   2. Assess fluid intake
   3. Decide if the bladder distension is causing an impediment to the progress of the labor
   4. Determine whether or not a possible complication is anticipated
   5. Assess the ability of the woman to void postpartum in a reasonable time
   6. Perform urinary catheterization using sterile technique
   7. Educate regarding risks of infection post procedure
TRIPLE I (CHORIOAMNIONITIS)

A. DEFINITION
Intrauterine infection and/or inflammation, referred to as Triple I and previously referred to as chorioamnionitis, is an infection/inflammation of any combination of the amniotic fluid, placenta, fetus, fetal membranes, or decidua

B. ETIOLOGY
1. Prolonged (greater than 24 hours) rupture of membranes with or without labor
2. Repeated vaginal exams
3. Manipulative vaginal or intrauterine procedures
4. Other risk factors include: nulliparity, meconium-stained amniotic fluid, presence of genital tract pathogens (e.g., STIs, GBS, BV), alcohol and tobacco use, and Triple I (previously referred to as chorioamnionitis) in previous pregnancy
5. Maternal chronic disease, maternal nutritional status, and emotional stress may increase a client's susceptibility to infection by effects on immune system
6. Most common infecting organisms are those that ascend from the vagina (e.g., Group B *Streptococcus*, anaerobes)
7. Infrequently occurs with intact membranes

C. SEQUELAE
1. Maternal
   a. Rupture of membranes
   b. Premature labor
   c. Postpartum infection
2. Neonatal
   a. Sepsis, pneumonia, meningitis, GBS disease (early or late onset)
   b. Respiratory distress
   c. Stillbirth
   d. Premature birth
   e. Chronic lung disease
   f. Brain injury leading to cerebral palsy and other neurodevelopmental disabilities

D. SIGNS AND SYMPTOMS
1. Antepartum and intrapartum, one or more symptoms may occur
   a. Maternal fever of 100.4° F (38° C) or higher
   b. Maternal tachycardia greater than 100 bpm
   c. Fetal tachycardia greater than 160 bpm
   d. Uterine tenderness
   e. Vaginal walls warm/hot to touch
   f. Foul-smelling, purulent, and/or meconium stained amniotic fluid
   g. Elevated WBCs (defined as white blood cell count greater than 15,000/mm³)
   h. Abnormal labor pattern
2. Immediate postpartum
   a. Infant possibly hypothermic
   b. Maternal hemorrhage
   c. APGAR below 7
d. APGAR 7 or above, then infant decompensates 10–25 minutes after birth

E. MANAGEMENT

1. Maternal factors that require transfer of care; see “Determining Appropriate Client Care Provider” in Part I for complete list of factors
   a. Relevant intrapartum factors
      (a) Fever of 100.4° F for more than 4 hours
      (b) Signs and symptoms of maternal infection
      (c) Prolonged rupture of membranes (greater than 24 hours) with no progress of labor
      (d) Significant meconium stained fluid when birth is not imminent
   b. Relevant postpartum factor: signs of postpartum infection not responsive to treatment requires transfer

2. Newborn factors may require transfer or consultation; see “Determining Appropriate Client Care Provider” in Part I

3. Antibiotic treatment for mother and infant is recommended
UTERINE RUPTURE

A. DEFINITION
   1. Complete: Involves a tear that passes through the entire uterine wall. This type of rupture is the most dangerous, especially if it occurs in the fundus.
   2. Incomplete (also called “dehiscence” or “window”): Involves a tear through the myometrium, but the peritoneum is intact. May be asymptomatic or involve minimal bleeding.

B. ETIOLOGY
   1. Prolonged, obstructed, or dysfunctional labor
   2. Fetal malpresentations
   3. High parity
   4. Previous uterine surgery; see “Trial of Labor After Cesarean and Vaginal Birth After Cesarean” in Part IV for more details
   5. Injudicious use of uterine stimulants
   6. Operative procedures
   7. External pressure causing uterine trauma
   8. Manual exploration of the uterus or manual removal of placenta
   9. Placenta accreta

C. SIGNS AND SYMPTOMS
   1. Maternal
      a. Mother complains of:
         (a) Sudden, sharp, tearing suprapubic and/or abdominal pain at height of contraction
         (b) Followed by relief of pain
         (c) Followed by abrupt cessation of labor
         (d) Elevated heart rate and decreased blood pressure
      b. Slight or frank bright red vaginal bleeding
      c. Shock which may be out of proportion to external blood loss if bleeding is intraperitoneal
      d. Referred shoulder pain secondary to intraperitoneal bleeding
      e. Uterus is felt as round, firm, and contracted beside the fetus
      f. Fetal parts are easily palpable
      g. Presenting part recedes and is moveable above the inlet
   2. Fetal
      a. Fetal tachycardia with minimal variability
      b. Repetitive late decelerations followed by bradycardia or loss of heart tones
      c. Violent fetal movement followed by decreased or no fetal activity

D. MANAGEMENT
   1. Transfer of care for signs and symptoms of uterine rupture is required; see “Determining Appropriate Client Care Provider” in Part I
   2. Activate EMS
   3. Treat for shock and blood loss
   4. Transport
WATER BIRTH

A. DEFINITION
Any part or all of a labor, birth, and third stage taking place while immersed in water. Immersion depth is defined as a minimum of 17 inches or water level that covers the pregnant belly of a client in sitting position.

B. ETIOLOGY
1. Women’s experiences of using water for labor and birth are generally positive
2. Water birth reportedly causes feelings of relaxation, involved decision-making, and more control

C. INDICATIONS
Recommended immersion during labor and birth when the following conditions are satisfied:
1. Uncomplicated pregnancy of at least 37 weeks gestation
2. Established labor pattern
3. Reassuring FHT
4. Absence of bleeding concern
5. Client desire

D. CONTRAINDICATIONS
1. Contraindications for birth in water:
   a. Preterm labor
   b. Excessive bleeding
   c. Maternal fever of 100.4° F or greater, or suspected maternal infection
   d. Any condition which requires continuous FHT tracing
   e. Untreated blood or skin infection
   f. Fearful birth attendant
   g. Physical inflexibility in the client
   h. Water temperature over 100° F
2. Controversial contraindications for birth in water and associated considerations:
   a. Meconium staining in amniotic fluid
      (a) Meconium washes off prior to immersion from water
      (b) Suction of nose and airway can happen at surface
      (c) Some practices only limit contraindication to thick meconium
   b. HIV-positive status; although evidence shows that HIV virus cannot survive water birth environment
   c. Hepatitis A, B, or C infection; evidence shows that Hepatitis viruses may survive the water birth environment
   d. Herpes infection: some practitioners feel dilution of viral shedding from non-active and non-open lesion(s) in water birth will decrease risk of transmission
   e. Vaginal Birth After Cesarean in water: controversy is most typically associated with the concept of having a VBAC itself, and not about having a VBAC in water
   f. Shoulder dystocia or macrosomia with concern for incidence of shoulder dystocia
      (a) Growing body of evidence that indicates management of shoulder dystocia may be easier for the provider with client immersed in water
(b) Research indicates shoulder dystocia cannot be predicted

g. Tight nuchal cord
   (a) Under no circumstances should the cord be clamped or cut under the water
   (b) Somersaulting an infant out of cord entanglement underwater is very easy
   (c) Be aware of cord location and tension during any maneuvers
   (d) Be cautious of cord tearing and evulsion

h. Water temperature
   (a) How low the temperature should be allowed to reach, “always above 92° F”
   (b) How high the temperature should be allowed to go, “never higher than 100° F”
   (c) Inappropriate water temperature may cause fetal tachycardia

i. Placental delivery in water, objections include:
   (a) Inability to judge blood loss; consider evaluating blood loss via color evaluation
   (b) Possible water embolism, however there is no scientific evidence of risk and no reported cases
   (c) Inability to contain all the byproducts of conception in one place; consider placing the placenta and its pieces in a floating container which can be done without difficulty

E. MANAGEMENT
   1. Educate client on the potential advantages and extra considerations of water immersion for labor, birth, and third stage
   2. FHTs should be monitored according to practice guidelines; use of a waterproof Doppler is strongly recommended rather than asking client to exit pool for checking FHTs
   3. Client should be encouraged to maintain adequate hydration and leave the pool to urinate at regular intervals
   4. The water should be kept as clean as possible.
      a. Stool and blood clots should be removed from the pool immediately
      b. The pool should be drained, cleaned, and refilled if contaminants cannot be easily removed
   5. The baby should be born completely underwater with no air contact until the head is brought to the surface
      a. Air and temperature change may stimulate breathing and lead to water aspiration
      b. If a change in position during delivery causes the baby to come in contact with air, the birth should be finished in the air; this can be accomplished by having the birthing woman stand up
   6. Care should be taken to avoid undue traction on the cord as there have been reports of cord tearing and evulsion
   7. Cutting and clamping of the cord is not recommended in the water
   8. The warm water helps maintain the newborn's temperature to prevent hypothermia
      a. Keep baby’s body submerged with head out only for best heat conservation
      b. Skin to skin is best
   9. Encourage breast contact immediately; decrease water level or insert object to lift woman if breastfeeding is not possible due to high water levels
   10. As when caring for any mother or newborn, the midwife is responsible for
a. Using her clinical judgment
b. Responding appropriately to problems that may arise
c. Documenting her actions

F. PERSONAL PROTECTION CONSIDERATIONS FOR THE MIDWIFE
1. Wear gloves long enough to not flood when submerging arms
2. Screening client for: hepatitis, HIV, syphilis, gonorrhea, and chlamydia testing prior to delivery (due to possible transmission to baby and/or midwife)
3. Waterproof chest or clothing protection

G. BIRTH POOL CLEANING CONSIDERATIONS
1. Consider informed release for reused equipment
2. Birth pools should be cleaned completely between uses with a chlorine-releasing agent
   a. Follow the CDC and/or manufacturers recommendations for disinfecting pool
3. All reused pumps, jets, filters, hoses, and any other equipment which may come in contact with contaminants in the course of a water birth should also be rinsed inside and out with a chlorine-releasing agent
4. Consider using new hoses and/or birth pools for each birth
5. Outdoor and indoor hot tubs and jetted pools are acceptable for client use for immersion during labor and birth if they are cleaned and maintained prior to use in labor and birth, including the water filters
6. Small amounts of chlorine or bromine residue from cleaning agents are not harmful to mothers or infants
PART VII: THIRD STAGE CARE
PART VII: THIRD STAGE CARE

THIRD STAGE CARE SCHEDULE

A. DEFINITION
Care of the client during the period of time from the birth of the infant through the birth of the placenta.

B. MANAGEMENT
1. Facilitate bonding, skin to skin, and early breastfeeding of infant
2. Evaluate condition of mother
   a. Monitor vital signs
   b. Monitor blood loss
   c. Monitor fundal height
3. Obtain cord blood if indicated
4. Facilitate delivery of placenta if needed
   a. Determine whether or not placenta has separated
   b. After separation
      (a) Encourage maternal pushing efforts while uterus is cramping
      (b) Apply gentle cord traction in coordination with maternal pushing efforts if needed
   c. If signs and symptoms of hemorrhage or hidden or frank bleeding are present, identify the source and treat appropriately
   d. If no separation, assess for need for manual removal
5. Screen for signs and symptoms of other complications of third stage
A. DEFINITION
Evacuation of the placenta from the uterus by hand.

B. INDICATIONS
1. All other attempts to deliver placenta have failed
2. Steady flow of blood from vagina

C. MANAGEMENT
1. Engage woman's cooperation
2. Catheterize bladder if indicated
3. Consider IV before or after removal
4. Using sterile technique, place whole hand into uterus by following umbilical cord to placenta
5. Grasp uterus abdominally with external hand to keep fundus well contracted and to provide counterforce to internal hand's actions
6. Using internal hand, quickly feel entire fetal surface of placenta to gauge size
7. Find area of placental separation to use as starting point
8. Place the back of the hand against the uterine wall and, with fingers between the placenta and the uterus, carefully sweep back and forth from side to side, separating the placenta from the uterine wall
9. If you come to an area that does not separate easily, STOP: you may have an accreta and need to transfer immediately; see “Placenta Accreta” in Part VII and “Determining Appropriate Client Care Provider” in Part I
10. When the entire placenta has been separated from the uterus, grasp placenta in palm of hand and slowly remove hand from uterus and vagina while continuing to grasp fundus abdominally
11. Administer antihemorrhagic medications as appropriate
12. Immediately inspect placenta, membranes, and cord
13. Treat for shock if necessary
14. Activate EMS if necessary or if first attempt is not successful
15. Consult for prophylactic antibiotics and/or utilize natural therapies
16. Monitor closely for infection
17. Consult or transfer as necessary; refer to “Determining Appropriate Client Care Provider” in Part I as well as using good clinical judgment
PLACENTA ACCRETA

A. DEFINITION
Abnormal adherence of placenta directly to or through the myometrium. Placenta accreta occurs when or all or part of the placenta attaches abnormally to the myometrium. Three grades of abnormal placental attachment are defined according to the depth of invasion.

B. RISK FACTORS
1. Previous uterine curettage
2. Previous cesarean birth or other uterine surgery
3. Placenta previa
4. Previous accreta

C. SIGNS AND SYMPTOMS
1. Placenta does not deliver
2. Bleeding may be minimal to non-existent OR steady flow of blood after non-adherent areas separate from uterus
3. Attempt to manually remove placenta fails due to abnormal adherence

D. MANAGEMENT
1. Stabilize mother
2. Activate EMS
3. Administer Pitocin and Methergine to cause strong uterine contractions to control bleeding if indicated
4. Treat for shock
5. Start IV
6. Transport immediately; see “Determining Appropriate Client Care Provider” in Part I
A. DEFINITION
Undelivered placenta or placental fragments.

B. ETIOLOGY
1. Separated but retained, with or without bleeding
2. Partially separated or partial accreta
3. Completely adherent

C. MANAGEMENT OF RETAINED PLACENTA
1. Check for placental separation
2. Facilitate placental delivery, not necessarily in this order:
   a. Consider gentle traction to the cord
   b. Consider upright/squatting maternal position
   c. Encourage nursing or nipple stimulation
   d. Assess for bladder distention
      (a) Encourage voiding
      (b) Catheterize if necessary
   e. Consider natural therapies
   f. Administer antihemorrhagic medications as appropriate
3. Feel for location of the placenta
   a. Use sterile technique
   b. Follow cord up to cervical os
   c. If present, deliver by controlled cord traction
4. If placenta not delivered, with or without bleeding:
   a. Start IV with 1000cc Lactated Ringers
   b. Assess vital signs, contractions, bleeding, and fundal height
   c. Administer antihemorrhagic medications as appropriate
   d. Consider natural therapies
   e. Administer oxygen
   f. Consider manual removal; see “Manual Removal of Placenta” in this Part VII
   g. Immediate transfer is required if placenta undelivered or mother unstable; see “Determining Appropriate Client Care Provider” in Part I
PART VIII: POSTPARTUM CARE FOR THE MOTHER
POSTPARTUM CARE SCHEDULE

A. CARE SCHEDULE
   Postpartum care consists of the following minimum schedule although it is not limited to this schedule:
   1. 24-48 hours
   2. 3–5 days
   3. 2–3 weeks
   4. 4–6 weeks

B. POSTPARTUM CARE
   The following should be evaluated at the postpartum visit:
   1. Breastfeeding and condition of breasts
   2. Perineum and repairs
   3. Nutrition, including increased maternal nutritional needs if breastfeeding
   4. Elimination
   5. Psychosocial adjustments to new roles (including partner, family, and siblings), including bonding and parenting
   6. Vital signs
   7. Rest and activity level; obtaining enough rest and exercise
   8. Fundus/lochia
   9. Sexuality and making sexual readjustment
   10. Addressing and supporting fertility goals, including seeking contraceptive education/products
   11. Reintegration into the work force

C. LEGAL REQUIREMENTS FOR NEW MEXICO BIRTHS
   1. By 10 days postpartum, the birth certificate, paternity statement, and enumeration of birth for social security should be completed and sent to the state
   2. Newborn screening should be completed and sent to the appropriate place in the required time frame.
   3. If client is on Medicaid, fax infant Notification of Birth to appropriate CMS office

D. FINAL VISIT
   The final visit is typically from 4–6 weeks postpartum and should consist of the evaluation listed above for postpartum are as well as the following:
   1. Exercise
   2. Well-woman care as needed
   3. Follow up visits or phone calls as needed for support, education, and evaluations
   4. Referrals as needed for family planning, counseling, etc.

E. INFANT EVALUATION
   See “Newborn Care Schedule” in Part IX
PART VIII: Postpartum Care for the Mother

AFTERBIRTH PAINS

A. DEFINITION
Sensation caused by the continuing sequential contraction and relaxation of the uterus during the postpartum period. Sensation is more common and uncomfortable with increasing parity and in women who breastfeeding.

B. SIGNS AND SYMPTOMS
1. Cramping ranging from menstrual-like cramps to stronger contractions; may present in the lower back as well
2. Increase in cramping with breastfeeding

C. MANAGEMENT
1. The basis for relief is an empty and continuously well-contracted uterus
2. Keep bladder empty
3. Assess for bleeding: rule out clots, possible retained placenta fragments; see “Postpartum Hemorrhage (Immediate)” and “Postpartum Hemorrhage (Late)” in Part VIII, and “Retained Placenta” in Part VII
4. Encourage the woman to check her uterus regularly for firmness
   a. Rub uterus periodically; educate client how to massage uterus to maintain contraction as needed
   b. Encourage breastfeeding
   c. Offer natural remedies to stimulate uterine tone to maintain appropriately contracted state
   d. Lying prone encourages the uterus to contract, may increase discomfort until uterus is well contracted
5. Try natural therapies or over the counter pain relief medication
6. Assure normalcy and that it will pass
7. Educate client about purpose and importance of postpartum uterine contractions and typical time line for complete involution
BIMANUAL COMPRESSION

A. DEFINITION
Manually compressing the uterus in order to reduce or stop hemorrhage with a poorly contracted uterus.

1. External Bimanual Compression: The compression of the uterus between an external hand on the fundus and an external hand placed suprapubically.
2. Internal Bimanual Compression: The compression of the uterus between an external hand on the fundus and a fist placed vaginally with knuckles against the uterine cervix.

B. INDICATION
1. Uncontrolled postpartum bleeding following the birth of the placenta
2. Uterine atony
3. Uterine atony unresponsive to vigorous fundal massage, administration of Pitocin, Methergine, Misoprostol, natural therapies, and/or urinary catheterization

C. MANAGEMENT AND TECHNIQUE
1. Bimanual compression: This is a more difficult, extremely painful treatment for severe PPH
   a. One hand is placed on the fundus while the other, using sterile technique, is placed as a fist inside the vagina until the knuckles come in contact with the uterine wall. The uterus is squeezed between the fist and the hand to provide direct pressure to stop bleeding and contract the uterus
   b. Continue internal bimanual compression until bleeding stops
2. Additional management
   a. Consider IV therapy
   b. Administer antihemorrhagic medications as appropriate
   c. Consider natural therapies
   d. See “Postpartum Hemorrhage (Immediate)” and “Postpartum Hemorrhage (Late)” in Part VIII
BREAST CARE

A. SUGGESTIONS FOR THE BREASTFEEDING MOTHER
   1. Keep breasts clean, washing only with water; avoid using soap on nipples and areola, as it can be drying and lead to cracked nipples
   2. Keep nipples dry, exposing them to fresh air and sunshine frequently
   3. Provide good support to the breasts by wearing a comfortable, properly fitting nursing bra
   4. Always break the suction of baby’s latch with your finger before removing baby from the breast
   5. Drink plenty of fluids
   6. Good nutrition and supplements
   7. Get good rest

B. ENSURE PROPER NURSING POSITIONS, PROPER LATCH, AND SIGNS OF SWALLOWING
   1. Decrease stress
   2. If nipples become tender
      a. Be sure baby is properly positioned
      b. Apply warm compresses to enhance let-down
      c. Breastfeed more frequently
      d. Nurse on the sore nipple first
      e. Expose nipples to air and sunlight to promote healing
      f. Apply breast milk or natural remedies to nipples
   3. Watch for signs and symptoms of engorgement
      a. Breasts feel full, firm, hard
      b. Breasts are tender, throbbing, painful
      c. Breasts are warm to the touch
      d. Skin becomes tight, shiny, or red
      e. Veins may become visible
      f. Increased maternal temperature
   4. If breasts become engorged
      a. Go to bed and increase frequency of feedings
      b. Apply warm compresses to breasts prior to breastfeeding
      c. Shower, letting water flow over breasts
      d. Soak breasts in warm water
      e. Express milk manually or with a pump prior to nursing to help baby latch onto nipple
      f. Express milk to empty breasts if uncomfortably full
      g. Wear supportive nursing bra that does not pinch or bind
      h. Consider natural therapies
   5. Educate and assess for signs of infection
   6. Anticipate difficulties latching with difficult or complicated births, and refer babies with latch or feeding problems to a lactation consultant
   7. Refer to La Leche League, breastfeeding consultant as indicated
BREAST INFECTION (MASTITIS)

A. DEFINITION
   An inflammation of the breast, which develops as a result of bacterial infection.

B. ETIOLOGY
   1. Over-active or over-stressed mom
   2. Breast over-distension
   3. Clogged duct
   4. Cracking or fissures of the nipple
   5. Depression

C. SIGNS AND SYMPTOMS
   1. Precursory signs
      a. Severe engorgement
      b. Slight fever
      c. Mild pain in one segment of the breast which is exaggerated when the baby nurses
   2. Signs and symptoms of mastitis
      a. Rapid onset
      b. Rapid elevation of temperature to 103-104° F
      c. Increased pulse rate
      d. Chills, general malaise, headache, muscle aches
      e. Indurated and reddened area or red streak of the breast, usually painful
      f. Hard, sizable lumps may be palpated
      g. Heat radiating over infected area
   3. Signs and symptoms of abscess
      a. Discharge of pus
      b. Remittent fever with chills
      c. Breasts swollen and extremely painful; large, hard mass with an area of fluctuation, reddening, and bluish tinge to the skin indicating the location of the pus filled abscess

D. MANAGEMENT
   1. Continue nursing, beginning on the affected side each time
   2. Use hot moist packs
   3. Drink plenty of fluids
   4. Bed rest during the acute phase
   5. Consider natural therapies
   6. Consult if no improvement or at mother's request for possible antibiotic treatment
   7. If breast abscess diagnosed:
      a. Consult
      b. Breastfeeding should be discontinued on that side until drained and healing, since the duct system can communicate with the abscess
      c. Note that failure to treat mastitis with appropriate antibiotics increases the risk of abscess
POSTPARTUM HEMORRHAGE (IMMEDIATE)

A. DEFINITION

Excessive bleeding that can occur anytime within the first 24 hours after the birth of the infant.

B. ETIOLOGY

1. Uterine atony
   a. Multiple pregnancy
   b. Large baby
   c. Maternal exhaustion
   d. Prolonged second stage
   e. Abnormal labor pattern
   f. Precipitous labor
   g. Distended bladder
2. Retained placental fragments
3. Trauma or lacerations
4. Clotting disorder
5. Uterine rupture
6. Partial separation of the placenta

C. SIGNS AND SYMPTOMS

1. Uncontrolled bleeding
2. Signs and symptoms of shock
3. Excessive blood loss
4. Concealed bleeding
   a. Rising uterus
   b. Increasing pain

D. MANAGEMENT

Not necessarily in this order:
1. Determine source of bleeding; use the Four Ts mnemonic to remember steps as presented by Advanced Life Support in Obstetrics (see http://www.aafp.org/cme/programs/also.html)
   a. Tone: Uterine
   b. Trauma: Laceration
   c. Tissue: Retained placenta
   d. Thrombin: Clotting defect
2. Facilitate birth of placenta; see “Retained Placenta” in Part VII
3. If placenta delivered and uterus is not well contracted, express clots and apply fundal massage until the uterus is firm
4. Apply direct pressure to any bleeding lacerations
5. Assess placenta for completeness and manually remove fragments as indicated; see “Manual Removal of Placenta” in Part VII
6. Catheterize bladder if indicated
7. Consider internal or external uterine bimanual compression; see “Bimanual Compression” in Part VIII
8. Administer antihemorrhagic medications as appropriate
9. Consider natural therapies
10. Monitor vital signs
11. Start IV as indicated
12. Consider external aortic compression
13. Treat for shock and activate EMS as necessary
14. Transport as necessary and bring placenta with transport; see “Determining Appropriate Client Care Provider” in Part I for associated factors requiring transfer
15. Postpartum labs as appropriate
16. Anticipate postpartum sequelae and see appropriate guidelines
   a. Anemia
   b. Depression
   c. Infection
   d. Breastfeeding difficulties
POSTPARTUM HEMORRHAGE (LATE)

A. DEFINITION
   A hemorrhage occurring after 24 hours postpartum, most commonly 1–2 weeks postpartum and up to 6 weeks postpartum.

B. ETIOLOGY
   1. Retained portion(s) of the placenta
   2. Rigorous maternal activity
   3. Infection
   4. Dehiscence of surgical scar
   5. Hematoma
   6. Bleeding disorders
   7. Unknown causes

C. SIGNS AND SYMPTOMS
   1. Sudden onset bright red uterine bleeding
   2. Excessive large blood clots
   3. Subinvolution of the uterus
   4. Signs and symptoms of infection
   5. Signs and symptoms of shock

D. MANAGEMENT
   1. Attempt to control bleeding; see “Postpartum Hemorrhage (Immediate)” in Part VIII
   2. Ultrasound to rule out retained fragments
   3. Consider antibiotic treatment
   4. Consider natural therapies
   5. Consult and transfer as needed or required; see “Determining Appropriate Client Care Provider” in Part I
POSTPARTUM MOOD DISORDERS

A. DEFINITIONS:
1. Maternity or baby blues: A mild, self-limiting form of depression commonly occurring during the first few days postpartum and lasting up to two weeks.
2. Postpartum depression: Moderate to severe depression in a woman after she has given birth. It may occur soon after delivery or up to a year later. Most of the time, it occurs within the first 3 months after delivery.
3. Postpartum psychosis: A rare but serious psychiatric emergency requiring immediate intervention. It usually begins within 1 to 3 months of delivery.

B. CONTRIBUTING FACTORS
1. Difficulties in relationship with domestic partner
2. Unwanted pregnancy
3. Lack of familial or social support
4. Traumatic birth experience
5. Previous mental health illness
6. Family history of mental health illness
7. History of abuse or trauma
8. Hormonal imbalance
9. Sleep deprivation
10. Low blood sugar
11. Thyroid imbalance
12. Chemical and vitamin imbalance
13. Lack of exercise
14. Lack of breastfeeding or bonding
15. Isolation
16. Currently on medication or stopping medication during pregnancy and/or postpartum

C. SIGNS AND SYMPTOMS
1. Baby blues
   a. Usual onset with milk coming in (3–5 days postpartum)
   b. Unexplained weeping, sadness, irritability, anxiety, confusion
   c. Transient, does not consistently affect ability to function
   d. Resolves by 10 days to 2 weeks
2. Depression
   a. Feelings of overwhelming sadness, grief, guilt, or shame
   b. Withdrawal, social isolation
   c. Loss of interest in infant, and/or excessive concern for infant
   d. Anxiety
   e. Lack of interest in daily activities
   f. Decreased energy
   g. Sleep disturbances
   h. Rapid weight loss with decreased appetite
   i. Memory loss
3. Psychosis
a. Sudden onset, severe, usually within the first month (can occur within 3–14 days postpartum)
b. Depression signs and symptoms from above
c. Paranoid delusions
d. Suicidal thoughts and impulses
e. Inability to care for self and children
f. Hallucinations (visual and/or auditory)
g. Threats of violence toward self, infant, or other family members

D. MANAGEMENT
1. Refer to appropriate care providers, family, friends, community resources
2. Determine level of mood disorder (see Appendix I as one type of guide)
3. Consider thyroid screening
4. Consider natural therapies
5. Immediate intervention may be appropriate
6. Notify Child Protective Services if client's children are in danger of abuse or neglect
7. For antepartum clients, consultation is required for any current severe psychiatric condition requiring medication within a 6-month period prior to pregnancy; see “Determining Appropriate Client Care Provider” in Part I

E. RESOURCES
1. Depression after Delivery (DAD): 1-800-944-4773, 908-575-9121, and depressionafterdelivery.com
3. Postpartum Survival Guide by Ann Dunnewold and Diane G. Sanford
4. Behind the Smile by Marie Osmond
5. Down Came the Rain: My Journey through Postpartum Depression by Brooke Shields
6. Edinburgh Postnatal Depression Scale; see Appendix I
POSTPARTUM PERINEAL CARE

A. DEFINITION
Care of the perineum after changes occurring during birth, ranging from normal stretching, swelling, trauma, tear, or episiotomy.

B. SIGNS AND SYMPTOMS
1. Tender and painful perineal area
2. Signs and symptoms dependent on location of tear
3. Reluctance or difficulty with elimination
4. Assess for REEDA
   a. Redness
   b. Edema
   c. Ecchymosis
   d. Discharge
   e. Approximation
5. Hemorrhoids
6. Hematoma

C. MANAGEMENT
1. Assess vulva after birth (does not have to be done immediately or urgently unless active bleeding is noted)
2. Assess need for repair; see “Perineal Tears and Repair” in Part VIII
3. Educate and encourage the use of methods for
   a. Preventing infection
   b. Reducing swelling
   c. Increasing circulation
   d. Maintaining hygiene
   e. Providing comfort
   f. Reducing activity levels
   g. Advising pelvic rest
   h. Encouraging nutrition and hydration to assure bowel and bladder function
4. Encourage sitz baths, natural light, and air
5. Follow-up
   a. Examine perineum as needed
   b. Assess for foul odor
   c. Discuss any fears or concerns
   d. Ask specifically about urinary or anal incontinence
   e. Consult or transfer if healing is unsatisfactory
PERINEAL TEARS AND REPAIR

A. DEFINITION
Perineal, labial, periurethral, vaginal, and vulvar tears that occur spontaneously or as the result of an episiotomy.

B. ETIOLOGY
1. Normal process of birth
2. Weakened tissue from previous scar
3. Poor perineal integrity
4. Previous trauma
5. History of physical or sexual abuse
6. Precipitous birth
7. Tight muscle tone
8. Dystocia
9. Fetal malpresentation, position, or compound presentation

C. SIGNS AND SYMPTOMS
1. Bleeding
2. Tissue damage
3. Vaginal and perineal examination reveals tear
4. Pain

D. MANAGEMENT
1. Determine need for repair or transfer
   a. Evaluate
      (a) Degree
         i. Length and depth
         ii. Third and fourth degree tears require immediate transfer for repair by an experienced provider; see “Determining Appropriate Client Care Provider” in Part I
      (b) Assess for REEDA
         i. Redness
         ii. Edema
         iii. Ecchymosis
         iv. Discharge
         v. Approximation
      (c) Bleeding and vital signs
      (d) Maternal activity level postpartum
      (e) Maternal desires and feelings
   2. Repair as necessary or desired
      a. Administer local anesthetic if needed after assessing allergy history
      b. Repair
      c. Follow up as necessary
      d. If the repair needed is beyond midwife’s experience or comfort level, consult with or transfer to a more experienced midwife or other physician to complete the repair
3. Client education for all lacerations (repaired or not repaired)
   a. Teach mother appropriate perineal hygiene for comfort, to speed healing, and
      prevent infection
   b. Educate mother about ice, sitz baths, and other natural remedies
   c. See “Postpartum Perineal Care” in Part VIII
POSTPARTUM HEMATOMA

A. DEFINITION
   A swelling or mass of blood in the vulva or retroperineal area, caused by the rupture of a vessel in the soft tissue and usually concealed.

B. ETIOLOGY
   1. Trauma during the course of birth
   2. Stretching deep tissue
   3. Rupturing a deep vessel
   4. Episiotomy

C. SIGNS AND SYMPTOMS
   1. Sudden onset of severe pain
   2. Rectal pressure, need for bowel movement
   3. Possible difficulty in voiding
   4. Enlarged firm mass, usually unilateral; often not visible due to location in rectovaginal area
   5. Purplish discoloration
   6. If involving the broad ligament
      a. Severe lateral uterine pain
      b. Flank pain
      c. Abdominal distension

D. MANAGEMENT
   1. Assess vital signs regularly
   2. Consider natural therapies
   3. Small vulvar hematoma and not enlarging
      a. Application of ice packs
      b. Teach good hygiene
      c. Observe to confirm absorption rather than size increase
   4. If large and growing, or maternal signs of pain and/or increased blood loss
      a. Treat for shock as indicated
      b. Immediate transfer is required in cases of hematoma increasing in size or pain; see “Determining Appropriate Client Care Provider” in Part I
POSTPARTUM INFECTION

A. DEFINITION
An infection of the reproductive tract associated with birth and usually occurring 24 hours after birth to 10 days postpartum.

B. ETIOLOGY
Bacterial infection.

C. PREDISPOSING FACTORS
1. Cesarean birth
2. Prolonged rupture of membranes
3. Prolonged labor
4. Frequent vaginal exams during labor
5. Anemia
6. Postpartum hemorrhage
7. Malnutrition
8. Retained placental fragments
9. Cervical, vaginal, or perineal lacerations
10. Hematomas
11. Underlying stress
12. Pre-existing infection
13. Inability to void in labor
14. Contamination during birth

D. SIGNS AND SYMPTOMS
1. Fever
2. Abdominal or perineal tenderness and pain
3. Malaise, pallor, lassitude
4. Tachycardia
5. Chills
6. Foul, purulent discharge
7. Elevated WBCs
8. Positive genital culture

E. MANAGEMENT
1. Obtain appropriate laboratory work
   a. CBC screen
   b. Genital culture
   c. Urinalysis
2. Treat for infection with natural therapies and/or antibiotics and follow up with client within 24 hours of initiating therapy
3. Monitor temperature
4. Educate about hygiene, rest, nutrition, and hydration
5. Consult as appropriate
6. Immediate transfer is required with signs of infection not responsive to treatment; see “Determining Appropriate Client Care Provider” in Part I
UTERINE INVERSION

A. DEFINITION
Condition in which the uterus turns inside out so that the fundus either:
1. Protrudes through the cervical os (incomplete inversion),
2. Descends to the introitus (complete inversion), or
3. Extends beyond the vulva (prolapsed inversion).

B. ETIOLOGY
1. Strong cord traction while placenta still attached
2. Uterine atony with dilated cervix
3. External fundal pressure to help expel placenta with poorly contracted uterus
4. Accreta
5. Increasing parity

C. SIGNS AND SYMPTOMS
1. Uterus observed at introitus or protruding beyond vulva
2. Fundus felt protruding through cervical os upon manual examination
3. Maternal shock
4. Hemorrhage

D. MANAGEMENT
1. Immediate transfer is required in cases of uterine inversion or prolapse; see “Determining Appropriate Client Care Provider” in Part I
   a. Activate EMS and prepare for transfer
   b. Position mother in Trendelenburg position
   c. Try to reposition uterus
      (a) Place entire hand in vagina with inverted fundus in palm of hands and fingertips at junction of inversion
      (b) Gently walk fingers up the walls of the uterus as fundus is repositioned; hold in place for several seconds
      (c) If successful, perform internal bimanual compression to control bleeding; see “Bimanual Compression” in Part VIII
   d. Administer antihemorrhagic medications as appropriate ONLY if the uterus was successfully repositioned
   e. Treat for shock
      (a) Administer oxygen
      (b) Start IV therapy
2. Educate regarding risk of infection post procedure and strengthening of muscle tone
3. Antepartum clients with a history of uterine inversion require consultation; see “Determining Appropriate Client Care Provider” in Part I
VENOUS THROMBOSIS

A. DEFINITION
   The presence of a blood clot in a vein, including deep venous thrombosis (DVT—a blood clot in the venous system of the lower extremities or pelvis) and pulmonary embolism (a blood clot which has broken from its original location and traveled to the vessels of the lungs).

B. ETIOLOGY
   1. Venous stasis
   2. Injury to a vein
   3. Clotting abnormalities
   4. More common in the presence of varicosities
   5. Pregnancy

C. SIGNS AND SYMPTOMS
   1. Leg pain
   2. Fever
   3. Tachycardia
   4. Heat, redness, and tenderness at site of thrombosis
   5. Edema
   6. Positive Homan's sign
   7. Mnemonic as presented by ALSO to remember DVT signs and symptoms; note that DVT in pregnancy occurs in 12% of women with at least one of LEFt criteria and 0% occurrence with none
      o L: Left leg
      o E: Edema (greater than or equal to 2 cm)
      o Ft: First trimester at the time symptoms present

D. SEQUELA
   1. Clot may dislodge and lead to pulmonary embolism

E. MANAGEMENT
   1. Do not massage affected area
   2. Refer for treatment
   3. Prevention
      a. Screen for history of clots
      b. Educate about proper hydration and frequent walking when traveling
      c. Avoid recommendation of bed rest for conditions in which it is not proven to have benefit
   4. Antepartum clients with a history of pulmonary embolism or deep vein thrombosis require primary care by a physician or CNM; see “Determining Appropriate Client Care Provider” in Part I
PART IX: NEWBORN CARE
PART IX: NEWBORN CARE

NEWBORN CARE SCHEDULE

A. DEFINITION
Care of the newborn from birth through the neonatal period.

B. SCHEDULE
The timing of the neonatal care schedule consists of (at the minimum):
1. Immediate care and evaluation
2. 24-48 hours
3. 3-5 days
4. 2-3 weeks
5. 4-6 weeks

C. IMMEDIATE NEWBORN CARE
1. Honor and welcome baby
2. Complete immediate newborn assessment
   a. Assess infant's need for resuscitation; see “Neonatal Resuscitation” in Part IX
   b. Neonatal distress not responsive to interventions and neonatal seizures are risk factors that require immediate transfer; see “Determining Appropriate Client Care Provider” in Part I
   c. APGAR score at 1 and 5 (10 minutes if indicated)
   d. Perform infant vitals as appropriate
3. Facilitate bonding and breastfeeding
4. Perform complete newborn exam (neurological and physical assessment)
5. Administer prophylactic ophthalmic ointment and vitamin K per parent’s consent; see “Prophylactic Eye Treatment of the Newborn” in Part IX
6. Educate parents on normal newborn care, behaviors, and physiology
7. Educate parents on warning signs of abnormal newborn behavior
8. Recommend newborn provider appointment within the first six weeks or sooner as necessary; assist with finding/connecting with a pediatric provider
9. See “Determining Appropriate Client Care Provider” in Part I for newborn risk factors that require consultation

D. WELL NEWBORN VISITS
1. The following should be evaluated at well newborn visits:
   a. Umbilicus
   b. Vitals
   c. Feeding and elimination
   d. Skin (color/hydration)
   e. Auscultation of heart and lungs
   f. Weight
   g. Sleep/wake patterns
   h. General condition/reflexes/fontanels
   i. Educate on well baby care, developmental stages, immunizations, and circumcision
2. Provide standard treatment, testing, and referral for newborns; see “Treatment, Screening, and Referral for Newborns” in Part IX
3. See “Determining Appropriate Client Care Provider” in Part I for a list of newborn risk factors that require consultation or transfer.
TREATMENT, SCREENING, AND REFERRAL FOR NEWBORNS

A. Immediate treatment for newborn
   1. Antibiotic eye prophylaxis; see “Prophylactic Eye Treatment of the Newborn”
   2. Vitamin K; see “Vitamin K Administration”
   3. If mother Rh Negative, determine newborn blood type and RH status; see also “Rh Incompatibility” in Part V
   4. If client declines any standard treatment or testing, document refusal with a client-signed informed consent form or with a note in client’s chart (an informed consent form for the midwife’s practice is recommended versus only noting refusal in chart)

B. Required initial neonatal testing by the state of New Mexico
   Please note: LMs practicing outside of the state should refer to and follow the local jurisdiction’s requirements; consider providing or referring for this screening if not required
   1. Newborn genetic screening test; see “Newborn Genetic Screen”
      a. First newborn screening test
         (a) Administer between 24 and 48 hours
         (b) If screen declined: signed, documented, and faxed “Newborn Screening Test Refusal” (see Appendix E)
      b. Second newborn screening test is administered at 10-14 days after birth
   2. Newborn hearing screen; see “Newborn Hearing Screen” section for more detail
      a. If hearing screening is planned: signed, documented and faxed “Newborn Hearing Screening Referral Form” (see Appendix D)
      b. If screen is declined: signed, documented, and faxed “Newborn Screening Test Refusal Form” (see Appendix E)
   3. Newborn hearing screen; see “Newborn Hearing Screen”
      a. Referral filled out, documented, and faxed to state (see Appendix D)
      b. If screen is declined: signed, documented, and faxed “Newborn Screening Test Refusal” (see Appendix E)
   4. Critical congenital heart disease screening; see “Chronic Congenital Heart Disease Pulse Oximetry Screening” this Part IX
      a. Test between 24 and 36 hours
      b. If screen declined: fax results of signed, documented “Newborn Screening Test Refusal” (see Appendix E)
ANKYLOGLOSSIA (TONGUE-TIE OR LIP-TIE)

A. DEFINITION
A condition that restricts the range of motion of the tongue or lip.

B. ETIOLOGY
Typically, the lingual frenulum and the labial frenulum separate before birth allowing the tongue and lip free range of motion. With tongue-tie, the lingual frenulum remains attached to the bottom of the tongue. With lip-tie, the labial frenulum remains attached to the posterior side of the upper lip. It is more common in boys with a male to female ratio of 3:1 and is considered a congenital anomaly. The prevalence for a tight labial frenulum is 4.4 to 4.8%.

C. SIGNS AND SYMPTOMS
1. Breastfeeding problems
   a. Breastfeeding requires an infant to keep their tongue over the lower gum and to flange their upper lip while sucking
   b. If either frenulum is too tight restricting these movements it may cause significant nipple pain and/or poor weight gain
2. Speech difficulties: a tight lingual frenulum can interfere with the ability to make certain sounds
3. Poor oral hygiene: a tight lingual frenulum may cause difficulty sweeping food and oral debris from the teeth and increase occurrence of tooth decay and gingivitis
4. Other challenges with oral activities

D. MANAGEMENT
1. Watchful waiting: sometimes the lingual frenulum loosens over time and resolves
2. Consider frenotomy (also known as a frenulectomy or frenulotomy): the surgical release or removal of a frenulum, a small fold of tissue that prevents an organ in the body from moving too far
   a. For the purposes of this section, frenotomy is in reference to an anterior or posterior ankyloglossia (tongue-tie or lip-tie)
   b. Performed by a trained and qualified provider;
      (a) An LM may perform this procedure with additional documented training per “Mechanism for Expansion of Practice” in Part II
      (b) Client signs midwife’s practice’s informed consent form for procedure if LM performing
   c. Educate client on what to expect during and after the procedure
   d. Follow-up with client after the procedure
BREAST PUMP INSURANCE PROCUREMENT

A. DEFINITION
Procurement of a breast pump through a client’s insurance for the purpose of facilitating lactation.

B. ETIOLOGY
There are multiple reasons why a breast pump may be needed to facilitate breastfeeding. Refer to possible diagnosis reasons given below. Note language is taken from ICD9 without diagnosis codes listed because it is understood that there are updates to the ICD and codes may change. The hope is that with the diagnosis language a midwife could look up the most current ICD codes.

C. DIAGNOSIS CODES
1. Relating to mom
   a. Abscess of breast
   b. Abscess of nipple
   c. Cracked nipple
   d. Dermatitis contact
   e. Engorgement of breasts
   f. Infections of nipple
   g. Nonpurulent mastitis
2. Other disorders of lactation
   a. Other specified infection of breast and nipple
   b. Retracted nipple
   c. Suppressed lactation
   d. Maintain milk supply
   e. Twin pregnancy post-partum condition or complication
   f. Unspecified disorder of lactation
   g. Unspecified infection of the breast and nipple
3. Relating to infant
   a. Abnormal loss of weight
   b. Abnormal tongue position
   c. Breast milk jaundice
   d. Cleft palate/lip
   e. Down's Syndrome
   f. Dysphagia
4. Failure to thrive
   a. Feeding difficulty in the newborn
   b. Neonatal *Candida* infection
   c. Other transitory neonatal factors
   d. Suck reflex abnormal

D. MANAGEMENT
1. Clients receiving WIC can obtain a breast pump through WIC
2. Private and Medicaid insured clients can obtain a breast pump through their MCO, if it is medically necessary
3. Steps for procurement:
   a. Determine the appropriate diagnosis code
   b. Determine the appropriate brand and type of pump necessary
      (a) Manual CPT code E0602
      (b) Hospital Grade Electric CPT Code E0604
      (c) Individual Electric Breast Pump purchase CPT Code E0603
   c. Contact the medical supply company used by the client’s insurance
CHRONIC CONGENITAL HEART DISEASE PULSE OXIMETRY SCREENING

A. DEFINITION
Newborn screening for critical congenital heart disease (CCHD) can identify newborns with these conditions before signs and symptoms are evident.

B. SCHEDULING
1. Current published recommendations focus on screening newborns at 24-36 hours
2. Pulse oximetry screening should not replace taking a complete family health history and pregnancy history, or completing a physical examination which sometimes can detect a CCHD before the development of low levels of oxygen (hypoxemia) in the blood

C. EQUIPMENT
1. A pulse oximeter is used to measure the percentage of hemoglobin in the blood that is saturated with oxygen
2. An FDA approved neonatal pulse oximeter with a neonatal probe must be used in this screening

D. ETIOLOGY
1. Primary screening targets
   a. Hypoplastic left heart syndrome
   b. Pulmonary atresia with intact septum
   c. Tetralogy of Fallot
   d. Total anomalous pulmonary venous return
   e. Transposition of the great arteries
   f. Tricuspid atresia
   g. Truncus arteriosus
2. Secondary screening targets
   a. Coarctation of the aorta
   b. Double outlet right ventricle
   c. Ebstein anomaly
   d. Interrupted aortic arch
   e. Single ventricle
3. Population statistics
   a. About 3% of all newborns are born with a congenital defect
   b. Nearly 1% (about 18 per 10,000) of all newborns have a CCHD
4. CCHDs are the leading cause of birth defect-associated infant illness and death; infants with CCHD require catheter-based intervention or heart surgery during the neonatal period
5. Delayed diagnosis of CCHD may result in the infant having a poorer preoperative condition and worse cardiopulmonary and neurological outcomes after treatment
6. Effective surgeries are available for most of these diseases

E. MANAGEMENT
1. Complete the informed decision making process
a. If parent(s) declines CCHD pulse oximetry testing, a Newborn Screening Test Refusal (Appendix E) must be signed, faxed to the NM Newborn Screening Program, and filed in the client’s chart
b. If parent(s) consents to the CCHD pulse oximetry testing
   (a) Send or fax in the completed CCHD Results Form to the NM Newborn Screening Program (see Appendix C)
   (b) Screen following the algorithm below (please note: percentages refer to oxygen saturation as measured by pulse oximeter)

2. Failed screens
   a. Any oxygen saturation measure less than 90% (in the initial screen or in repeat screens);
   b. Oxygen saturation is greater than 90% but less than 95% in the right hand and foot on three measures, each separated by one hour; or
   c. A greater than 3% absolute difference exists in oxygen saturation between the right hand and foot on three measures, each separated by one hour
d. Referral for failed screens
   (a) Any infant who fails the screen should have a diagnostic echocardiogram, which would involve either an echocardiogram within the hospital or birthing center, transport to another institution for the procedure, or use of telemedicine for remote evaluation
   (b) The infant’s pediatrician should be notified immediately and the infant might need to be seen by a cardiologist

e. False positive information
   (a) False positive rates are low overall
      (a) In a Swedish study published in 2009 in *BMJ* it was found that of infants with a failed screen, 25% had CCHD, 47% had another disease process such as pulmonary pathology or sepsis, and 28% were well
      (b) In a New Jersey study published in 2013 in *Pediatrics* it was found that of infants with a failed screen, 10% had CCHD, 23% had another disease process causing hypoxemia, and 67% had non-critical congenital heart defect or were well
   (b) Ways to reduce false positive screens
      (a) Screen the newborn while he or she is alert
      (b) Screen the newborn when he or she is at least 24 hours old

3. Passed screens
   a. Any screening with an oxygen saturation measure that is greater than or equal to 95% in the right hand or foot with a less than or equal to 3% absolute difference between the right hand or foot is considered a passed screen and screening would end
   b. False negative information: pulse oximetry screening does not detect all critical CHDs, so it is possible for a newborn with a passing screening result to still have a CCHD or other CHD
A. DEFINITION
Significant hearing loss is the most common condition present at birth. Early identification of loss, fitting of high-quality hearing aids, cochlear implant, and comprehensive early intervention services can minimize or avoid many negative outcomes experienced by children with hearing loss including improved school performance, communication skills, and speech-language development; better social skills and emotional health; decreased family stress; and improved quality of life. The NM Newborn Hearing Screening Program goal is for all infants to receive a hearing screen within the first month of life.

B. ETIOLOGY OF CONGENITAL HEARING LOSS
1. Prematurity
2. Very low birth weight, less than 1500 grams (3.3 lbs)
3. Illness or trauma prior to birth
4. Viral infections
   a. Toxoplasmosis
   b. Syphilis
   c. Rubella
   d. Cytomegalovirus
   e. Herpes
5. Genetic
6. Hyperbilirubinemia at birth
7. Low APGAR scores at 1 and 5 minutes

C. SIGNS AND SYMPTOMS
Hearing loss in infants from birth to 3 months
1. Does not startle to loud sounds
2. Does not indicate through body language, including smiling, that infant recognizes caregiver’s voice
3. Does not coo or make other pleasure sounds
4. Does not have differentiated cries for different needs

D. MANAGEMENT
1. Communicate the importance of newborn hearing screening to parents orally and in writing using the educational materials provided by the Newborn Hearing Screening Program (referral forms and educational materials can be ordered by calling Children's Medical Services at 1-877-890-4692)
2. If trained per the “Mechanism for Expansion of Practice”, and with access to Otoacoustic Emissions (OAE) hearing screening equipment, screen the newborn’s hearing during a follow-up well baby visit
3. Scheduling considerations
   a. It has been documented that OAE testing has a much higher false positive rate if performed within the first 24 hours of life
   b. The false positive rate falls to 4% by 72 hours of life
4. Refer the infant to an outpatient provider such as a hospital nursery, audiology office, or a pediatrician who performs newborn hearing screening.

5. With planned hearing screening: sign, document and fax the “Newborn Hearing Screening Referral Form” (see Appendix D) within 72 hours of birth.

6. If screen is declined: sign, document, and fax “Newborn Screening Test Refusal” Form (see Appendix E) within 72 hours of birth.

7. More information about the NM Department of Health Newborn Hearing Screening Program can be found at http://nmhealth.org/about/phd/fhb/cms/nbhs/
NEWBORN GENETIC (METABOLIC) SCREEN

A. DEFINITION
Newborn genetic screening tests required by New Mexico law to look for developmental, genetic, and metabolic disorders in the newborn. Screening tests do not diagnose, rather they show which neonates need further testing.

B. SCHEDULING
1. 24-48 hours of age or at discharge
2. And 10-14 days of age

C. EQUIPMENT
1. Sterile lancet with tip less than 2.4mm
2. Sterile alcohol prep
3. Sterile gauze pad
4. Gloves
5. Adhesive bandage or gauze
6. NBS blood collection card

D. OBTAINING BLOOD COLLECTION TESTING KITS
1. Contact the NM Newborn Genetic Screening Program 1-877-890-4692. Two-part testing kits are available to Licensed Midwives at a cost and are reimbursable by insurance.
2. The kits are considered a medical collection device. They must be stored according to the manufacturer instructions and not tested after the expiration date.

E. MANAGEMENT
1. Educate client about newborn genetic screening and screening schedule
   a. It is recommended by the State of New Mexico that an infant be screened twice for increased validity
      (a) First screen identifies almost 90% of all conditions
      (b) Second screen identifies almost 10% additional conditions
   b. The first screen should occur between 24-48 hours after birth
   c. The second screen should occur between 10-14 days after birth
2. If the parent consents to the newborn genetic screening procedure:
   a. Complete ALL form information
   b. Do not contaminate filter paper circles by allowing the circles to come in contact with spillage or by touching before or after blood collection
   c. Follow directions on the back of the screening card for placement of puncture site
   d. Warm site with soft cloth, moistened with warm water up to 41° C, for three to five minutes
   e. Cleanse site with alcohol prep
   f. Wipe dry with sterile gauze pad
   g. Puncture heel and wipe away first blood drop with sterile gauze pad
   h. Allow another LARGE blood drop to form
      (a) Lightly touch filter paper to LARGE blood drop
(b) Allow blood to soak through and completely fill circle with SINGLE application
(c) Apply blood to one side of filter paper only
(d) Fill remaining circles in same way
(e) Dry blood spots on a dry, clean, flat, horizontal non-absorbent surface for a minimum of four hours
(f) Mail completed form directly to Newborn Screening Lab

Please note: the first screen should be sent overnight using UPS forms supplied by DOH; the second NBS screen and form should be sent by regular USPS (US Postal Service) mail.

3. If the parent declines Newborn Genetic Screening, complete the Informed Dissent process:
   a. Review risks/possible consequences of not screening and review the two brochures provided by newborn genetic screening program: 1) New Mexico’s Newborn Screening disorders; 2) These Tests Could Save your Baby’s Life
   b. Complete and have the client sign the Newborn Screening Test Refusal form (see Appendix E)
   c. Fax or send the refusal to the NM Newborn Screening Program
      (a) Give a copy to the parent
      (b) Place original form in chart
NEONATAL RESUSCITATION

A. DEFINITION
A necessary therapy given to a newborn in cardiac or respiratory failure or shock. Resuscitation aims to provide adequate ventilation, oxygenation, and cardiac output to ensure that an appropriate amount of oxygen is delivered to the brain, heart, and other vital organs.

B. ETIOLOGY
1. Asphyxia (either in utero or after delivery)
2. Prematurity
3. Drugs administered to or taken by the mother
4. Congenital neuromuscular disease
5. Congenital malformation
6. Intrapartum hypoxemia
7. Unknown factors

C. SIGNS AND SYMPTOMS
1. Poor or absent respiratory effort
2. Heart rate below 100 bpm
3. Cyanosis

D. MANAGEMENT
1. Refer to the neonatal resuscitation guidelines in accordance with American Academy of Pediatrics and American Heart Association Neonatal Resuscitation Guidelines
2. Immediate transfer is required in the following cases; see “Determining Appropriate Client Care Provider” in Part I
   a. Neonatal distress not responsive to interventions
   b. Newborn seizures
3. Consultation is required with the following relevant newborn risk factors; see “Determining Appropriate Client Care Provider” in Part I for the full list
   a. Respiratory distress or abnormal respiratory patterns
   b. Cardiac irregularities
   c. Prolonged pale, cyanotic, or gray color
NEONATAL JAUNDICE AND HYPERBILIRUBINEMIA

A. DEFINITION
A condition that occurs when a newborn has a high level of bilirubin in the blood causing the infant’s skin and sclera to appear yellow. Bilirubin is a yellow-pigmented substance the body makes when it is replacing old red blood cells. Bilirubin is broken down in the liver and it is removed from the body in the stool. It is normal for somewhat higher levels of bilirubin to be present after birth.

1. Physiological: A benign condition that is often most noticeable 2–4 days after birth and often disappears within 2 weeks. Two types of physiological jaundice occur in infants who are breastfed and of at least 35 weeks gestation.
   a. Breastfeeding jaundice: A condition often seen during the first week of life that occurs when infants do not nurse well or when the mother’s milk is slow to come in.
   b. Breast milk jaundice: May appear after day 7 of life in some healthy, breastfed infants. It typically peaks during weeks 2 and 3, but may persist for a month or more. Substances in the breast milk may affect the breakdown of bilirubin in the liver. This condition is different than breastfeeding jaundice.

2. Pathological: Bilirubin levels are excessively high and may lead to death or irreversible neurotoxicity. Severe newborn jaundice may occur due to a condition that increases the number of red blood cells that need to be replaced in the body, or a condition or treatment that makes it harder for the infant’s body to remove bilirubin.

B. ETIOLOGY
1. Some jaundice is a normal part of newborn transition for healthy infants of at least 35 weeks gestational age
2. Increasing and persistent jaundice can be caused by an underlying disorder. Pathologic jaundice can appear much earlier or later than would be seen with physiologic jaundice. Conditions that can cause pathologic jaundice include:
   a. Internal hemorrhage
   b. Cephalohematoma or significant bruising (difficult birth)
   c. Sepsis
   d. Other viral or bacterial infections that may be congenital or early onset
   e. Hypoxia
   f. Rh incompatibility between the mother's and the infant's blood types
   g. Liver disease or disorder
   h. An enzyme deficiency
   i. A shape abnormality of infant's red blood cells
   j. Many inherited or genetic disorders
3. Risk Factors for Development of Severe Hyperbilirubinemia in Infants of 35 or More Weeks’ Gestation (in Approximate Order of Importance)
   a. Major
      (a) Total serum bilirubin (TSB) or transcutaneous bilirubin (TcB) level in the high-risk zone of the hour-specific nomogram (see bilitool.org)
      (b) Jaundice observed in first 24 hours
      (c) Blood type different between mother and infant
      (d) Preterm birth and infant 35–36 weeks gestational age at birth
(e) Previous sibling received phototherapy
(f) Cephalohematoma or significant bruising
(g) Difficulty breastfeeding, especially with excessive weight loss
(h) East Asian race

b. Minor
   (a) TSB or TcB level in the high intermediate-risk zone
   (b) Gestational age 37–38 weeks
   (c) Jaundice observed before 24-48 hours
   (d) Previous sibling with jaundice
   (e) Macrosomic infant of a diabetic mother
   (f) Maternal age 25 years or older
   (g) Male gender

c. Decreased risk (factors associated with decreased risk of significant jaundice, listed in order of decreasing importance)
   (a) TSB or TcB level in the low-risk zone
   (b) Gestational age greater than or equal to 41 weeks
   (c) Exclusive bottle feeding
   (d) Black race

C. SIGNS AND SYMPTOMS
1. Yellowning of the skin and sclera starting at the head and neck, extending downward depending on severity
2. Physiological
   a. May first become apparent 24–36 hours after birth (breastfeeding jaundice) or after 7 days (breast milk jaundice)
   b. May peak at day 2-4 (breastfeeding jaundice) or weeks 2-3 (breast milk jaundice)
   c. Typically resolves by day 10-14 (breastfeeding jaundice) or around day 30 (breast milk jaundice)
   d. No alterations in vital signs or consciousness, although poor feeding may be present in infants with breastfeeding jaundice or whose mother’s milk is slow to come in
   e. Bilirubin levels do not exceed levels normal for physiological jaundice by hour of life and gestational age
3. Pathological
   a. Lethargy
   b. Poor feeding
   c. Projectile vomiting
   d. High-pitched cry
   e. Extremely dark urine
   f. Light stools
   g. Fever
   h. Jaundice observable within first 24 hours of life
   i. Total bilirubin serum content increases by greater than 0.2 mg/dL per hour
   j. Elevated total serum bilirubin concentration greater than the hour-specific cutoff of the nomogram (see bilitool.org)
   k. Elevated direct bilirubin (this is concerning for biliary atresia)
1. New onset or worsening of jaundice at greater than 10-14 days

D. MANAGEMENT
   1. Review maternal and infant history for risk factors for pathological jaundice
   2. Review neonatal history for time of onset of jaundice and signs noted above
   3. Assess infant for the following issues:
      a. Degree of yellowing of skin and sclera
      b. Abdominal distension
      c. Skin turgor
      d. Fontanels
      e. Irritability
      f. Weight loss
      g. Stool and urine: color and quantity
      h. Cry
      i. Feeding
      j. Lethargy
      k. Vital signs
      l. Signs and symptoms of infection
      m. Signs and symptoms of trauma
   4. Educate parents about jaundice signs and risks
   5. Encourage mother to breastfeeding frequently (AAP recommends advising mother to breastfeeding at least 8–12 times per day for first several days to prevent jaundice)
   6. Consider natural therapies
   7. Consultation or referral is indicated if abnormal findings occur or if jaundice increases or persists
   8. Consultation is required if jaundice occurs within 24 hours of birth and if hyperbilirubinemia presents; see “Determining Appropriate Client Care Provider” in Part I for the full list of newborn risk factors requiring consultation
A. DEFINITION
   The application of medication into the newborn's eyes required by law to prevent
   ophthalmia neonatorum or ophthalmic chlamydial infections.

B. INDICATIONS
   *Neisseria gonorrhoeae*, *Chlamydia trachomatis*, or any other bacterial infection present
   at time of birth. New Mexico law mandates prophylactic treatment of all newborns within
   the first hours of life.

C. MANAGEMENT
   1. Educate parents on legal and medical sequelae
   2. Have client read and sign an informed consent form to accept or decline
   3. If client consents, apply ophthalmic ointment
      a. Wash hands immediately prior to application
      b. Administer ophthalmic ointment according to the formulary in lower conjunctival
         surface of each eye starting at the inner canthus
      c. Administration can be delayed 2 hours after birth to allow for bonding
      d. Observe for hypersensitivity (inability to focus, edema, inflammation)
      e. Side effects usually disappear in 24–48 hours
   4. Consider breast milk as an alternative prophylactic ophthalmic treatment for those
      who waive the application of ophthalmic ointment
PART IX: NEWBORN CARE

THRUSH

A. DEFINITION
Yeast infection of the mouth caused by *Candida*.

B. ETIOLOGY
1. Maternal or neonatal antibiotics
2. Inadequately cleaned surfaces which come in contact with neonatal mouth, maternal breast tissue, and milk
   a. Bottle nipples
   b. Pump flanges
   c. Pacifiers

C. SIGNS AND SYMPTOMS
1. Infant
   a. Usually develops suddenly, but may be chronic
   b. Creamy white “cottage cheese” like appearance with slightly raised lesions usually on cheeks or tongue, but may also be present on palate, gums, tonsils, or throat
   c. Pain or difficulty swallowing and sucking
   d. Infant may have difficulty latching and “bob” on and off many times while clearly hungry and fussy
   e. Develop diaper rash
2. Breastfeeding mother
   a. Mother will often report sudden onset of “shooting” pain in nipples and/or breast
   b. Maternal nipples may appear red and shiny

D. MANAGEMENT
1. Gently touch gauze-covered finger to lesion; if thrush, the lesion is unlikely to come off easily
2. Advise washing all bottle nipples, breast pump flanges, pacifiers, etc. in soap and water immediately after use
3. Advise sterilization of all bottle nipples, breast pump flanges, pacifiers, etc. by boiling for 20 minutes 1 time weekly
4. Wash all breast pads, bras, etc. that have come in contact with the breast and dry the items on high heat or in the sun
5. Consider natural remedies
6. Consider referral to prescriptive authority
7. If maternal vaginal infection is present, refer to “Candidiasis Infection” in Part IV
VITAMIN K ADMINISTRATION

A. DEFINITION
Routine prophylactic administration of vitamin K is recommended for all newborns to prevent hemorrhagic disease due to vitamin K deficiency. Newborns particularly at risk for hemorrhagic disease include those who experience:
1. Difficult or interventive birth with trauma
2. Prematurity
3. Any condition which may compromise liver function
4. Antepartum exposure to antagonistic medications taken by the mother, including anticonvulsants, antituberculins, anticoagulants, and barbiturates

B. BACKGROUND
1. Vitamin K
   a. Vitamin K is a fat-soluble vitamin that is necessary to turn certain proteins into active clotting factors
   b. All babies are born with low levels of vitamin K
   c. Babies use up their levels of vitamin K quickly following birth
   d. Colonization of the bacteria that produces vitamin K in an infant’s gut is promoted through breastfeeding, but stores build up gradually over time and may not be sufficient to stop hemorrhage if it should occur
2. Hemorrhagic disease, a sequela of insufficient vitamin K, usually occurs between the second and fifth day of life, but can occur weeks and months after birth
3. Supplementation recommendations
   a. The American Association of Pediatrics (AAP) recommends all newborns receive a one-time intramuscular (IM) injection of the neonatal dosage of vitamin K1 Phytonadione after birth
   b. At the present time, there is no approved form of oral vitamin K in the United States
   (a) The AAP has issued a further recommendation that, when an appropriate oral form of vitamin K1 is developed, it should be given as follows: 2 mg at birth with subsequent doses at 1-2 weeks and 4 weeks in exclusively breastfed infants
   (b) Oral dosage of vitamin K must be repeated to be effective

C. SIGNS AND SYMPTOMS OF HEMMORHAGIC DISEASE
1. Skin bruising
2. Petechiae
3. Bleeding
   a. Blood seepage from body openings
   b. Internal unseen bleeding
4. Seizures
5. Death

D. MANAGEMENT
1. Prenatal recommendations
a. Parents should receive information about the benefits and risks of vitamin K administration to their newborn including signs and symptoms of hemorrhagic disease
b. Education regarding prenatal vitamin K supplementation for all women
c. Consider natural therapies
d. Counsel women who must take medications known to be antagonistic to vitamin K, including anticoagulants (e.g., warfarin sodium, Coumadin), anticonvulsants (e.g., phenytoin (Dilantin)), antituberculins (i.e., TB medications), and barbiturates (e.g., Phenobarbital), to take 10 mg of oral vitamin K supplement daily from 36 weeks gestation to birth

2. Postpartum
   a. Give information and informed consent to parents; have them sign waiver
   b. Recommend administering vitamin K for all babies having circumcision

3. Administration
   a. If parent(s) consents, administer vitamin K according to formulary
   b. Educate about signs and symptoms of severe allergic reactions
      (a) Itching, hives, swelling in face or hands, swelling or tingling in mouth, throat, chest tightness, trouble breathing
      (b) Chest pain, sudden headache, leg pain
      (c) Lightheadedness, dizziness, or fainting
PART X: REFERENCES
ACRONYMS

AAP: American Academy of Pediatrics
ABO: Blood group systems
ACOG: American College of Obstetricians and Gynecologists
AFI: Amniotic fluid index
AIDS: Acquired immune deficiency syndrome
ALSO: Advanced Life Support in Obstetrics
APGAR: Appearance, Pulse, Grimace, Activity, Respiration (neonatal health assessment)
AROM: Artificial rupture of membranes
ASCUS: Atypical squamous cells of unknown significance
ALT: Alanine transaminase (liver function screening factor)
AST: Antibody screen (e.g., Rh antibodies), or Aspartate aminotransferase (e.g. liver function screening factor)
BM: Bowel movement
C/S: Cesarean section
CBC: Complete blood count
CCHD: Critical congenital heart defect
CDC: Center for Disease Control
CEU: Continuing education unit
CHD: Coronary heart disease
CIN: Cervical intraepithelial neoplasia
CMS: Centers for Medicare & Medicaid Services
CNM: Certified nurse-midwife
CNS: Central nervous system
CPD: Cephalopelvic disproportion
CPR: Cardiopulmonary resuscitation
CPT: Current procedural terminology; code for insurance billing developed and updated by the AMA
CRS: Congenital Rubella Syndrome
CT: Computed tomography (scan)
CVA: Costovertebral angle
D&C: Dilation and curettage
D5LR: Dextrose 5% in lactated ringers
DES: Diethylstilbestrol
DHEAS: lab test for dehydroepiandrosterone sulfate
DIC: Disseminated intravascular coagulation
DNA: Deoxyribonucleic acid
DOH: Department of Health, New Mexico (see https://nmhealth.org/)
DOM: Doctor of oriental medicine
DVT: Deep vein thrombosis
DX: Diagnosis
E2: Estradiol
EC/TZ: Endocervical/transformation zone
EDD: Estimated date of delivery
EFW: Estimated fetal weight
EMS: Emergency medical system
Acronyms

EMT: Emergency medical technician
ERCD: Elective repeat cesarean delivery
FDA: Food and Drug Administration
FHT: Fetal heart tone
FMR1: Fragile X mental retardation 1; a human gene that codes for a protein called fragile X mental retardation protein, or FMRP
FOB: Father of the baby
FSH: Follicle stimulating hormone
GBS: Group B streptococcus
GC/CT: Gonorrhea (GC) and Chlamydia (CT) lab test
GDM: Gestational diabetes mellitus
GTT: Glucose tolerance test
HCG: Human chorionic gonadotropin (may also be written as hCG)
HCT: Hematocrit
HELP: Hemolysis elevated liver enzymes low platelet count (HELP Syndrome)
HIPAA: the federal Health Insurance Portability and Accountability Act of 1996
HIV: Human immunodeficiency virus
HPV: Human papillomavirus
HSIL: High-grade squamous intraepithelial lesion
HSV: Herpes simplex virus
HX: History
ICD: International classifications of disease
IM: Intramuscular
IUD: Intrauterine device
IUGR: Intrauterine growth restriction
IUI: Intrauterine insemination
IV: Intravenous (as in intravenous therapy)
KOH: Potassium hydroxide
LEEP: Loop electrosurgical excision procedure
LH: Luteinizing hormone
LM: Licensed midwife
LMP: Last menstrual period
LNMP: Last normal menstrual period
LSIL: Low grade squamous intraepithelial lesion
MANA: Midwives Alliance of North America
MRI: Magnetic resonance imaging
MSAFP: Maternal serum alpha-fetoprotein screening
NARM: North American Registry of Midwives
NICU: Neonatal intensive care unit
NILM: Negative for intraepithelial lesion or malignancy
NIPT: Non-invasive prenatal testing
NMMA: New Mexico Midwives Association
NOS: Not otherwise specified
NRL: Natural rubber latex
NS: Normal saline
NSAID: Nonsteroidal anti-inflammatory drug
NST: Nonstress test
OAE: Otoacoustic emissions
OB: Obstetrician
OSHA: Occupational Health and Safety Administration
OTC: Over-the-counter
Pap: Papanicolaou test
PCR: Polymerase chain reaction
PHD: Public Health Division (see https://nmhealth.org/about/phd/)
PID: Pelvic inflammatory disease
PMS: Premenstrual syndrome
PPH: Postpartum hemorrhage
PROM: Premature rupture of membranes
ROM: Rupture of membranes
RBC: Red blood cell
RCOG: Royal College of Obstetricians and Gynecologists (United Kingdom)
Rh: Rhesus factor
Rh IgG: Rhesus immunoglobulin G
RhoGAM: Rh(D) immune globulin injectable drug
RN: Registered nurse
ROM: Rupture of membranes
S/S: Signs and symptoms
SAB: Spontaneous abortion
SGA: Small for gestational age
SOB: Short of breath
SROM: Spontaneous rupture of membranes
STI: Sexually transmitted infection
TB: Tuberculosis
TcB: Transcutaneous bilirubin
TSB: Total serum bilirubin
TIBC: Total iron binding capacity
TOLAC: Trial of labor after cesarean
TORCH: Acronym for toxoplasmosis, other infections, rubella, cytomegalovirus infection, and herpes simplex
TSH: Thyroid stimulating hormone
TTN: Transient tachypnea of the newborn
URI: Upper respiratory infection
UTI: Urinary tract infection
VBAC: Vaginal birth after cesarean
WBC: White blood cell
WHO: World Health Organization
WIC: Special supplemental nutrition program for women, infants and children (federal assistance program)
COMMON UNITS OF MEASUREMENT

bpm: Beats per minute
C: Celsius temperature scale
cc: Cubic centimeter
cm: Centimeter
F: Fahrenheit temperature scale
g: Gram
gtt: Guttae (Latin for “drops”)
hr: Hour
IU: International unit
kg: Kilograms
L: Liters
lbs: Pounds
mcg: Microgram
mg: Milligram
min: Minute
mL: Milliliter
mm: Millimeter
mm3: Cubic millimeter
mm Hg: millimeters of mercury (i.e., for blood pressure)
oz: Ounces
APPENDIX A
STANDARDS AND CORE COMPETENCIES OF PRACTICE FOR LICENSED MIDWIVES IN NEW MEXICO

This document is adapted from the Midwives Alliance of North America (MANA) Core Competencies, and is used with permission of MANA. The MANA Core Competencies are not copyrighted.

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 caregiving relationship.
C. Midwives work as autonomous practitioners, collaborating with other health and social service providers when appropriate.
D. Midwives understand that physical, emotional, psychosocial, 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 caregiving.
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 is 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 limitation 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 indication 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 modalities 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. Pre-existing conditions in a woman’s health history, which are likely to influence her well-being when she becomes pregnant.
D. Nutritional requirements of pregnant women and methods of nutritional assessment and counseling.
E. Changes in emotional, psychosocial, 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, risks, and benefits of bio-technical screening methods and diagnostic tests used during pregnancy.
K. Anatomy, physiology, and evaluation of the soft and bony structures 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- women.
Appendix A
Standards and Core Competencies of Practice for Licensed Midwives in New Mexico

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

**Well-Woman Care and Family Planning**

VII. The entry-level 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 the 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.
APPENDIX B
NEW MEXICO DEPARTMENT OF HEALTH RULE, LICENSED MIDWIVES, 16.11.3 NMAC

TITLE 16                 OCCUPATIONAL AND PROFESSIONAL LICENSING
CHAPTER 11        MIDWIVES
PART 3                   LICENSED MIDWIVES

16.11.3.1 ISSUING AGENCY: New Mexico Department of Health Public Health Division Maternal Health Program [10-31-96; Recompiled 12/31/01]

16.11.3.2 SCOPE: These regulations apply to any Licensed Midwives practicing in the State of New Mexico or licensed by the New Mexico Department of Health, Public Health Division [10-31-96; Recompiled 12/31/01].

16.11.3.3 STATUTORY AUTHORITY: The regulations set forth herein are promulgated by the Secretary of the Department of Health by authority of Section 9-7-6 (F) NMSA 1978 and Section 24-1-21 NMSA 1978. The Public Health Division of the Department of Health shall administer and enforce these regulations.

A. GUIDELINES: In the absence of specific direction in these regulations as to standard of practice or ethics, the Standards and Core Competencies of Practice for Licensed Midwives in New Mexico, the New Mexico Midwives Association: Practice Guidelines or equivalent approved by the NMMA and the Division, and the procedures and policies of the Department of Health and Public Health Division are adopted as standards of practice and are incorporated by reference herein.

B. OTHER LAW AND REGULATIONS: These regulations are subject to the provisions of the Department of Health's Regulations Governing Promulgation of Regulations and Regulations Governing Public Access to Department Records. In addition, Department regulations on related subjects include: registration of nurse-midwives; prevention of infant blindness; newborn screening for certain congenital diseases and other inborn metabolic errors; registration of births, deaths and fetal deaths, and control of diseases and conditions of public health significance. Copies of regulations may be obtained by writing to the Public Health Division, P.O. Box 26110, 1190 St. Francis Dr., Santa Fe, NM 87502-6110

C. AUTHORITY OF THE DEPARTMENT OF HEALTH AND THE PUBLIC HEALTH DIVISION: The Department of Health through its Public Health Division may deny, revoke or suspend any license held or applied for or reprimand or place a license on probation on the grounds stated in these regulations pursuant to 24-1-3R NMSA 1978 [2-5-80...10-31-96; Recompiled 12/31/01].

16.11.3.4 DURATION: Permanent. [10-31-96; Recompiled 12/31/01]

16.11.3.5 EFFECTIVE DATE: October 31, 1996 unless a later date is cited at the end of a section or paragraph. [10-31-96; Recompiled 12/31/01]
Appendix B
New Mexico Department of Health Rule, Licensed Midwives, 16.11.3 NMAC

[Compiler’s note: The term "or paragraph," above, is no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

16.11.3.6 **OBJECTIVE:** The regulations establish policies, standards and criteria relating to the educational and examination requirements, issuing of permits and licenses, practice, and continuing education of persons who practice licensed midwifery
[12-12-67...10-31-96; Recompiled 12/31/01].

16.11.3.7 **DEFINITIONS:**

A. "Apprentice" means a person holding a high school diploma or a GED who 1) wishes to make application for basic education in the art and science of midwifery by apprenticeship, 2) has a formal preceptor relationship defined in writing with a midwifery instructor who is in good standing with the Midwife Licensing Authority of the Public Health Division and who meets the requirements of 16.11.3.7.13 and agrees in writing to fulfill the basic educational and clinical experience requirements described in 16.11.3.9.1 and 11.3.9.2

B. "Board" means the Licensed Midwifery Advisory Board established under these regulations

C. "Certified Nurse-Midwife" means a graduate of a midwifery education program accredited by the American College of Nurse-Midwives Division of Accreditation who, has been certified and licensed pursuant to laws, regulations, and procedures of her/his jurisdiction

D. Certified Professional Midwife (CPM) means an independent practitioner who has met the standards for certification set by the North American Registry of Midwives (NARM). A CPM may not practice in New Mexico unless she/he holds a New Mexico license to practice midwifery.

E. "Contact hour" means a unit of 1) 50 to 60 minutes of a formal learning experience that directly relates to maternal, infant, and well-woman health and related professional, ethical, legal, or business topics or 2) 2 hours of clinical practice in maternal, infant, and well-woman health care that is supervised and documented in writing.

F. "Continuing education" means 1) participation in a formal learning experience presented by an instructor who has credentials in the educational areas set out in 16.11.3.10 and for which written certification is given by the instructor, and/or 2) a self-study program that has been pre-approved by the Division.

G. "Department" means the Department of Health.

H. "Division" means the Public Health Division of the Department of Health.

I. "Incompetence" is defined as follows: In performing midwifery functions, a midwife is under a legal duty to possess and to apply the knowledge, skill and care that is ordinarily possessed and exercised by other midwives of the same licensure status and required by the generally accepted standards of the profession including those standards set forth in these regulations and their referenced documents. The failure to possess or to apply to a substantial degree such knowledge, skill and care constitutes incompetence for purposes of disciplinary proceedings.

J. "License" means a document issued by the Department to a person meeting the professional requirements described in these Regulations.

K. "Licensed Midwife" means a person who has successfully completed all the requirements of 16.11.3.8.3 and is in good standing with the Division.
L. "Licensed Midwifery" means the provision of health care and management of women in the antepartum, intrapartum, postpartum, and interconceptual periods and infants up to 6 weeks of age. This care occurs within a health care system which provides for midwifery protocols, medical consultation, co-management or referral and is in accord with the "Standards and Core Competencies of Practice for Licensed Midwives in New Mexico" and the "New Mexico Midwives Association: Practice Guidelines".

M. "Licensing Period" means a two year period for which permits or licenses are issued. Licenses may be issued at any time but shall expire on March 31 of the second year.

N. "Midwifery Instructor" means a qualified licensed midwife, certified nurse-midwife, or licensed physician who 1) practices obstetrics, 2) who has at least one (1) year of clinical practice after completing their education and licensing process, 3) who has a formal training and supervisory relationship with an apprentice midwife that is documented in writing, and 4) who is listed with the Division.

O. "New Mexico Midwifery Student Workbook (Student Workbook)" means an instrument approved by the Division, in which the preceptor documents the successful completion of the student's theoretical and clinical education and attainment of safe beginning practice of core competencies.

P. "Peer Review" means the review of the practice standards and outcomes of a Licensed Midwife by a group of her or his peers according to the NMMA or other Division recognized institutional criteria; and as governed by NM Review Organization on Indemnity Act. NM Stat. ANN. Little SS. 41-9-1 to 7 1978.

Q. "Permit" means documentation issued by the Department to a person meeting the professional requirements described in these Regulations authorizing the practice of midwifery at the apprentice level described in 16.11.3.8.2.

R. "Physician" means a person who is currently practicing obstetrics and is licensed and in good standing in their jurisdiction to practice medicine or osteopathy.

S. "Preceptor" means the same as "midwifery instructor".

T. "Supervision" means the instruction, guidance, and continued evaluation of an apprentice midwife in the art and science of midwifery by a midwifery instructor or preceptor with whom the apprentice has a formal relationship defined in writing and who retains ultimate responsibility for clients seen by apprentices.

[2-5-80...10-31-96; Rn, 16.11.3.7.19, 12-31-97; 12-31-97; Recompiled 12/31/01]

16.11.3.8 PERMITS AND LICENSES:

A. GENERAL PROVISIONS:

(1) A licensed midwife may provide any care or services allowed by these regulations

(2) An apprentice midwife may provide any care or services allowed by these regulations as set out in 16.11.3.12.1 only under the supervision of a midwifery instructor. The midwifery instructor reviews and evaluates all care provided by and attends every labor and delivery managed by the apprentice. The midwifery instructor retains the responsibility for clients seen by apprentices

(3) The Division requires full disclosure of past midwifery licensure, suspensions, and revocations which will be considered before granting any license or permit

B. APPRENTICE MIDWIFE PERMITS:

(1) Application for apprentice midwife permit must include all of the following:
(a) Proof of high school diploma or GED  
(b) A completed agreement by the midwifery instructor to the preceptor relationship on the Division's form  
(c) A completed apprentice application on the Division's form  
(d) Payment of fifty dollars ($50) to the Division  

(2) Upon proof of successful completion, the Division will supply to qualifying apprentice applicants an apprentice midwife permit and necessary regulatory information applicable to apprenticeship.  
(a) An apprentice midwife permit  
(b) "The New Mexico Midwifery Educational Standards and Requirements"  
(c) "Standards and Core Competencies for the Practice of Licensed Midwifery in New Mexico"  
(d) "New Mexico Midwives Association: Policies and Procedures"  
(e) A copy of Licensed Midwives Regulations, NMAC 16.11.3  

(3) An apprentice must have successfully completed basic education requirements in midwifery and the requisite examination process no later than the end of the fourth year after the initial apprentice permit is issued. Before taking the written examination for licensure, an apprentice must successfully complete the following:  
(a) A minimum of twelve (12) months of theoretical and clinical education described in 16.11.3.10  
(b) Submit to the Division a completed Student Workbook or its Division-approved equivalent, or transcripts showing successful completion of a midwifery education program licensed by the New Mexico Commission for Higher Education or accredited by the Midwifery Education Accreditation Council or other United States Department of Education-recognized accrediting agency.  
(c) Submit to the Division an application to licensed midwifery examination on the Division's form  
(d) Payment to the Division of the examination fee designated by the Division.  

(4) **RENEWAL OF PERMITS:** An apprentice midwifery permit may be renewed once after the initial two years permit period. An applicant for renewal shall submit to the Department:  
(a) A completed renewal application on the Division's form  
(b) Renewal payment of fifty dollars ($50)  

**C. MIDWIFE LICENSURE:**  
(1) An applicant for midwifery licensure must meet the following requirements  
(a) Complete the Division-approved examination with a passing score no more than one year before applying for licensure, or submit proof of CPM certification and complete an abbreviated Division-approved examination with a passing score.  
(b) Submit to the Division evidence of current certification in cardiopulmonary resuscitation of the adult and IV therapy and current recognition by the Neonatal Resuscitation Program of the American Academy of Pediatrics.  
(c) Submit a complete application on the Division's form which shall include the applicants licensing and disciplinary history  
(d) Submit to the Division a fee of fifty dollars ($50)
(2) After reviewing and approving duly submitted applications, the Division shall issue to qualifying applicants a license and a wallet-size card. Practicing licensed midwives must display a current license prominently in their main practice location.

(3) **RENEWAL OF LICENSURE:** A midwifery license must be renewed by March 31st of the second year after it is issued. The completed application must be received by the Division at least two weeks before the expiration date of the current license. To be considered for relicensure, a midwife must have duly made quarterly reports to the Division as described in 16.11.3.12.12. Practicing midwifery for compensation or using the initials LM after ones name without a current midwifery license is grounds for disciplinary action. An applicant for renewal shall submit to the Division:

   (a) A completed renewal application on the Division's form
   (b) Evidence of successful completion of thirty (30) contact hours of continuing education that conforms with the definitions of "contact hour" and of "continuing education" in 16.11.3.7.
   (c) Evidence of current certification in cardiopulmonary resuscitation of the adult and IV therapy, and current recognition by the Neonatal Resuscitation Program of the American Academy of Pediatrics.
   (d) Evidence of peer review participation within the four (4) years preceding application and submission of quarterly reports described in 16.11.3.12.12.
   (e) Renewal payment of fifty dollars ($50)

(4) Reinstatement of licenses lapsed no longer than four (4) years may be allowed by the Division, upon fulfillment of all the requirements of Sections 8.3.3.1, 8.3.3.2, 8.3.3.3, 8.3.3.4, and 8.3.3.5. Besides the usual renewal payment, there will be an additional fee of twenty dollars ($20) for reinstatement of license. Practicing without a current license is grounds for disciplinary or legal action.

D. **RECIPROCITY:** There is no reciprocity with other jurisdictions.

E. **FEES:** All fees are non-refundable and shall be made by certified check or money order.

   (1) Applications for apprenticeship must be accompanied by payment by check or money order to the Division in the amount of fifty dollars ($50)
   (2) Applications for licensure must be accompanied by payment by check or money order to the Division in the amount of fifty dollars ($50)
   (3) Application for renewal of permits/licenses shall be accompanied by a payment of fifty dollars ($50)
   (4) Application for examination shall be accompanied by the fee designated by the Division. This amount does not include the licensing fee.

[2-5-80...10-31-96; 12-31-97; Recompiled 12/31/01]

**16.11.3.9 DISCIPLINARY ACTION:**

A. **GROUNDS FOR ACTION:**

   (1) Charges of incompetence may be based upon a single act of incompetence or upon a course of conduct or series of acts or omissions which extend over a period of time and which, taken as a whole, demonstrate incompetence. It shall not be necessary to show that actual harm resulted from the act or omission or series of acts or omissions so long as the conduct is of such a character that harm could have resulted to the patient/client or to the public from the act or omission or series of acts or omissions.
(2) For purposes of these regulations "unprofessional conduct" includes, but is not limited to, the following:

(a) Dissemination of a patient's/client's health information and/or treatment plan acquired during the course of employment to individuals not entitled to such information and where such information is protected by law and/or hospital/agency policy from disclosure.

(b) Falsifying or altering patient/client records or personnel records for the purpose of reflecting incorrect or incomplete information.

(c) Misappropriation of money, drugs or property.

(d) Obtaining or attempting to obtain any fee for patient/client services for one's self or for another through fraud, misrepresentation, or deceit.

(e) Aiding, abetting, assisting or hiring an individual to violate any duly promulgated regulation of the Departments Midwife Licensing Authority.

(f) Obtaining, possessing, administering or furnishing prescription drugs to any person, including but not limited to one's self, except as directed by a person authorized by law to prescribe.

(g) Failure to make or keep accurate, intelligible entries in records as required by law, policy and standards for the practice of midwifery.

(h) Obtaining or attempting to obtain a license to practice midwifery oneself or for another through fraud, deceit, misrepresentation or any other act of dishonesty in any phase of the licensure by examination or endorsement process, or relicensure process.

(i) Practicing midwifery in New Mexico without a valid, current New Mexico license or permit, or aiding, abetting or assisting another to practice midwifery without a valid, current New Mexico license.

(j) Failure to report a midwife who appears to have violated regulations for the practice of licensed or certified nurse midwifery. Anyone reporting an alleged violation of these regulations shall be immune from liability unless the person acted in bad faith or with malicious purpose.

(k) Intentionally engaging in sexual contact with and/or toward a patient/client in a manner that is commonly recognized as outside the scope of the individual midwife's practice.

(l) Abandoning a patient(s)/client(s) when the abandonment results or may result in potential or actual harm or danger to the patient(s)/client(s).

(m) Engaging in the practice of midwifery when judgment or physical ability is impaired by alcohol or drugs or controlled substances.

(n) Practice which is beyond the scope of licensure.

(o) Delegation of medication administration, assessment, evaluation and judgment to non-licensed persons.

(p) As required by the New Mexico Parental Responsibility Act (Section 40-5A-1 et seq. NMSA 1978).

(q) Submitting false or altered documents for the purpose of obtaining licensure or permits.

(r) Failure to meet the requirements of the Bureau of Vital Records and Health Statistics regulations.

(s) Violation of the Departments regulations governing the practice of licensed midwifery.
(t) Failure to provide the Division in a timely manner with requested information.

B. DISCIPLINARY PROCEEDINGS: Disciplinary proceedings are conducted in accordance with the Uniform Licensing Act, 61-1-1 et seq., NMSA 1978 and Open Meetings Act 10-15-1 et seq., NMSA 1978

(1) FILING OF A COMPLAINT:
(a) A sworn notarized complaint must be filed with the Division before a disciplinary proceeding can be initiated
   (i) A complaint is an allegation of a wrongful act(s) or an omission(s)
   (ii) A complaint may include knowledge of a judgment or settlement against a licensee
(b) A sworn complaint may be filed by any person, including a member of the Division's Midwifery Advisory Board

(2) INVESTIGATION OF A COMPLAINT:
(a) All complaints alleging a violation of the regulations adopted by the Public Health Division will be investigated to determine whether a violation of applicable law or rule has occurred
   (b) The investigation may result in a Notice of Contemplated Action (NCA) being issued by the Division if a violation exists; or a dismissal of the complaint because no actionable violation exists.

(3) REQUEST FOR A HEARING, NOTICE OF HEARING, AND REQUEST FOR CONTINUANCE:
(a) A Notice of Hearing, designating the date, time and place of the hearing, shall be mailed to the licensee or applicant for licensure via certified mail upon the timely receipt of a written request for a hearing.
   (i) If a settlement is negotiated, the proposed stipulation and agreement shall be presented to the Public Health Division Director for final approval.
   (ii) The proposed stipulation and agreement does not divest the Public Health Division Director of the authority to require a formal hearing or final approval, amendment, or rejection.
   (iii) If a settlement is not reached, a hearing shall be held.
(c) Once a hearing has been scheduled, any requests for a continuance must be presented to the Division's hearing officer, in writing, at least ten (10) days prior to the scheduled hearing. The hearing officer may approve or deny the request.
   (d) If a person fails to appear after requesting a hearing, the Division may proceed to consider the matter as a default and make a decision.
   (e) If no request for a hearing is made within the time and manner required by the ULA, the Division may take the action contemplated in the NCA. Such action shall be final.

(4) ADMINISTRATIVE HEARING:
(a) All hearings before the Division shall be conducted in the same manner as a hearing in a court of law with the exception that the rules of evidence may be relaxed in the hearing pursuant to the Uniform Licensing Act.
(i) Hearsay evidence is admissible if it is of a kind commonly relied upon by reasonable prudent people in the conduct of serious affairs.

(ii) Disciplinary action against midwifery license or certificate must not be based solely on hearsay evidence.

(b) The hearing officer may take testimony, examine witnesses and direct a continuance of any case.

(c) The hearing officer shall have the power to issue subpoenas to compel the attendance of witnesses or the production of books, documents or records pertinent to the matter of a case before the Divisions Licensing Authority.

(d) The hearing officer shall issue a report and recommended finding to the Department Secretary in accordance with the Uniform Licensing Act.

5) DECISION OF THE DIVISIONS LICENSING AUTHORITY: A copy of the written decision shall be mailed via certified mail to the applicant/licensee or certificate holder in accordance with the Uniform Licensing Act, Section 61-1-14 (NMSA 1978).

C. PUBLIC NOTIFICATION OF DISCIPLINARY ACTION: The following are means in which disciplinary actions are made available to the public.

(1) Information regarding disciplinary actions shall be entered into the license file or applicant's file.

(2) Submission of disciplinary action to any appropriate disciplinary Data Bank and/or notification to each state in which the licensee holds a license or has been licensed.

D. REINSTATEMENT OF LICENSE OR CERTIFICATE:

(1) Individuals who request reinstatement of their license or who request that their probation be lifted must be prepared to provide the Division with substantial evidence to support their request. This evidence must be in the form of notarized written reports or sworn written testimony from individuals who have personal knowledge of the licensees or certificate holders activities and progress during the period of probation, suspension or revocation.

(2) Requests for reinstatement of a revoked license or certificate shall not be considered by the Division prior to the expiration of one year from the date of the order of revocation. The date at which time the Division Directors signature is affixed to the order of revocation or suspension is the controlling date, unless otherwise specified in the order.

(3) Requests for reinstatement of a suspended license or certificate shall be considered at such time as provided by the Division in the order of suspension.

(4) Reinstatement of a revoked or suspended license requires proof of meeting the renewal requirements as set forth in these regulations, any remedial education or supervised practice required by Division, and payment of the reinstatement of current or lapsed license fee [10-31-96; Recompiled 12/31/01].

16.11.3.10 COURSE OF EDUCATION: The Division will use the Standards and Core Competencies for the Practice of Licensed Midwifery in New Mexico as a guideline in determining the acceptability of an applicants educational experience. The midwifery instructor will conduct the course of education for the apprentice as set out in 16.11.3.7.13 and 16.11.3.8.1.2 as outlined below in 16.11.3.10.1 and 16.11.3.10.2.

A. THEORETICAL INSTRUCTION: Theoretical instruction must include these areas of study.

(1) HUMAN LIFE SCIENCE: Anatomy and physiology, fetal development, genetic screening, applied microbiology.
(2) PSYCHO/SOCIAL ISSUES: Communication and counseling, cultural concerns, human sexuality, perinatal education

(3) ANTEPARTUM MANAGEMENT: History taking, physical assessment, risk screening, provision of care, normal course, complications, pharmacology, nutrition, diagnostic laboratory tests and procedures

(4) INTRAPARTUM MANAGEMENT: History taking, physical assessment, risk screening, provision of care, normal course, complications, pharmacology, diagnostic laboratory tests and procedures, and adult cardiopulmonary resuscitation;

(5) POSTPARTUM MANAGEMENT: History taking, physical assessment, risk screening, provision of care, normal course, complications, pharmacology, diagnostic laboratory tests and procedures, family planning

(6) NEWBORN MANAGEMENT: History taking, physical assessment, risk screening, provision of care, normal course, complications, diagnostic laboratory tests and procedures, and neonatal resuscitation;

(7) WELL-WOMAN REPRODUCTIVE HEALTH CARE: History taking, physical assessment, risk screening, provision of care, diagnostic laboratory tests and procedures, treatment, family planning

(8) PROFESSIONAL ISSUES: History of Midwifery, Division regulations regarding prevention of infant blindness; newborn screening for certain congenital diseases and other inborn metabolic errors; registration of births, deaths, and fetal deaths, and control of diseases and conditions of public health significance; ethics, laws and regulations, starting a small business

B. CLINICAL EXPERIENCE: Clinical experience for an apprentice must include the following: License Requirements;

(1) Complete well-woman health assessment: 25
(2) Prenatal visits of at least 15 different women: 100
(3) Labor observations and managements: 40
(4) Start an IV successfully: 1
(5) Delivery of newborn and placenta: 25
(6) Newborn examinations: 30
(7) Use of prophylactic eye medications: 15
(8) Postpartum visits to mother and baby within 36 hours of delivery: 30
(9) Blood collection for Newborn Metabolic Screening: 15
(10) Six week postpartum and/or yearly physical exams and pap smears: 15
(11) Family planning visits, consultations, and/or referrals: 30
(12) Neonatal intensive care nursery observation at UNM Hospital or equivalent high risk medical facility nursery experience: After at least 6 months of apprenticeship
(13) High risk obstetric care observation at UNM Hospital special OB clinic or equivalent medical facility experience: After at least 6 months of apprenticeship
(14) Provision of one complete series of prepared childbirth classes: After at least 6 months of apprenticeship
(15) Observation of one complete breast feeding information series: After at least 6 months of apprenticeship

[2-5-80...10-31-96; 12-31-97; Recompiled 12/31/01]
16.11.3.11 **EXAMINATION:** The Division will administer an examination for licensure of midwives at least twice yearly. A candidate for examination who receives a failing score shall be eligible to retake the examination within four years of the start date of their initial apprentice permit by meeting the following requirements:

A. Submitting another examination fee.
   (1) Repealed.
   (2) Repealed.
   (3) Repealed.
   (4) Repealed.

B. Holding a current midwifery apprentice permit. Applicants may retain their permits and renew them, provided that the four year limitation on holding an apprentice permit has not expired.

C. If an applicant fails the examination more than once, she or he must wait a period of not less than six (6) months before taking the examination again and during that time must be apprenticed to a preceptor or in a formal midwifery school, and must submit a new completed Student Workbook or new completed transcripts from a formal education program, and must submit another examination fee.

[3-19-87...10-31-96; Rn, 16.11.3.11.2.3; 12-31-96; 12-31-97; Recompiled 12/31/01]

16.11.3.12 **RESPONSIBILITIES AND SCOPE OF PRACTICE:**

A. **SCOPE OF PRACTICE:** The licensed midwife may provide care to women without general health or obstetrical complications as defined by the *Standards and Core Competencies of Practice for Licensed Midwives in New Mexico* and the *New Mexico Midwives Association: Policies and Procedures*, or equivalent approved by the NMMA and the Division. Such care includes:
   (1) Prenatal care and counseling
   (2) Intrapartum care and support
   (3) Postpartum care and counseling
   (4) Well-woman care
   (5) Immediate newborn care
   (6) Administration of specific drugs and medications as outlined in the New Mexico Midwives Association Policies and Procedures

B. **PHYSICIAN VISIT:** Each woman accepted for care must be referred at least once to a duly licensed physician within four (4) weeks of her initial midwifery visit. The referral must be documented in the chart

C. **RESPONSIBILITY TO CONSULT:** It shall be the responsibility of the midwife to develop a means for consultation with or referral/transfer to a physician or hospital if there are significant deviations from the normal in the health status of either mothers or infants as set out in the Standards and Core Competencies for the Practice of Licensed Midwifery in New Mexico

D. **LIMITATION OF PHYSICIAN LIABILITY:** Any consultative relationship with a physician shall not by itself provide the basis for finding a physician liable for any acts or omissions by a licensed midwife

E. **INFORMED CONSENT:** The licensed midwife must obtain written, informed consent regarding the care to be provided by the licensed midwife from the woman upon accepting her for care. At a minimum, the licensed midwife must first honestly explain the
following to any woman seeking midwifery care to ensure that her choices are comprehensive and informed

1. Midwife's educational background
2. The risks and benefits of midwifery care
3. The nature and scope of the care to be given; and
4. The nature and terms of the financial agreement

F. The licensed midwife may not accept a woman as a client who does not meet the minimum criteria set out in the Standards and Core Competencies of Practice for Licensed Midwives in New Mexico

G. BIRTH REGISTRATION: The licensed midwife must complete a New Mexico Certificate of Live Birth Registration and file it with the Bureau of Vital Records and Health Statistics of the Department of Health within ten (10) days of the birth of any child in the State of New Mexico. No licensed midwife shall register nor enable any other party to register as a New Mexico birth any child not born in the state. Failure to meet the Vital Records regulations shall be grounds for disciplinary action

H. RECORDS: The licensed midwife will document and maintain clients' records according to current "Standards and Core Competencies for the Practice of Licensed Midwifery in New Mexico." Inactive records shall be maintained no less than ten (10) years

I. MORTALITY: IMMEDIATE REPORTING: The licensed midwife must report within 48 hours to the Division any neonatal or maternal mortality in patients for whom she has cared in the perinatal period

J. REPORTABLE DISEASES: The licensed midwife must report any reportable contagious disease to the public health officer pursuant to the Public Health Act, 24-1-15

K. The licensed midwife shall participate in peer review at least once every four (4) years in accordance with the requirements of the Division and Article XI of the New Mexico Midwifery Association.

L. QUARTERLY REPORTS: At the end of each quarter of a year each licensed midwife shall submit to the Division a report on the Division's form of the disposition of each patient she or he has given care to. Quarters shall be January 1st to March 31st, April 1st to June 30th, July 1st to September 30th, and October 1st to December 31st. Reports shall be submitted by the tenth (10th) day after the end of each quarter

M. CHANGES OF ADDRESS OR PHONE NUMBER: A licensed midwife must report a change of her or his address or phone number within 30 days of the change.

[12-31-97; Recompiled 12/31/01]

16.11.3.13 ADVISORY BOARD: The Division shall appoint a Licensed Midwifery Advisory Board

A. The Boards activities will be:

1. Review complaints against Licensed Midwives as requested by the Division and make recommendations to the Division
2. Remain current in clinical practice and professional issues and advise the Division accordingly
4. Conduct other relevant business as requested by the Division
B. **ADVISORY BOARD MEMBERSHIP:** The Licensed Midwifery Advisory Board shall be composed of nine (9) members and one (1) ex-officio member; the membership shall be as follows:

1. Three (3) state licensed midwives, at least two of whom shall be actively practicing
2. One state licensed certified nurse-midwife actively practicing midwifery
3. Three (3) consumer members
4. One (1) state licensed physician actively practicing obstetrics
5. One (1) member from the Division; and
6. A representative of the Maternal and Child Health Bureau in the Public Health Division will be an ex-officio member of the Board

C. **ADVISORY BOARD PROCEDURES:** Board members shall be appointed for staggered three year terms and not more than two consecutive terms, except for the member from the Division, who shall serve at the pleasure of the Division Director and who shall not be limited as to terms

1. Board members shall serve without compensation; they may submit for reimbursement for in-state travel and per diem for Division-called Board meetings according to Department of Finance and Administration Regulations
2. Any member failing to attend two (2) consecutive meetings without good cause and an excused absence prior to the meeting(s) shall be deemed to have resigned from the Board

16.11.3.14 **SEVERABILITY:** If any part or application of the Regulations Governing the Practice of Licensed Midwifery is held invalid, the remainder or its application to other situations or persons shall not be affected

**HISTORY OF 16.11.3 NMAC:** [RESERVED]
APPENDIX C
CRITICAL CONGENITAL HEART DEFECT (CCHD) RESULTS FORM

The following form is used to report the results of CCHD screening to the New Mexico Department of Health. Order original forms from or submit completed forms to the New Mexico Newborn Screening Program. See Children’s Medical Services Bureau’s page on the DOH’s website at https://nmhealth.org/about/phd/fhb/cms/nbgs/ for contact information.
APPENDIX D
NEWBORN HEARING SCREENING REFERRAL

The following form is used to report results of screening to the Newborn Hearing Screening Program. The form is available in triplicate carbon copy; contact the Newborn Hearing Screening Program to order original forms for your practice. See also https://nmhealth.org/about/phd/fhb/cms/nbhs/ for a PDF copy of this form and resources about the screening to share with parents.
MIDWIFE REPORTING FORM

Midwife Name or Name of Center: ____________________________

Baby’s Last Name: ____________________ First Name: ____________

Baby’s Gender: ___ Male ___ Female Baby’s Date of Birth: ____________

Baby’s Hearing Was Screened By Midwife or Center: ________Yes_______No

If Hearing Was Screened:

Date(s) of Screen(s): ____________________ Right Ear: PASS / REFER

_________________________ Left Ear: PASS / REFER

_________________________ Right Ear: PASS / REFER

_________________________ Left Ear: PASS / REFER

Total # of Screens: _______________ (Screen NO More than 3 times)

Doctor Who Will Follow Baby:

Name: ____________________________ Practice: ____________________________

Address, City, State: ________________________________________________

Phone Number: ____________________________

Parent Contact Information:

Mother’s Name: ____________________ Mother’s DOB: ____________

Mother’s Primary Language: ____________________________

Mailing Address: ________________________________________________

City: ____________________ State: ________ Zip Code: ____________

Phone Number: ________ Message Phone Number: ____________

Email Address: ____________________________

Mother’s signature for release: ____________________ Date: ____________

Mother Wants Contact from Newborn Hearing Screening Program: _________Yes___________No

Comments: ____________________________

All Fields on Form Must Be Complete. Fax or Mail to Children’s Medical Services within 10 days of baby’s birth as follows:

Fax: (505) 827-5995 or (505) 476-8896

Mail:
Department of Health, Children’s Medical Services, Newborn Hearing Screening Program
1190 S. St. Francis Drive, Santa Fe, NM 87505

Questions for Newborn Hearing Screening Program: Call (505) 476-8852 or Toll Free at 1 (877) 890-4692

Revised 9/28/2015
APPENDIX E
NEWBORN SCREENING TEST REFUSAL

The following form is used to provide documentation to the Newborn Screening Program as required by law of clients choosing to decline any or all state mandated newborn screenings.
New Mexico
Newborn Screening Program
Newborn Screening Test Refusal

Name of Infant (Print) ___________________________ Hospital of Birth/Name of Midwife ___________________________

Birth Date ___________________________ Street Address ___________________________

Mother’s Name ___________________________ City/State/Zip ___________________________

1) I have received the Department of Health brochure entitled New Mexico Newborn Screening Tests and Critical Congenital Heart Disease handout, concerning the newborn screening tests for metabolic, endocrine, hemoglobin, hearing and critical congenital heart disorders.

2) I have been informed and I understand that these tests are required by State Law for all infants born in New Mexico.

3) I have been informed and I understand that these tests are given to detect these disorders as babies may look normal and symptoms may not appear for several weeks or months.

4) I have been informed and I understand that untreated, these conditions may cause permanent damage to my child, including serious cognitive impairment, growth failure and in some cases death.

5) I have discussed the testing requirements with ___________________________ and I have had explained, and I understand all the risks involved if these tests are not given to my child.

6) I have been informed and I understand the nature of the tests and how these tests are given.

7) I object to the following screen(s):
   ___ Newborn Genetic Screen
   ___ Newborn Critical Congenital Heart Disease
   ___ Newborn Hearing Screening

and I do not want ___________________________ tested for these conditions.

   Name of Infant ___________________________

8) Would you share with us the reason why you chose not to have your baby screened?

________________________________________________________________________

My decision was freely made without force or encouragement by my doctor, midwife, hospital personnel, or state officials and I accept the legal responsibility for the consequences of this decision.

Signed ___________________________ Relationship ___________________________

Print ___________________________ Date ___/___/___

Witnessed by ___________________________ Date ___/___/___

__________________________ / ___________________________ / ___________________________

Original Copy
Infant’s Medical Record NM Newborn Screening Program Copy
2040 S Pacheco St Parent/Guardian
Santa Fe, NM 87505 Date 03/12/2014
APPENDIX F
NOTIFIABLE DISEASES OR CONDITIONS IN THE STATE OF NEW MEXICO

The New Mexico Department of Health Regulations Governing the Control of Disease and Conditions of Public Health Significance requires the reporting of specific infections and conditions. This is the list, taken directly from the most recent version of NMAC 7.4.3.13 (last updated 06/15/16), of all diseases and conditions that the DOH must be notified of. Please check for updates to this list and reporting specifications. NMAC 7.4.3 is available on the NMAC compilation website at http://164.64.110.134/parts/title07/07.004.0003.html.

A. All reports including electronic laboratory reports of notifiable conditions, must include:
   1. the disease or condition being reported;
   2. patient’s name, date of birth/age, gender, race/ethnicity, address, patient telephone numbers, and occupation;
   3. physician or licensed healthcare professional name and telephone number; and
   4. healthcare facility or laboratory name and telephone number, if applicable.

B. Laboratory or clinical samples for conditions marked with (*) are required to be sent to the scientific laboratory division.

C. Emergency reporting of diseases or conditions: The following diseases, confirmed or suspected, require immediate reporting by telephone to the epidemiology and response division at (505) 827-0006. If no answer, call 1-866-885-6485.
   1. Infectious diseases:
      a. Anthrax*;
      b. Avian or novel influenza*;
      c. Bordetella species*;
      d. Botulism (any type) *;
      e. Cholera*;
      f. Diphtheria*;
      g. Haemophilus Influenzae Invasive Infections*;
      h. Measles;
      i. Meningococcal Infections, invasive*;
      j. Middle East Respiratory Syndrome;
      k. Plague*;
      l. Poliomyelitis, paralytic and non-paralytic;
      m. Rabies;
      n. Rubella (including congenital);
      o. Severe Acute Respiratory Syndrome (SARS)*;
      p. Smallpox*;
      q. Tularemia*;
      r. Typhoid fever*;
      s. Yellow fever.
   2. Other conditions:
      a. Suspected foodborne illness in two or more unrelated persons*;
      b. Suspected waterborne illness or conditions in two or more unrelated persons*;
      c. Illnesses or conditions suspected to be caused by the intentional or accidental release of biologic or chemical agents*;
d. Acute illnesses or conditions of any type involving large numbers of persons in the same geographic area;

e. Severe smallpox vaccine reaction;

f. Other illnesses or conditions of public health significance

3. Infectious diseases in animals:

a. Anthrax;

b. Plague;

c. Rabies;

d. Tularemia.

D. Routine reporting of diseases or conditions:

1. Infectious diseases (report case within 24 hours to epidemiology and response division at 505-827-0006; or contact the local health office).

a. Arboviral disease

b. Brucellosis;

c. *Campylobacter* infections*;

d. Chikungunya virus disease;

e. *Clostridium difficile*;

f. Coccidioidomycosis;

g. Colorado tick fever;

h. Cryptosporidiosis;

i. Cysticercosis;

j. Cyclosporiasis;

k. Dengue

l. *E. coli* 0157:H7 infections*;

m. *E. coli*, shiga-toxin producing (STEC) infections*;

n. Encephalitis, other;

o. Giardiasis;

p. Group A streptococcal invasive infections*;

q. Group B streptococcal invasive infections*;

r. Hansen’s Disease/Leprosy;

s. Hantavirus pulmonary syndrome;

t. Hemolytic uremic syndrome;

u. Hepatitis A, acute;

v. Hepatitis B, acute or chronic;

w. Hepatitis C, acute or chronic;

x. Hepatitis E, acute;

y. Influenza-associated pediatric death

z. Influenza, laboratory confirmed hospitalization only;

aa. Legionnaires’ disease;

bb. Leptospirosis;

cc. Listeriosis*;

dd. Lyme disease;

ee. Malaria;

ff. Mumps;

gg. Necrotizing fasciitis*;

hh. Psittacosis;
Appendix F
Notifiable Diseases or Conditions in the State of New Mexico

ii. Q fever;
jj. Relapsing fever;
kk. Rocky Mountain spotted fever;
ll. Salmonellosis*;
mm. Shigellosis*;
nn. St. Louis encephalitis infections;
oo. *Streptococcus pneumoniae*, invasive infections*;
pp. Tetanus;
qq. Trichinellosis;
rr. Toxic shock syndrome;
s. Varicella;
tt. *Vibrio* infections*;
uu. *West Nile Virus* infections;
v. Western equine encephalitis infections;
w. *Yersinia* infections*.

2. Infectious diseases in animals (report case within 24 hours to epidemiology and response division at 505-827-0006; or contact the local health office).
   a. Arboviral, other;
b. Brucellosis;
c. Psittacosis;
d. *West Nile Virus* infections.

3. Tuberculosis* or other nontuberculous mycobacterial infections (including *Mycobacterium avium* complex or leprosy). Report suspect or confirmed cases within 24 hours to tuberculosis program, NM Department of Health, P. O. Box 26110, Santa Fe, NM 87502-6110; or call (505-827-2471) or 505-827-2473.

4. Sexually transmitted diseases. Report to infectious disease bureau - STD program, NM Department of Health, P.O. Box 26110, Santa Fe, NM 87502-6110, fax 505-476-3638; or call 505-476-3636.
   a. Chancroid;
b. *Chlamydia trachomatis* infections;
c. Gonorrhea;
d. Syphilis.

5. HIV (human immunodeficiency virus) and AIDS (acquired immunodeficiency syndrome). Report to HIV and hepatitis epidemiology program, 1190 St. Francis Dr., N1350, Santa Fe, NM 87502, fax 505-476-3544 or call 505-476-3515.
   a. All confirmed positive HIV antibody tests (screening test plus confirmatory test);
b. All tests for HIV RNA or HIV cDNA (‘viral load tests’);
c. All tests to detect HIV proteins;
d. All positive HIV cultures;
e. All HIV genotype tests;
f. All CD4 lymphocyte tests (count and percent);
g. Opportunistic infections, cancers and any other test or condition indicative of HIV or AIDS.

6. Occupational illness and injury. Report to epidemiology and response division, NM Department of Health, P.O. Box 26110, Santa Fe, NM 87502-6110; or call 505-827-0006.
   a. Asbestosis;
b. Coal worker’s pneumoconiosis;
c. Hypersensitivity pneumonitis;
d. Mesothelioma;
e. Noise induced hearing loss;
f. Occupational asthma;
g. Occupational burn hospitalization;
h. Occupational injury death;
i. Occupational pesticide poisoning;
j. Occupational traumatic amputation;
k. Silicosis;
l. Other illnesses or injuries related to occupational exposure.

7. Health conditions related to environmental exposures and certain injuries. Report to epidemiology and response division, NM Department of Health, P.O. Box 26110, Santa Fe, NM 87502-6110; or call 505-827-0006.
   a. Environmental exposures:
      (a) All pesticide poisoning;
      (b) Arsenic in urine greater than 50 micrograms/liter;
      (c) Carbon monoxide poisoning;
      (d) Infant methemoglobinemia;
      (e) Lead (all blood levels);
      (f) Mercury in urine greater than 3 micrograms/liter or mercury in blood greater than 5 micrograms/liter;
      (g) Uranium in urine greater than 0.2 micrograms/liter or 0.2 micrograms/gram creatinine;
      (h) Other suspected environmentally-induced health conditions.
   b. Injuries:
      (a) Drug overdose;
      (b) Firearm injuries;
      (c) Traumatic brain injuries;
      (d) Fracture due to fall among older adults.

8. Adverse vaccine reactions. Report to vaccine adverse events reporting system, https://vaers.hhs.gov. Send copy of report to immunization program vaccine manager, NM Department of Health, P.O. Box 26110, Santa Fe, NM 87502-6110; fax 505-827-1741.

9. Healthcare-associated infections:
   a. Acute care hospitals only report through NHSN and confer rights to NMDOH
      (a) Central line-associated bloodstream infections (CLABSI) events;
      (b) *Clostridium difficile* infections.
   b. Report all infections, including non-healthcare-associated, within 24 hours to epidemiology and response division by fax at 505-827-0013 or by phone at 505-827-0006.
      (a) Carbapenem-resistant enterobacteriaceae*;
      (b) Carbapenem-resistant pseudomonas aeruginosa*.

10. Cancer. Report to NMDOH designee: NM Tumor Registry, UNM School of Medicine, Albuquerque, NM 87131. Report all malignant and in situ neoplasms and all intracranial neoplasms, regardless of the tissue of origin.
11. Human papillomavirus (HPV). Laboratories report the following tests to designee (NM HPV Pap Registry):
   a. Papanicolaou test results (all results);
   b. Cervical, vulvar and vaginal pathology results (all results);
   c. HPV test results (all results).

   a. Report to Epidemiology and Response Division, NM Department of Health, P.O. Box 26110, Santa Fe, NM 87502-6110; or call 505-827-0006.
   b. All birth defects diagnosed by age 4 years, including:
      (a) Defects diagnosed during pregnancy;
      (b) Defects diagnosed on fetal deaths;
      (c) Defects found in chromosome testing on amniotic fluid, chorionic villus sampling and products of conception for Trisomy 13, Trisomy 18 and Trisomy 21.

13. Genetic and congenital hearing screening. Report to Children’s Medical Services, 2040 S. Pacheco, Santa Fe, NM 87505; or call 505-476-8868.
   a. Neonatal screening for congenital hearing loss (all results);
   b. Suspected or confirmed congenital hearing loss in one or both ears;
   c. Newborn critical congenital heart defect screening (all results);
   d. All conditions identified through statewide newborn genetic screening.
APPENDIX G
BEST PRACTICE GUIDELINES FOR TRANSFER FROM
PLANNED HOME BIRTH TO HOSPITAL

The following is taken directly from the Home Birth Summit’s document, “Best Practice Guidelines: Transfer from Planned Home Birth to Hospital” (see http://www.homebirthsummit.org/best-practice-transfer-guidelines/).

“We believe that collaboration within an integrated maternity care system is essential for optimal mother-baby outcomes. All women and families planning a home or birth center birth have a right to respectful, safe, and seamless consultation, referral, transport and transfer of care when necessary. When ongoing inter-professional dialogue and cooperation occur, everyone benefits.”

Collaborative care throughout the antepartum, intrapartum, and postpartum periods is crucial to safety whenever birth is planned outside the hospital setting. Coordination of care and communication of expectations during transfer of care between settings improve health outcomes and consumer satisfaction.

Model practices for the midwife

- In the prenatal period, the midwife provides information to the woman about hospital care and procedures that may be necessary and documents that a plan has been developed with the woman for hospital transfer should the need arise.
- The midwife assesses the status of the woman, fetus, and newborn throughout the maternity care cycle to determine if a transfer will be necessary.
- The midwife notifies the receiving provider or hospital of the incoming transfer, reason for transfer, brief relevant clinical history, planned mode of transport, and expected time of arrival.
- The midwife continues to provide routine or urgent care in route in coordination with any emergency services personnel and addresses the psychosocial needs of the woman during the change of birth setting.
- Upon arrival at the hospital, the midwife provides a verbal report, including details on current health status and need for urgent care. The midwife also provides a legible copy of relevant prenatal and labor medical records.
- The midwife may continue in a primary role as appropriate to her scope of practice and privileges at the hospital. Otherwise the midwife transfers clinical responsibility to the hospital provider.
- The midwife promotes good communication by ensuring that the woman understands the hospital provider’s plan of care and the hospital provider understands the woman’s need for information regarding care options.
- If the woman chooses, the midwife may remain to provide continuity and support.

Model practices for the hospital provider and staff

- Hospital providers and staff are sensitive to the psychosocial needs of the woman that result from the change of birth setting.
- Hospital providers and staff communicate directly with the midwife to obtain clinical information in addition to the information provided by the woman.
Timely access to maternity and newborn care providers may be best accomplished by direct admission to the labor and delivery or pediatric unit.

Whenever possible, the woman and her newborn are kept together during the transfer and after admission to the hospital.

Hospital providers and staff participate in a shared decision-making process with the woman to create an ongoing plan of care that incorporates the values, beliefs, and preferences of the woman.

If the woman chooses, hospital personnel will accommodate the presence of the midwife as well as the woman’s primary support person during assessments and procedures.

The hospital provider and the midwife coordinate follow up care for the woman and newborn, and care may revert to the midwife upon discharge.

Relevant medical records, such as a discharge summary, are sent to the referring midwife.

**Quality improvement and policy development**

All stakeholders involved in the transfer and/or transport process, including midwives based at home or in the hospital, obstetricians, pediatricians, family medicine physicians, nurses, emergency medical services personnel, and home birth consumer representatives, should participate in the policy development process. Policies and quality improvement processes should incorporate the model practices above and delineate at a minimum the following:

- Communication channels and information needed to alert the hospital to an incoming transfer.
- Provision for notification and assembly of staff rapidly in case of emergency transfer.
- Opportunities to debrief the case with providers and with the woman prior to hospital discharge.
- Documentation of the woman’s perspective regarding her care during transfer.
- A defined process to regularly review transfers that includes all stakeholders with a shared goal of quality improvement and safety. This process should be protected without risk of discovery.
- Opportunities for education regarding home birth practice, shared continuing medical education, and relationship building that are incorporated into medical, midwifery and nursing education programs. Multi-disciplinary sessions to address system issues may enhance relationship building and the work culture.

Quality of care is improved when policies and procedures are in place to govern best practices for coordination and communication during the process of transfer or transport from a home or birth center to a hospital.
APPENDIX H
NEW MEXICO MIDWIVES ASSOCIATION INFORMED CONSENT FOR
OUT-OF-HOSPITAL VAGINAL BIRTH AFTER CESAREAN (VBAC)

The following form is available to New Mexico midwives to use to document the informed consent process when consulting with clients about the risks and benefits of VBAC in the community (home or freestanding birth center) setting.
INFORMED CONSENT FOR OUT-OF-HOSPITAL TRIAL OF LABOR AFTER CESAREAN (TOLAC) AND VAGINAL BIRTH AFTER CESAREAN (VBAC)

*Client is to initial each paragraph.

I have been told the risks of having a trial of labor after a cesarean birth (TOLAC) and having a vaginal birth after a cesarean birth (VBAC), for both me and my baby. I understand the special risk is that my uterus could tear open in labor. (The medical word for this is “uterine rupture”.) The risk of my uterus tearing open is greater for me than it is for a woman who has never had a cesarean birth. This is because the place where my uterus was cut open could tear open again.

I understand that my uterus could tear open whether I have my baby in a hospital, at home, or in a birth center.

If my uterus tears open, my baby could have brain damage for the rest of his or her life, or I could bleed very heavily, or both could happen. My baby could die, I could die, or both of us could die.

If my uterus tears open, I will need to have a cesarean to deliver my baby and stop the bleeding. For the least damage to my baby and/or me, the cesarean needs to be done quickly. If I am having my baby at home or in a birth center, the time it takes to travel to the hospital for a cesarean may cause more damage than if I were having my baby at a hospital and able to have an immediate cesarean.

I might need a cesarean for other reasons, even if my uterus does not tear open. If I do have a cesarean I am more likely to have problems like infection and heavy bleeding than if I had planned a scheduled repeat cesarean birth.

I understand that I could choose to have a planned repeat cesarean instead of a planned VBAC. I have been told the risks of TOLAC, VBAC, and of having a repeat cesarean birth.

If my midwife decides at any time that my baby or I need to go to a hospital, I will go to the hospital even if I disagree. Also, I understand that if I decide to go to a hospital at any time, my midwife will go with me to the hospital even if she does not think I need to go.

I have read, and I understand, the above information. My midwife has informed me of my risks. I understand that the New Mexico Midwives Association Practice Guideline “Trial of Labor After Cesarean and Vaginal Birth After Cesarean” has more information and is
available to me through the Department of Health website. All my questions about TOLAC and VBAC have been answered and I understand the answers.

I confirm that: (Initial all that are true)

__________ I have had only one cesarean birth.

__________ My medical records say the cut was made across the lower part of my uterus. I understand that the cut in my uterus may have been made in a different place or direction from the cut in my skin.

__________ There are at least 18 months from the date of my cesarean to the due date of this pregnancy.

__________ I will have an ultrasound during my pregnancy to find out if the placenta is in a dangerous position.

__________ I will have my birth within a 30-minute distance from a hospital where a cesarean could be done, and pediatric care could be provided to my baby.

__________ I understand all of the special risks of a TOLAC and VBAC birth and the risks of having a TOLAC and VBAC at home or at a birth center, and I choose to plan a home or birth center TOLAC and VBAC birth.

Date: ________________________ Client Signature: ____________________________

Date: ________________________ Midwife Signature: ____________________________
APPENDIX I

EDINBURGH POSTNATAL DEPRESSION SCALE (EPDS)

The Edinburgh Postnatal Depression Scale has been developed to assist primary health care providers to detect mothers suffering from postnatal depression: a distressing disorder more prolonged than the “blues” (which occur in the first week after birth) but less severe than puerperal psychosis. Previous studies have shown that postnatal depression affects at least 10% of women and that many depressed mothers remain untreated. These mothers may cope with their baby and with household tasks, but their enjoyment of life is seriously affected and it is possible that there are long term effects on the family.

The EPDS was developed at health centers in Livingston and Edinburgh. It consists of ten short statements. The mother underlines which of the four possible responses is closest to how she has been feeling the last week. Most mothers complete the scale without difficulty in less than 5 minutes.

The validation study showed that mothers who scored above threshold 92.3% were likely to be suffering from a depressive illness of varying severity. Nevertheless, the EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt during the previous week and in doubtful cases may be usefully repeated in 2 weeks. The scale will not diagnose mothers with anxiety neuroses, phobias, or personality disorder.

Users may reproduce the scale without further permission providing they respect copyright by quoting the names of the authors, the title, and the source of the paper in all reproduced copies.

Instruction for users:
1. The mother is asked to underline the response, which comes closest to how she has been feeling in the previous 7 days.
2. All ten items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others.
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.
5. The EPDS may be used at 6-8 weeks to screen postnatal women. The child health clinic, postnatal check-up, or a home visit may provide suitable opportunities for its completion.
6. Scoring:
   1. Response categories are scored 0, 1, 2, 3 according to increased severity of symptoms.
   2. Items marked with an asterisk are reverse scored (3, 2, 1, 0)
   3. The total score is calculated by adding together the scores for each of the ten items
Edinburgh Postnatal Depression Scale (EPDS)

Client Name

As you have recently had a baby, we would like to know how you are feeling. Please UNDERLINE the answer that comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

*I have been able to laugh and see the funny side of things.
As much as I always could    Not quite so much now    Definitely not much now    Not at all

*I have looked forward with enjoyment to things.
As much as I ever did     Rather less than I used to     Definitely less than I used to     Hardly at all

*I have blamed myself unnecessarily when things went wrong.
Yes, most of the time    Yes, some of the time    Not very often    No, never

*I have been anxious or worried for no good reason.
No, not at all    Hardly ever    Yes, sometimes    Yes, very often

*I have felt scared or panicky for not very good reasons.
Yes, quite a lot     Yes, sometimes     No, not much     No, not at all

*Things have been getting on top of me.
Yes, most of the time I haven’t been able to cope at all    Yes, sometimes I haven’t been coping as well as usual
No, most of the time I have coped quite well    No, I have been coping as well as ever

*I have been so unhappy that I have had difficulty sleeping.
Yes, most of the time    Yes, sometimes    Not very often    No, not at all

*I have felt sad or miserable.
Yes, most of the time    Yes, sometimes    Not very often    No, not at all

*I have been so unhappy that I have been crying.
Yes, most of the time    Yes, quite often    Only occasionally    No, never

*The thought of harming myself has occurred to me.
Yes, quite often    Sometimes    Hardly ever    Never
