Safety of Home Birth

Amanda Cagle

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Instructor: Ruth Ann Colby Martin

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With fewer than 1% of all U.S. births occurring at home, it is fair to say that home birth is a rare occurrence. However, home birth rates have been on the rise across the nation since the mid-2000s, indicating a trend for out-of-hospital birth experiences (Cheyney et al., 2014). In recent years, domestic and international research on the safety of home birth has gained in both quantity and quality; this provides an opportunity for pinpointing ideal candidates as well as the specific factors that make home birth safe. Thus far, researchers have identified home birth as a safe option for low-risk birthers seeking normal physiologic birth under the care of professionally competent providers who employ evidence-based practices.

A low-risk birther has a healthy medical history and is carrying an uncomplicated pregnancy. Low-risk people who choose home birth are more likely to experience multiple positive outcomes. These include high rates of normal physiologic birth, low rates of surgical or assisted birth, low rates of interventions, and no increase in adverse events (Cheyney et al., 2014; Davis et al., 2011). In the largest U.S.-based study on home birth, Cheyney et al. (2014) found that over 93% of all home births resulted in a spontaneous vaginal birth not requiring vacuum or forceps assistance for delivery. This outcome can also be seen in other cultures where midwifery-led care is the norm in and out of hospital settings. For instance, researchers in New Zealand noted that those who planned home births were four times more likely to have a normal vaginal birth than those who planned a hospital birth, even when the same midwives cared for all the birthers in the study (Miller & Skinner, 2012). This indicates that birthplace location, not just type of provider, can have great impact on the outcomes of a birth.

These increased rates of normal physiologic birth can be attributed to many factors that are unique to birth in a home. Some subjective factors that lead to better outcomes at home births include a heightened sense of self-confidence and comfort in birthing people. In one study, home birthers routinely expressed feeling emotionally supported by their care team, which led to greater relaxation during birth (Janssen, Henderson, & Vedam, 2009). Objective measurements of home birth safety have also been cited. Weisband, Klebanoff, Gallo, Shoben, & Norris (2018) found that planned home birth with a midwife carried a low preterm labor rate of just 5%, which is consistent with findings from Cheyney et al. (2014) wherein about 96% of all planned home births made it to full-term status. Outcomes for newborns are also encouraging, as rates of low birth weight babies are lower for those who plan to birth at home (Cheyney et al., 2014). Additionally, NICU admission were found to be lower for home births (Davis et al., 2011).

Many obstetric interventions shown to negatively affect birth outcomes are either not available or are not routinely used in home births. For instance, multiple studies have shown a reduction in the need to induce or augment labor with medications, with under 5% of all home birthers needing synthetic oxytocin to birth (Cheyney et al., 2014). Additionally, the need for pharmacological pain relief, such as epidural management, is also used in significantly smaller proportions of planned home births (Cheyney et al., 2014; Davis et al., 2011; Weisband et al., 2018). One of the reasons medications are less likely to be administered in these labors is that midwives are less likely to routinely setup intravenous fluids at home. Instead, midwives suggest eating and drinking throughout birth to maintain healthy nutrition (Miller & Skinner, 2012).

Midwives at home births also encourage mobility at every stage to promote comfort and an optimal fetal position. This is evident in the fact that upright positions like squatting, kneeling, and hands and knees are the most common positions for birth at home. To this end, midwives utilize intermittent strategies for fetal monitoring with low-technology devices that do not require being attached to a stationary machine (Miller & Skinner, 2012). This approach has been shown to reduce a person’s likelihood of needing an episiotomy, lower the rates of vacuum or forceps delivery support, and reduce fetal heart abnormalities in labor. Perhaps because of this increase in mobility on the part of the birther, fewer invasive vaginal exams are experienced at home births, with researchers noting that some home birthers experience no vaginal exams during labor at all (Miller & Skinner, 2012). Moreover, the practice of artificially rupturing the membranes, which can only occur if vaginal exams are taking place, is also less likely to be performed at home births (Davis et al., 2011). Leaving the membranes intact until they spontaneously release reduces the transmission rates of harmful pathogens that can lead to intrauterine infection in the birther (Miller & Skinner, 2012).

Though there are additional positive outcomes associated with home birth not stated here, it is perhaps more important to discuss that the safe quality of home birth is due to the presence of an independent care provider who is an expert in normal, physiological birth. Midwives exist in many forms and can practice in a multitude of settings, but researchers identified three common themes unique to home birth midwives: a focus on evidence-based practice protocols where the birther is at the center of the model of care; a familiarity with up to date research in their field; high levels of professional competence (Janssen et al., 2009). A potent example of the efficacy of home birth midwives is the Cesarean birth rate in midwife-attended home birth, which is just 5.2% (Cheyney et al., 2014), compared to the Cesarean birth rate of midwife-attended hospital birth, 15-20% depending on facility type (Weisband et al., 2018). Because midwives in home birth settings practice without oversight restrictions from doctors or hospitals, they can provide continuity of care and more on one-on-one time to people throughout pregnancy and birth. This ultimately leads to healthier, safer outcomes for the low-risk birthers who qualify for this care (Janssen et al., 2009).

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