



BACKGROUND PAPER

POSITION STATEMENT FOR PLANNED BIRTH AT HOME

Women have a fundamental right to determine where and how to give birth. This right is supported in the Convention on the Elimination of All Forms of Discrimination Against All Women (CEDAW) to which Australia is a signatory (CEDAW, 1999). Article 12 of the CEDAW requires countries to provide free and accessible health services for women in relation to pregnancy and postnatal care. It is the responsibility of health services to support women choosing birth at home. Further, the right to information, informed consent and refusal to consent, respect for choices and preferences, liberty, autonomy, self-determination, and freedom from coercion are all supported by the *Respectful Maternity Care: Universal Rights of Childbearing Women* (White Ribbon Alliance, 2011).

Why women choose birth at home

In Australia less than 0.3% (n=923) of women have a planned birth at home each year (AIHW 2016). Whilst birth at home is clearly an uncommon choice, there is evidence of strong consumer demand for alternative places of birth. Over 60% of public submissions to the Commonwealth government's 2008 National Maternity Services Review were from women advocating for and requesting birth at home (Dahlen, 2011). Data from the 2018 National Strategic Approach to Maternity Services is not yet available for inclusion in this paper.

A woman's desire to give birth at home is usually inspired by a belief in birth as a normal, healthy process. Women who plan a birth at home usually undertake a very detailed process of decision-making where they carefully consider the risks and benefits of hospital and home (Murray-Davis et al, 2012; Cheyney, 2008; Catling-Paull, 2011).

Some women choose birth at home because they fear that they will not have control over what happens to them in hospital. This may be related to a past negative hospital birth experience or trauma. Women who plan to birth at home highly value having an intimate space to give birth in, with only a trusted midwife and the woman's chosen support person/s in attendance (Cheyney 2008).

Other women choose to give birth at home without a midwife (free birth) when their pregnancy is considered 'high risk'. Women who purposely birth 'outside the system' do so because they perceive the risks of birth in hospital differently to other women or health professionals (Jackson, Dahlen & Schmied 2012). These women feel that they are making a choice that protects them and their baby from the risks associated with birthing in hospital and thus provides them with the best and safest birthing option (Jackson, Dahlen & Schmied 2012).

Women may choose to free birth, or birth with an unregistered birth worker, because the option of birth at home with a registered care provider is unavailable, or very difficult or expensive to access. Further, unavailability of a second midwife to attend birth at home, especially in rural areas, as well as lack of insurance for intrapartum care is reducing women's access to registered health professionals (Rigg, Schmied, Peters & Dahlen, 2017).

Safety: birth as a normal physiological process

Research evidence confirms that women at low risk of complications who give birth at home with a midwife in attendance are more likely to have positive outcomes when compared with those who birth in hospital. Outcomes include being more likely to achieve a normal vaginal birth, greater success breastfeeding, less perineal trauma and postpartum haemorrhage, and higher levels of maternal satisfaction (Catling-Paull et al., 2013; Scarf et al., 2018).

Women who plan a birth at home have significantly reduced rates of interventions and adverse outcomes such as induction, augmentation, episiotomy, third degree tears, operative vaginal birth, caesarean and postpartum haemorrhage (Brocklehurst, 2012; Davis et al., 2011). Infant mortality and morbidity is comparable between cohorts (de Jonge et al., 2009; Scarf et al., 2018) and maternal morbidity is less at home because of reduced obstetric intervention (Hutton, Reitsma & Kaufman, 2009; Scarf et al., 2018).

In a 2013 study, women who had their babies in a publicly funded birth at home model in NSW had a 90% chance of having a normal birth and a 5% chance of having a caesarean section (Catling-Paull et al., 2013).

The ACM provides standards for clinical midwifery practice in its *Birth at Home Midwifery Practice Standards* on their website: www.midwives.org.au

Transfer

Midwives attending birth at home should have clear communication pathways with the local ambulance service and their hospital of transfer, including the midwifery and medical team. This ensures they are able to facilitate transfer into hospital for medical assessment when any birthing situation becomes complex in a timely and safe manner.

In hospital, the time it takes for theatre to be set up from an emergency decision can take as long as 30 minutes (Wagner, 2001).

The ACM provides guidance in its *Transfer from Planned Birth at Home Guidelines* on their website: www.midwives.org.au

Cost: savings to the public system

Birth at home is a more cost effective option for the taxpayer and public health system (Scarf, Catling, Viney & Homer, 2016). The average cost for a woman having her first baby in a continuity model of midwifery care in Australia is \$3,903.00 per woman, compared with average standard hospital care costs of \$5,494.00 per woman (Tracy & Tracy, 2003). Although the costs of birth at home have not been calculated in Australia, UK research has found that birth at home provides a 35% saving compared to hospital birth and a 27% saving compared to a Birth Centre birth (Schroeder, et al., 2012).

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