# Access to Midwifery Care National Chartbook

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AMERICAN COLLEGE of NURSE-MIDWIVES

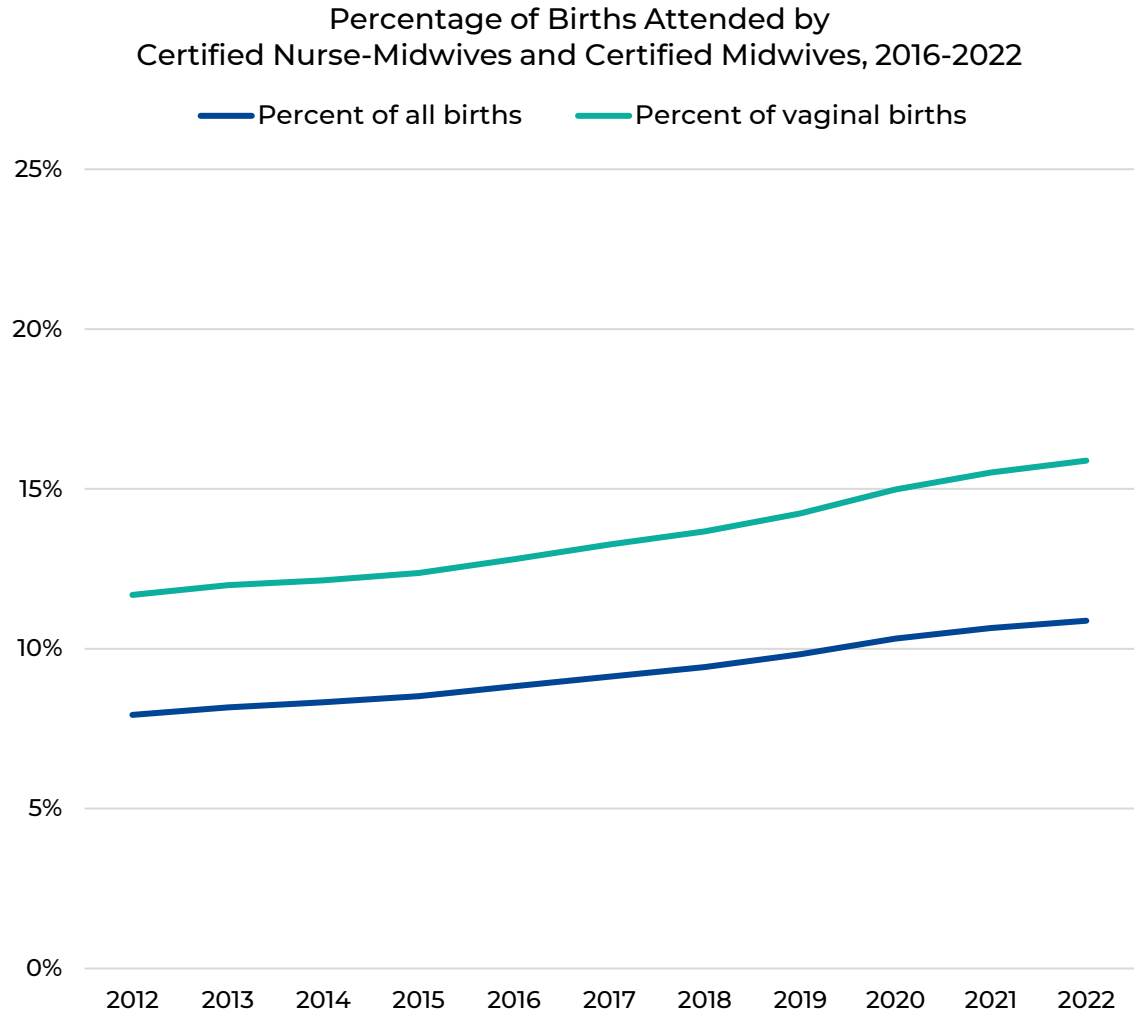
# Midwife-Attended Births

The number of births attended by certified nurse-midwives and certified midwives is increasing.

Between 2012 and 2022, the proportion of births attended by midwives increased from 7.9% to 10.9%.

Between 2012 and 2022, the proportion of vaginal births attended by midwives increased from 11.7% to 15.9%.

Midwifery-attended birth for people at low risk is associated with a 30% lower risk for cesarean birth.




Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Natality on CDC WONDER Online Database. Data are from the Natality Records 2007-2022, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.

References: Souter, Vivienne MD; Nethery, Elizabeth MSc, MSM; Kopas, Mary Lou MN, ARNP, CNM; Wurz, Hannah MSN, ARNP, CNM; Sitcov, Kristin BS; Caughey, Aaron B. MD, PhD. Comparison of Midwifery and Obstetric Care in Low-Risk Hospital Births. Obstetrics & Gynecology 134(5):p 1056-1065, November 2019. DOI: 10.1097/AOG.0000000000003521

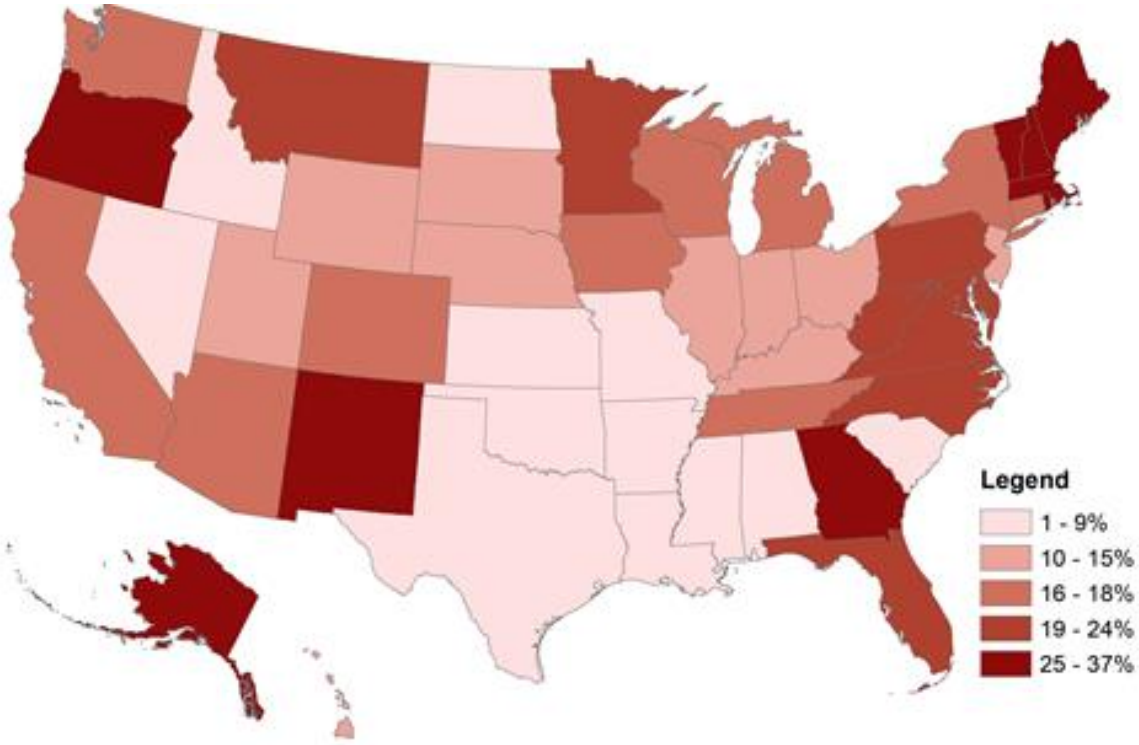
# Variation in Midwife-Attended Vaginal Birth

There is wide variation in the state proportion of births attended by midwives.

This variation is not explained by variations in population risk. In 2022, the proportion of midwife-attended births for people with no maternal risk factors recorded on the birth certificate vary from less than 1% in Alabama to 32% in Vermont.

In 2022, 65% of births had no maternal risk factors recorded on the birth certificate. Midwives attended 13% of these births. Based on these data, the US has the low-risk birth volume to increase the midwifery workforce to five times its current size.

## Percent of Vaginal Births Midwife-Attended, 2022




Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Natality on CDC WONDER Online Database. Data are from the Natality Records 2007-2022, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.

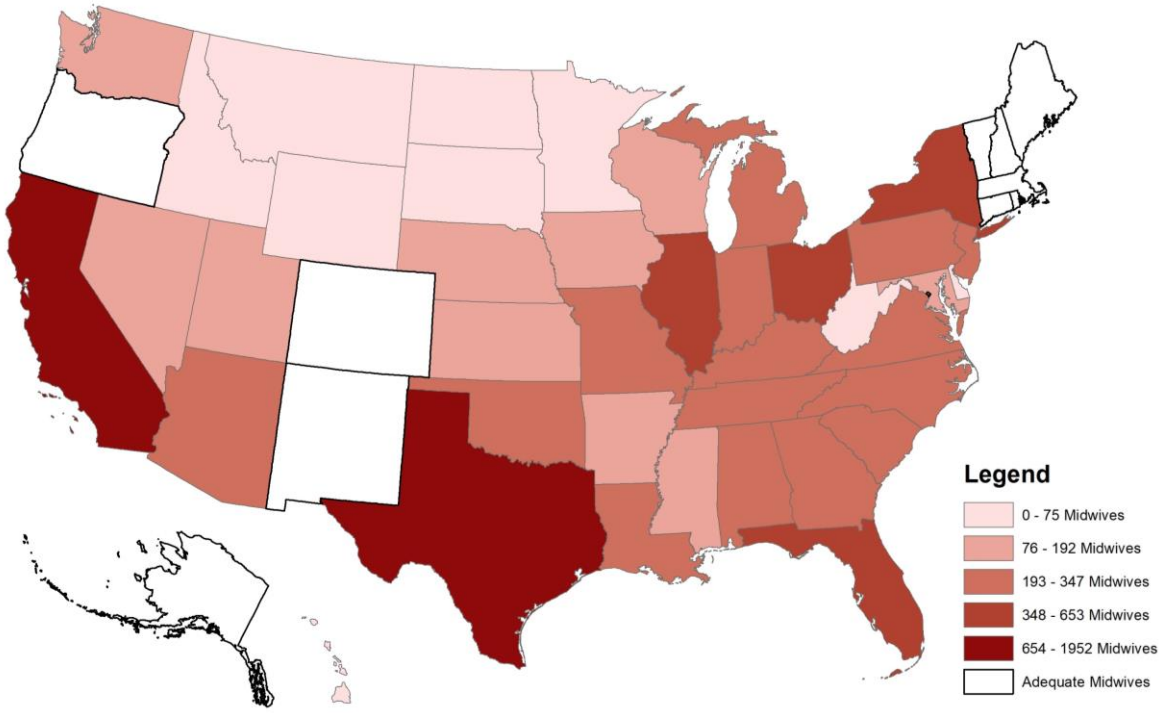
# Quantifying States' Midwifery Shortage

The World Health Organization estimates that the minimum adequate midwifery workforce is 6 midwives per 1,000 live births.

Only eleven states have a midwifery workforce that meets the minimum density recommended by the World Health Organization.

The size of the midwifery shortage in each state reflects the number of midwives necessary to achieve a density of 6 midwives per 1,000 births.

## Number of Midwives Needed to Achieve Midwifery Workforce, 2022




Data Sources: National Plan and Provider Enumeration System (NPPES) Data Dissemination File, August 2022; Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Natality on CDC WONDER Online Database. Data are from the Natality Records 2007-2022, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.

Reference: United Nations Population Fund. (2011). State of the Worlds Midwifery, 2011 Delivering Health, Saving Lives. (pages 17-18). Available at https://www.unfpa.org/sites/default/files/pub-pdf/en_SOWMR_Full.pdf

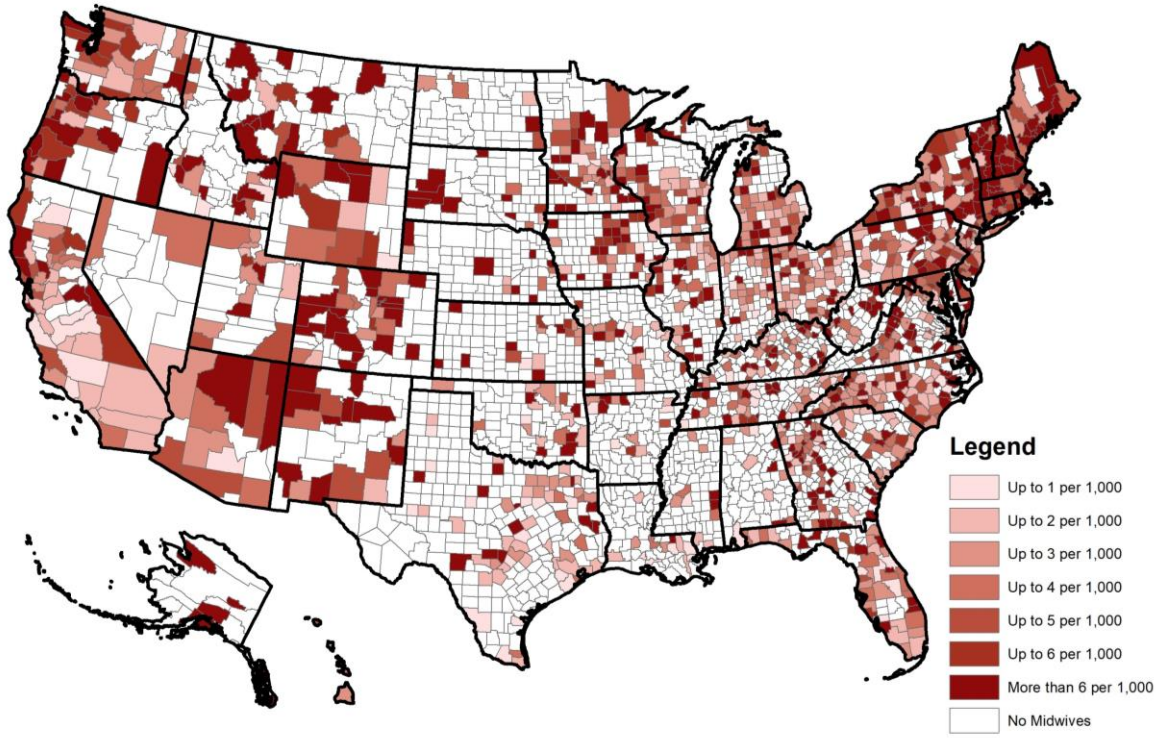
# Quantifying County Midwifery Shortage

Midwives are present in 41.6% of counties. These counties were the maternal residence for 87.2% of births in 2021.

Counties with midwives had a higher proportion of college graduates (27.4% vs 19.2%; p<.001). Counties with midwives also had lower proportion of women without health insurance (9.6% vs 11.7%; p<.001).

Most states have a maldistribution of midwives, with midwives concentrated in urban counties.

## Distribution of Midwives in the United States, 2022




Data Sources: National Plan and Provider Enumeration System (NPPES) Data Dissemination File, August 2022; Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Natality on CDC WONDER Online Database. Data are from the Natality Records 2007-2022, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.

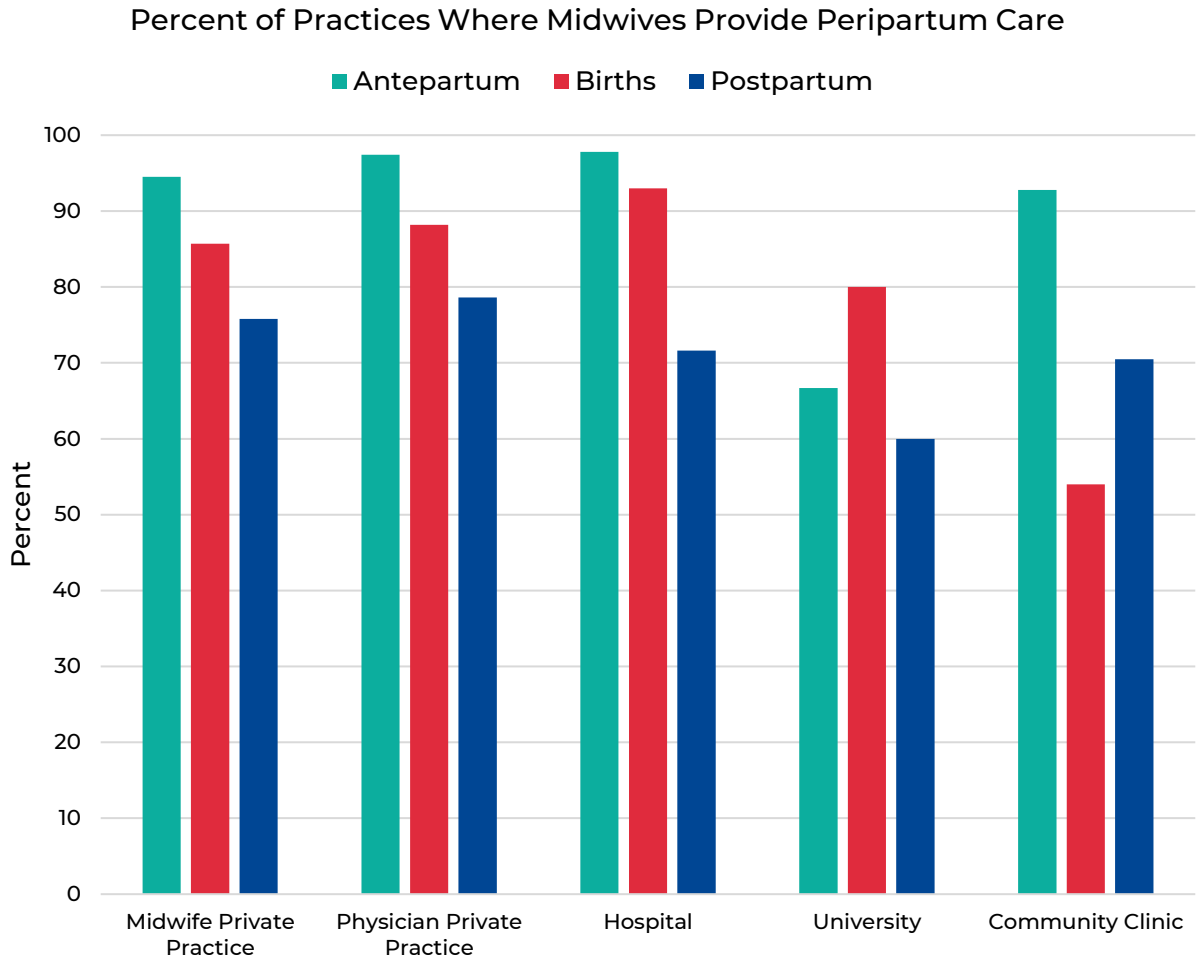
Reference: United Nations Population Fund. (2011). State of the Worlds Midwifery, 2011 Delivering Health, Saving Lives. (pages 17-18). Available at https://www.unfpa.org/sites/default/files/pub-pdf/en_SOWMR_Full.pdf

# Midwives' Contributions to the Peripartum Care Team

Midwives work in a variety of practice settings as a member of interdisciplinary care teams to provide care for populations with different needs. Midwives' contributions to peripartum care vary by the practice setting.

In all practice settings, midwives are less likely to be the team member providing postpartum care than antepartum care.

Data Source: ACNM Midwifery Workforce Committee 2021 COVID-19 Practice Survey. N = 727 completed surveys that reported on the practices of 3301 midwives.

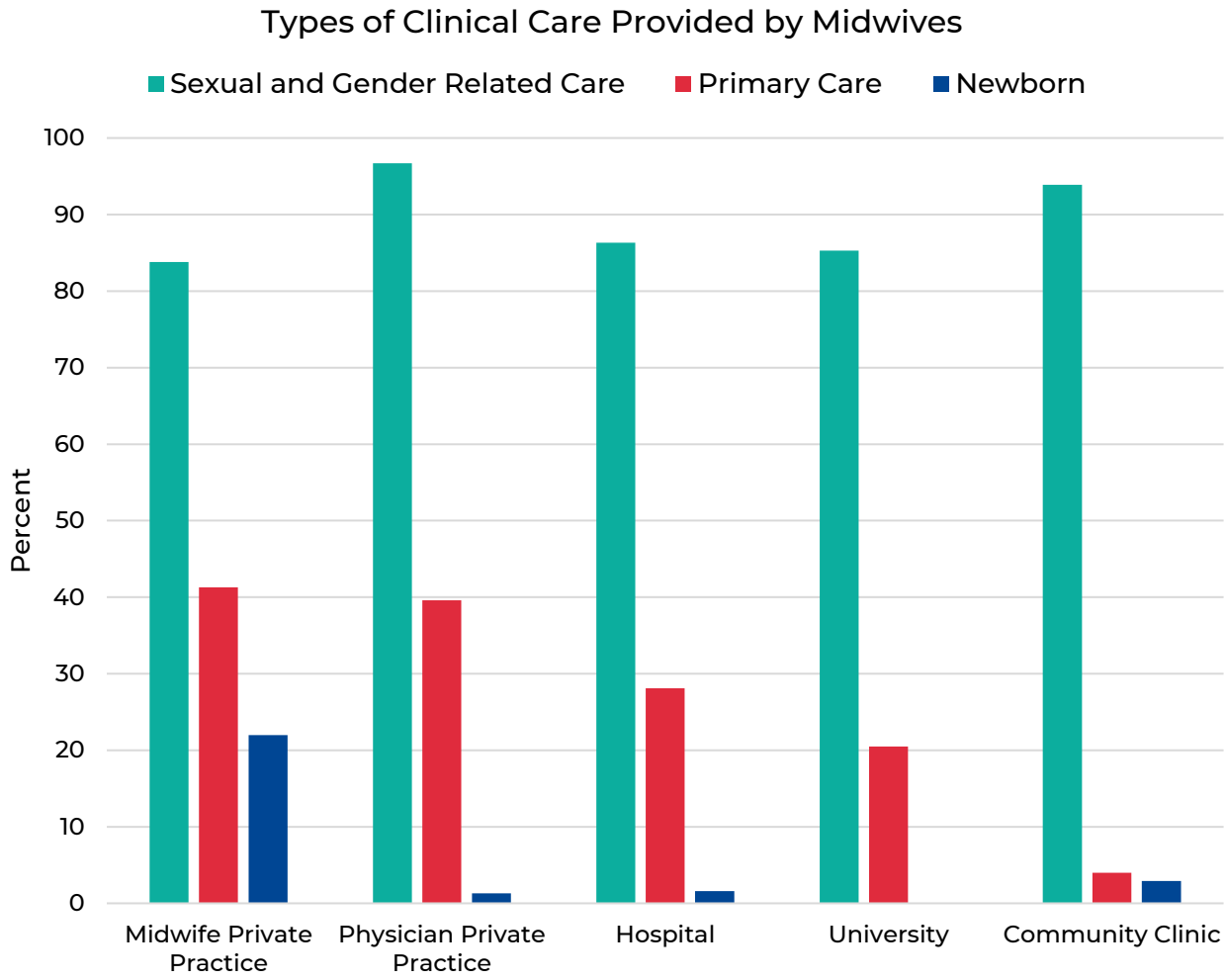


# Midwives are not Working in Their Full Scope

Midwives scope of care includes peripartum care, sexual and gender related care, primary care, and newborn care.

Midwives are likely to be providing sexual and gender related care across all practice settings.

In contrast, midwives are unlikely to be providing primary care or newborn care.




Data Source: ACNM Midwifery Workforce Committee 2021 COVID-19 Practice Survey. N = 727 completed surveys that reported on the practices of 3301 midwives.

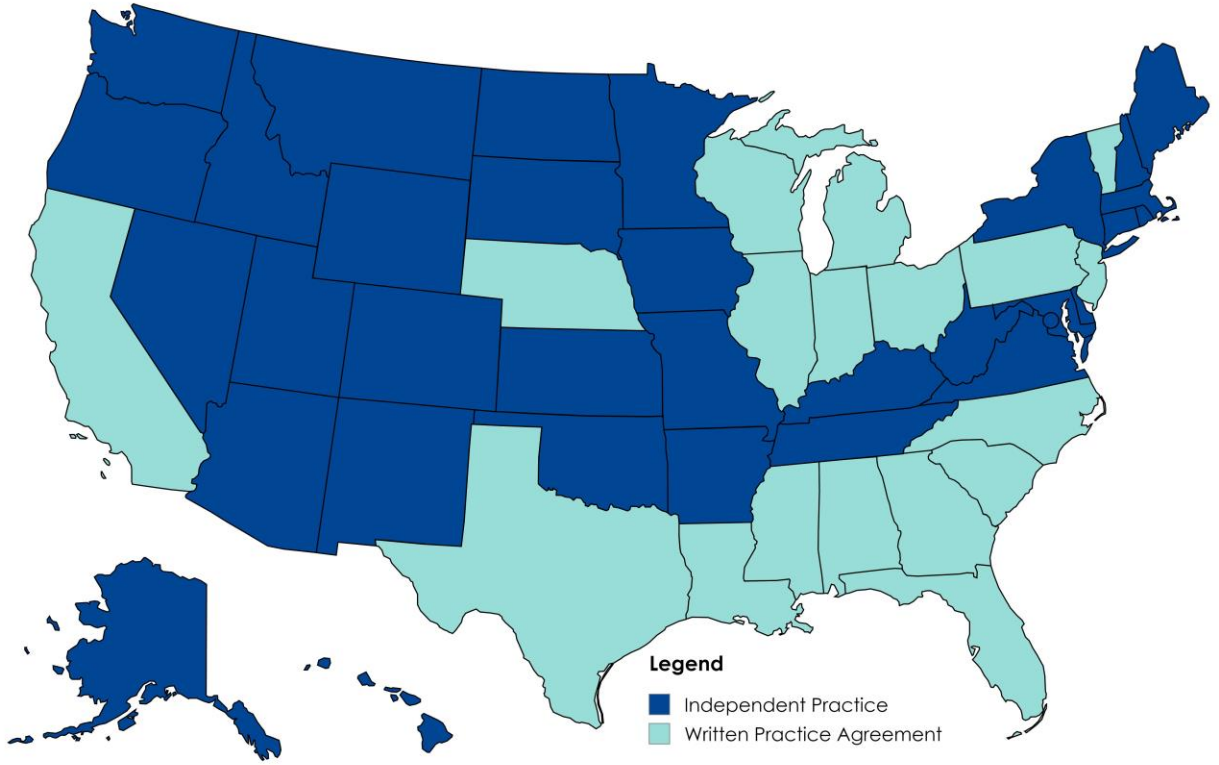
# Variations in Midwifery Licensure

State licensing is the process by which a state confirms the health care worker is competent to practice and designates the health care worker as legally able to practice within the state. Requirements for licensing are generally set by state statute and the licensing process is overseen by a regulatory authority in the state.

In thirty-two states and the District of Columbia, midwives are licensed based on evidence of education and certification (independent). In the other states, midwives must also provide evidence of a written practice agreement with a physician to be licensed or provide services as a health care worker (restricted). Three of these states provide a pathway to independent practice after a designated number of hours of practice.

Written contracts with physicians restrict midwives to practice in facilities where a physician colleague is willing to enter a contractual relationship.

## Midwifery Licensure Requirements, 2023




Data source: ACNM Review of state policies.

# Variations in Prescriptive Authority

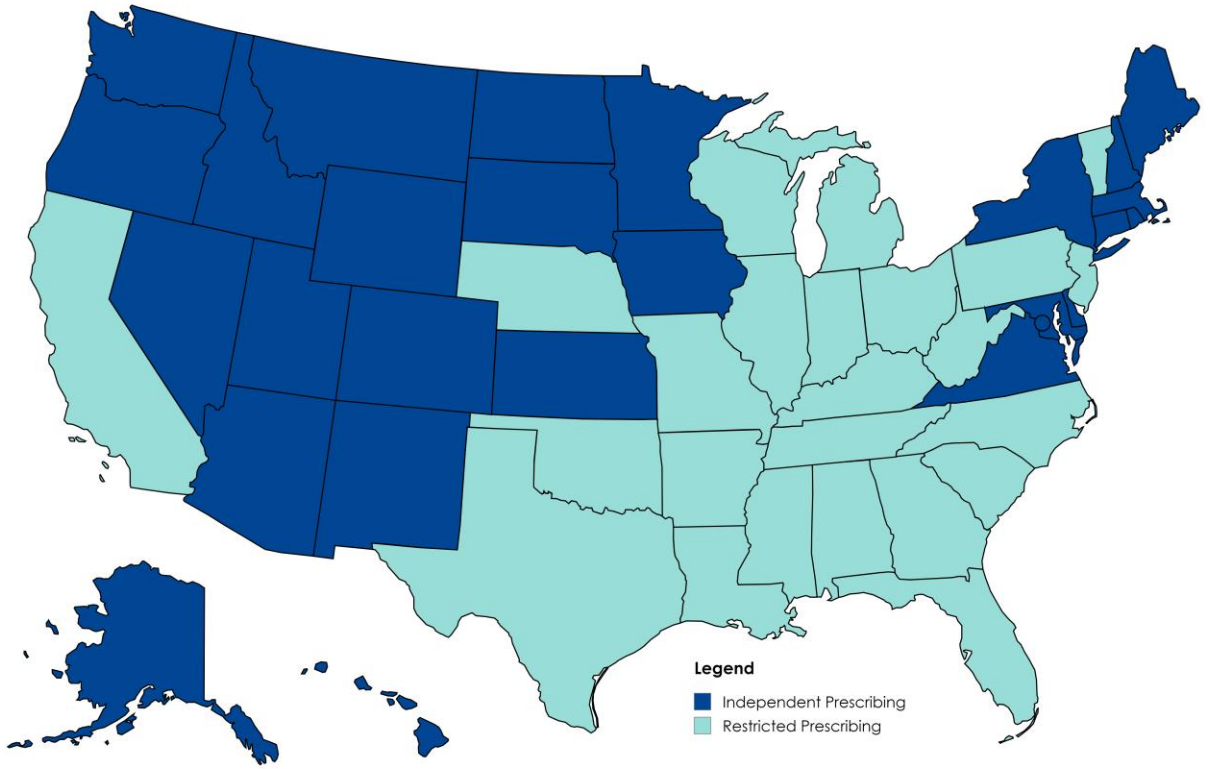
Prescriptive authority means the state recognizes the midwife as eligible to prescribe medications as part of patient care.

In twenty-seven states and the District of Columbia, midwives are granted independent prescribing authority that aligns with the midwife scope of practice. In other states, midwives must obtain a written contract with a physician to prescribe some or all medications for their patients. Six of these states offer a pathway to independent prescriptive authority after a time of supervised prescribing.

Restrictions on prescriptive authority may include all medications or be limited to narcotics used for labor pain management.

State restriction on prescribing abortifacients were not included in this map.

## Midwifery Prescriptive Authority, 2023



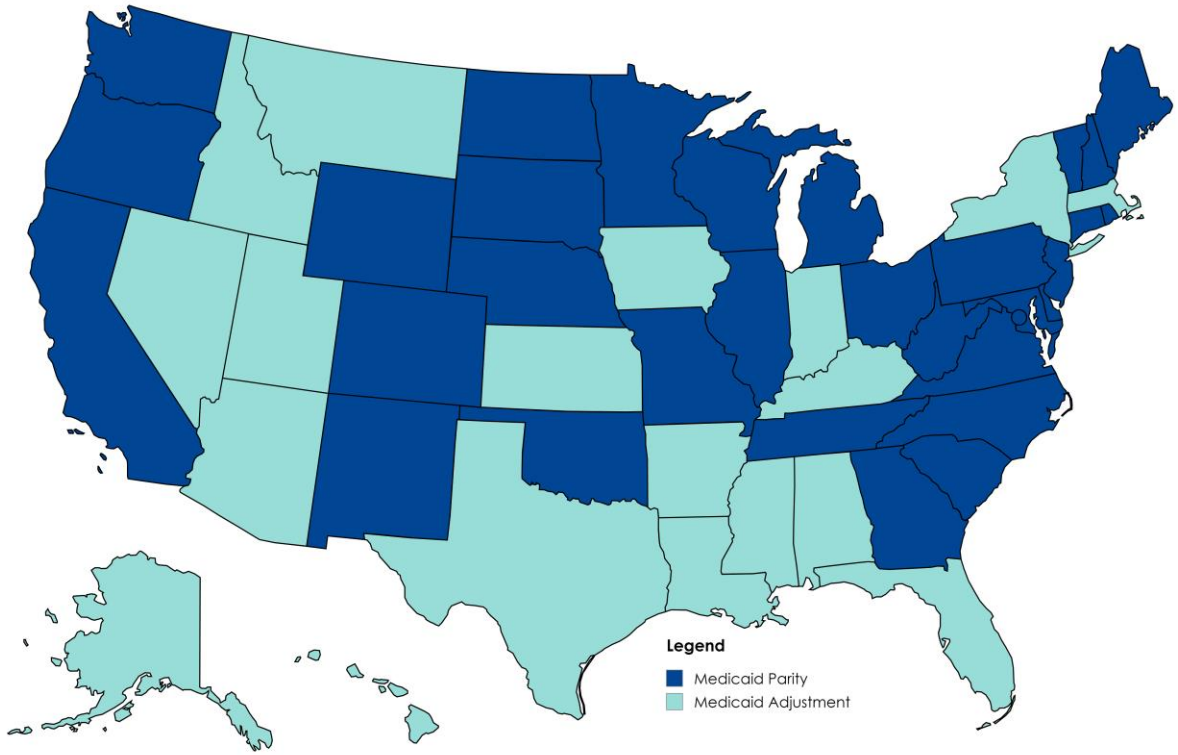

Data source: ACNM Review of state policies.

# Variations in Medicaid Reimbursement, 2023

In thirty-one states, Medicaid will reimburse midwives at the same rate as physicians. In the other states, midwives receive an adjusted fee that ranges from 75% of a physician fee to 97% of the physician fee.

Adjusting Medicaid reimbursement for midwives makes independent midwife practices unsustainable. A review of practice costs identified that in 24 of the 50 states, the actual costs of providing maternity care exceeds the payment received by midwives.

## Midwifery Medicaid Reimbursement, 2023



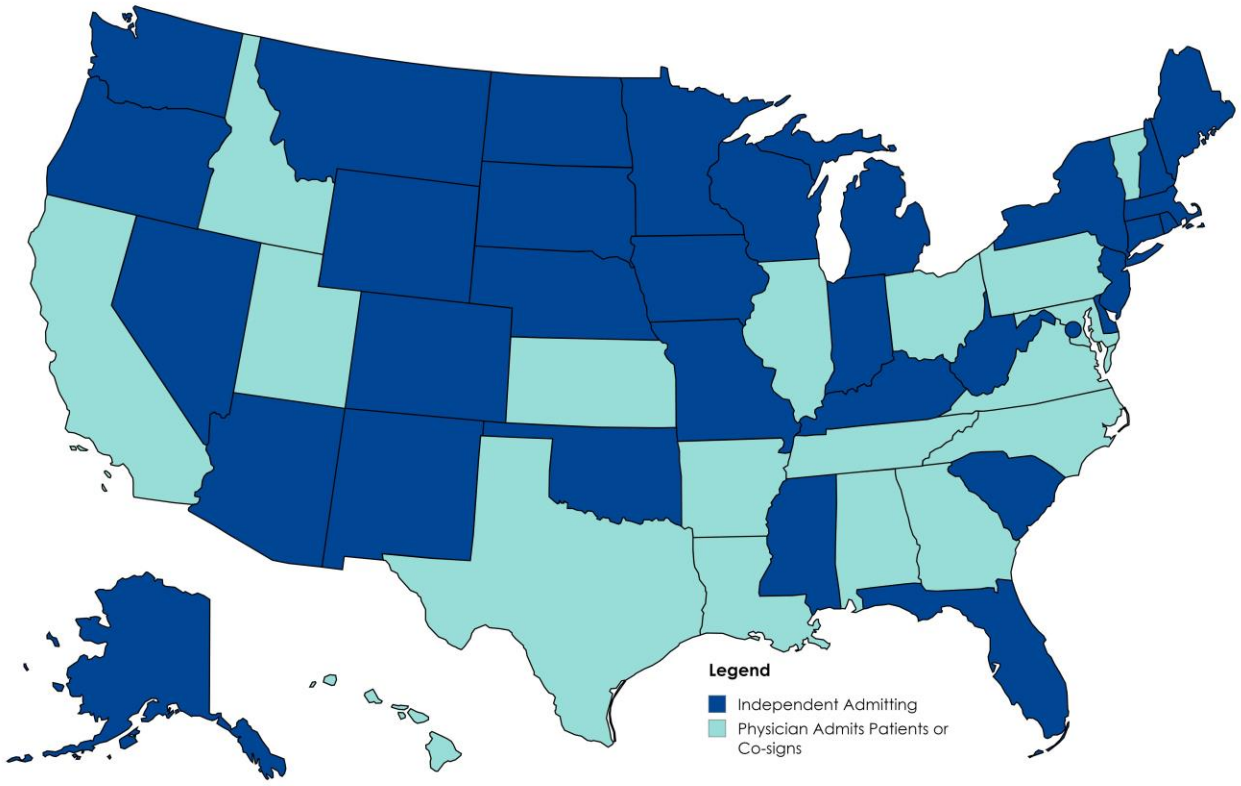

Reference: Baker, M. V., Butler-Tobah, Y. S., Famuyide, A. O., & Theiler, R. N. (2021). Medicaid Cost and Reimbursement for Low-Risk Prenatal Care in the United States. *Journal of midwifery & women's health*, *66*(5), 589–596. https://doi.org/10.1111/jmwh.13271

# Variations in Hospital Admitting

In thirty-three states and the District of Columbia, midwives can admit patients to the hospital for birth. In the other states, midwives must rely on physician colleagues to admit patients. In some instances, physician colleagues must cosign all midwife orders – creating a situation where two providers are asked to do the work of one.

Only two states (New Mexico, Oregon), and Washington DC have laws that specifically protect the right of midwives to join medical staff and have independent admitting privileges. In states where the right is not protected, the decision is made by individual hospitals.

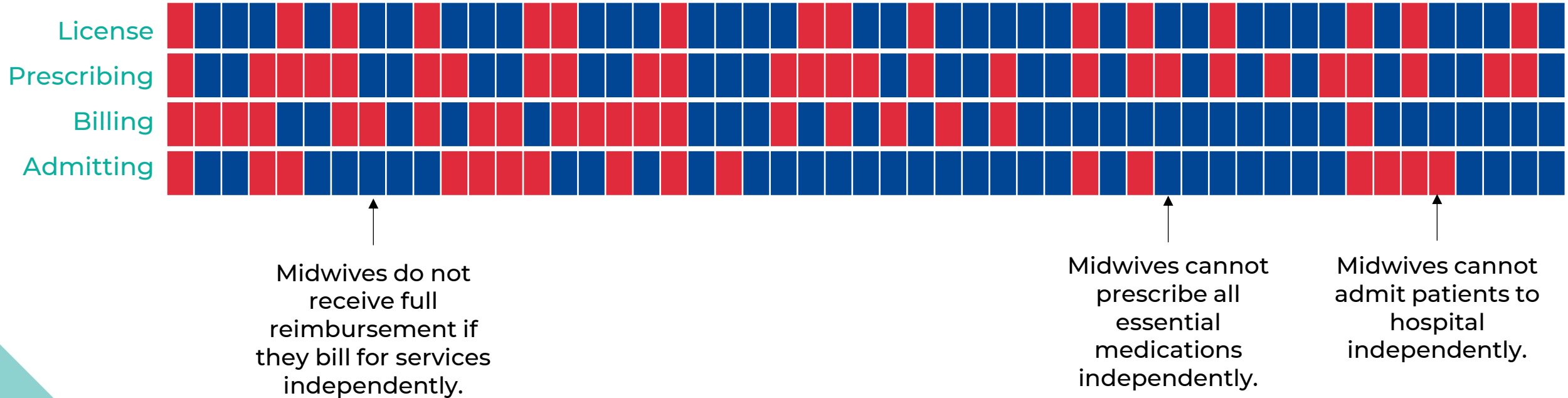
## Midwifery Hospital Admitting, 2023




Data source: ACNM Review of state policies.

# Lack of Standardization of Midwifery Regulation

There are four ways a state can restrict midwives' independent practice. Any restriction on midwife independence will link midwifery practice with physician practice, creating an environment where the supply of midwives is dependent on physician demand for midwife employees instead of consumer demand for midwife services. In this figure, each column represents a state. Blue represents an asset, and red is an opportunity. Each column represents a state, in alphabetical order.



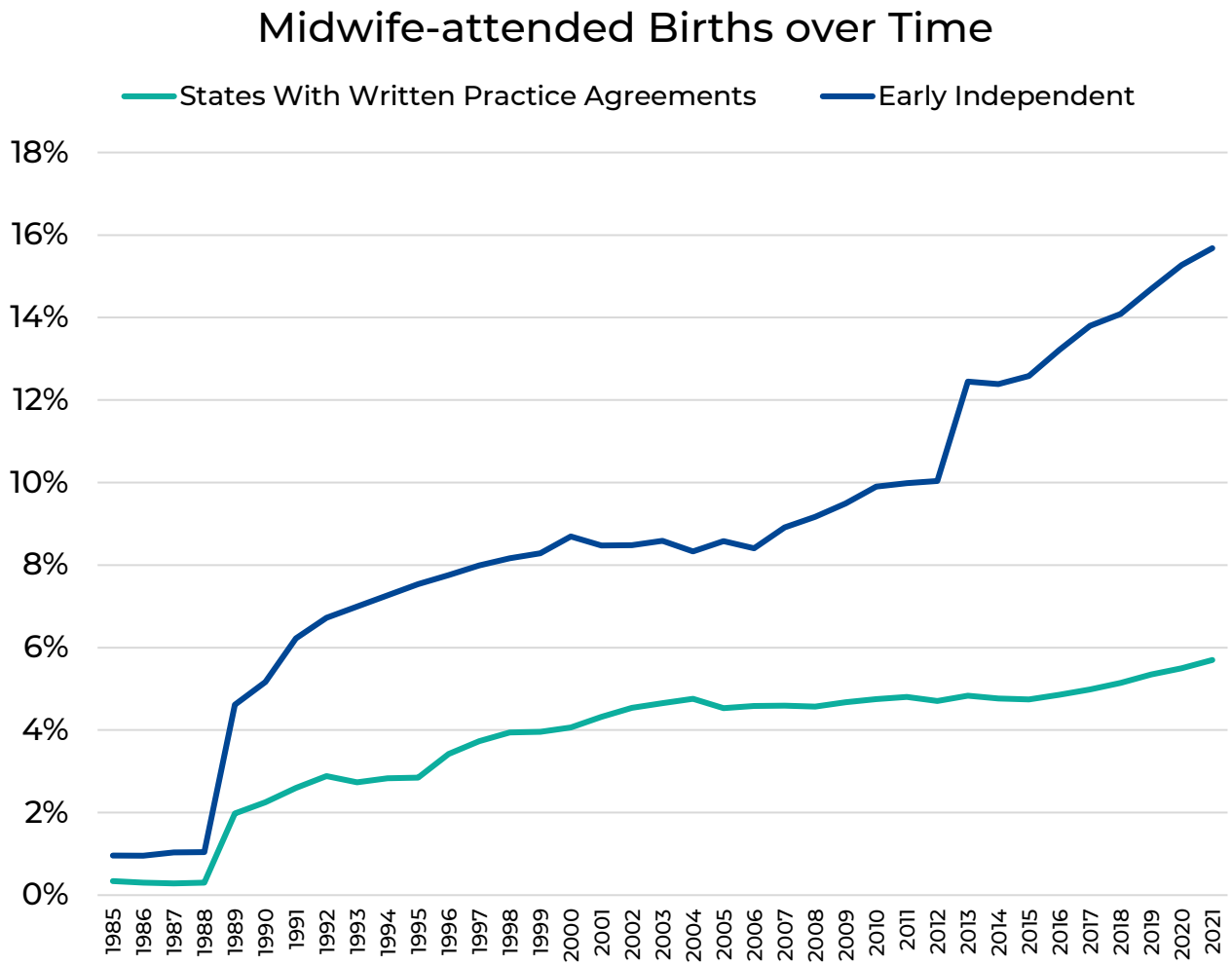
# Growth of the Midwifery Workforce

This graph only shows two groups of states. The blue line is the group of states that adopted early independent practice for midwifery. The red line is the average for the group of states that have always required a midwife to obtain a written practice agreement with a physician.

Prior to 1989, the profession of the birth attendant was not listed on the birth certificate if the birth occurred in hospitals.

These data show that states that adopted early independent midwifery practice experienced faster growth of the midwifery workforce than states that still restrict midwives by requiring written practice agreements with physicians.

Data Source: National Vital Statistics System Vital Statistics Natality Birth Data U.S. Data Files, Accessed through National Bureau of Economic Research (2023). Available at https://www.nber.org/research/data/vital-statistics-natality-birth-data



# Midwifery Independence and Workforce Size

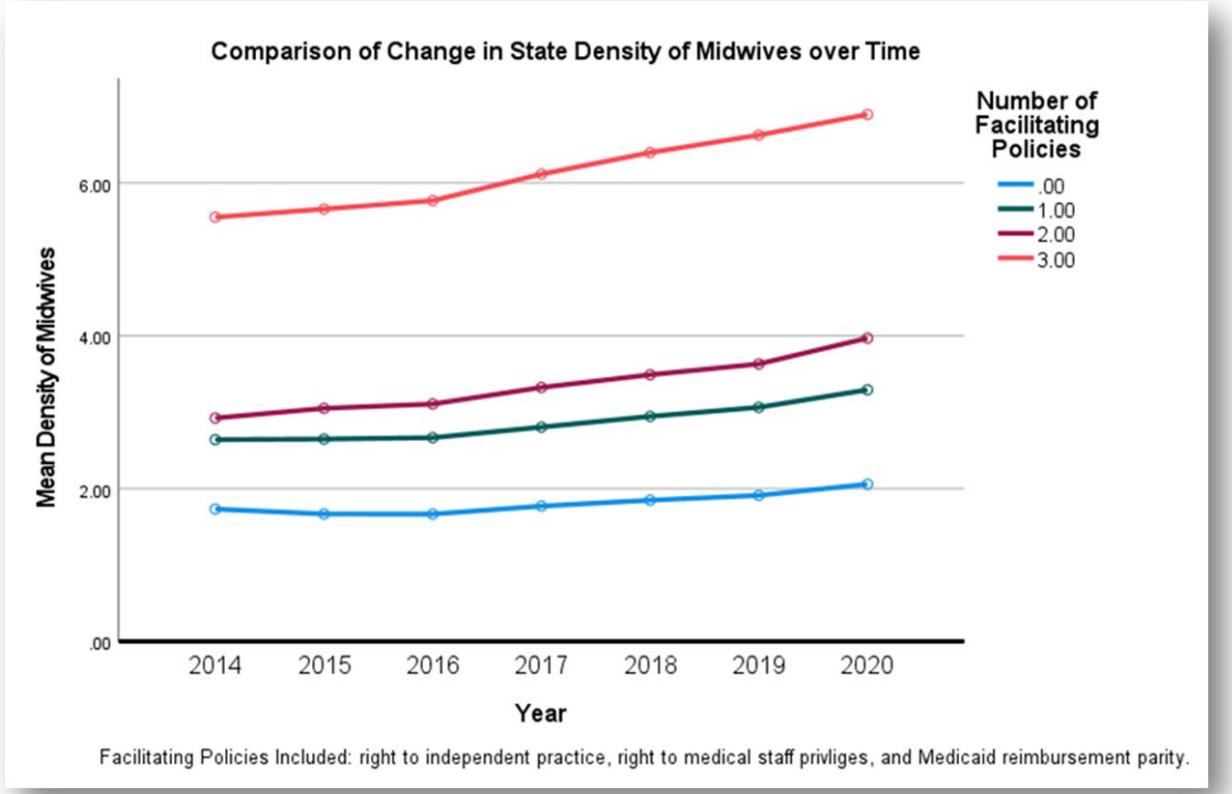
States have three policies that act as facilitators of midwifery practice:

Licensing midwives for full independent practice, including prescribing all essential medications

Reimbursing midwives the full Medicaid physician fee for services

Ensuring midwives can admit their clients to the hospital independently

States that adopt all three policies have a larger midwifery workforce, and experience faster growth of the midwifery workforce, than states that adopt 2, 1 or none of these policies.

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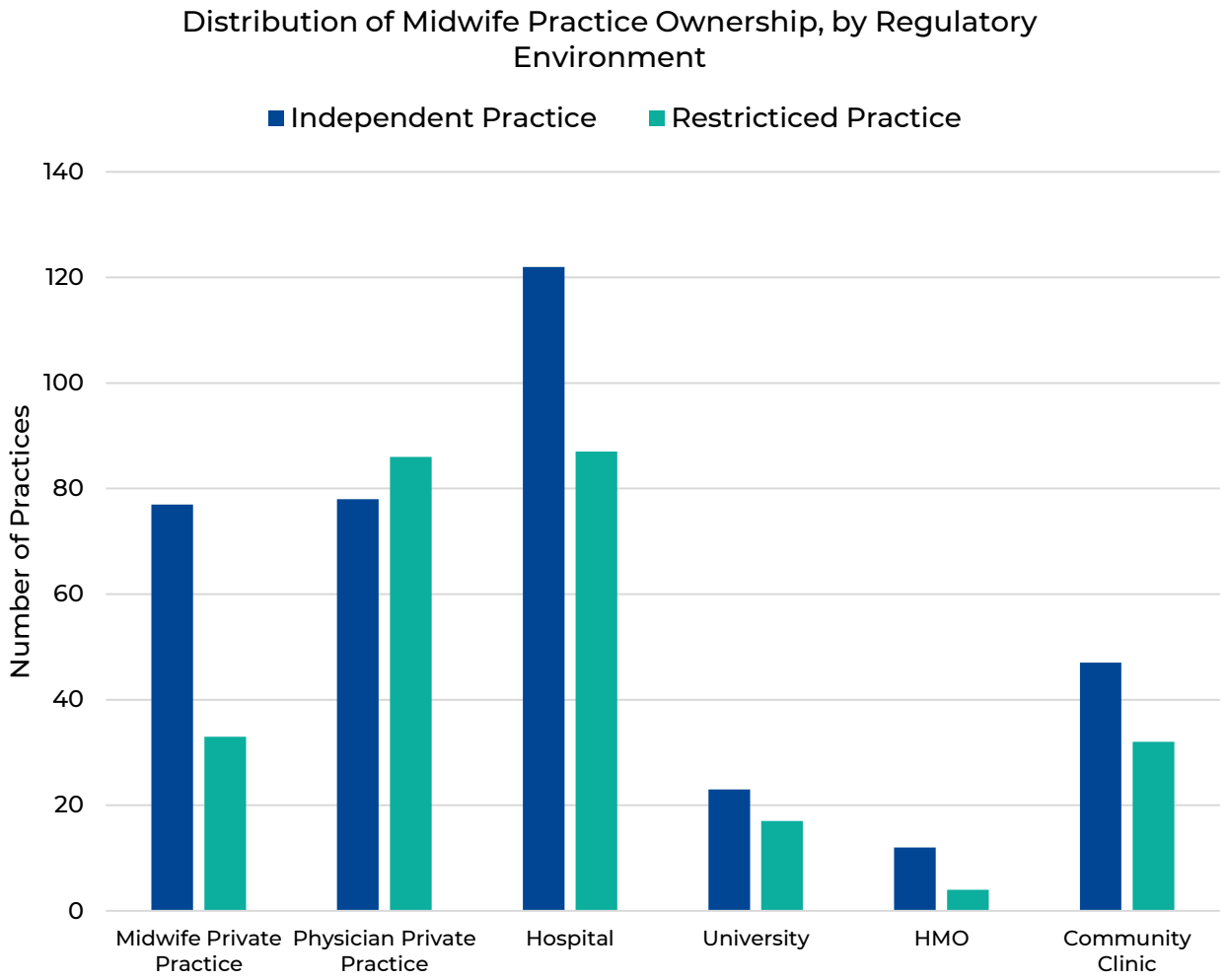
# Midwife Practice Ownership

Most midwife clinical practices are privately owned, or hospital owned. Practice ownership varied by state midwife regulation.

In states with independent midwifery practice, most practices are owned by hospitals and equal proportions of practices are owned by midwives and physicians.

In states that requires a written practice agreement, physicians and hospitals own equal proportions of practices while midwives own the same proportion of practices as community clinics (12.4%, 12.0%).

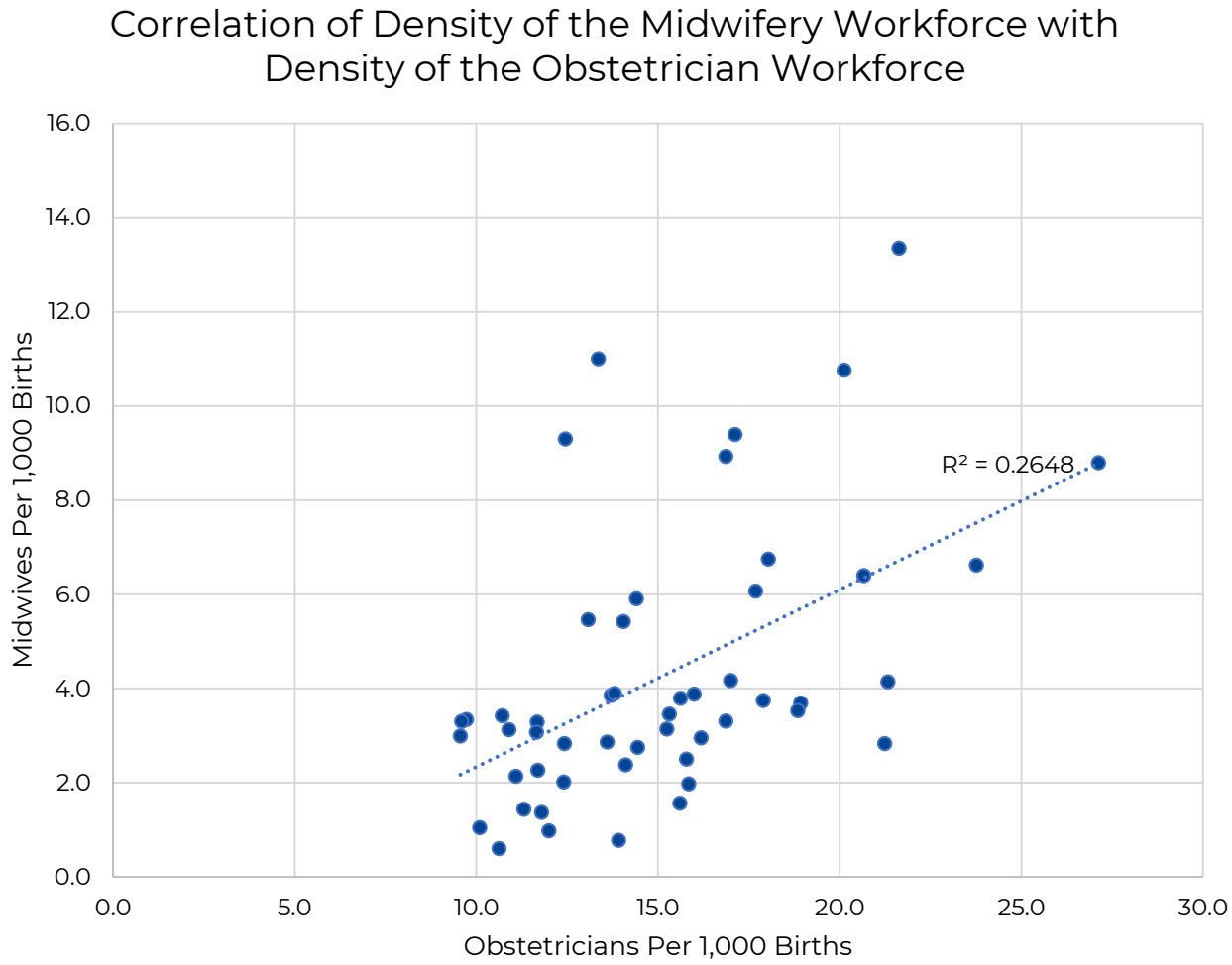
Restricted midwifery practice appears to shift the supply of midwifery practices to physician demand for midwifery colleagues rather than consumer demand for midwifery services.




Data Source: ACNM Midwifery Workforce Committee 2021 COVID-19 Practice Survey. N = 727 completed surveys that reported on the practices of 3301 midwives.

# Correlation of Density of Midwives with Density of Obstetricians

Comparing the state density of midwives to the density of obstetricians reveals a linear correlation that suggests, in general, states with more obstetricians also have more midwives.



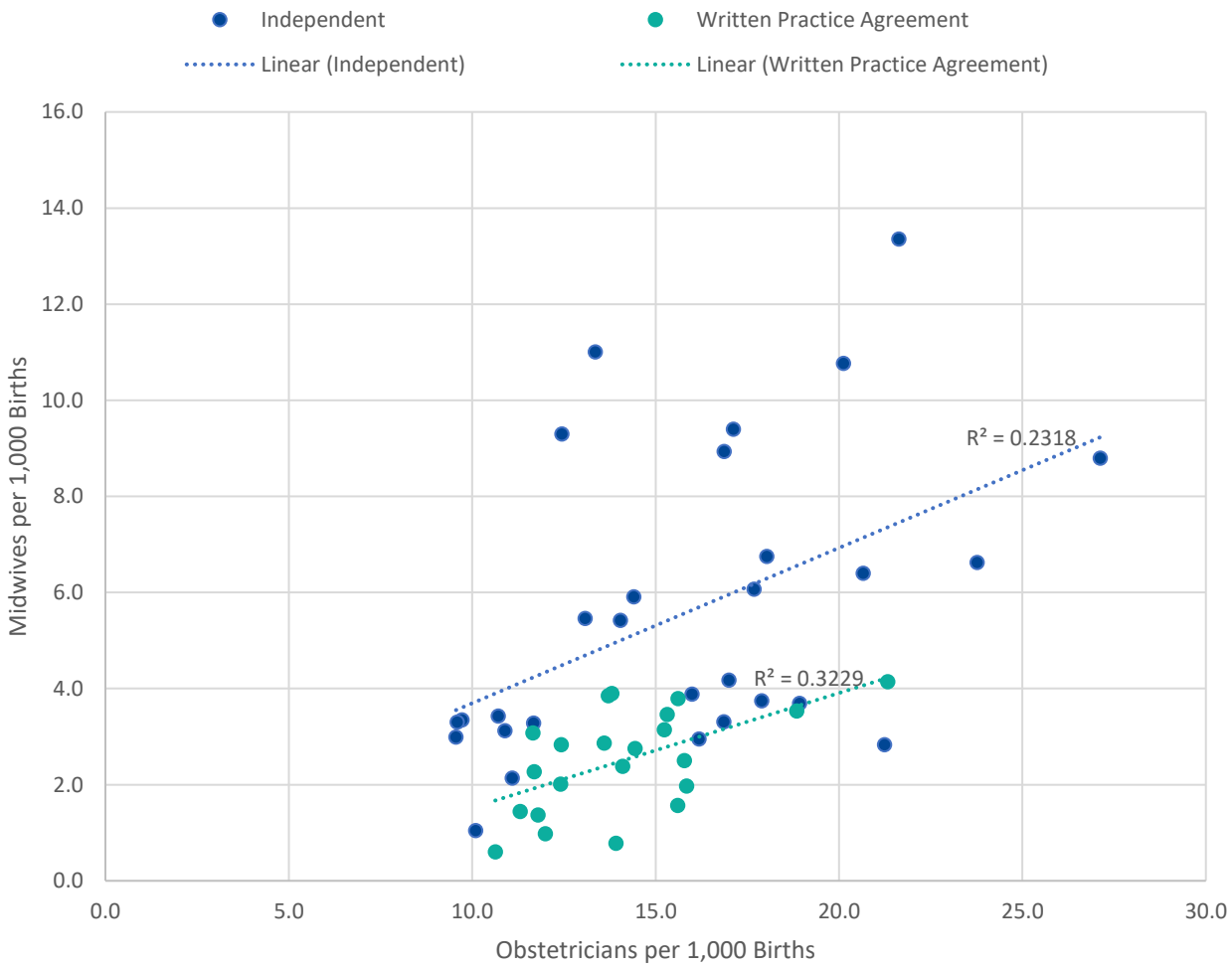

Data Sources: National Plan and Provider Enumeration System (NPPES) Data Dissemination File, August 2022.

# Role of Independent Midwifery Practice on the Correlation of Density of Midwives with Density of Obstetricians

Comparing the correlation of density of midwives to density of obstetricians in restricted compared to independent states reveals that the correlation is stronger in states that require a written collaborative agreement.

This finding supports the conclusion that written practice agreements shift the supply of midwives from consumer demand for midwifery services to physician demand for midwife colleagues.

Written practice agreements prevent expansion of the workforce by requiring growth of the obstetrician workforce before the midwifery workforce can expand.



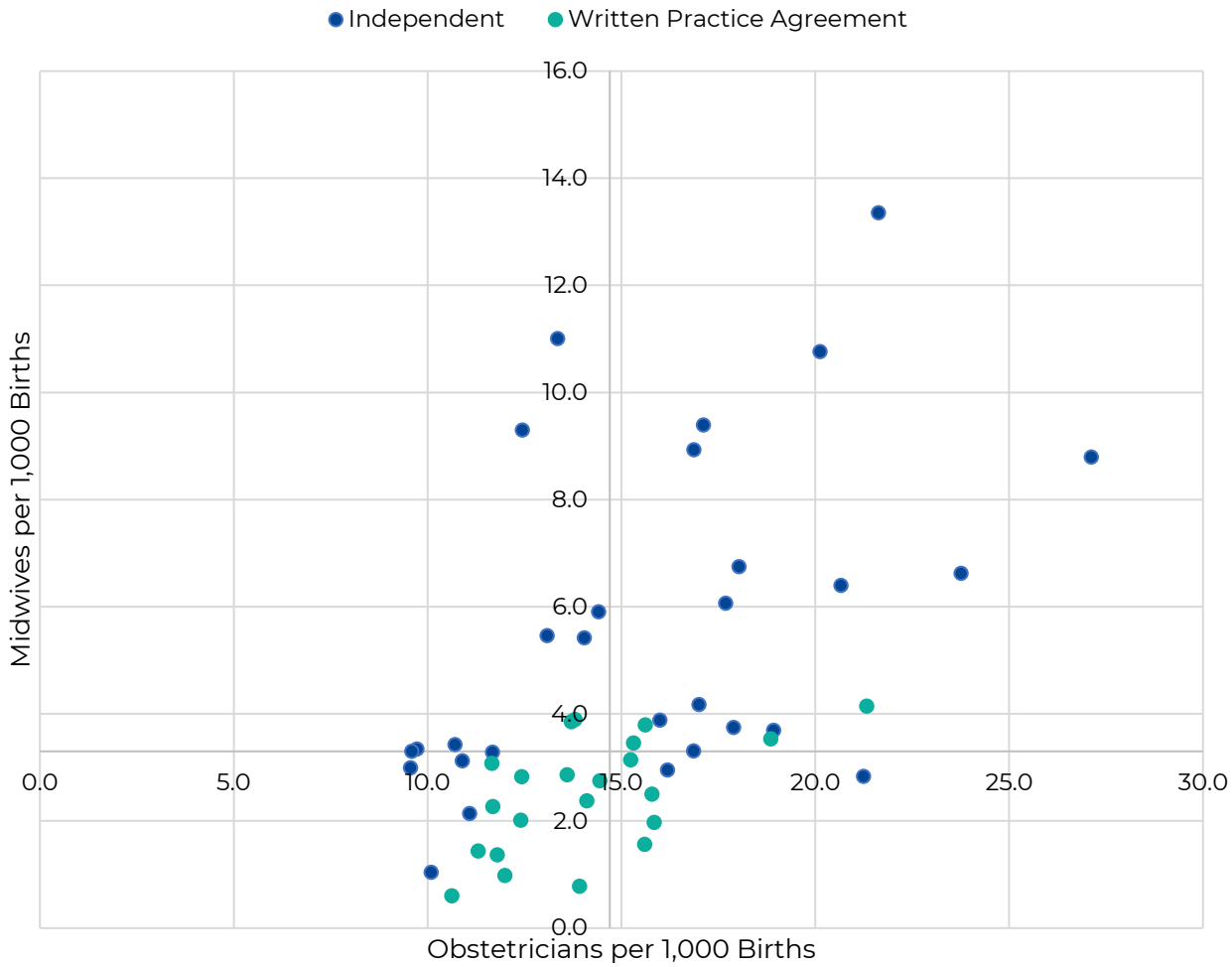

Data Sources: National Plan and Provider Enumeration System (NPPES) Data Dissemination File, August 2022.

# Role of Independent Midwifery Practice on the Density of Midwives with Density of Obstetricians

States with independent midwifery practice are less likely to have a lower-than-average density of both midwives and obstetricians (16% vs 50%).

In contrast, states with independent practice are more likely to have an above average density of both midwives and obstetricians (43% vs 19%).

This suggests that states with independent midwifery practice have policy environments that are more favorable for all types of sexual and reproductive healthcare.



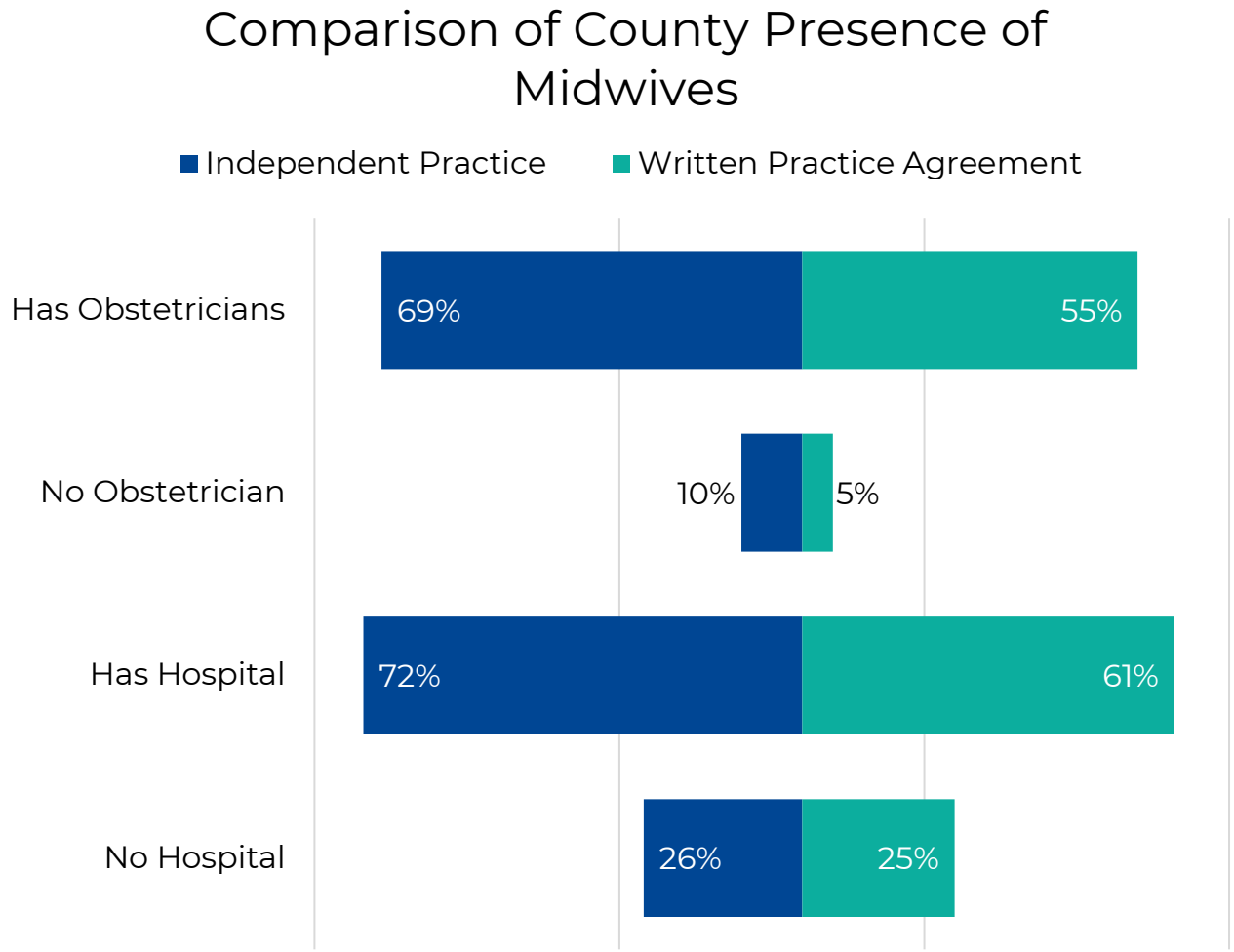

Data Sources: National Plan and Provider Enumeration System (NPPES) Data Dissemination File, August 2022.

# Distribution of Midwives

Midwives are in more counties in states with independent practice than states that require a written practice agreement (46.3% vs 39.2%; p<.001).

Midwives are in more counties with obstetricians and more counties with hospitals in states with independent practice compared to states with written practice agreements.

Midwives are in more counties without obstetricians in states with independent practice compared to states with written practice agreements, which supports the claim that written practice agreements prevent midwives from working where there are no obstetricians.

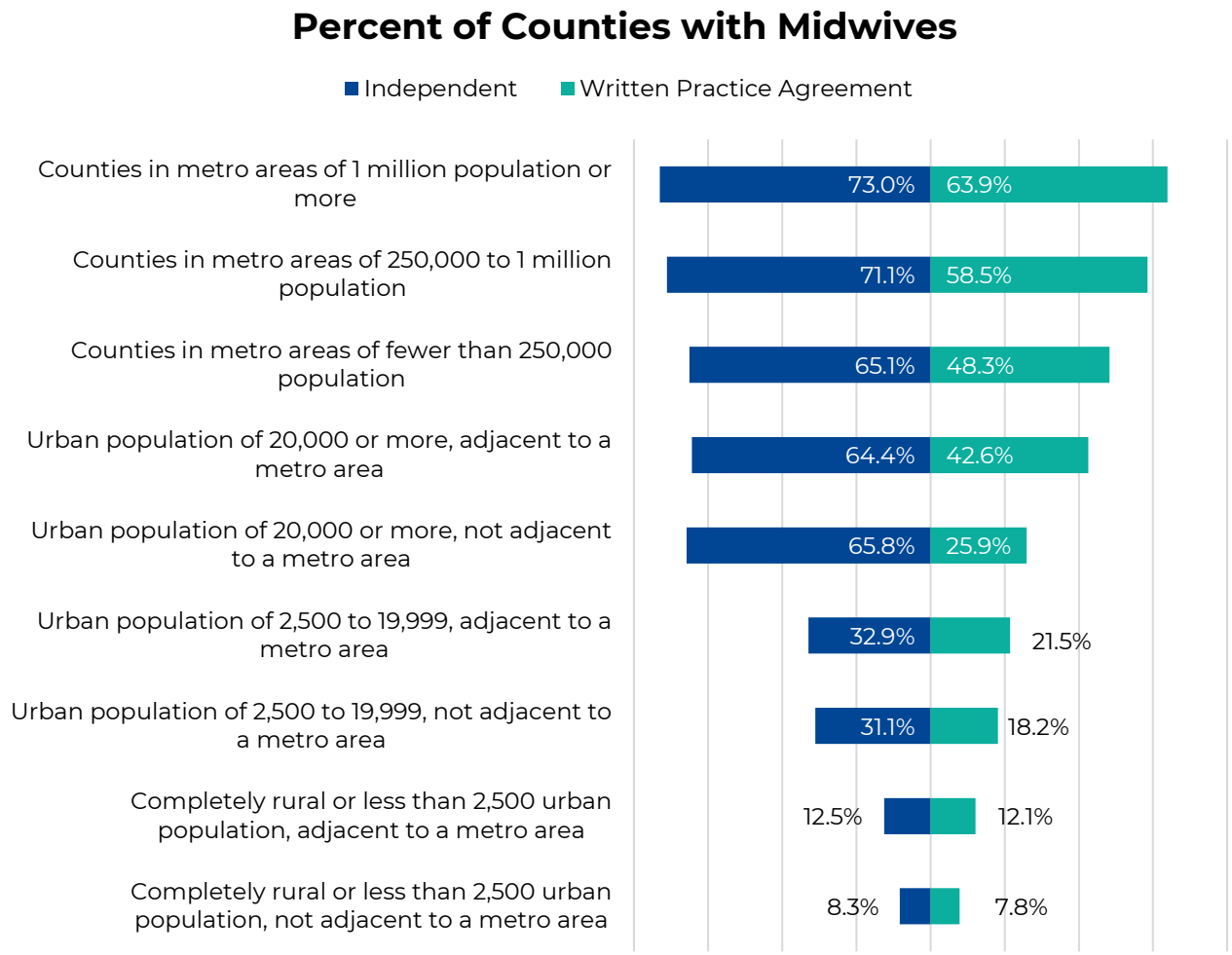



Data Sources: National Plan and Provider Enumeration System (NPPES) Data Dissemination File, August 2022.

# Percent of counties with midwives by Rural Urban Continuum Code, Restricted vs Independent Practice States

Restricted practice states have more counties than independent states (2105 vs. 1037). Independent and restricted states have a similar proportion of metro counties (34.7% vs 38.3%), but independent practice states have a larger proportion of completely rural counties (25.2% vs 18.2%).

States with independent midwifery practice have a higher proportion of counties with midwives for seven of the nine categories of the rural-urban continuum.



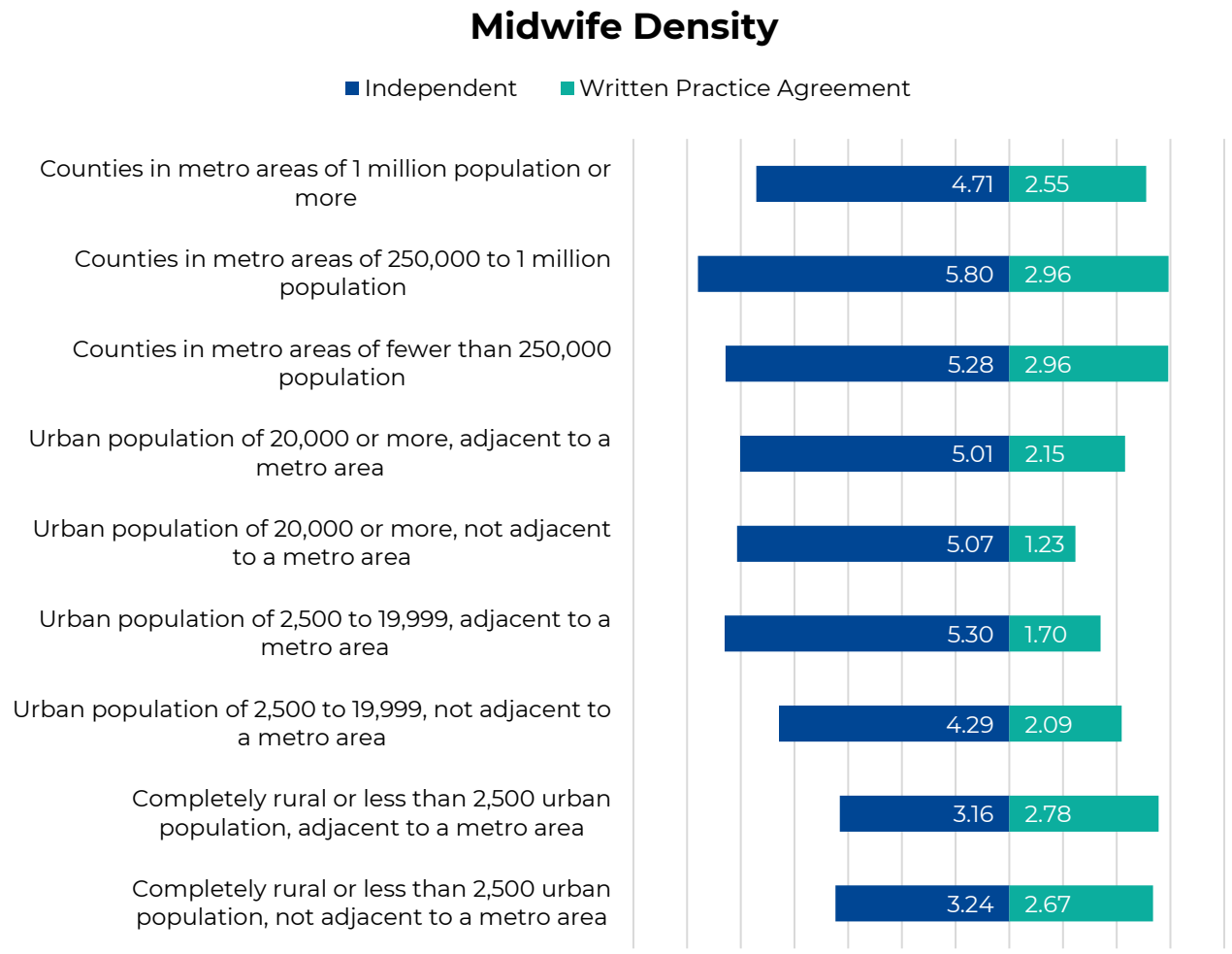

Data Sources: National Plan and Provider Enumeration System (NPPES) Data Dissemination File, August 2022.

# Midwife Density by Rural Urban Continuum Code, Restricted vs Independent Practice States

Most midwives (88.7%; n=10,550) work in metro counties. Of the rest, 7.1% (n=850) work in counties adjacent to a metro area and 4.1% (n=489) in a county not adjacent to a metro area. In 2023, only 1% (n=131) of midwives work in counties that are completely rural.

The national density of midwives is 3.32 midwives per 1,000 births.

Calculating midwife density for each county category allows the description of midwife density across the rural-urban continuum. States with independent midwifery practice have a higher density of midwives in all county categories.

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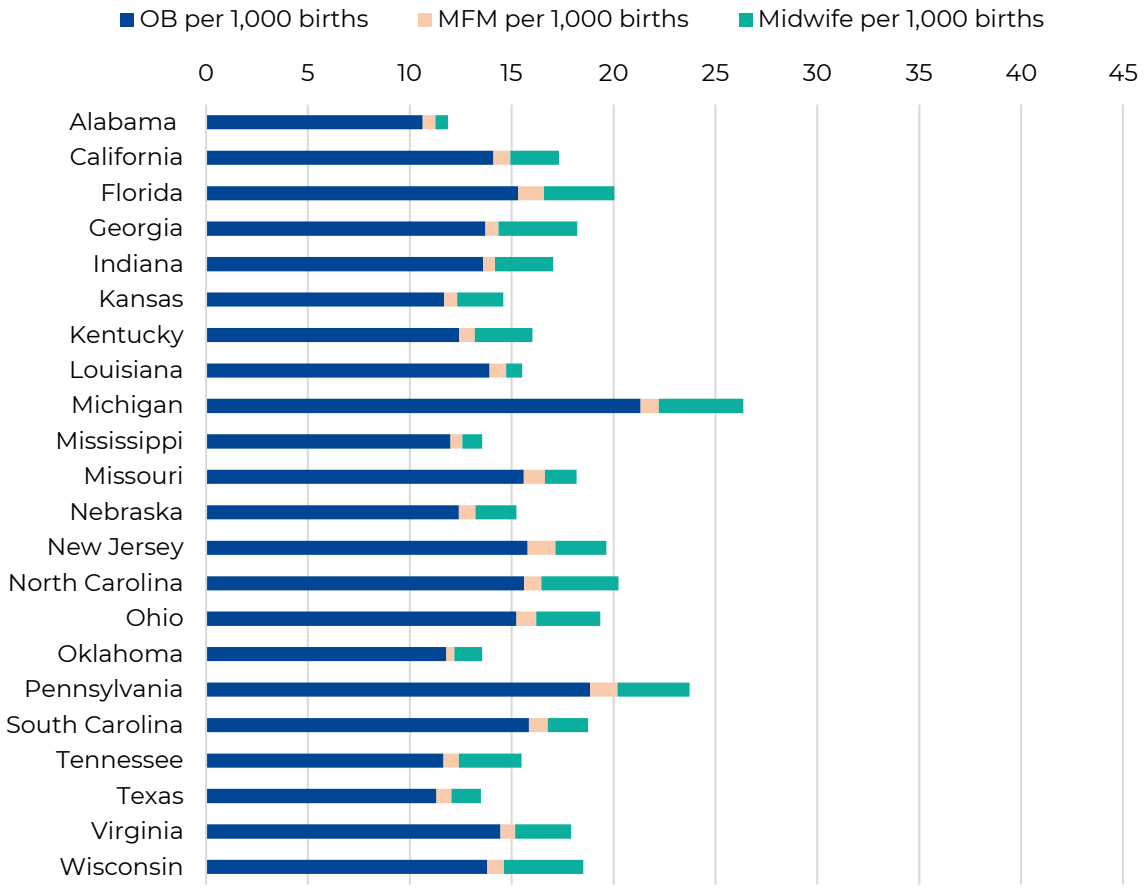
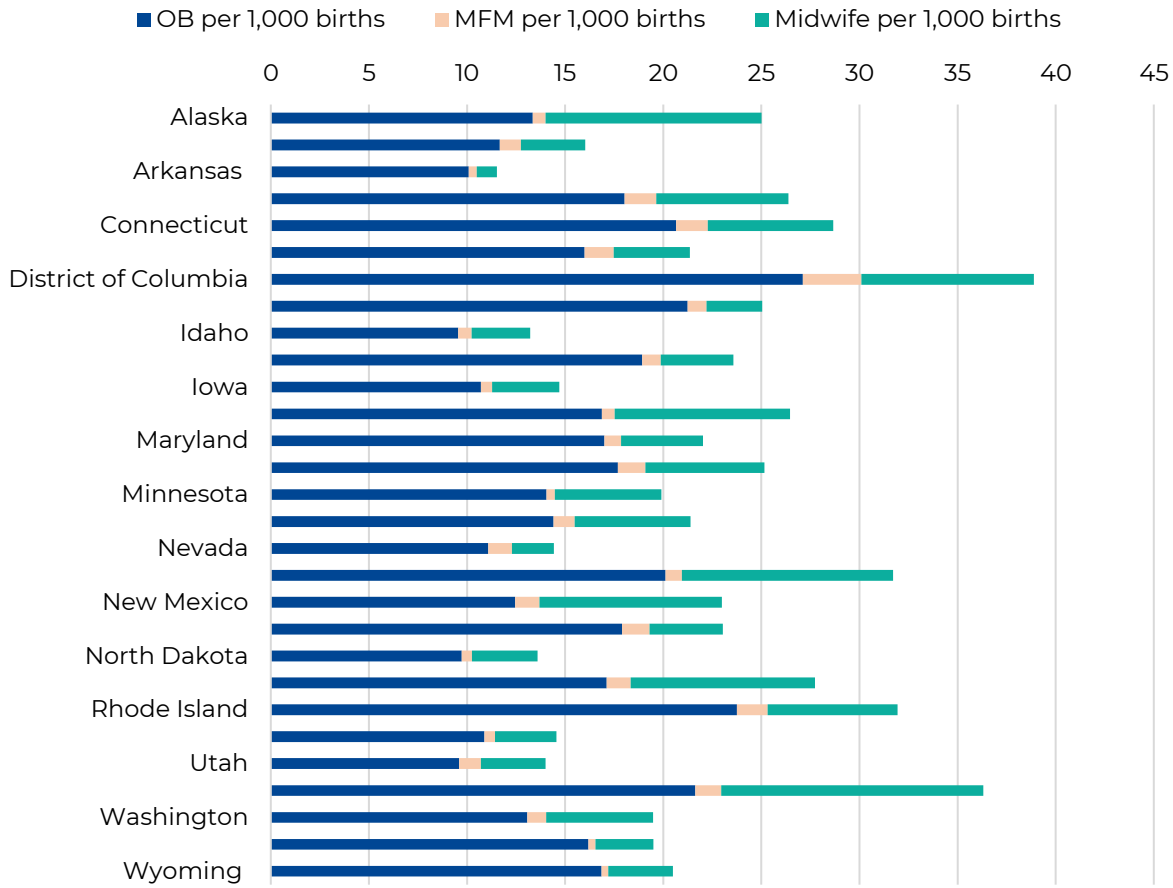
# Comparing Density of the Workforce by Midwifery Regulation

## States Requiring Written Practice Agreements




## States with Independent Midwifery Practice



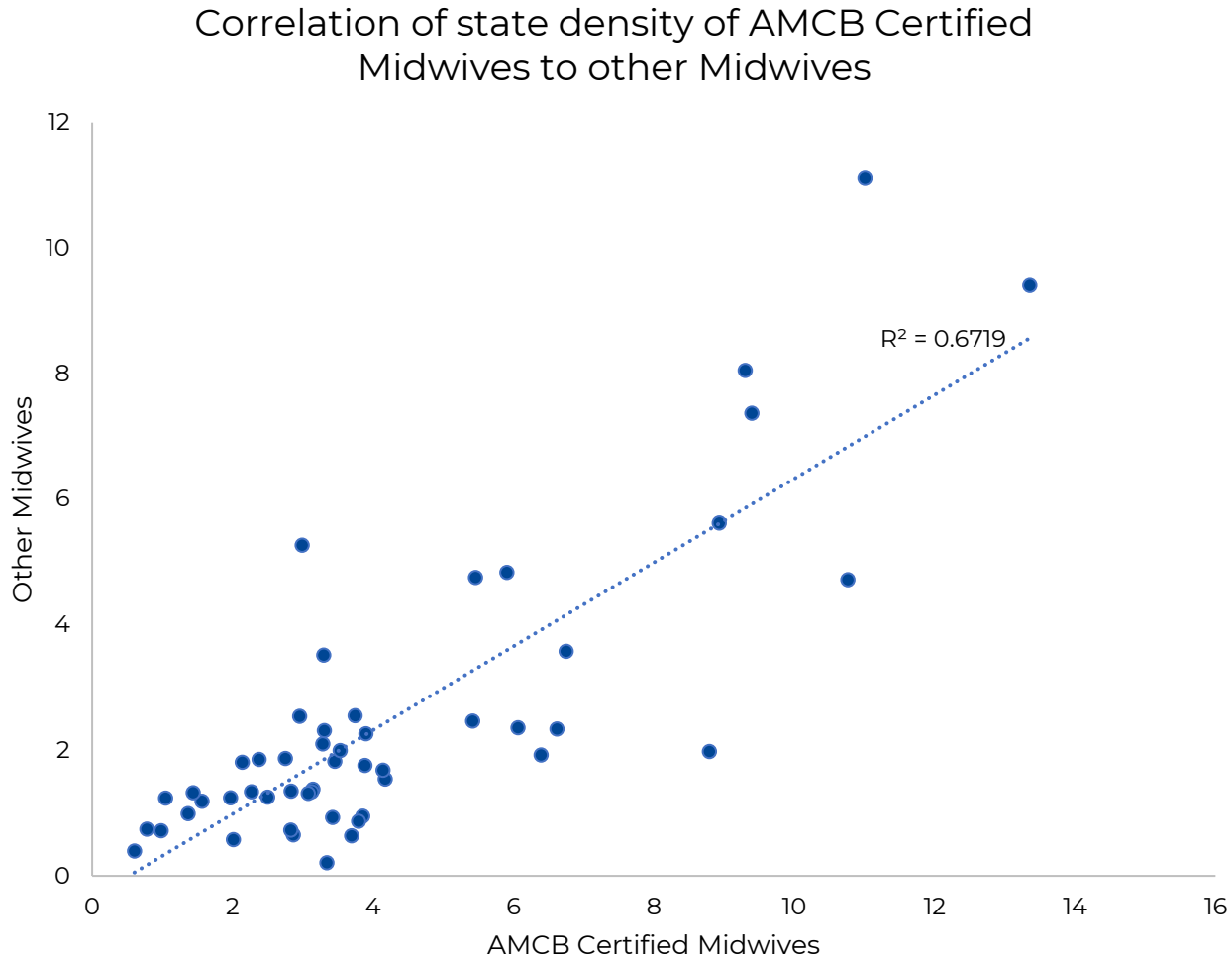

Data Sources: National Plan and Provider Enumeration System (NPPES) Data Dissemination File, August 2022.

# Density of Midwives by Certification

In the United States, there are two pathways to certification as a midwife. The American Midwifery Certification Board (AMCB) oversees Certified Nurse-Midwives and Certified Midwives. Other midwives are prepared for home and birth center settings and can be certified by the North American Registry of Midwives (NARM).

Though AMCB certified midwives and other midwives are regulated by different boards and receive practice authority through different statues in most states, there is a strong correlation in their densities.

This suggests that state acceptance of midwives as a part of the healthcare workforce is the driver of the size of the midwifery workforce.



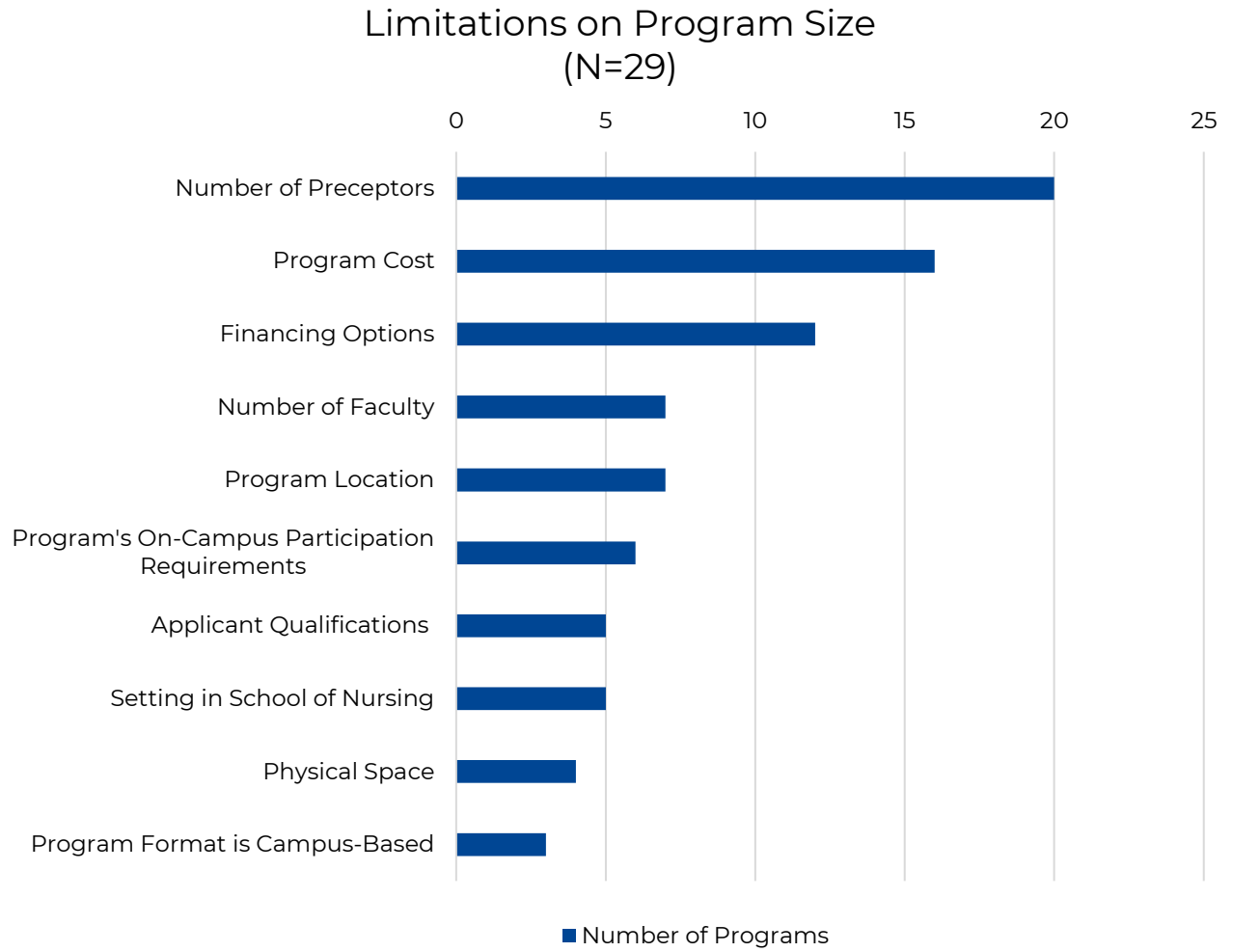

Data Sources: National Plan and Provider Enumeration System (NPPES) Data Dissemination File, August 2022.

# Limitations on Midwifery Education Program size

Twenty-nine midwifery education program directors provided responses to the survey question about the main limitation on increasing the number of students.

The most common limitation to growing midwifery education programs is than inadequate number of preceptors, which translates to a shortage of clinical sites.

Other limitations include program costs to students and financing the program.

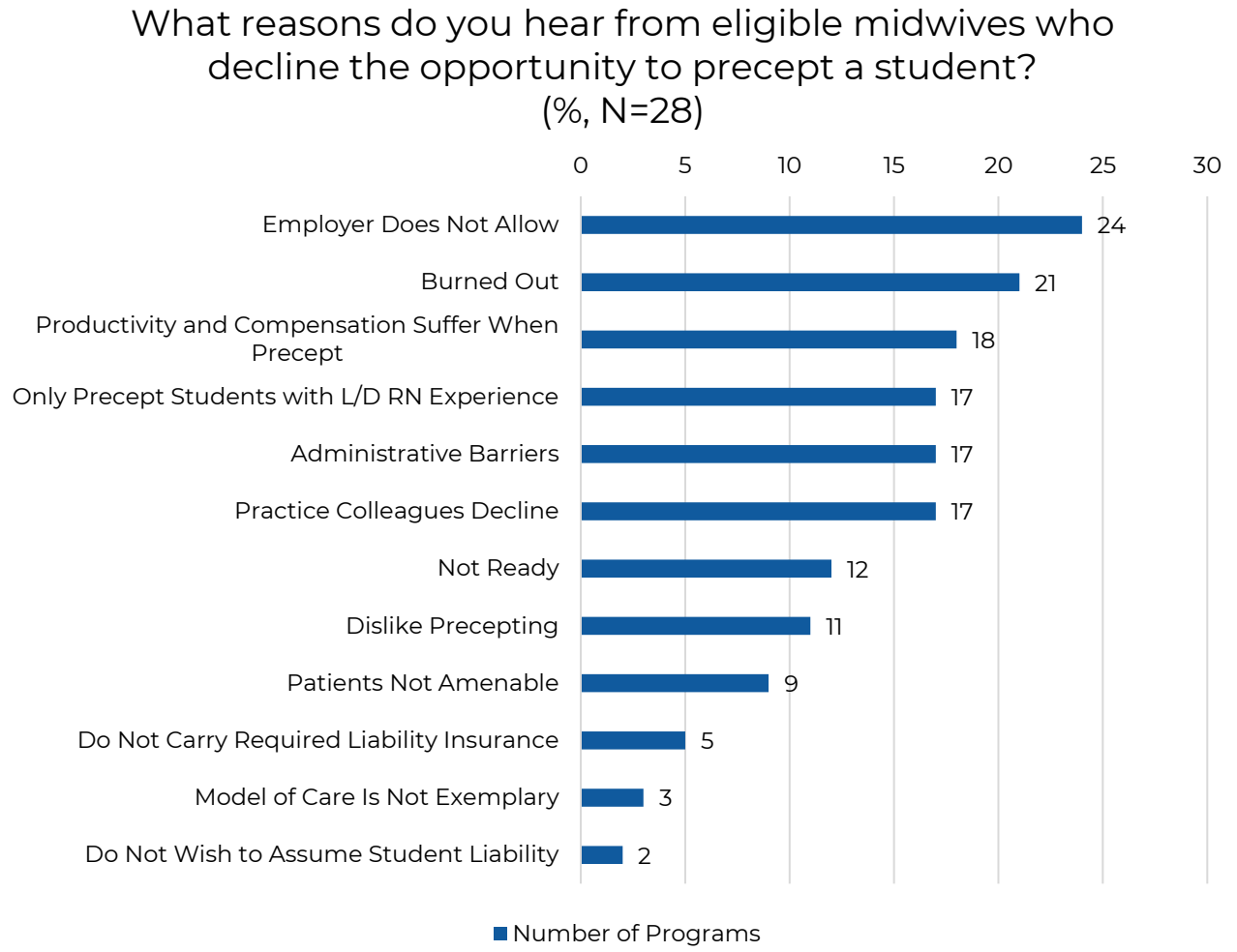



Data Source: ACNM Faculty Survey, Fall 2022.

# Reasons midwives decline to precept a student

The most common reason midwifery education program directors are told a midwife must decline the opportunity to precept students is that the employer does not allow the midwife to precept.

Program directors also reported commonly hearing that midwives are “burned out” from precepting or that their productivity and compensation suffer when they precept.



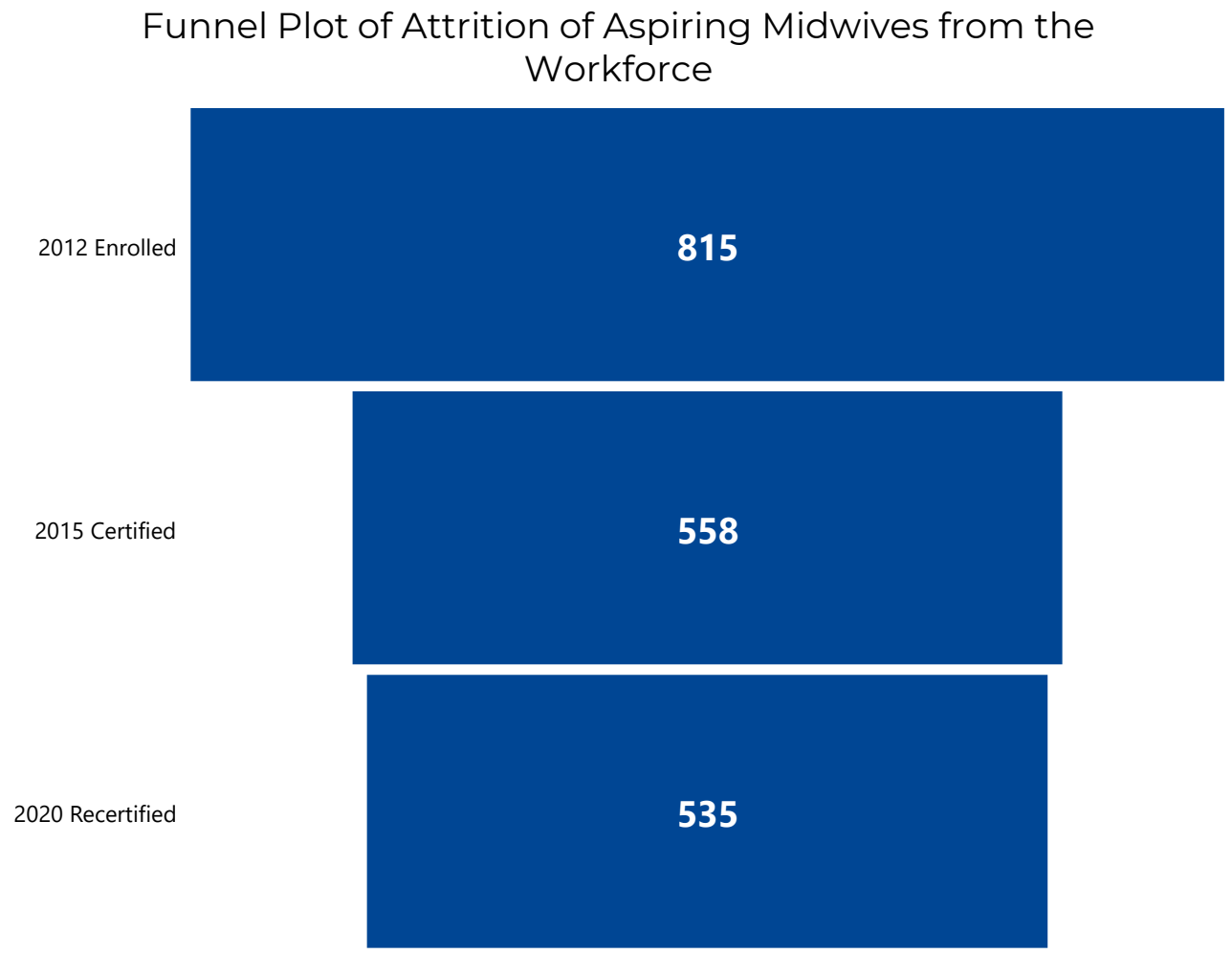

Data Source: ACNM Faculty Survey, Fall 2022.

# Attrition of aspiring midwives from the workforce

A total of 815 student midwives began midwifery education programs in 2012.

Data is not available to track the number of enrolled students who complete midwifery programs and become certified. To estimate attrition, we assume midwifery students who enrolled in 2012 would have been certified during the 2014 or 2015 calendar year. Based on the number of first time certificants in 2015, we estimate between 20 – 30% of these students did not become certified within three years of enrollment.

Of the 558 midwives who certified for the first time in 2015, 535 (95.9%) recertified during the 2020 recertification cycle.



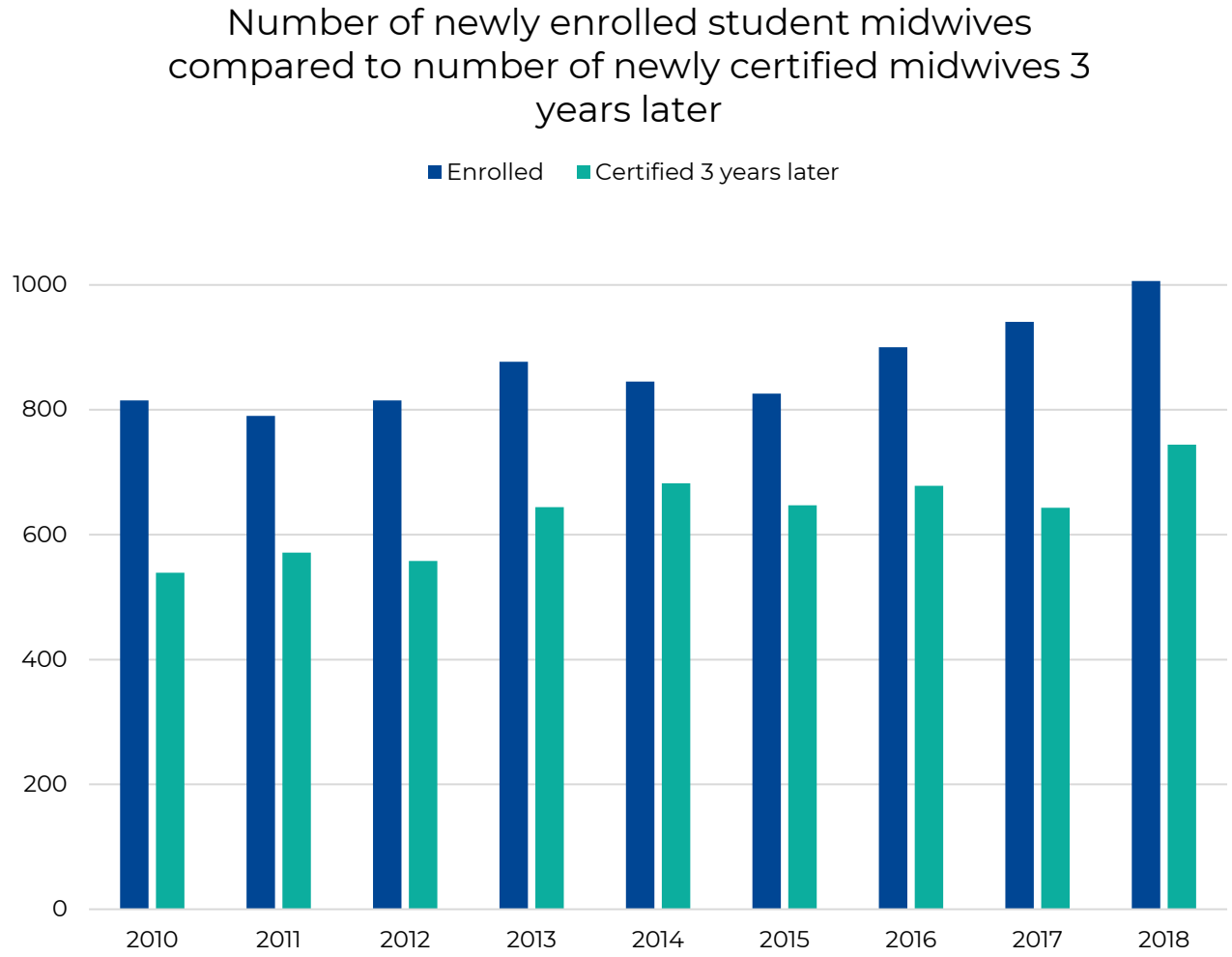

Data sources: Midwifery Education Trends Report, 2013; AMCB Annual Report 2015; AMCB Annual Report 2020.

# Attrition before certification

By examining the trends in midwifery education program enrollment and first-time certification 3 years a later, we see an increase in the number of students but relatively stable attrition prior to certification.

Trends in midwifery education 2019 demonstrated that the number of new certificants each year is slightly less than the number of new graduates. Using certification data suggests a 20-30% attrition rate for midwifery education.

The most recent attrition report was published in 2011. At that time, between 6% and 16% of student midwives withdrew from programs.



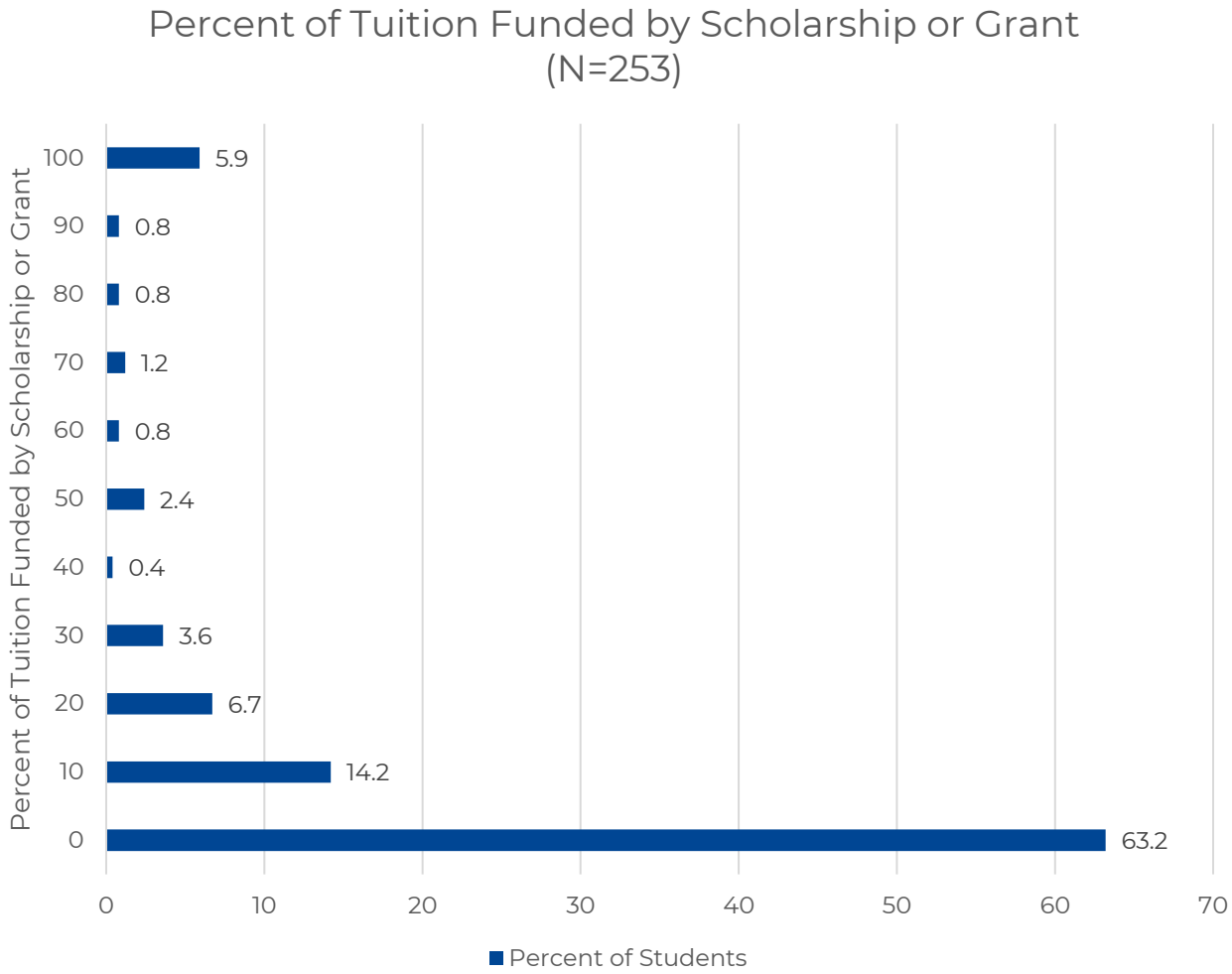

Data Sources: Midwifery Education Trends Reports; American Midwifery Certification Board Annual Reports.

# Funding for Midwifery Education

Most (63.2%) students in midwifery education programs receive no scholarships or grants to help fund their midwifery education. An additional 24.5% receive funding that covers less than 40% of their costs.

The majority of students in midwifery education programs are working and attending school part-time. Most (60%) work at least 20 hours per week; more than half (55%) provide at least half of the family income.

Data Source: ACNM Student Survey, Summer 2022.



# Race and ethnic categories of midwives, 2016-2020

Among midwives currently in the workforce, most midwives (84.4%) reported their race category as white or Caucasian.

Midwives first certified during 2016-2020 were more likely to report their race or ethnic categories as Asian, Black of African American, or Hispanic or Latino.

This suggests the profession is attracting a more diverse student population. Data was not available to examine retention.

| | All Midwives n=11,963 | Midwives > 5 Years n=8,765 | Newly Certified Midwives n=3,198 | *p* |
|---|---|---|---|---|
| American Indian, Alaskan Native, Native Hawaiian or Pacific Islander | 67 (0.6%) | 45 (0.5%) | 22 (0.7%) | .264 |
| Asian | 221 (1.9%) | 130 (1.5%) | 91 (2.9%) | <.001 |
| Black or African American | 833 (7.0%) | 553 (6.3%) | 280 (8.8%) | <.001 |
| Hispanic or Latino | 603 (5.0%) | 388 (4.4%) | 215 (6.7%) | <.001 |
| White or Caucasian | 10137 (84.4%) | 7580 (86.5%) | 2557 (79.6%) | <.001 |
| More than One Race | 102 (0.9%) | 69 (0.8%) | 33 (1.0%) | .198 |

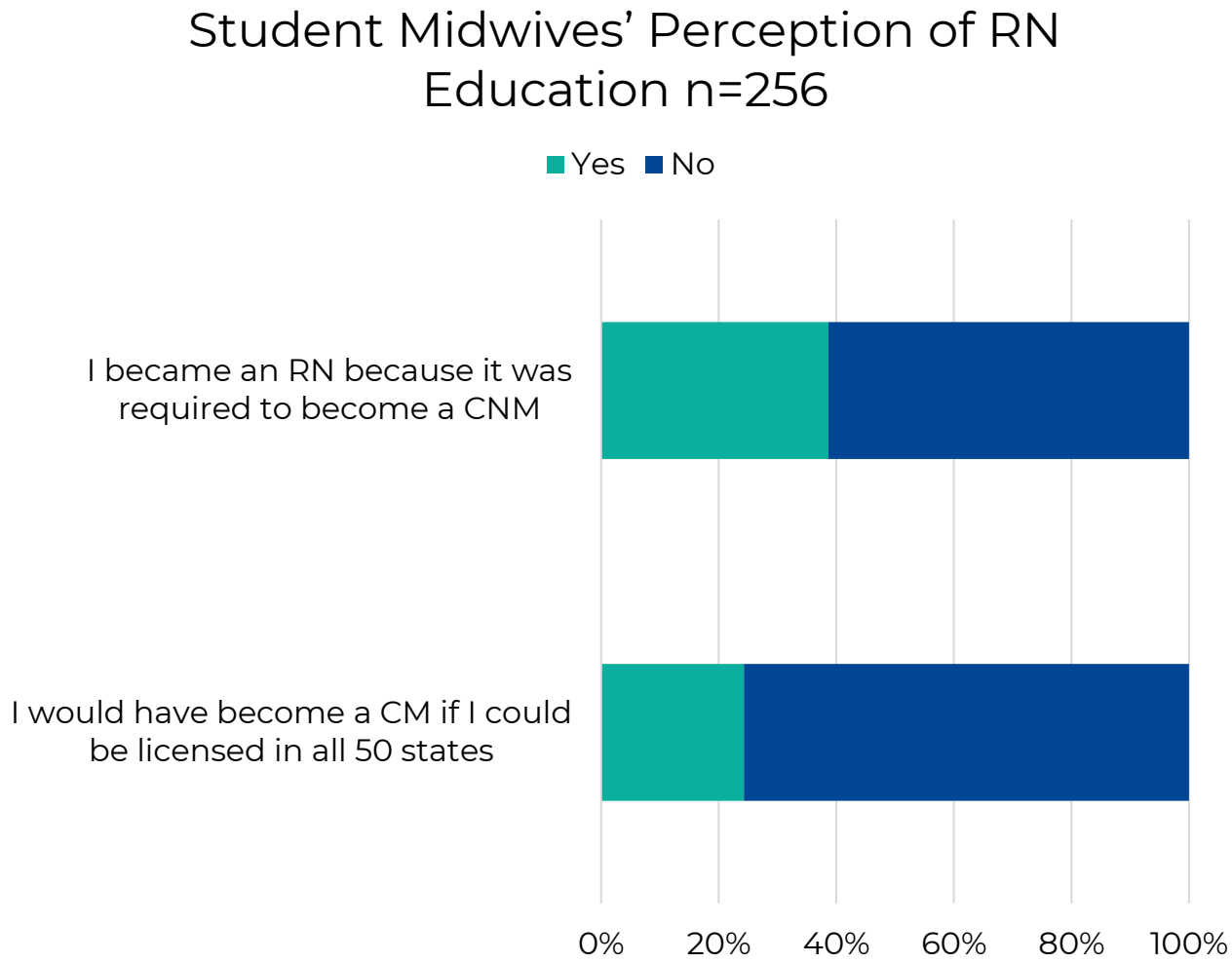
Data Source: AMCB Certification Data, 2016-2020.

# Opportunities to expand midwifery education

Certified Nurse-Midwives (CNMs) can be licensed in all 50 states. Certified Midwives (CMs) can be licensed in 11 states plus the District of Columbia. The major difference is that education programs for CNMs require students to pursue education and licensure as a nurse before entering or while enrolled in midwifery education.

Nearly two-fifths (37.9%) of midwifery students reported they became an RN because it was required to become a CNM.

Nearly a quarter (23.4%) reported they would have chosen to become a Certified Midwife if they could be licensed in all 50 states.




Data Source: ACNM Student Survey, Summer 2022

# Experience as a nurse prior to midwifery education

Almost one-quarter of midwives applying for certification as Certified Nurse-Midwives for the first time between 2016 and 2020 worked as a nurse for less than one year (22.6%), including 15.5% who never worked as a nurse.

Midwives in states with midwifery education programs were more likely to begin midwifery education with one year or less of nurse practice (26.6%) than midwives in states without a midwifery education program (12.9%).

| | All Midwives n=2,386 | Midwives of Color n=451 | White Midwives n=1,874 | *p* |
|---|---|---|---|---|
| No RN practice | 421 (17.6%) | 66 (14.6%) | 344 (18.4%) | .638 |
| 1 Year | 171 (7.2%) | 34 (7.5%) | 136 (7.3%) | .559 |
| 2 – 4 years | 604 (25.3%) | 133 (29.5%) | 458 (24.4%) | .027 |
| 5 – 9 years | 648 (27.2%) | 134 (29.7%) | 493 (26.3%) | .144 |
| 10 or more years | 542 (22.7%) | 84 (18.6%) | 443 (23.6%) | .022 |

Data Source: AMCB Certification Data, 2016-2020.

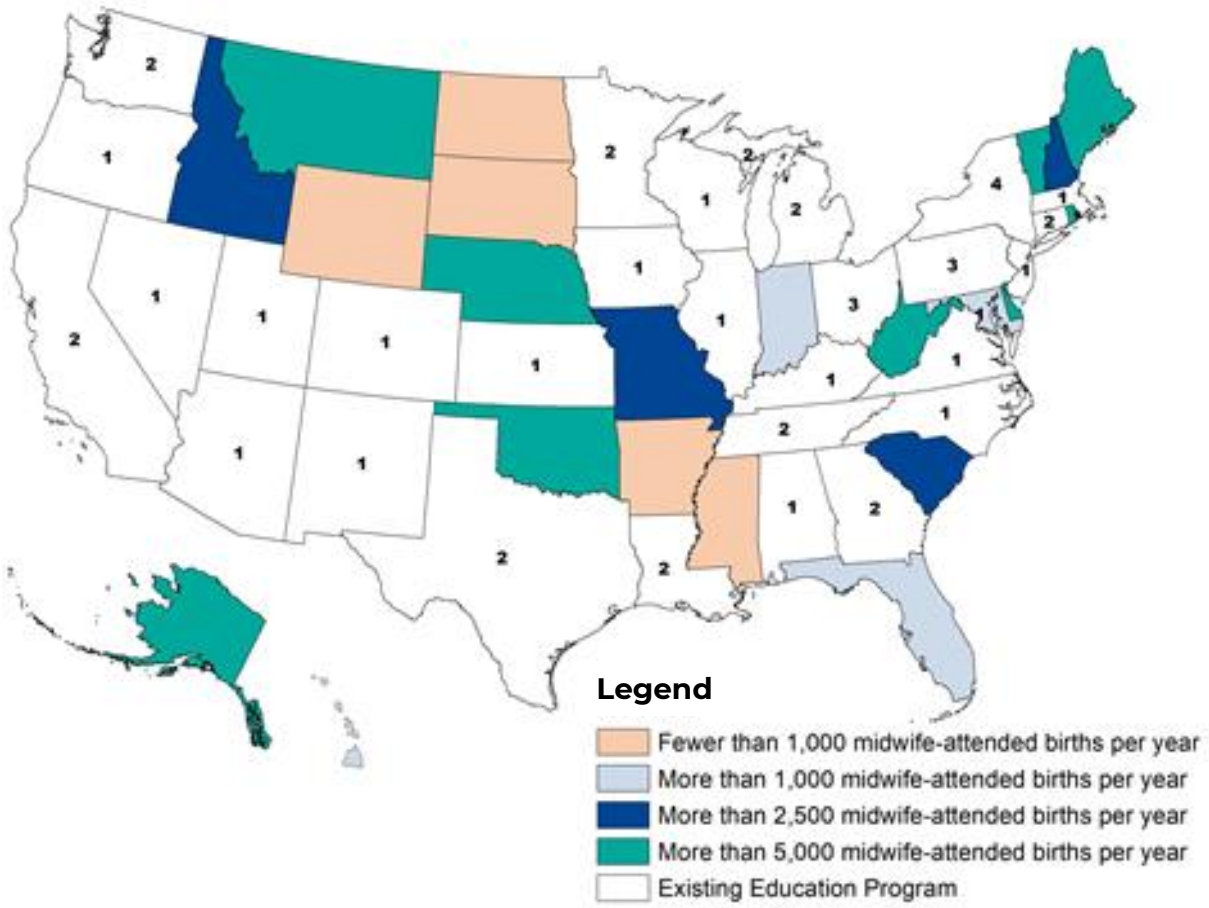
# Increasing access to midwifery education

This map shows the number of midwife education programs per state or the number of midwife-attended births per year for states without midwifery education programs.

Increasing access to midwifery education requires a multi-level approach to ensure future midwives can:

- Enroll in programs that are recognized by their state regulatory board
- Participate in clinical preceptorship within the full scope of midwifery practice
- Finance their education and progress to graduation in a timely manner

## Opportunities to Expand Midwifery Education, 2023



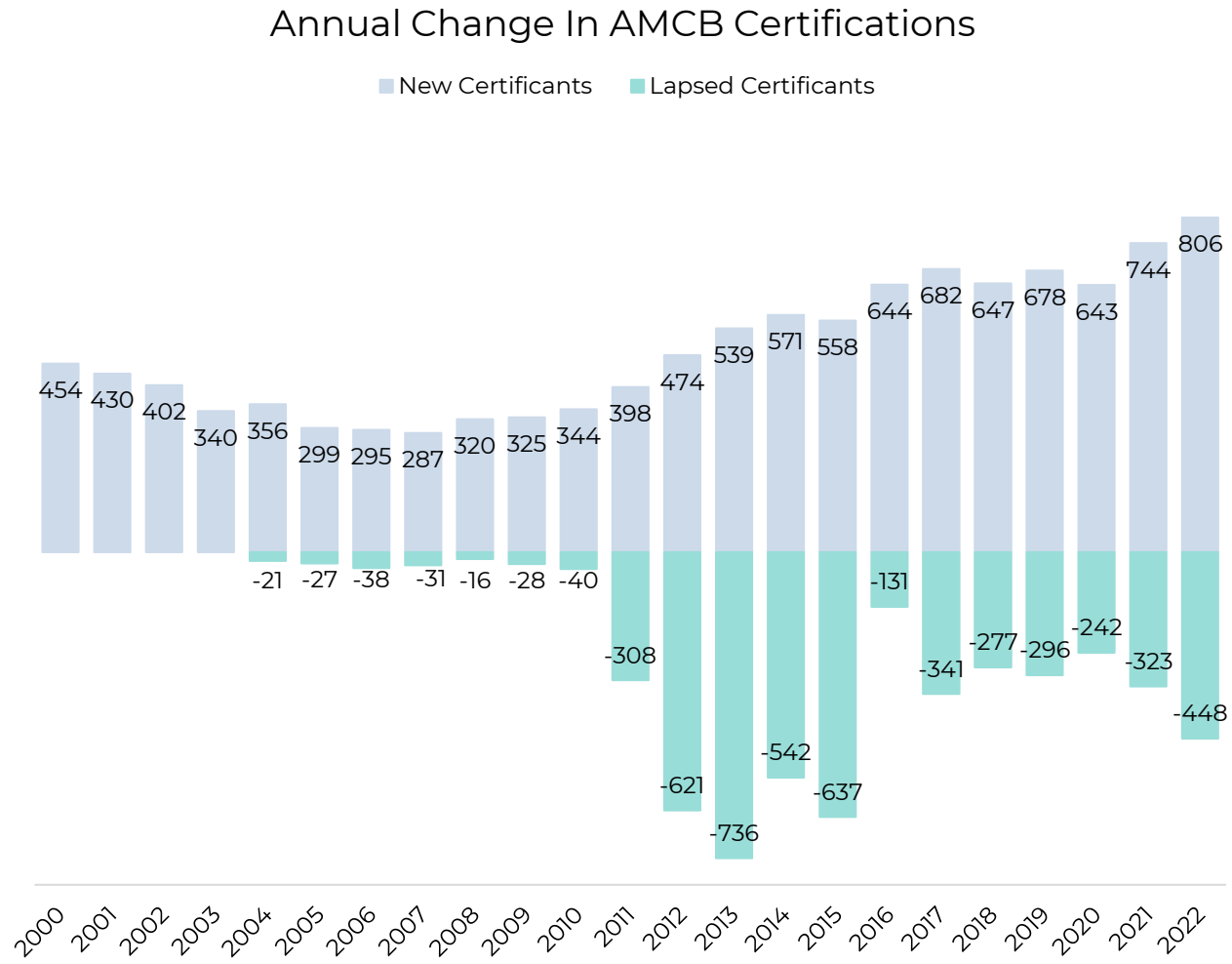

Data Sources: Accreditation Commission for Midwifery Education (ACME) List of Midwifery Education Programs; Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Natality on CDC WONDER Online Database. Data are from the Natality Records 2007-2022, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.

# Net gain in midwives

Prior to 2011, AMCB certificates did not require renewal. AMCB implemented a 5-year certification cycle in 2011, and many midwives let their certificates lapse. Between 2011 and 2015, new certifications (2,540) did not keep up with lapsed certifications (-2,844) for a net loss of 304 midwives.

During the second 5-year certification cycle (2016-2020), there were more new certifications (3,294) than lapsed certifications (1,287) for a net gain of 2,007 midwives. This is an average of 401 new midwives per year.

Since 2020, the number of new certifications increased with the expansion of midwifery education, but lapsed certifications also increased resulting in an average net gain of 390 new midwives per year.

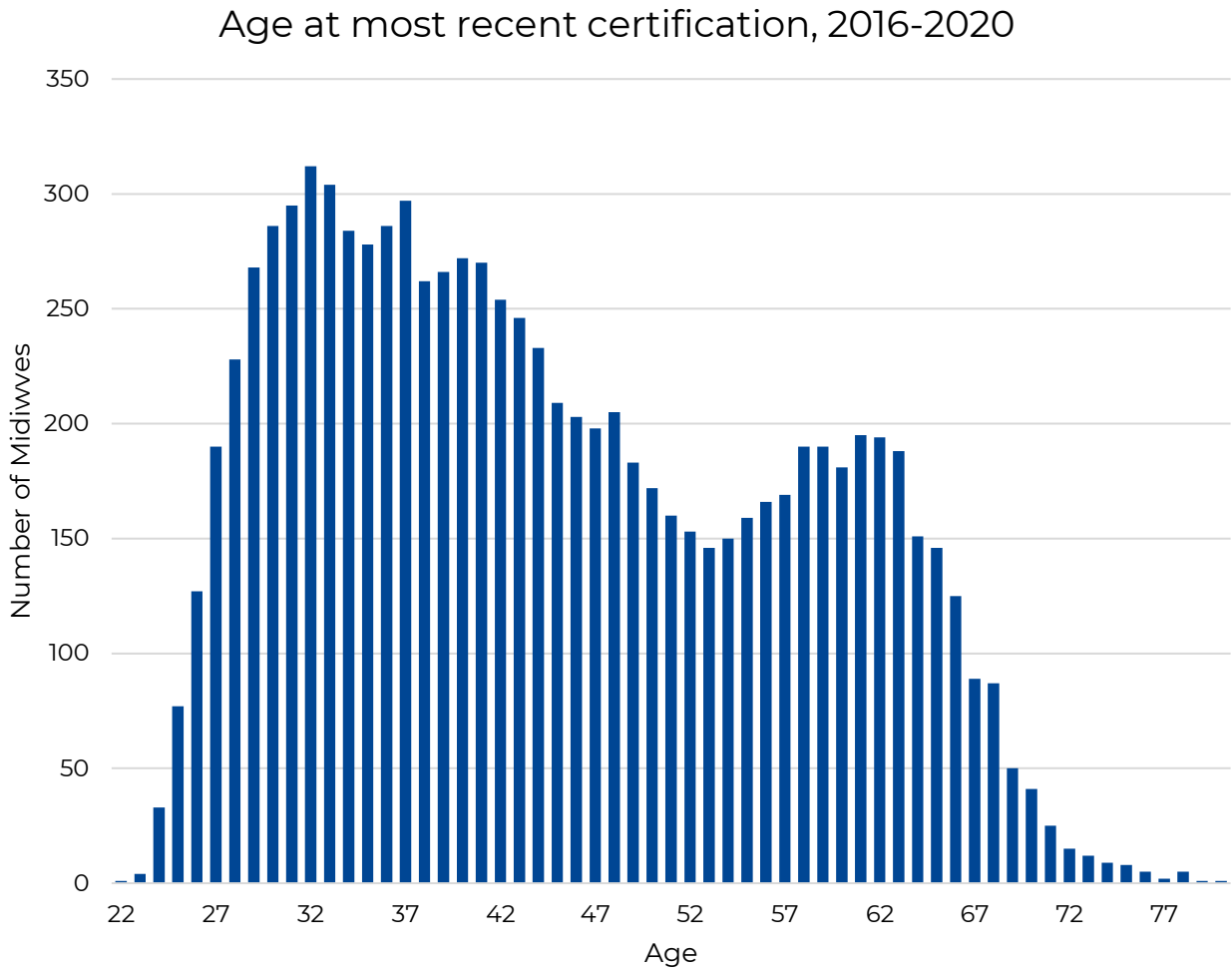



Data Sources: American Midwifery Certification Board Annual Reports.

# Projected workforce exit

During the most recent 5-year certification cycle (2016-2020), 6.7% (n=621) of midwives were aged 65 or older. At that time, 9.8% (n=909) of midwives were aged 60-64, and 9.4% (n=874) were aged 55-59.

Based on these data, we can project that 2,404 midwives (25% of the 2020 workforce) will be retirement age or beyond by 2030.



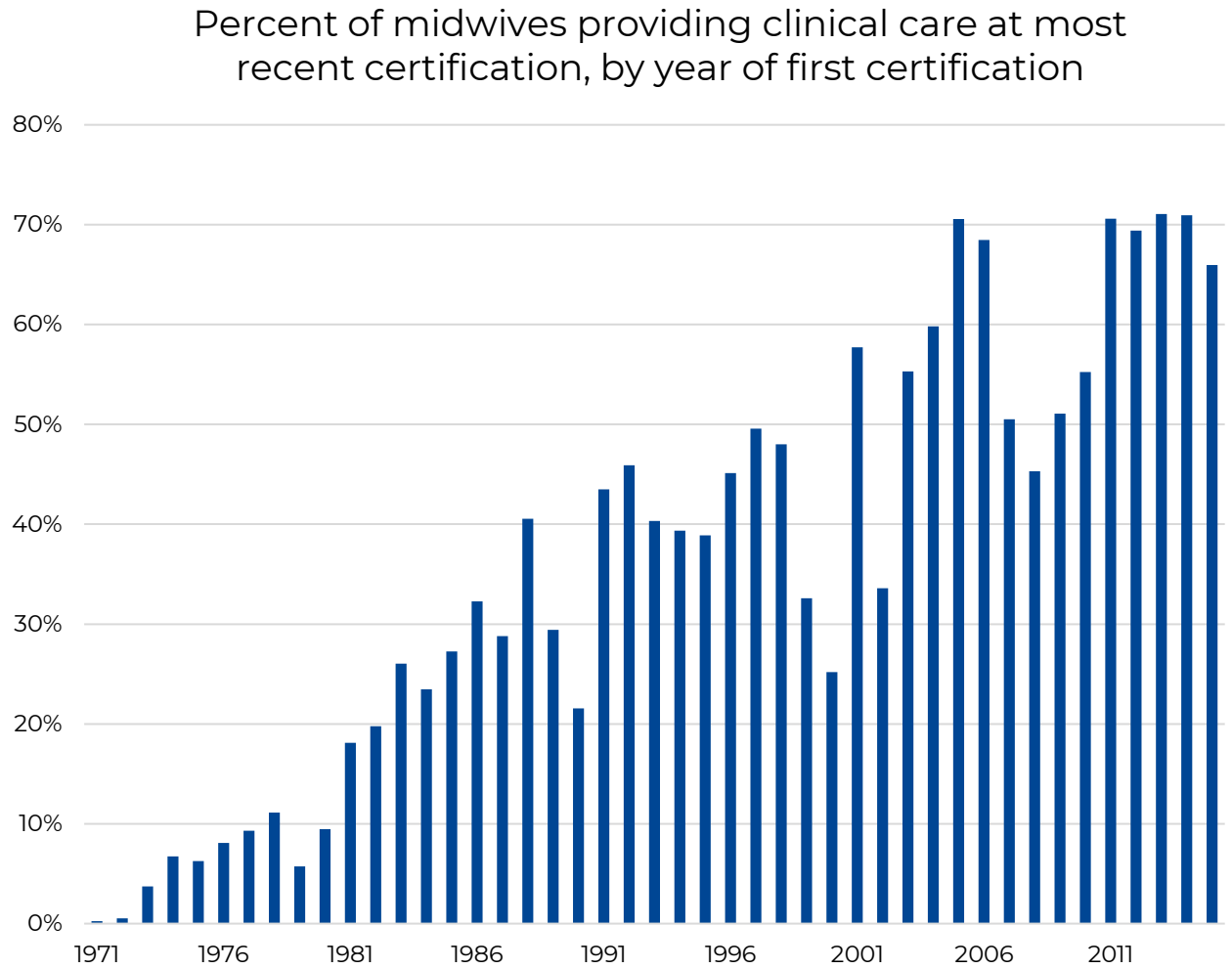

Data Source: AMCB Certification Data, 2016-2020.

# Attrition from clinical midwifery practice

The AMCB recertification application asks midwives to indicate if they provide clinical care for any part of their midwifery work. We compared these data to the number of newly certified midwives each year to determine the percent of midwives providing clinical care.

During the 2016-2020 certification cycle, midwives had an overall pattern of decreased clinical work with increasing years from initial certification. In addition, midwives first certified during a recession (1990-1991, 1999-2000, 2007-2010) appear to leave clinical practice at a higher rate than midwives not first certified during recession.

Data Source: AMCB Certification Data, 2016-2020.



# Characteristics of AMCB Certified Nurse-Midwives and Certified Midwives across employment statuses (N=9704)

| Status | Employed as midwife (n=7405) | Employed outside midwifery (n=1645) | Not employed (n=349) | Retired (n=305) |
|---|---|---|---|---|
| Age[a] | 53.5 (11.3) | 57.6 (10.8) [b] | 54.8 (11.9) | 70.2 (5.5)[b] |
| Age at first certification[a] | 34.3 (6.7) | 34.8 (7.2) | 33.4 (6.9) | 37.9 (7.9)[c] |
| Race[d,e] | | | | |
| American Indian, Native Hawaiian, Alaska Native, Pacific islander | 38 (0.5) | 7 (0.4) | 1 (.3) | 0 (0) |
| Asian | 101 (1.4) | 29 (1.8) | 5 (1.4) | 3 (1.0) |
| Black or African American | 424 (5.7) | 129 (7.8) | 16 (4.6) | 17 (5.6) |
| Hispanic or Latino | 329 (4.4) | 59 (3.6) | 17 (4.9) | 8 (2.6) |
| White or Caucasian | 6438 (84.2) | 1342 (81.5) | 292 (83.7) | 263 (86.2) |
| More than one race | 52 (0.4) | 17 (1.0) | 4 (1.1) | 1 (0.3) |
| Choose not to respond/ Missing | 223 (3.0) | 63 (3.8) | 14 (4.0) | 13 (4.3) |

[a] Mean (SD); [b] Significant difference from referent group “Employed as midwife” P<.001; [c] Age of first certification affected by historic changes in certification policies; [d] Frequency (%); [e]No statistical difference across “race”

# Survey responses of people no longer practicing midwifery

| What is your current employment status? (N=646) | % | n |
|---|---|---|
| Employed in the field of midwifery but not providing clinical midwifery | 7.9 | 51 |
| Employed in health care but not working in midwifery in any capacity | 41.0 | 265 |
| Employed in a non-health care related field | 6.7 | 43 |
| Not employed or not working | 35.8 | 231 |
| None of the above | 3.9 | 25 |
| Employed in clinical midwifery* | 4.8 | 31 |

| If working in healthcare but practicing under a different certifications/licensures, which of these certifications/licensures are you practicing under? (N=163; not mutually exclusive) | | |
|---|---|---|
| Adult Health Nurse Practitioner | 2.5 | 4 |
| Family Nurse Practitioner | 22.1 | 36 |
| Women's health Care Nurse Practitioner | 15.3 | 25 |
| Psychiatric Mental Health Nurse Practitioner | 10.4 | 17 |
| Pediatric Nurse Practitioner | 0.6 | 1 |
| Clinical Nurse Specialists | 2.5 | 4 |
| Certified Professional Midwife | 0.0 | 0 |
| Registered Nurse | 44.8 | 73 |
| Certified lactation Consultant | 4.3 | 7 |
| Other | 7.4 | 12 |

*Respondents to the survey who returned to practice between the time of last certification and survey administration or incorrectly reported that they were not working at the time of last certification.

| What factors affected your decision to no longer practice midwifery? (n=646; check all that apply) | N | % |
|---|---|---|
| Inadequate compensation | 159 | 24.6 |
| Lack of employment opportunity in my area | 158 | 24.5 |
| Experienced racism and/or discrimination in my work as a midwife | 41 | 6.3 |
| Work-life balance | 325 | 50.3 |
| Unable to practice according to the midwifery model of care | 145 | 22.4 |
| Unsupportive work environments | 224 | 34.7 |
| Not interested in the work | 6 | 0.9 |
| Lack of inter-professional respect | 138 | 21.4 |
| Personal health issues | 73 | 11.3 |
| Burnout | 186 | 28.8 |
| Schedule | 207 | 32.0 |
| State-level regulatory restrictions on my ability to practice midwifery | 59 | 9.1 |
| Hospital-level restrictions on my ability to practice midwifery | 78 | 12.1 |
| Issues related to malpractice insurance | 49 | 7.6 |
| Unmanageable workload | 87 | 13.5 |
| Unable to practice consistently with my values | 129 | 20.0 |
| Lack of opportunity for career advancement | 64 | 9.9 |
| Other | 190 | 29.4 |

| What factors affected your decision to no longer practice midwifery? (n=646) | Compensation | Opportunity in my area | Racism or discrimination | Work-life balance | Midwifery model of care | Practice climate | Not interested | Lack of respect | Personal health | Burnout | Schedule | State-level reg restrictions | Hospital-level restrictions | malpractice insurance | Workload | Value incongruence | Lack career advancement |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Compensation | - | | | | | | | | | | | | | | | | |
| Opportunity in my area | 46 | - | | | | | | | | | | | | | | | |
| Racism or discrimination | 15 | 17 | - | | | | | | | | | | | | | | |
| Work-life balance | 112 | 76 | 20 | - | | | | | | | | | | | | | |
| Midwifery model of care | 58 | 35 | 10 | 85 | - | | | | | | | | | | | | |
| Practice climate | 89 | 67 | 29 | 133 | 97 | - | | | | | | | | | | | |
| Not interested in work | 3 | 1 | 1 | 4 | 1 | 2 | - | | | | | | | | | | |
| Lack of respect | 62 | 43 | 22 | 82 | 72 | 107 | 2 | - | | | | | | | | | |
| Personal health | 22 | 15 | 2 | 36 | 15 | 29 | 0 | 18 | - | | | | | | | | |
| Burnout | 72 | 28 | 14 | 138 | 53 | 89 | 2 | 59 | 29 | - | | | | | | | |
| Schedule | 84 | 50 | 13 | 173 | 51 | 91 | 4 | 55 | 28 | 96 | - | | | | | | |
| State-level restrictions | 28 | 33 | 9 | 37 | 22 | 31 | 0 | 23 | 8 | 19 | 16 | - | | | | | |
| Hospital-level restrictions | 38 | 40 | 11 | 38 | 38 | 45 | 1 | 41 | 9 | 27 | 20 | 26 | - | | | | |
| Malpractice insurance | 24 | 18 | 3 | 30 | 15 | 24 | 0 | 14 | 6 | 14 | 23 | 10 | 8 | - | | | |
| Workload | 43 | 17 | 9 | 67 | 30 | 53 | 0 | 33 | 11 | 51 | 54 | 8 | 9 | 7 | - | | |
| Value incongruence | 57 | 31 | 16 | 73 | 77 | 88 | 2 | 71 | 20 | 61 | 50 | 19 | 36 | 14 | 34 | - | |
| Lack career advancement | 39 | 29 | 9 | 38 | 16 | 38 | 1 | 29 | 9 | 29 | 26 | 15 | 17 | 8 | 9 | 20 | - |

People generally reported multiple reasons for leaving clinical midwifery practice. This slide reflects how those factors overlapped. Notably, the least common reason endorsed was “no longer interested in the work.”