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No. 372-Statement on Planned Homebirth

This Committee Opinion has been prepared by Clinical Practice Obstetrics and reviewed by the Guideline Management and Oversight Committee and approved by the Board of the Society of Obstetricians and Gynaecologists of Canada.

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KEY MESSAGES

1. Registered Midwives and some physicians provide homebirth care in Canada.
2. The SOGC reaffirms and emphasizes the importance of choice for women and their families in the birthing process. The SOGC promotes well-integrated community and hospital birthing care to ensure safe maternal and newborn care.
3. In Canada, planning a homebirth with a registered midwife or an appropriately trained physician in the integrated system described is a reasonable choice for persons with low degree of risk where the birth is anticipated to be uncomplicated and neither mother nor neonate will require resources beyond the local capacity.
4. All pregnant women should receive information about the risks and benefits of their chosen place for giving birth and should understand any identified limitation at their planned birth setting. Risk assessments should be ongoing throughout pregnancy and birth and care providers must ensure the individual is advised of any change in their risk status to support their ability to make an informed choice for most suitable birth site.
5. Communication amongst and between the hospital and community obstetric teams using set standards supporting emergency transport are critical components of a seamless integrated system and should remain a priority in supporting best practice outcomes for planned homebirths.
6. The SOGC endorses evidence-based practice and encourages ongoing research into optimizing birthing outcomes in all birth settings. Prospective data collection should capture all births and include planned and actual place of birth.

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All people have the right and responsibility to make informed decisions about their care in partnership with their health care providers. In order to facilitate informed choice, patients should be provided with information and support that is evidence-based, culturally appropriate and tailored to their needs.

This guideline was written using language that places women at the centre of care. That said, the SOGC is committed to respecting the rights of all people – including transgender, gender non-binary, and intersex people – for whom the guideline may apply. We encourage healthcare providers to engage in respectful conversation with patients regarding their gender identity as a critical part of providing safe and appropriate care. The values, beliefs and individual needs of each patient and their family should be sought and the final decision about the care and treatment options chosen by the patient should be respected.

PLACE OF BIRTH

The SOGC Policy Statement on Midwifery states: “SOGC recognizes and stresses the importance of choice for women and their families in the birthing process. The SOGC recognizes that women want to choose the setting in which they will give birth. All women should receive information about the risks and benefits of their chosen place for giving birth and should understand any identified limitation of care at their planned birth setting. The SOGC endorses evidence-based practice and encourages ongoing research into the safety of birth settings.”¹

The SOGC values the importance of choice. Options may be limited, and sometimes plans may change. Decisions regarding place of birth must take into consideration available resources, the evolving health of mother and baby, and the mother’s beliefs, values, and wishes. For example, some communities have no birth care providers; some have no midwives and few physicians who practice obstetrics offer homebirth services. Where midwifery is available, birthplace options may include home, free-standing birth centre, or hospital.

Out-of-hospital birth numbers are rising in Canada.^{2,3} The increase may be attributed to the growth of available midwifery services, a desire for a low-intervention birth, and increasing comfort with birth outside of a hospital setting.⁴ Canadian regulated health care providers, including Registered Midwives and physicians with specific expertise, may offer choice of birthplace as a standard of care within their jurisdictions. Registered Midwives in most jurisdictions in Canada are required to offer choice of birthplace for appropriately screened individuals who have a low degree of risk and where the birth is anticipated to be uncomplicated. Quality standards set by provincial and territorial regulators require Registered Midwives who attend homebirth to have hospital privileges, a second qualified care provider present at the birth, emergency equipment and supplies, and ongoing risk assessment and emergency transport protocols.

^a At least 2 provincial physician regulatory colleges have removed restrictions from physicians attending homebirths. In 2001 the College of Physicians and Surgeons of Ontario rescinded their policy against physicians attending homebirths, stating that “there’s no indication that a policy statement on homebirths is actually needed in the present-day environment (and) there is no need to separate homebirths from other medical procedures.”⁵ In 2009 the College of Physicians and Surgeons of British Columbia (CPSBC) rescinded its policy against homebirths.⁶ In 2018, the CPSBC affirmed it “supports a woman’s right to personal autonomy and decision making in obstetrical care and respects a physician’s autonomy in their decision to offer home birth services to their patient.”⁷

Midwives in all regulated settings are publicly funded regardless of place of birth and are well integrated into the health care system. This team-based approach involves anticipatory planning in the event a transfer to hospital is necessitated.

Although safety of planned homebirth is debated in some jurisdictions, most notably the United States, many other settings such as the United Kingdom, The Netherlands, and New Zealand support this choice, as do Canadian provincial and territorial governments. For example, there are no regulatory restrictions on physicians in most Canadian jurisdictions for providing intrapartum care at home.^a Randomized controlled trials have proven unfeasible due to lack of equipoise.^{8–10} Publications are often difficult to compare as methodologies are complicated by lack of clarity on intended place of birth, risk status, standardization of provider qualifications or presence of qualified providers, appropriate comparison group, standardized language, accuracy of birth certificate data, accuracy of prospective data collection, and integration of homebirth providers into existing health care systems. To address these and other relevant issues, a systematic approach to appraise the quality of research on birth settings has been established.¹¹

Findings from comparable universal health systems based upon the aforementioned criteria are helpful in providing outcomes that may be applicable to the Canadian homebirth context. Such findings include homebirth provided by regulated and integrated health care providers where transfer plans are pre-planned, and no punitive or financial disincentives exist for those transfers. Ideally, prospective data collection will reduce information bias; will accurately identify health care provider and risk assessment details in both home and hospital birth settings; will ensure appropriately matched comparison groups and standardized well-defined outcomes; and will ensure that the intended place of birth at outset of labour includes an intention-to-treat analysis. Considering these criteria and research from Canada and many similar settings, data support the safety of homebirth, with most studies reporting an association with improved maternal outcomes in low-risk pregnancies, including fewer interventions and complications.^{12–30}

ABBREVIATIONS

CI	confidence interval
RR	relative risk
SOGC	Society of Obstetricians and Gynaecologists of Canada

Over the last 2 decades the Canadian experience with homebirth has been extensively studied. Outcomes in British Columbia and Ontario for 21 936 intended homebirths versus 23 508 intended hospital births, in which all births in both settings were attended by the same Registered Midwives, have been evaluated.^{18–20,28} A meta-analysis of these 4 studies comparing outcomes for women planning homebirth with those planning hospital birth found a significant increase in spontaneous vaginal birth (91% vs. 85.9%; RR 1.06; 95% CI 1.05–1.07, $P < 0.00001$) and a significant reduction in interventions and maternal morbidity, including induced and augmented labour (6.4% vs. 19.1%; RR 0.61; 95% CI 0.58–0.65, $P < 0.00001$), pharmacologic pain relief (16.4% vs. 43.2%; RR 0.38; 95% CI 0.37–0.39, $P < 0.00001$), obstetric anal sphincter injury (1.4% vs. 2.4%; RR 0.58; 95% CI 0.49–0.65, $P < 0.00001$), episiotomy (4.1% vs. 6.1%; RR 0.68; 95% CI 0.62–0.74, $P < 0.00001$), instrumented birth (3.1% vs. 5.5%; RR 0.56; 95% CI 0.53–0.63, $P < 0.00001$), Caesarean birth (5.8% vs. 8.6%; RR 0.69; 95% CI 0.65–0.74, $P < 0.00001$), and infection (0.7% vs. 3.5%; RR 0.20; 95% CI 0.08–0.49, $P = 0.0005$).³¹ Although postpartum hemorrhage occurred less often in those planning homebirth across studies, blood loss was measured differently, so the data were not pooled.

Outcomes of planned home births compared with planned hospital births attended by registered midwives in British Columbia and Ontario found no differences in intrapartum stillbirth and neonatal death in the first 28 days, excluding major anomalies (1.1/1000 vs. 0.9/1000; RR 1.26; 95% CI 0.70–2.28, $P = 0.45$). There were no differences for nullipara (1.9/1000 both groups; RR 0.99; 95% CI 0.45–2.21, $P = 0.99$) or parous clients (0.8 vs. 0.4/1000; RR 1.80; 95% CI 0.6–5.37, $P = 0.29$). Neonatal death in the first 7 days was not different (0.4/1000 vs. 0.6/1000; RR 0.71; 95% CI 0.23–2.25, $P = 0.57$). Likewise, there were no differences in Apgar scores below 7 at 5 minutes (1.5% vs. 1.4%; RR 1.09; 95% CI 0.76–1.58, $P = 0.64$), neonatal intensive care unit admission (1.5% vs. 1.7%; RR 0.89; 95% CI 0.68–1.16, $P = 0.37$), or severe adverse neonatal outcomes. These data sets are, like most, underpowered to report the occurrence of rare events such as maternal mortality.

Most studies that include countries where midwifery is regulated or integrated into the health care system, including Canada, describe comparable neonatal outcomes.^{12,13,15,18–20,26–29,32–35} Perinatal morbidity and mortality were the primary outcomes analyzed in 743 070 low-risk intended homebirths and intended hospital births with midwives in the Netherlands.¹⁵ There was no difference in perinatal mortality in the first 28 days

between intended homebirth or intended hospital birth for either nullipara (1.02/1000 for planned homebirths vs. 1.09/1000 for planned hospital births; odds ratio 0.99; 95% CI 0.79–1.24) or parous women (0.59/1000 intended homebirths vs. 0.58/1000 for intended hospital births; adjusted odds ratio 0.99; 95% CI 0.87–1.55). Similarly, there were no differences between groups for neonatal intensive care unit admissions up to 28 days and low Apgar scores less than 7. The results were adjusted for gestational age, socioeconomic position, and ethnicity. These neonatal outcomes are consistent with the Canadian meta-analysis findings. Several studies from countries that do not meet Canadian standards for homebirth and lack the necessary criteria previously outlined have reported an increase in neonatal morbidity and mortality in out-of-hospital births.^{17,22,36–39} These studies underscore the importance of a systems-based approach highlighted in Canada that supports homebirth safety.⁴⁰

Thus, the data indicate that individuals at low risk for poor perinatal outcomes who plan homebirth with a regulated provider in an integrated health care system may have improved obstetric outcomes without increased neonatal morbidity or mortality.^{15,18–20,28,29,31} These findings may be associated with provider skill level, interprofessional collaboration and communication, a proactive system-based approach that supports complete home and hospital integration, timely and coordinated referral processes, protection from financial disincentives, the unique characteristics of those who plan homebirth, and full access to obstetric services should transfer from home to hospital be required.⁴⁰

The SOGC reaffirms and emphasizes the importance of choice for individuals and their families in the birthing process. In Canada, homebirth with a registered midwife or an appropriately trained physician is a reasonable choice for those who are evaluated to be at lower risk of obstetric or neonatal complications. All pregnant women should receive information about the risks and benefits of their chosen place for giving birth and should understand any identified limitation at their planned birth setting. Risk assessments should be ongoing throughout pregnancy and birth, and care providers must ensure the individual is advised of any change in their risk status to support their ability to make an informed choice for most suitable birth site.

Communication among and between the hospital and community care providers and policies and procedures providing for timely and appropriate emergency transport are critical components of an integrated system and should

remain a priority to support best practice outcomes. Where individuals make choices that are in conflict with recommendations, every effort should be made to maintain a therapeutic relationship and a respectful harm reduction approach from the team and include communication among all team members. SOGC Consensus Statement about multidisciplinary teams recognized the importance of collaborative practice and concluded that well-planned multidisciplinary care “will produce optimal care for our patients and rewarding and successful practices for all members of the care team.”⁴¹ The SOGC endorses evidence-based practice and encourages ongoing research into the safety of all birth settings. Prospective data collection should capture all births and include planned and actual place of birth.

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