WHY NOT HOME?

THE SURPRISING BIRTH CHOICES OF DOCTORS AND NURSES

Dear reader,

I'm a nurse practitioner - I'm not a particularly radical person, yet when I talk to people about my own home birth the reaction is nearly always some variation of "that's crazy!" or "I could never do that." But I don't have a higher than normal pain tolerance and I've never felt any "braver" than anyone else who decides to have a child. I also had no desire to put myself or my baby at unnecessary risk.

What moved me to choose home birth is its simplicity and its power. At home, families experience birth as a part of life, rather than something that interrupts life, or happens outside.

As a clinician, I looked at the evidence on birth outcomes at home and in the hospital. I considered my values and risks, and felt like I had the best chance of having both a positive experience and a healthy birth for me and my baby at home. Not everyone will make that same decision.

My intention for this film is to challenge our cultural assumptions about what birth is and what it can be. I did not create it to be polarizing, sensational, or dogmatic. Instead, it's personal, nuanced, and real. It's about home birth through the lens of women who attend birth in hospitals and chose to have their own children at home. It is a chance to break down stereotypes and open the discussion about maternity care in new ways.

Home birth will never be for everyone, but neither will hospital birth. Women and families deserve to have accurate information and access to maternity care across a continuum that includes home birth and meets the varied needs and values of each unique family.

Sincerely,
Jessicca Moore, FNP
Director/Producer *Why Not Home?*

This guide is meant to be read, shared and used as a tool to help women and families make informed decisions about their birth and to reduce the fear and judgement surrounding the choice to give birth at home.

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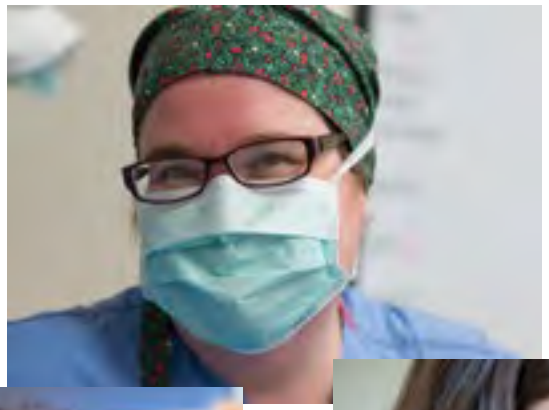


WHAT IS HOME BIRTH?

Home birth is labor and birth that are planned and carried out at home, guided by midwives or other home birth professionals.

Until the early twentieth century most births in the United States occurred at home and were attended by midwives. Today, by contrast, nearly 99% of babies in the US are born in hospitals, with just over 1% born at home or birth centers.[1] Changes to the healthcare landscape over the last century have shifted birth from a community and family event to a medical event.

Because we are so far removed from home birth as the cultural norm, many fears and misconceptions have arisen about home births and the midwives who attend them.

"For the last three to four generations, we've heavily medicalized childbirth. We have this saying in anthropology that normal is simply what you're used to. If every birth you attend has a lot of technology attached with it, you start to think this is really the only way babies can be born."
– Melissa Cheyney, PhD, Associate Professor of Anthropology Oregon State University, CPM, *Why Not Home?*

THOUGHT QUESTIONS:

- What do you think of as normal when it comes to birth?
- What fears or concerns do you have about home birth?
- What is it about home birth that interests you?

Photo courtesy of Tanashia Huff.

"I'm hoping that if they see other Black women doing it and they see a Black midwife supporting them that they'll realize that, you know, it's for all women, not just rich white women." – Tanashia Huff, RN, Student Midwife *Why Not Home?*

THOUGHT QUESTIONS

- Why might someone choose a midwife to assist with birth?
- What images come to mind when you think of a midwife?
- What types of providers are available in your community?

WHAT IS A MIDWIFE?

Modern midwives are professionals who are trained to support families through healthy, low risk pregnancy. They are prepared to guide labor and birth, and to anticipate and manage emergencies that might arise.[2]

Most home birth midwives work in pairs with either an assistant or a second midwife - one to focus on the mother and the other on the baby. Typically, midwives come prepared with oxygen, a Doppler to monitor the baby's heart rate, equipment for infant resuscitation, basic first aid and medication in case of hemorrhage. If you are planning a home birth, it's important to understand what tools your midwife will bring to your birth.

In the United States, as early as the mid-seventeenth century and continuing to the early twentieth century, many Black women served as midwives. By contrast, midwives practicing today and the women they care for are predominantly white. The International Center for Traditional Childbearing and The Grand Challenge, among others, are working to address this inequality and ensure that the profession is more representative and inclusive of our diverse population.

In the United States there are several different paths to midwifery. Licensure and regulation of midwives varies according to state regulations. For more information about midwifery training and certification see **Deep Dive - Midwifery Training and Maternity Care on page 12.**

"My initial reaction (when Grace first brought up the idea about having a home birth) was lukewarm. I was hesitant being a soon to be new parent ... I was more like, 'Are you kidding me? You don't want to do this in a hospital?' But by the third trimester I had done some research on my own and started to feel more comfortable with the idea of home birth." – Mike Hochstoeger, Expecting Father, Personal interview.

Controversy & Choice

Professionals continue to debate the safety of home birth and whether or not the healthcare system should support women's choice in this matter. The controversy is fed at least in part by the view that women and families are ill-equipped to make these decisions, and by the lack of high quality data.

Due to a variety of issues with data collection and reporting, much of the commonly cited home birth literature from the United States indicates an increased risk of poor outcomes for babies born at home **(see Deep Dive - Home Birth Safety for Mothers and Babies page 13)**. This perception has fed into the stigma around home birth, specifically the idea that parents who choose home birth, and the care providers who support them, are more concerned about a positive birth experience than the safety of newborn children.[3] Still, families are choosing home birth in growing numbers.

Home birth rates in the United States have risen by more than 50% in the past 10 years. With information more accessible than ever, women and families are better able to weigh potential risks. Those choosing home birth are more likely to be white, married, and not having their first baby.[4] Many of these families are deciding that their needs are better met at home with the support of a midwife.

THOUGHT QUESTIONS:

- Do women and families have a right to choose their intended place of birth?
- Do you know anyone who has had a home birth?
- How has their experience affected your perception of home birth?

HOME BIRTH – PERCEPTIONS & REALITY

Perception: Birth is complicated and dangerous.

Most expecting parents in our society have never witnessed birth. Many of our cultural perceptions around birth come from the scary and dramatic images on television and in movies. Many people have worst-case "If I hadn't been in the hospital," stories that feed the fear that birth, in general, is dangerous. And so birth at home, without access to an operating room and surgeons, would be even more dangerous.

"The whole thing of, "If I hadn't have been in the hospital," it's a hard comparison because if you hadn't have been in the hospital things may have well gone very differently from the beginning."

– Denise Cobb, RN Personal Interview

Reality: Birth in any setting presents some risk (see more details on page 8).
Because of the current perceptions of home birth, there is a higher social risk to the family if something goes wrong. Negative outcomes can occur in any setting. Increasing collaboration and understanding will help to decrease the stigma and judgement around home birth.

"If something went wrong in the hospital I would have got nothing but sympathy from my friends and my coworkers, but if something went wrong at home there was going to be a lot of judgement."

– Robyn Lamar, MD, OB/GYN *Why Not Home?*

Perception: Home birth is for "them," not "us"

Because home birth remains relatively rare in the United States, there may be some perception that only certain types of people choose it. For example, people from a certain religious faith, or who carry a specific political perspective, or who live in extremely rural areas, or others. As is true with all kinds of stereotyping, ideas about "those people" transfer to their choice of home birth.

"Honestly, I thought people who birthed at home were crazy up until I got pregnant. It was drilled into my head during (medical) training that home birth was not appropriate for anybody. So it took me a long time to be able to come around and say actually, there are a lot of benefits there and this is what I want." – Michelle Minikel, MD, *Why Not Home?*

Reality: With a good understanding of the risks and benefits in all settings, home birth with a skilled midwife, or birth attendant, can be for anyone with a low risk pregnancy who feels like it's a good fit for them and their family (read about that on page 7).

Here are some of the reasons the parents we met in *Why Not Home?*, all of whom attend birth in the hospital, chose home birth:

Michelle Minikel, MD: Among the nurses and among all of the staff (in a hospital), there's a heightened sense of... activity and anxiety, and things going on, and I really wanted to remove that from my birthing experience.

Denise Cobb, RN: I wanted to know who was going to be there for my births and only have people there that I really wanted.

Robyn Lamar, MD: I knew if I gave birth in the hospital, there'd be a higher risk of all sorts of interventions, including operative delivery. So I felt like there was no choice that was zero risk. And my job was to choose the set of risks that I was most comfortable with.

Tanashia Huff, RN, Midwifery Student: It was at home... and it was in my own space, and I felt like I had some control over it and my babies were able to witness it and know that they will have that choice, too.

Photo by Monica Burkett, "A Sacred Project."

Perception: Labor and birth will be too painful for me to tolerate

The pain of labor is one of the things many parents are most afraid of. Many people look to pain medication and epidural anesthesia available in hospitals as a major benefit to hospital birth. Labor is intense, but has a purpose and an arc - a beginning, a middle, and hopefully a beautiful end. The intensity of the experience is part of the transition to motherhood for many women.

"I really am a person with low pain tolerance. (But) during labor, I had this moment between contractions and it dawned on me, I feel fine. It's hard work, but here I am with my husband by my side and my midwife ready... I felt so much warmth and love and that really hadn't occurred to me that during labor you could feel such lovely things."
– Robyn Lamar, MD, OB/GYN Interview

Reality: Laboring at home gives mothers access to a full range of support that is hard to replicate in the hospital. Freedom of movement, going outside in early labor, generally being uninterrupted by nurses, aides, or staffing shift changes, being in water (some hospitals offer this option, but many don't), and having the privacy and freedom to do whatever it is that the mom feels like she needs, all help enormously in managing the intensity of labor.

Perception: Birth is too messy for me to handle at home

Alongside the fears of safety and health, the scary stories and media portrayals of birth often feature a big, medical, bloody mess.

"You have this idea that birth is going to be a lot of bodily fluids, a lot of blood, and for guys who are squeamish, kind of like me... That was kind of one thing that I was like, 'Oh my God, wonder what's going to happen there.' But in hindsight that was totally overblown. It wasn't bad at all." – Mike, Hochstoeger, Expecting Father, Personal Interview

Reality: Home birth professionals help families prepare for birth in many ways, including how to anticipate and handle any 'mess' that might occur. In *Why Not Home?* we see many different configurations of home birth including in a tub, in bed, and on a birthing stool. Many families who choose home birth find the benefits of being at home far outweigh any inconvenience.

Perception: Birth is scary for children to see

Another common concern is that the act of labor, which can be challenging and painful, is not something that parents want other family members, in particular older siblings, to see.

In the film, Robyn remembers her little sister's birth:
"They woke us up right at the end so we got to be there when she was born and I still remember it just as being one of the most exciting things I'd ever seen. And I was super proud and excited to have been there... Regardless of what you see after that, what you grow up with is what you think of as normal. And I think even all of medical school couldn't really erase that idea, this is what birth should be like." – Robyn Lamar, MD, OB/GYN *Why Not Home?*

Reality: Parents can prepare for a home birth as they would a hospital birth, arranging for child care for their little ones. Alternatively, midwives who assist at home births attend to the whole family during pregnancy and prepare families for what to expect. When the adults and communities around them are unafraid, children will likely respond in kind.

Perception: People Will Think I'm Crazy

Part of the reason *Why Not Home?* is an important film right now is because home birth remains a small percentage of births and is surrounded by myths and misunderstanding. It is likely that as you consider home birth and discuss it with your family and friends, you will hear surprised reactions and maybe even outright disapproval.

"I had never, discussed home birth with anyone,... nobody in my circle of friends or groups had done it. In fact, when I expressed that we were going to have a home birth they were kind blown away, like, "I can't believe you're doing this." Though after the fact, and when they heard how it went, I definitely think that some of them have reconsidered." – Mike Hochstoeger, Expecting Father, *Why Not Home?*

Reality: Home birth is a very personal decision for you and your family. As knowledge about home birth increases and as home birth becomes more common, the stigma and misunderstanding will decrease as well.

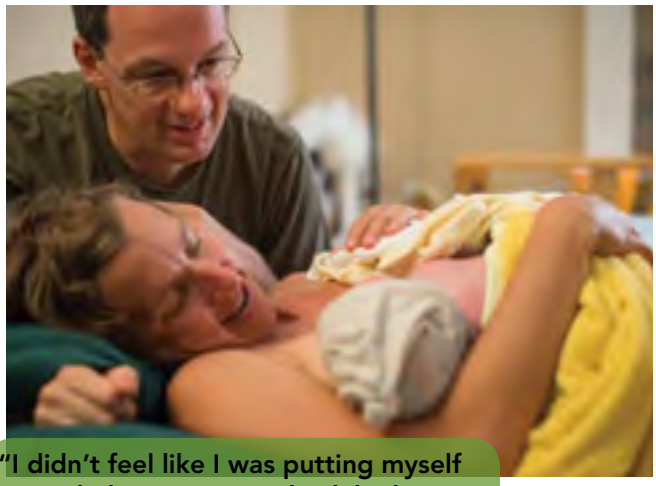
WHAT ABOUT RISK?

Perception of risk and actual risk are two different things. The stories we hear and experiences we've had effect our perception and influence the behavior of both healthcare providers and parents.

Parents, midwives, doctors and other health care providers value safety and do everything they can to ensure healthy mothers and babies. With this understanding, good candidates for home birth are those who are assumed to be at "low-risk," that is:

- a healthy mother with no pre-existing or insulin dependent diabetes or high blood pressure;
- a pregnancy that is near term (37-42 weeks); and
- a single baby who is head down and in the best position for delivery.

These criteria describe 85% of all pregnancies.[5]



"I didn't feel like I was putting myself or my baby at increased risk by having her at home. And I certainly wouldn't have made that decision if I felt there was an increased risk."

– Michelle Minikel, MD, *Why Not Home?*

INTERPRETING THE RESEARCH

Part of the controversy around home birth arises from the challenges of understanding the research on home birth safety. As with any politicized and contentious issue, you can find research to support whatever position you agree with. Different groups can look at the same research and come to different conclusions.

For example, in the United Kingdom, home birth is recommended for low risk women. A 2007 statement from the Royal College of Obstetricians and Gynecologists and the Royal College of Midwives said:

"There is no reason why home birth should not be offered to women at low risk of complications and it may confer considerable benefits for them and their families."[6]

In the United States, however, the American College of Obstetrics and Gynecology (ACOG) made a 2013 statement that:

"Planned home birth is associated with a twofold to threefold increased risk of neonatal death when compared with planned hospital birth."[7]

Who is right?

The ACOG statement was based largely on the findings of the Wax meta-analysis referenced in *Why Not Home?*. That study excluded neo-natal mortality data from the Dutch study, the largest study available at the time. Since the 2010 Wax study, more research has been done both in the United States and in other countries. These larger and more recent findings show a decrease or disappearance of the neo-natal mortality discrepancy reported by Wax.

For more information on the current research influencing these recommendations, see **Deep Dive - Home Birth Safety for Mothers and Babies on page 13**.

THOUGHT QUESTIONS:

- If you are pregnant, what are your known risks?
- How can a person get a clear and unbiased picture of the data?
- What information do you need to make a decision about birth settings?

A SAFE BIRTH

During pregnancy, labor, and delivery, there is a dynamic relationship between mother and baby. Maintaining the health and safety of both is a shared priority. While different situations may carry more risk for either mother or baby, the goal is always to weigh the risks to both and make decisions that minimize those risks.

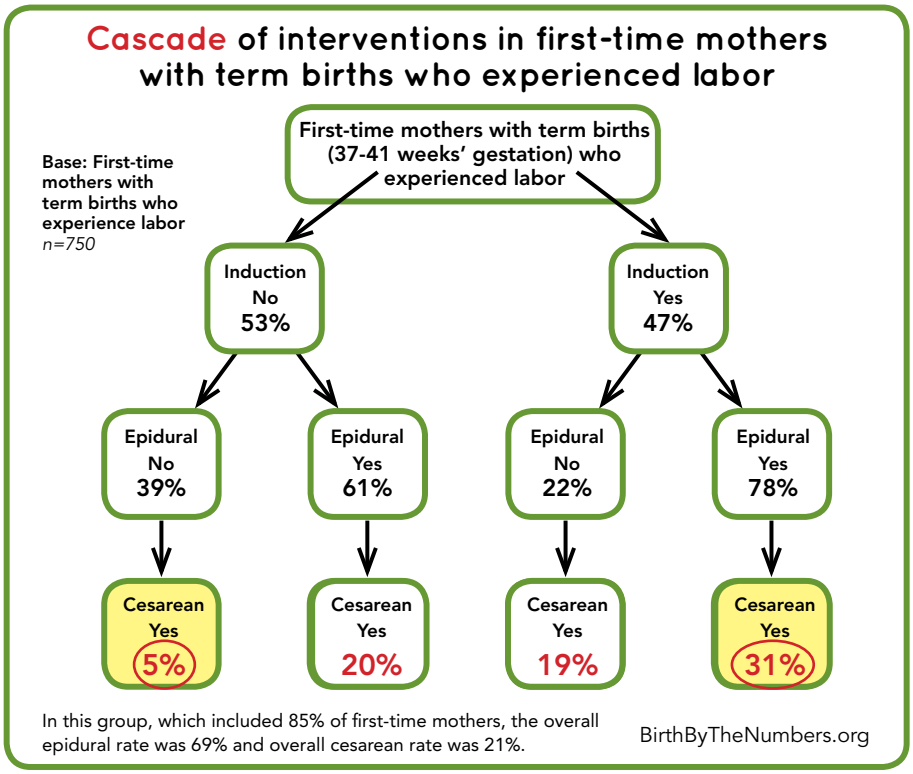
When we talk about the safety of homebirth, it is most common to talk about the risk to infants first. But it is also important to consider the risk to mothers.

"If you look at it in comparison to other countries, (the U.S.) rates near the bottom of large industrialized countries in terms of maternal mortality." – Eugene Declercq, Ph.D, Professor of Public Health, Boston University, *Why Not Home?*

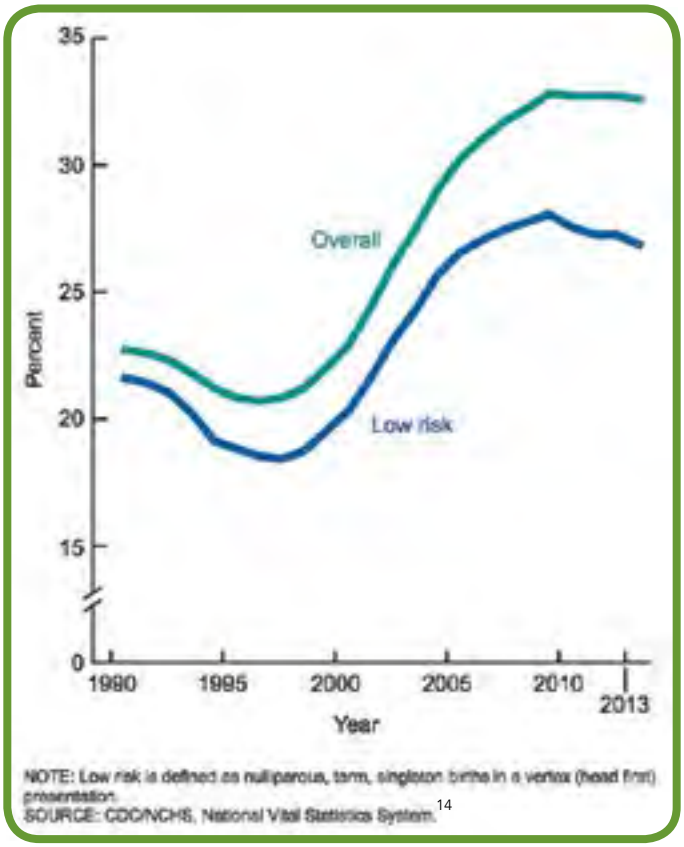
Home birth and hospital birth each carry a different set of risks. In the United States, mothers who give birth in hospitals are at much higher risk for a number of interventions during birth than those who give birth at home. Some of these interventions can lead to serious complications for both mother and baby.

For example, 94% of home births result in vaginal birth with no interventions.[8] In hospitals, that number drops to less than 50%.[9] Half of those interventions, including labor induction, epidural anesthesia, operative birth assistance like forceps or vacuum, episiotomies and C-Sections, have no apparent clinical indication. That means there is nothing to demonstrate that the intervention was required for the maternal or neonatal health.[10] Additionally, there is a known effect called the **cascade** in hospitals, where one intervention leads to the need for another. This escalating progression of interventions becomes necessary because of the way each intervention interrupts the natural flow of labor-inducing hormones, increases stress on the baby, and impacts a woman's ability to push.[11]

The chart below documents the cascade of interventions experienced by 750 low-risk first time mothers included in Dr. Eugene Declercq's "Listening to Mothers" study. He looked at two of the most common interventions: labor induction and epidural anesthesia. Those mothers who had both induction and an epidural were 6 times more likely to have a cesarean section than those who had neither.[12]



The rising Cesarean section (C-Section) rate in the United States is particularly concerning. According to a 2014 consensus report from the American College of Obstetrics and Gynecology, the increase in C-section rates has not significantly improved maternal or neonatal outcomes.[13]



"We know that women have worse postnatal outcomes with a Caesarian. Women wind up in the hospital more, re-hospitalized after their birth."
– Candice Belanoff, ScD, MPH *Why Not Home?*

"Early labor can kind of start and stop, and that doesn't mean that anything bad is happening. If you think someone's in active labor… when they're just 4cm, you might be really wrong. They might be at 4cm for the rest of the day and that can be normal. But if you admit people (to the hospital) with the expectation that they're going to keep dilating and if they don't something's wrong then you start intervening when really you don't need to."

– Robyn Lamar, MD, OB/GYN *Why Not Home?*

The increase in C-Section rates does not appear to be due to need, but rather to changes in practice.[15] For example, in a large study of nearly 40,000 first-time C-Sections the number one reason given for the c-section was "failure to progress," or labor not proceeding in the expected amount of time.[16]

In contrast, midwives rely on physiologic or natural birth. They believe that the body will know what to do and when, and will set its own time frame. This view makes them much less likely to intervene unless a clear medical need arises.

Without the pressures of hospital staffing and labor and delivery beds, women can labor at home as long as they are comfortable and there are no complications. Ami, in the film, labored for seven days before delivering her healthy baby. Many women would not choose to labor so long, but it's unlikely that Ami would have had that choice if she were in the hospital.

THOUGHT QUESTIONS:

- How does one balance the risk of intervention in the hospital against the risk of birth at home?
- What risks are you most likely to encounter and which risks do you most want to avoid?
- If you are a birth provider or an expectant mother, how can you minimize the risk of unnecessary interventions in the hospital setting?
- How does the hospital and/or provider you are considering support physiologic birth? Will you be able to move freely in labor and eat and drink?
- What are your local hospital's c-section rates?[17]

WHAT ABOUT COMPLICATIONS?

There is no such thing as a risk-free birth, at home or in the hospital. Midwives prepare by continually assessing mother and baby as term nears, and by closely monitoring labor. Midwives are trained to recognize and anticipate potential complications. Contrary to the Hollywood image, few complications happen suddenly and without warning. If complications arise that require another level of care, midwives will coordinate transfer to the hospital. For this reason, it's important to have a clear plan for transfer to the nearest hospital.

Collaboration and Communication Between Home and Hospital

For parents who choose home birth, the likelihood of transfer to a hospital for any reason is between 10-30%.Transfer rates are higher for first time mothers and lower for women who have had prior deliveries.Transfers may occur for any number of reasons, most often for the failure of labor to progress, desire for pain medication, malpresentation of the fetus, or maternal exhaustion.[18]

In those places where home birth is better integrated into the health care system, the rate of transfers seems to be higher than in those places where it is not.[19] This may be the result of hesitancy to make transfers on the part of mothers and midwives because of challenges that come up in the United States, where home birth is generally not well accepted, and where systems are seldom integrated.

Dr. Tim Fisher, Chair, Department of Obstetrics and Gynecology at New Hampshire's Cheshire Medical Center/Dartmouth Hitchcock believes that the biggest barriers to collaboration are:

- Lack of consistency in midwifery education, competency assessment, licensure and regulation;
- Lack of physician education around midwifery care;
- Unwillingness to engage meaningfully with women and families to help understand their values and preferences and provide unbiased education about risks and safety of home/birth center versus hospital birth; and
- Physician unwillingness to engage collaboratively with appropriately trained and licensed midwives around mutually-agreed upon protocols for consultation and transfer.[20]

Dr. Fisher's labor and delivery practice have overcome these challenges. "We (at the hospital) are fortunate to have very good relationships with a core group of excellent certified professional midwives that has been the result of respectful two-way communication and deliberate efforts to get together periodically to review transfer cases and clarify mutual expectations about communication, consultation, and transfer."[21] This collaboration is a model for how to improve home birth outcomes in the case where hospital transfer becomes necessary.

Read more in the **Deep Dive: Home to Hospital Transfers on page 15.**

"The term train wreck comes up a lot of if you talk about home birth transfers and birth center transfers. I think that that term is our responsibility as physicians because we've created a culture of fear in which out of hospital birth practitioners are scared to bring their patients to us."

– Alexandra Johnson, MD, *Why Not Home?*

THOUGHT QUESTIONS:

- When did your midwife last transfer a mother from a home birth? How did it go?
- If you are a care provider what are the barriers to collaboration in your community?
- What is one action that could facilitate collaboration between midwives and other maternity care providers in your community?

OTHER HOME BIRTH CONSIDERATIONS

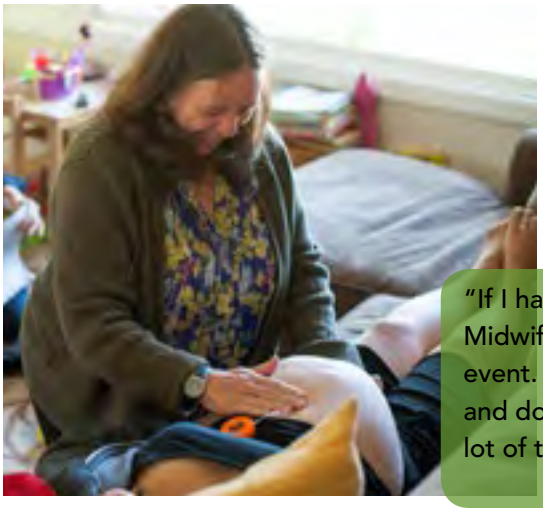
Cost. It is challenging to find data comparing home birth cost to hospital birth across countries because of the differences in health care systems. A 2012 cost-effectiveness study in England demonstrated that planned home birth for low-risk pregnancies was roughly 50% less expensive than hospital birth.[22]

Unfortunately, in the United States, home birth is not often covered by private insurance or Medicaid, and so many parents must pay out of pocket. Even though the overall cost to the system for home birth is significantly less than a hospital birth, the cost to the individual may be much more because of this lack of coverage.

Cost and lack of insurance and Medicaid reimbursement is one of the factors currently limiting access to home birth. As home birth becomes more common and safety data is better understood, it is more likely to be covered by insurance companies.

Liability. The field of obstetrics is notoriously litigious. The intricacies of malpractice coverage, reimbursement, and hospital policies and privileges can make it difficult for providers who would otherwise want to support home birth to do so. It is helpful to understand these real barriers to collaboration while advocating for changes to the the system that would support improved collaboration across a continuum of care (see Resources section).

Policy. The training and licensure of Direct Entry Midwives is inconsistent across states, fueling mistrust and concern about the way home birth midwives are trained. Several efforts are in place to address this concern, and make home birth as visible, consistent, and safe as it can be (see Resources section).



DEEP DIVE - MIDWIFERY TRAINING & MATERNITY CARE

Midwives are specifically trained to manage low risk birth, or about 85% of the births in the United States.[23]

"If I had one change to make, it would probably be the wider use of midwifery. Midwifery care starts from the presumption that birth is a normal physiological event. And that helps because it is. And so once you start from that perception and don't treat every birth as a disaster about to happen, you can mitigate a lot of the difficulties that arise because we start to intervene."

– Eugene Declercq, PhD Boston University, *Why Not Home?*

The United States is one of the only countries where the majority of births are attended by OB/GYNs. Only 8% of births are attended by midwives in any setting, while the other 92% of births are attended by either Family Physicians or Obstetrician/Gynecologists (OB/GYNs).[24]

We continue to train significantly fewer midwives than OB/GYNs even though the evidence suggests that the care that midwives are providing to low risk women is as good or better than that provided by their OB/GYN colleagues and costs less.[25]

Increasing the number of midwifery training programs is an important strategy to improve maternal health outcomes and address the shortage of women's health providers.

Paths to Midwifery

There are several pathways to becoming a practicing midwife in the United States. Direct Entry Midwife refers to any midwife who is not also a nurse.

- Certified Nurse Midwives (CNMs) complete Registered Nurse (RN) training and then obtain a graduate degree in midwifery. Ninety-five percent of CNMs attend birth in the hospital setting.[26] All 50 states license CNMs, though many of these states have regulations that make it difficult for them to attend home birth.
- Certified Midwives (CMs) complete a graduate degree in midwifery, but without the nursing background of CNMs. Only 5 states currently license CMs.[27]
- Certified Professional Midwives (CPMs) are direct entry midwives who have completed a training program focused on home and birth center birth and have met the standards of care outlined by the North American Registry of Midwives.[28]
- Licensed Midwives (LM) are direct entry midwives who meet their state's requirements for licensure. Each of the 29 states who license direct entry midwives set their own standard for licensure.
- Other Direct Entry Midwives go through various training programs that may or may not be accredited by a nationally recognized organization.[29]

Presently in the United States most home births are attended by CPMs or other Direct Entry Midwives. The National Association of Certified Professional Midwives, the North American Registry of Midwives, and the Midwives Alliance of North American, among others, are advocating for the United States to adopt consistent standards for the licensure of Direct Entry Midwives. Standards for training and accreditation of educational programs can be based on the standards of either the North American Registry of Midwives (CPMs) or the American Midwifery Certification Board (CNMs/CMs). Standardized training and licensure for Direct Entry Midwives could help increase trust and understanding between midwives, physicians, and the families they care for and may also strengthen efforts to gain medicaid and other insurance reimbursement for home birth.

DEEP DIVE - HOME BIRTH SAFETY FOR MOTHERS & BABIES

As discussed earlier in this guide, the existing data for the safety of homebirth can be confusing.

Perfect Data

Randomized controlled trials are the gold standard of medical evidence. However, in the case of birth, it is difficult or impossible to ethically justify randomly assigning mothers to a certain birthplace, as would be necessary to achieve for this 'gold standard' of medical research. The few attempts that have been made have had so few willing participants that the findings could not be widely applied.[30]

Instead, home birth studies rely on different kinds of observational studies, that is recording and comparing large numbers of births planned at home and planned at hospitals or birth centers. Each of these kinds of studies have limitations, but as the numbers of births observed and recorded increases, the data becomes more reliable.

Many past observational studies have reviewed vital records to compare results. These studies are problematic as they do not account for the intended place of birth. As a result data from vital records may be clouded by unplanned home births, and home to hospital transfers.

"When you're choosing where you want to give birth, risk is probably one of the first things on people's mind. It's a complicated question. The pat answer is 'well there are no randomized controlled trials'...So it's hard to perfect data and we're just never going to have perfect data."

– Robyn Lamar, MD, OB/GYN *Why Not Home?*

Most Commonly Cited Research

The 2009 de Jonge study, referred to in this guide and in the film as The Dutch Study, was an observational study of over 500,0000 births in the Netherlands. The Netherlands has one of the highest rates of home birth among developed countries, nearly 20%.[31] The systems of care for pregnancy and birth support seamless, collaborative care between midwives and physicians, including a national registry of records. This study looked at births at home and in the hospital and found no statistically significant difference in neonatal death between planned home or hospital births.[32]

In 2010, Wax et al published a meta-analysis of 12 US and international studies, including the Dutch study. A meta-analysis is a kind of study that combines data from many studies to try to gain a more complete understanding of the whole. A meta analysis is limited by the quality of the data coming from each of the individual studies.

Wax's meta-analysis concluded that the neonatal mortality rate for home birth was two to three times higher for home birth than hospital birth.[33] Those numbers are alarming, as any neonatal death feels unacceptable. It is important to understand, however, that the overall risk was still very low. In the Wax study, the rate in hospitals was around 1/1,000, so a two-fold to three-fold increase represented maybe two neonates instead of one out of 1000. This is the main study that the American College of Obstetricians and Gynecologists uses to support its position against home birth.

Wax included the Dutch Study in most of his conclusions, but not in the assessment of neonatal mortality. This is because Wax defined neonatal mortality as death of an infant from 0-28 days after birth, while the Dutch study defined it as 0-7 days after birth. Therefore, in his assessment of neonatal mortality, Wax excluded over 90% of the original sample.

"So if you look at the Dutch studies or the British studies, I think many people would concur that within those systems, home birth appears to be as safe or safer than the hospital for some variables. The question is does it translate to the U.S.?"

— Melissa Cheyney, PhD, Associate Professor of Anthropology Oregon State University, Certified Professional Midwife, *Why Not Home?*

What would have happened if the Dutch study was included?

In 2014 de Jonge published another study of home and hospital outcomes. This time analyzing an even larger cohort than in his original paper, and followed infant outcomes out to 28 days. This study still found no difference between neonatal mortality in home and hospital birth.[34]

If Wax had included de Jonge's findings in his original meta analysis, he would not have found a statistically significant difference in neonatal death between planned home birth and hospital birth.

Is home birth more dangerous in the United States.?

The largest study on planned home birth in the U.S. was conducted by Dr. Melissa Cheyney using data from the Midwives Alliance of North America (MANA) registry. In this analysis 16,984 planned home births were recorded and analyzed. For low-risk births, the neonatal death rate was 1.3 / 1,000.[35] This rate is still higher than that reported by de Jonge, but lower than that reported by Wax.

MANA continues to register midwives to collect and report data. As the data set grows, a more accurate picture will continue to emerge.[36] While it is voluntary for midwives to report birth outcomes to MANA, the registry requires that women are registered when they enter prenatal care before the outcome of their birth is known and that the midwives participating report on all the births they attend. This assures that they do not exclude poor outcomes.[37]

Why are the outcomes in the United States and Dutch studies different?

The most plausible explanation is that in the Netherlands, where the home birth rate is nearly 20%, home birth is integrated into the maternity care system. That means there is active collaboration and communication between midwives and hospital providers. That collaboration improves the safety and the experience of mothers and babies who need to transfer from home to hospital during birth. In contrast, the Wax study includes data from studies in the U.S. and other countries where home birth is less integrated. Furthermore, many of the studies left after de Jonge was removed from the Wax study relied on imperfect data from birth certificates.[38]

DEEP DIVE: HOME TO HOSPITAL TRANSFERS

In 2014, Cheyney et al. completed a study of the challenges of home to hospital transfer in the United States. This study found that one contributing factor to unwillingness to transfer may be that parents who are choosing home birth are hesitant to transfer to a hospital because they are afraid they will receive unnecessary interventions there.

The Cheyney study also revealed other challenges around transfers. Hospital providers identified several barriers to facilitating smooth home to hospital transfers: perceptions that home birth transfers are being transferred because of birth mismanagement; lack of consistent clinical record keeping in the home setting to communicate about what is happening during transfers; fear of liability; and distrust in midwifery training. For their part, midwives identified barriers to smooth transfer as: differences in the ways physicians and midwives perceive risks around birth; the experience of being judged negatively by physicians because of previous 'bad' experiences with transfers or midwives; and failure of hospitals and physicians to take responsibility for negative birth outcomes.[39]

"Home birth is happening in the United States, and so how can we address our shared responsibility and make it the best it can be? Acknowledging that we have different approaches and ideas and attitudes and comfort levels with this (home birth). There still, certainly must be a way forward."

– Saraswathi Vedam, RM, MSN, SciD (hc) Fellow American College of Nurse Midwives, Professor of Midwifery, University of British Columbia

At Legacy Emanuel hospitals in Portland, Oregon such fears and differences have been overcome through collaboration. Oregon has one of the highest rates of home birth of any in the United States at 2-3%. After consistent complaints from several patients and midwives about their treatment, Duncan Neilson, chief of Women's Health Services at all five of Legacy's hospitals, saw this as an opportunity to improve home-to-hospital transfers and make them as safe as possible.

Changes he instituted included: hiring laborists to be on shift at the hospital, rather than using on-call private practice OB/GYNs; setting hospital policy that transfers would be accepted and assessed on a case by case basis, rather than assumed to be high-risk emergencies; and making the hospital more attractive to women seeking less interventional births, like offering water births. According to Nielson, "We used to have these horrible [home-birth] disasters show up at the ER. And we do not see those disasters now. They have just about gone away."[40] Similar success stories of collaboration have come up in hospitals around the country, including in California, New Hampshire, and other states.

A multi-disciplinary work group including OBs, midwives, EMS, nurses, and consumers from the Home Birth Summit has established Best Practice Transfer Guidelines.[41] These guidelines can be adopted by hospitals and communities looking to improve safety and improve communication in home to hospital transfers.

TAKE ACTION

While the debate continues about the safety of home birth in the United States, it is clear that for many women it offers considerable benefits. Research is ongoing and will continue to inform practice and policy. But each of us has a voice and an opportunity to improve birth in our own communities.

Ask Questions

As you've seen, the decision about where to give birth has implications for the outcome. Regardless of the setting or type of provider you choose to support you, it's important to ask questions. Start with some of the resources on page 17 and bring your questions to your care provider and make sure your values and their services are in alignment.

Listen

For too long the voices on either extreme have monopolized the conversation. Now is a time to look for common ground and listen and learn from best practices at home, hospital, and birth center. Before you make assumptions or pass judgement, listen with an open mind to what the person in front of you is saying. You may disagree, but there are ways to do so with respect. Keep the common goal of improving maternity care in front of you and assume the best in others.

Tell Your Story

Whether your birth went the way you expected or didn't, your story is important. Don't be afraid to tell it. It might be just what someone else needs to hear. Every birth is different and every birth is powerful. A diversity of stories normalizes the range of experiences that women have in birth.

If you are a care provider who is working collaboratively or if you are struggling in an environment of mistrust and poor communication your story is important and can be a catalyst for change.

Please share your story with us at www.whynothome.com or on social media #whynothome. Together we can change the cultural conversation and improve birth.

RESOURCES & REFERENCES

As you continue to learn and explore home birth as an option, we invite you to explore the following resources:

Websites:

Birth by the Numbers
Midwives Alliance of North America
Childbirth Connection: A Program of the National Partnership for Women and Families
International Confederation of Midwives
World Health Organization: Midwives
The Home Birth Consensus Summit
Evidence Based Birth
Find Your Hospital's C-Section Rate
International Center for Traditional Childbearing
The Grand Challenge
Citizens for Midwifery
Foundation for the Advancement of Midwifery

Articles:

Portland Monthly Magazine "The Big Push Towards Safe Home Birth"
New York Times Blog "Home vs Hospital Birth"
NPR "Should More Women Give Birth Outside of the Hospital?"

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"Birth is one of the most powerful rites of passage a woman can go through. It's a sheer testament to a woman's fortitude and strength and belief in herself."

– Heidi Hartsough, RN

Photo courtesy of Tanashia Huff.

"When a woman is pregnant, she should be able to choose if she wants a hospital birth or a home birth, and that those decisions can be equally as respected and either of those decisions that she can find, safe providers."

– Denise Cobb, RN

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To find a screening near you and for more resources visit www.whynothome.com