



## Interim Position Statement on Homebirth

### Introduction

Women have the right to choose where and how they wish to give birth. Whatever place of birth a woman chooses, each woman and her family have the right to expect that the care she receives is provided by appropriately skilled attendants, and is safe.

### Position of the Australian College of Midwives

This position statement clarifies the Australian College of Midwives' position with regard to the provision of midwifery care for women who plan to give birth at home.

It is the position of the Australian College of Midwives that home is an appropriate place of birth for women considered to be at low obstetric risk, and that women must be supported in safe, planned homebirth, by midwives and/or other appropriately qualified and regulated health professionals with adequate access to support, advice, and referral and transfer mechanisms.

The Australian College of Midwives supports the use of the *National Competency Standards for the Midwife*, the *Code of Professional Conduct for Midwives in Australia*, the *Code of Ethics for Midwives in Australia*, the *Australian College of Midwives National Midwifery Guidelines for Consultation and Referral* ("the *Guidelines*") and the *NHMRC Guidance on Collaborative Maternity Care* as the appropriate resources for guiding midwives in their practice.

### The Australian Context

In Australia, registered midwives are responsible and accountable professionals who provide support, care and advice to women and their families during pregnancy, birth and the postnatal period, which is in accordance with the *International Definition of a Midwife* (ICM, 2005). The definition states that such midwifery care can be provided in any setting, including the home.

Midwifery care is woman-centred and is provided in partnership with the woman (*ANMC National Competency Standards for the Midwife*).

Planned homebirth is a choice for a small number of women in Australia. According to *Australia's mothers and babies 2008* (the 18<sup>th</sup> annual report of pregnancy and childbirth from The Australian Institute of Health and Welfare National Perinatal Statistics Unit and the University of New South Wales), 0.3% of births in Australia were planned homebirths.

Midwifery care for a planned homebirth may be provided within a publicly-funded homebirth service or using the services of a privately practising midwife.

## **Key Principles**

The principles outlined in *Primary Maternity Services in Australia – A Framework for Implementation* (AHMAC 2008) are considered to be supporting principles for this document. In addition, the Australian College of Midwives recognises that;

- Safety includes cultural, emotional and psychological safety as well as clinical safety.
- Some women may choose a planned homebirth even when this is not recommended by her care providers. In such circumstances, a midwife should, after discussions with each woman and in consultation with other health professionals, work with the woman looking for options and resolutions within midwifery professional standards to address the woman's needs.
- Following documented discussions and appropriate consultation and referral as may be indicated, a midwife has the right to decline to continue to provide, or to accept, midwifery care if it is felt that this would require the midwife to practise outside of the midwife's scope, skills and competencies.
- Midwives have a duty of care to each woman they provide care to, and this means that in labour, or urgent situations, a midwife must attend the woman.

## **The evidence**

A comprehensive review of the evidence shows that planned homebirth is a safe option for women and their babies, when women are at low risk of complications, and when they receive care from suitably qualified attendants with adequate access to support, advice, and referral and transfer mechanisms. There is no evidence that shows an increased of risk of maternal morbidity or mortality in relation to homebirth.

While it is accepted that best evidence for the safety of a specified situation is through a Randomised Controlled Trial (RCT), there are no RCTs comparing home and hospital birth as few women would be willing to be randomly assigned to either home or hospital. However, there is evidence supporting homebirth as a safe option for women and their babies for the majority of healthy women at low obstetric risk using large cohort or observational studies.

A meta-analysis undertaken into the safety of homebirth (Olsen 1997), reviewed international controlled observational studies, comparing perinatal and maternal mortality. Of the six studies that met the inclusion criteria (out of 607 reviewed), none showed any significant differences in outcome between home or hospital birth for low-risk women and perinatal mortality rates between the groups were comparable. However, there were fewer interventions and morbidity in the homebirth groups, and notably a large reduction in rates of perineal trauma. This began a rigorous review of the global evidence around the safety of homebirth at the time. The next year Olsen and Jewell (1998) undertook a review of their meta-analysis and searched the Cochrane Register for controlled trials that compared home and hospital birth. Only one study by Dowswell et al. (1996) fitted the criteria but was too small to draw any conclusions. The Cochrane Register repeated the search again in 2006, but no new trials were found (Olsen and Jewell 2009).

There is a lack of homogenous Australian data of maternal and neonatal outcomes in studies of low-risk women who plan to have a homebirth. An important population-based study from South Australia regarding perinatal safety was conducted by Kennare et al (2010). The authors found similar rates of perinatal mortality to planned hospital births, but a significantly higher rate of intrapartum death and death from intrapartum asphyxia. These results have wide confidence intervals so should be interpreted with caution. Upon further exploration, the authors determined that factors that changed women's status to that of 'high-risk' were responsible for the majority of adverse outcomes. This study, together with Bastian et al (1998), Symon et al (2009) and Pang et al (2002) demonstrate the necessity to ensure ongoing risk assessment throughout pregnancy and transfer to hospital care when women's risk status changes to ensure safety.

It is inevitable that a number of women, despite careful selection for a homebirth, will need to transfer to hospital during their labour for unforeseen circumstances. Studies have shown intrapartum transfer rates of between 1.5% and 20%. Evidence is inconclusive regarding the risk of higher rates of morbidity or mortality in relation to intrapartum transfer to hospital.

Qualitative data from reviews of publicly-funded homebirth programs in Australia shows high levels of satisfaction amongst women using these services.

In the absence of a consistent definition of 'low obstetric risk', low obstetric risk is considered to be a pregnancy, labour and birth that are anticipated to be problem free. In assessing whether a woman is to be considered as low obstetric risk, a midwife should base the assessment on the woman's past medical history, past gynaecological/obstetric history and any other relevant issues as the pregnancy continues. *The Guidelines* provide guidance on what conditions may impact on the assessment.

In conclusion, it seems evident from the literature that planned homebirth is a safe option for women who are at low risk of complications and who receive care from qualified attendants with adequate access to support, advice, referral and transfer

mechanisms. There is no evidence that shows an increase of risk of maternal morbidity or mortality in relation to homebirth in these circumstances.

### **Health System Support**

As outlined in the *National Maternity Services Plan (2011)* (Action Items 1.2.2 and 3.4.2) all State and Territory health services have agreed to establish Access Agreements for Midwives in Private Practice to facilitate seamless continuity of care and carer and support appropriate networks for collaboration, consultation and referral.

Health services must therefore provide access to homebirth services for women choosing to birth at home, ensuring equity of access and with appropriate funding arrangements. Health services should establish, foster and facilitate the appropriate care pathways and interprofessional respect and collaboration between health professionals to enable seamless access to consultation, referral and transfer between services and care providers as required.

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NB: This statement is intended to provide midwives, women and maternity services with the Australian College of Midwives' position on given situations.

Statements are designed to educate and support best practice and should never be relied on as a substitute for full assessment with respect to an individual woman or her baby. It is the responsibility of each provider to be fully aware of the individual circumstances of each case with regard to the application of this statement.

Whilst the ACM endeavours to ensure that statements are accurate and current at the time of their preparation, each provider must have regard to relevant information, research or literature which may have been published or become available subsequently.