



**The Royal Australian
and New Zealand
College of Obstetricians
and Gynaecologists**

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Excellence in Women's Health

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College Statement

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Statement

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) does not endorse Home Birth.

In Australia about 0.2% of women deliver their babies at home. However this may be an underestimate, as it is unlikely that all babies born at home are recorded in perinatal data collection statistics.

Whilst mindful of a women's right to personal autonomy and decision making, RANZCOG cannot support the practice of Home Birth due to its inherent risks and the ready availability of safer birthing practices. Where a woman chooses to pursue Home Birth, it is important that this is an *informed* choice, considering all the benefits and possible adverse outcomes.

1. Perinatal and Maternal Outcomes

1.1. Perinatal Mortality

Whilst collection of accurate and reliable data from planned Home Birth is notoriously difficult (Mori et al, 2008; Gyte et al, 2009), it is likely that planned Home Birth is associated with poorer outcomes for both mother and baby (Bastian et al, 1998). Recent concerning data from Western Australia evidenced a higher perinatal mortality for planned Home Birth at term. For those planning a hospital birth the perinatal mortality for the years 2000–2006 was 2.22 per 1,000 births whilst that of planned Home Birth was 7.96 per 1,000 births. This 3-4 fold increase in perinatal

mortality was statistically significant (OR 3.58; 95% CI 1.8-6.9; $p < 0.001$) (Western Australian PIMC 12th Report, 2007).

In response to the concern regarding increased perinatal mortality apparent in women planning Home Birth, an inquiry into Home Birth was undertaken at the request of the West Australian government. The two investigators focussed on the need for accurate data collection and improvements in service provision (Homer & Nichol, 2009). Of particular concern was the apparent inappropriate selection of patients for Home Birth, as there is evidence that the perinatal mortality associated with care by an independent midwife can, at least in part, be ascribed to poor screening of women by the independent midwife (Symon et al, 2009). In that study there was similarly a 3.5-fold increase in perinatal mortality amongst those women booked under an independent midwife compared to conventional care.

The quantification of Home Birth outcomes requires sophistication of data collection that is difficult to accomplish. Perinatal data must be referable to 'place of intended birth' rather than identification of the outcome by the 'actual place of birth'. Classification by the latter is particularly misleading as intended Home Births transferred to hospital as complications arise will be recorded as a hospital birth, whilst otherwise uncomplicated but precipitate births occurring at home will be recorded as Home Births, even though the intention was to deliver in hospital.

1.2. Maternal Satisfaction

In those selecting Home Birth, it is likely that maternal satisfaction would be greater than birthing in hospital— providing serious adverse outcomes do not occur. Although the numbers required to assess maternal satisfaction would be relatively small, quality statistical data is largely lacking.

2. Alternatives to Home Birth

2.1. Collaborative Model of Care

Collaborative care between midwives and obstetricians (specialist or GP) in a hospital setting is considered the best model of maternity care. This model provides the opportunity for close surveillance of mother and baby during labour and the implementation of appropriate and timely interventions if problems arise. In the absence of complications, minimal intervention is required.

2.2. Alternative Birth Centres and Low Intervention Models of Care

It seems likely that birth in a 'home-like' setting with close proximity to hospital care can achieve some of the aesthetic appeal of Home Birth but with reduced exposure to risk. Even so, a review of the relevant clinical trials reveals a strong trend towards higher perinatal mortality with hospital birth in a home-like setting. An overview of the perinatal mortality in five trials ($n = 8529$) showed a relative risk of perinatal death of 1.83 (95% CI 0.99 to 3.38) when compared with conventional hospital birth (Hodnett et al, 2005).

De Jonge et al (2009) found no difference between "midwife-led care in hospital" when compared to "midwife-led care at home, with respect to "intrapartum perinatal mortality" in the Netherlands. It therefore appears likely that aspects of "midwife-led care" (e.g. lower levels of fetal surveillance and reduced levels of obstetric intervention) contribute to the higher perinatal mortality of Home Birth at term. The higher perinatal mortality in the Netherlands relative to other Western countries

has received attention in the literature (Mohangoo, 2008). Whilst the reasons are undoubtedly complex and it would be inappropriate to attribute this entirely to Home Birth, maternity care in the Netherlands has a tradition of “low intervention” (Keirse, 2009).

3. Homebirth for Australia and New Zealand?

3.1. Why should Australia have lower frequencies of Home-Birth?

Australia is a geographically diverse country and has a poorly developed infrastructure for Home Births. The geography does not suit itself to obstetric “flying squads” that are readily available to retrieve mothers from home when problems have arisen during labour and birth. Australia has the dual problems of vast distances in rural settings, and heavy city traffic in Melbourne and Sydney. Evidence is that approximately 12 to 43% of those identified as “low risk” in pregnancy will develop a complication necessitating transfer to care in a conventional birth suite setting (Mori et al, 2008; Stern et al, 1992). In many locations in Australia this cannot be accomplished expeditiously.

3.2. New Zealand

Although Home Birth is more common and more accepted in some areas of NZ, there are no robust, published data that prove that Home Birth is as safe as hospital birth. The “tyranny of distance” from remote and rural settings combined with an absence of “obstetric flying squads”, applies as much in New Zealand as in Australia.

4. Resource Utilisation

Home birth caters for only a relatively few women. It is resource intensive and those resources may be better utilised elsewhere.

5. Informed Choice?

A decision to give birth at home must be taken in the knowledge that there are relatively few resources available for the management of sudden unexpected complications that may affect *any* pregnancy or birth – even those without any acknowledged obstetric risk factors. These include most commonly acute fetal compromise (e.g. from cord compression in the second stage of labour) and postpartum haemorrhage. Women contemplating Home Birth need accurate information about these risks.

6. Minimal Standards for Home Birth

RANZCOG is aware of differing attitudes in the community regarding pregnancy and its management and accepts that the aspirations of parents vary considerably. Recognising that a small number of women have chosen, and will continue to choose, a domiciliary environment in which to give birth to their babies, the College makes the following recommendations:

- a. Women seeking Home Birth should be

- i. Informed regarding the increased risks of Home Birth in comparison to hospital birth for women and their babies, as demonstrated by available evidence
 - ii. Counselling regarding the significance of these risks as applied to their own obstetric condition
 - iii. Urged to consider giving birth in a suitable hospital environment such as a Birthing Centre.
- b. Women choosing Home Birth should be cared for by both an experienced medical practitioner and a registered midwife, each of whom has agreed to participate.
- c. It is recommended that women considering Home Birth should seek information from their Home Birth providers about the providers' experience in Home Birth, their training, experience and skills in the management of maternal and neonatal emergencies which may occur unexpectedly in the home. They also should be informed of the contingency plan in the event of an emergency including options for hospital transfer and pre-existing arrangements that are in place for transfer of care to an appropriate health care provider qualified to manage the complication(s) necessitating transfer from the home environs.
- d. The women and her baby must be cared for by health professionals with indemnity insurance:
- i. Insurance should be sufficient to cover adverse maternal or fetal outcomes
 - ii. Premiums must reflect the greater risk associated with provision of Home Birth care
 - iii. Details of indemnity cover should be transparent and declared to the patient
- e. All women booked for Home Birth should be recorded by the relevant Health Authority. The Health Authority and care provider must ensure adequate and compulsory documentation so that meaningful data can be obtained for quality assurance at both a local and national level.
- f. Health professionals caring for women having Home Birth have an obligation to ensure a system for immediate transfer to an obstetric hospital in the event of an emergency.
- g. Individuals conducting Home Birth have the same responsibility as other maternity carers to engage in multidisciplinary peer review and audit of practice.

7. Should Home Birth be offered as a “Model of Care”?

Home Birth should not be offered as a “Model of Care”.

It is clear that for the majority of women, the actual margin of safety they desire in giving birth is in fact very high (Walker et al, 2007). Provision of a ‘Home Birth’ service would falsely provide *de facto* evidence of an acceptable margin of safety for both mother and child that is not based in scientific evidence. However, it is acknowledged that there is a very small minority of women, who are prepared to assume substantial personal and fetal risk as a consequence of prioritising their birth experience (Walker et al, 2007).

8. Summary

- a. Home Birth is not endorsed as it is associated with an unacceptably high rate of adverse outcomes.
- b. Home Birth should not be offered as a model of care as there is a reasonable public expectation that any model of care that is offered has a margin of safety that would be acceptable to most women. This is not present in the setting of Home Birth
- c. Women contemplating Home Birth must be provided with accurate information about the risks involved
- d. Home Birth will remain in demand by a small number of women who choose to prioritise this aspect of their birth experience above that of risk minimisation.
- e. Women choosing Home Birth should be cared for by both an experienced medical practitioner and a registered midwife, each of whom has agreed to participate.
- f. Health professionals supervising Home Birth should have appropriate indemnity insurance. Indemnity insurance premiums must reflect the associated increased risks
- g. Women considering Home Birth should seek information from their Home Birth provider about the provider's experience in Home Birth and their contingency plan in the event of an emergency including options for hospital transfer.
- h. All women booked for Home Birth should be recorded by the relevant Health Authority. The Health Authority and care provider must ensure adequate and compulsory documentation so that meaningful data can be obtained for quality assurance at both a local and national level.
- i. Health professionals caring for women having Home Birth have an obligation to ensure a system for immediate transfer to an obstetric hospital in the event of an emergency.
- j. Individuals conducting Home Birth have the same responsibility as other maternity carers to engage in multidisciplinary peer review and audit of practice.

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Links to other related College Statements

Nil

Disclaimer:

This college statement is intended to provide general advice to Practitioners. The statement should never be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of each patient.

The statement has been prepared having regard to general circumstances. It is the responsibility of each Practitioner to have regard to the particular circumstances of each case, and the application of this statement in each case. In particular, clinical management must always be responsive to the needs of the individual patient and the particular circumstances of each case.

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