Home Births

This statement has been developed and reviewed by the Women’s Health Committee and approved by the RANZCOG Board and Council.

A list of Women’s Health Committee Members can be found in Appendix A.

Disclosure statements have been received from all members of this committee.

Disclaimer: This information is intended to provide general advice to practitioners. This information should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any patient. This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The document has been prepared having regard to general circumstances.

First endorsed by RANZCOG: March 1987
Current: July 2014
Review due: July 2017

Background: This statement was first developed by Women’s Health Committee in March 1987 and most recently reviewed in July 2014.

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1. Summary of recommendations

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<tr>
<th>Recommendation</th>
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<tr>
<td>Planned home birth is not endorsed as it is associated with an unacceptably high rate of adverse outcomes.</td>
<td>Consensus-based recommendation</td>
<td>Planned 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 planned home birth.</td>
<td>Consensus-based recommendation</td>
<td>Women contemplating planned home birth must be provided with accurate information about the risks involved.</td>
<td>Consensus-based recommendation</td>
<td>Health professionals supervising planned home birth should have appropriate indemnity insurance.</td>
<td>Consensus-based recommendation</td>
<td>Women planning home birth should seek information from their home birth provider about the provider’s experience and their contingency arrangements in the event of an emergency, including options for hospital transfer.</td>
<td>Consensus-based recommendation</td>
<td>All women booked for planned 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.</td>
<td>Consensus-based recommendation</td>
<td>Individuals conducting planned home birth have the same responsibility as other maternity carers to engage in multidisciplinary peer review and audit of practice.</td>
<td>Consensus-based recommendation</td>
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2. Introduction

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) does not endorse planned home birth.

Fewer than 1% of deliveries in Australia, and a greater proportion in New Zealand, are planned home births. The true incidence of planned home birth is somewhat difficult to accurately assess, particularly in New Zealand.

While supportive of the principle of personal autonomy in decision making, RANZCOG cannot support the practice of planned home birth due to its inherent risks and the ready availability of safer options for labour and delivery in Australia and New Zealand. Where a woman chooses to pursue planned home birth, it is important that reasons for this are explored and that her decision represents an informed choice, considering all the possible benefits and potential adverse maternal and perinatal outcomes.
3. Perinatal and maternal outcomes

The most recent meta-analysis of planned home birth in Western countries identified 12 studies of suitable quality for inclusion, providing a comparison of 342056 planned home births with 207551 planned hospital births. The overall neonatal death rate (NND) was almost three times higher for babies born without congenital anomalies in the home birth group. Since that study was published, an additional paper from the United States has reviewed planned home births during the period 1989 to 2005 in Missouri, and also reported and increased relative risk for perinatal death in the planned home birth group.

A US study of nearly 10.5 million singleton live births at term of babies without congenital anomalies showed a significantly raised risk of Neonatal Mortality for home births attended by midwives (RR=4.32), home birth attended by others (RR=5.87) compared with hospital birth attended by midwives (RR=1, incidence of 3.1/10,000 births).

The large prospective Birthplace in England study reported 45% of low risk nulliparous women planning home birth required transfer to hospital during labour or immediately after birth; and that low risk nulliparous patients had 2.8 times the incidence of adverse outcome for their babies compared with low risk nulliparous women delivering in hospital.

Data from Australia are not reassuring. Of the nine studies of planned home birth in Australia published in the last 20 years, all are retrospective except for a study from St George Hospital. Two do not report data from a control group for comparison, and three use control groups that include medium and high-risk labours. The one study with a matched control group did not match for medical and obstetric complications in the pregnancy.

In the studies where perinatal death rates are reported, the results for planned homebirth are either similar to, or are significantly higher than, those reported for hospital births. This is important, since hospital births are not necessarily low risk, meaning that the risk for a planned homebirth group should be lower. The available data report that planned homebirths undergo fewer interventions and have a lower rate of reported maternal complications.

4. Alternatives to Home Birth

4.1 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.

4.2 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 planned homebirth 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.
5. Home birth for Australia and New Zealand?

5.1 Why should Australia have lower frequencies of Home births?
Australia is a geographically diverse country and has a poorly developed infrastructure for planned homebirth. 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 traffic in the large cities. 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. In many locations in Australia this cannot be accomplished expeditiously.

Consideration should be given to the availability of emergency services in the community including the location of hospitals that provide maternity services in the area and their capacity to deal with acute life threatening emergencies, particularly after hours. In the event of an emergency requiring transfer to hospital, delays in expediting transfer may compromise the outcomes for mother and infant.

5.2 New Zealand
Although planned homebirth appears to be more common in some areas of New Zealand, there are no robust, published data that prove that planned homebirth is as safe as hospital birth. A single study, published in 1997, reviewed selected self-reported data from 9776 planned homebirths during the period 1973-93, with a comparison group of ‘low risk’ women delivering at the National Women’s Hospital in Auckland during the same period. The crude perinatal mortality rate for the planned homebirth group was 2.97/1000 compared to 2.34/1000 for the hospital group. No statistical adjustment was made and no information was given about missing data from the homebirth group.

6. Resource Utilisation
Home birth caters for only a relatively few women. No studies are available to evaluate the cost effectiveness of homebirth in comparison to birth in other settings.

7. 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. Women contemplating planned homebirth need accurate information about these risks.

8. Should planned home birth be offered as a model of care?
RANZCOG believes that planned home birth should not be offered as a model of care.
9. References


10. Links to other related College Statements

(C-Obs 33) Collaborative Maternity Care

(C-Obs 41) Standards of Maternity Care in Australia and New Zealand

(C-Gen 15) Evidence-based Medicine, Obstetrics and Gynaecology

11. Patient information

A range of RANZCOG Patient Information Pamphlets can be ordered via:

Appendices

Appendix A Women’s Health Committee Membership

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<thead>
<tr>
<th>Name</th>
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<tr>
<td>Associate Professor Stephen Robson</td>
<td>Chair</td>
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<tr>
<td>Professor Susan Walker</td>
<td>Deputy Chair - Obstetrics</td>
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<tr>
<td>Dr Gino Pecoraro</td>
<td>Deputy Chair - Gynaecology</td>
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<td>Professor Yee Leung</td>
<td>Member</td>
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<td>Associate Professor Anuschirawan Yazdani</td>
<td>Member</td>
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<td>Dr Simon Craig</td>
<td>Member</td>
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<td>Associate Professor Paul Duggan</td>
<td>Member</td>
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<td>Dr Vijay Roach</td>
<td>Member</td>
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<td>Dr Stephen Lyons</td>
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<td>Dr Ian Page</td>
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<td>Dr Donald Clark</td>
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<td>Dr Amber Moore</td>
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<td>Dr Martin Ritossa</td>
<td>Member</td>
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<td>Dr Benjamin Bopp</td>
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<td>Dr James Harvey</td>
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<td>Dr John Tait</td>
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<td>Dr Anthony Frumar</td>
<td>Member</td>
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<tr>
<td>Associate Professor Kirsten Black</td>
<td>Member</td>
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<tr>
<td>Dr Jacqueline Boyle</td>
<td>Chair of IWHC</td>
</tr>
<tr>
<td>Dr Louise Sterling</td>
<td>GPOAC representative</td>
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<tr>
<td>Ms Catherine Whitby</td>
<td>Council Consumer representative</td>
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<tr>
<td>Ms Susan Hughes</td>
<td>Consumer representative</td>
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<tr>
<td>Ms Sherryn Elworthy</td>
<td>Midwifery representative</td>
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<tr>
<td>Dr Scott White</td>
<td>Trainee representative</td>
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<tr>
<td>Dr Agnes Wilson</td>
<td>RANZCOG Guideline developer</td>
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Appendix B Overview of the development and review process for this statement

i. Steps in developing and updating this statement

This statement was originally developed in March 1987 and was most recently reviewed in July 2014. The Women’s Health Committee carried out the following steps in reviewing this statement:

- Declarations of interest were sought from all members prior to reviewing this statement.

- At the June 2014 teleconference, the existing statement was reviewed and updated (where appropriate) based on the available body of evidence and clinical expertise. Recommendations were graded as set out below in Appendix B part iii). This statement was approved by RANZCOG Board at their meeting on 1 August 2014.

ii. Declaration of interest process and management

Declaring interests is essential in order to prevent any potential conflict between the private interests of members, and their duties as part of the Women’s Health Committee.

A declaration of interest form specific to guidelines and statements was developed by RANZCOG and approved by the RANZCOG Board in September 2012. The Women’s Health Committee members were required to declare their relevant interests in writing on this form prior to participating in the review of this statement.
Members were required to update their information as soon as they become aware of any changes to their interests and there was also a standing agenda item at each meeting where declarations of interest were called for and recorded as part of the meeting minutes.

There were no significant real or perceived conflicts of interest that required management during the process of updating this statement.

**Appendix C Full Disclaimer**

This information is intended to provide general advice to practitioners, and should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any patient.

This information 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. Clinical management should be responsive to the needs of the individual patient and the particular circumstances of each case.

This information has been prepared having regard to the information available at the time of its preparation, and each practitioner should have regard to relevant information, research or material which may have been published or become available subsequently.

Whilst the College endeavours to ensure that information is accurate and current at the time of preparation, it takes no responsibility for matters arising from changed circumstances or information or material that may have become subsequently available.