Making Home Birth Even Safer for Mothers and Babies

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ABSTRACT

There is research that supports the safety of planned home birth for healthy women, and more women in the United States are choosing to give birth at home. Strategic initiatives developed at the Home Birth Summit in 2011 address issues related to planned home birth including integration into the health system. This editorial discusses the ongoing work on these initiatives including the development and endorsement of best practice guidelines for safe transfer from home to hospital. The American College of Obstetricians and Gynecologists revised policy statement on home birth calls for the integration of home birth into the health system. This is an important step in making home birth even safer for mothers and babies.

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The past few years have seen a flurry of both interest in and awareness of home birth with many women and professionals wondering, “Is it safe?”

There is an increasing amount of high-quality research on planned home birth in The Netherlands (de Jonge et al., 2015), in the United Kingdom (Brocklehurst et al., 2011), and in North America (Cheyney et al., 2014; Hutton et al., 2016). The research supports the safety of home birth for healthy women: There are fewer medical interventions and comparable outcomes compared to hospital birth. The Cochrane Database of Systematic Reviews suggests that there is no strong evidence from randomized trials to favor either planned hospital birth or planned home birth for low-risk pregnant women.

In addition, they note that evidence from observational studies suggest that planned home birth is safe and may lead to fewer interventions, fewer complications, and fewer neonatal problems (Olsen & Clausen, 2012).

In the last decade, there has been a dramatic increase in the number of women planning home births in the United States, although the number is still low with only slightly more than 1% of women having

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We invite readers to respond to the contents of this journal issue or share comments on other topics related to natural, safe, and healthy birth. Responses will be published as a letter to the editor. Please send comments to Wendy Budin, Editor-in-Chief (wendy.budin@rutgers.edu).

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planned home births (MacDorman, Matthews, & Declercq, 2012). Women who choose to give birth at home often say that their decision is at least in part related to avoiding interventions (Lothian, 2013).

In spite of the increase in demand for planned home birth and the wealth of research supporting its value and safety, it remains controversial in the United States with many, if not most, obstetricians insisting that the safest place for all women to give birth is in a hospital. In the United States, planned home birth is not integrated into the maternity health-care system, and there is considerable discussion around both the need for an integrated system and the risks that are associated with the current system. Professional guidelines, health and hospital policy, legal and ethical issues, insurance coverage, regulation and licensure of birth attendants, and access to home birth reflect and contribute to the problem and the controversies.

With these issues as a backdrop, in 2011, the major birth stakeholders including obstetricians, pediatricians, midwives, nurses, childbirth educators, lawyers, legislators, insurance companies, birth advocates, representatives from government agencies, and women were invited to attend a Home Birth Summit. They met to address their shared responsibility in providing safe maternity care across birth settings. This first Home Birth Summit set the stage for an unprecedented and effective collaboration of stakeholders that has raised awareness and created policy and practice change (Vedam, 2012).

The Home Birth Summit stakeholders agreed on nine Common Ground Statements related to autonomy and choice, interprofessional collaboration and communication, reductions in disparities and equality in access to care, regulation and licensure of home birth providers, consumer engagement and advocacy, interprofessional education, liability reform, research, data collection and knowledge translation, and physiologic birth. The statements provided the foundation for action (<http://www.homebirthsummit.org>). The stakeholders who attended the Summit were in positions of authority and influence and “went home” to create change.

Since 2011, there has been a flurry of activity around planned home birth and physiologic birth. In 2014, the Institute of Medicine held a workshop on Birth Setting, the first since 1982. *The Lancet* published two special issues on midwifery (2014 and 2016). *The Journal of Clinical Ethics* published a special issue on home birth (2013). Major midwifery and nursing organizations launched initiatives promoting physiologic birth (the American College of Nurse-Midwives' [ACNM, 2014] *Healthy Birth Initiative* and the Association of Women's Health, Obstetric and Neonatal Nurses' [2014] *Go the Full 40*). In 2016, the California Maternal Quality Care Collaborative launched the Toolkit to Support Vaginal Birth and Reduce the Primary Cesarean.

One of the most important common ground statements that came out of the Home Birth Summit in 2011 related to home birth being integrated into the maternity health-care system:

We believe that collaboration within an integrated maternity care system is essential for optimal mother-baby outcomes. All women and families planning a home or birth center birth have a right to respectful, safe, and seamless consultation, referral, transport and transfer of care when necessary. When ongoing inter-professional dialogue and cooperation occur, everyone benefits.

With this goal in mind, the Home Birth Summit Task Force (2014) developed best practice guidelines for transfer from home to hospital. In 2014, the American College of Obstetricians (ACOG) and ACNM endorsed the best practice guidelines for transfer from home to hospital that were developed.

And, in August 2016, the ACOG released a revised statement on home birth addressing the issue of transfer and the larger issue of an integrated maternity health system:

Although the College believes that hospitals and accredited birth centers are the safest settings for birth, each woman has the right to make a medically informed decision about delivery. Importantly, women should be informed that several factors are critical to reducing perinatal mortality rates and achieving favorable home birth outcomes. These factors include the appropriate selection of candidates for home birth; the availability of a certified nurse-midwife, certified midwife, or midwife whose education and licensure meet International Confederation of

Midwives' Global Standards for Midwifery Education or physician practicing obstetrics within an integrated and regulated health system; ready access to consultation; and access to safe and timely transport to nearby hospitals.

The home birth research does not support ACOG's belief that hospitals and accredited birth centers are the safest settings for birth. But the need for home birth to be integrated into the maternity care system (as it is in other countries) is clear. This is the first time that ACOG has called for an integrated health system, ready access to consultation, and access to safe and timely transport to hospitals. This is good news, and it is a big step in the right direction.

In an integrated system where there is mutual respect, health-care providers who attend home births will not hesitate to transfer women to the hospital and women will not fear being treated with anger or disapproval. We hope that ACOG's call for a truly integrated system that includes seamless transfer of women who require hospitalization will push hospitals and obstetricians to make it happen. A truly integrated system will make planned home birth, already a safe option for healthy women, even safer for mothers and their babies in the United States.

IN THIS ISSUE

In this issue's "Celebrate Birth" column, Jillian Wishart shares the story of the birth of her daughter, Hazel Belle. She eloquently describes the intensity of her contractions and the importance of the support she received from her husband, her midwives, her doula, and her mother and sister.

Fleming, Healy, Severtsen, and Donovan-Batson present the findings from their study that used a Heideggerian phenomenological approach to investigate planned home births that occurred in Washington State and provide meaning. The results of this study suggest that childbirth education is an essential and valued aspect of birthing. The authors suggest that childbirth educators can use the findings from this investigation as a means to increase their awareness of birthing in the home.

In an innovative study, Burgess describes an educational activity that was created for use with prelicensure nursing students in a maternal infant health course where students had the opportunity to experience intergenerational reflection of birth

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stories of older adults. These stories were transformative and brought new context to how the students understood current-day labor and birth practices. This activity allowed students to see how powerful the birth process is in a woman's life, in that these memories had the power to transcend time. Students were also able to build relationship and practice their communication skills with older adults, which in turn may also be beneficial for the older adults as well.

Canadian authors Bourget, Héon, Aita, and Michaud present a clinical project of the development and evaluation of an educational intervention that aimed at promoting the development of a sense of mastery of the anticipated paternal role in soon-to-be fathers. The participants highly appreciated the content and format of the educational intervention. They also expressed to have developed a sense of mastery of the anticipated paternal role. This interactive educational intervention, which focused on the specific needs of expectant fathers, seems appropriate to support men in their transition to fatherhood.

Munro, Dewar, Wilcox, Klein, and Janssen describe a project where they evaluated a patient education pamphlet on vaginal birth after cesarean (VBAC). Knowledge scores increased for all participants, but intentions to plan a VBAC did not change. Authors suggest that findings from this project may encourage the development of interventions to reduce women's fear of vaginal birth.

Lastly, authors Leach, Bowles, Jansen, and Gibson discuss findings from their qualitative study designed to explore the perception of women regarding long-term effects of childbirth education on future health-care decision making. Analysis of focus group narratives identified themes representing self-advocacy, new skills, anticipatory guidance, control, informed consent, and trust.

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