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PLANNED HOME BIRTH IN INDUSTRIALIZED COUNTRIES

by

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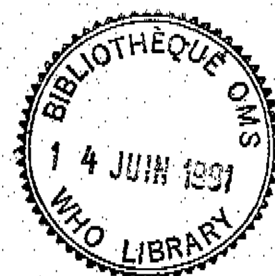

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EUR/HFA TARGET 7

This document presents the results of a study undertaken for the WHO Regional Office for Europe by Dr Michel Odent to promote work aimed at achieving the following target in the health for all strategy.[a]

TARGET 7

REDUCING INFANT MORTALITY RATES

By the year 2000, infant mortality in the Region should be less than 20 per 1000 live births.

Index terms

HOME CHILDBIRTH
OBSTETRICS
EVALUATION
DEVELOPED COUNTRIES
AUSTRALIA
AUSTRIA
BELGIUM
CANADA
DENMARK
FINLAND
FRANCE
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[a] *Targets for health for all.* Copenhagen, WHO Regional Office Europe, 1985 (European Health for All Series, No. 1).

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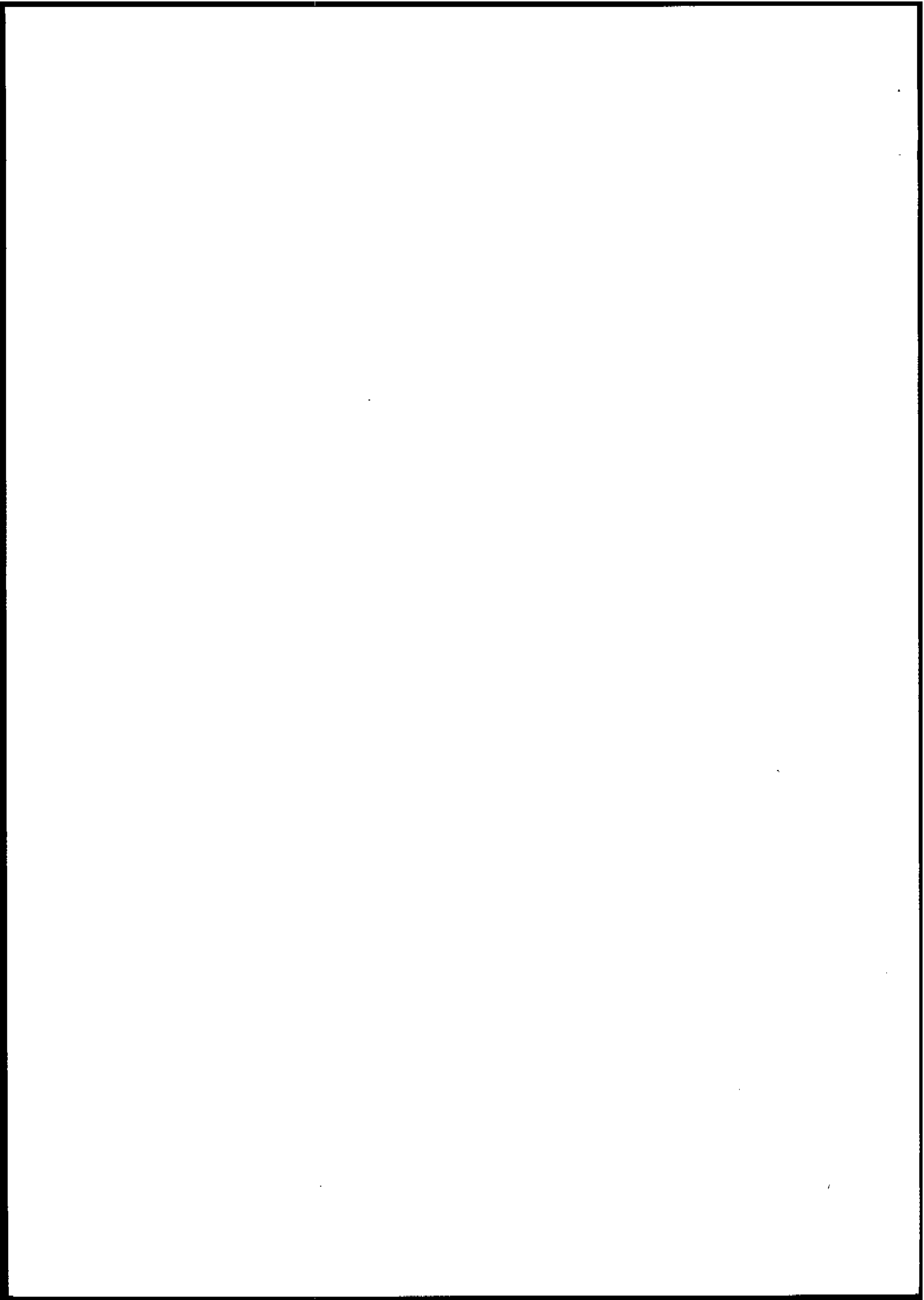

FOREWORD

The issue of place of birth will not go away. In a publication of the World Health Organization Regional Office for Europe Having a baby in Europe, it is said "discussions of home birth generate more heat than light." Because it is difficult to get quantitative data on planned home birth and because birth is a profound social event, more conducive to qualitative approaches, we have asked Dr Michel Odent, a physician with wide experience in both hospital birth and home birth, to prepare a report for us on planned home birth based on his own experience.

While the conclusions in this report are those of Dr Odent and do not represent official policy of WHO, they are nevertheless consistent with the WHO recommendations found in Having a baby in Europe, the Summary Report of the WHO Conference on Appropriate Technology for Birth, Fortaleza, Brazil, 22-26 April 1985 and the Summary Report of the WHO Symposium on Appropriate Technology following Birth, Trieste, Italy, 7-11 October 1986.

Marsden G. Wagner
Responsible Officer
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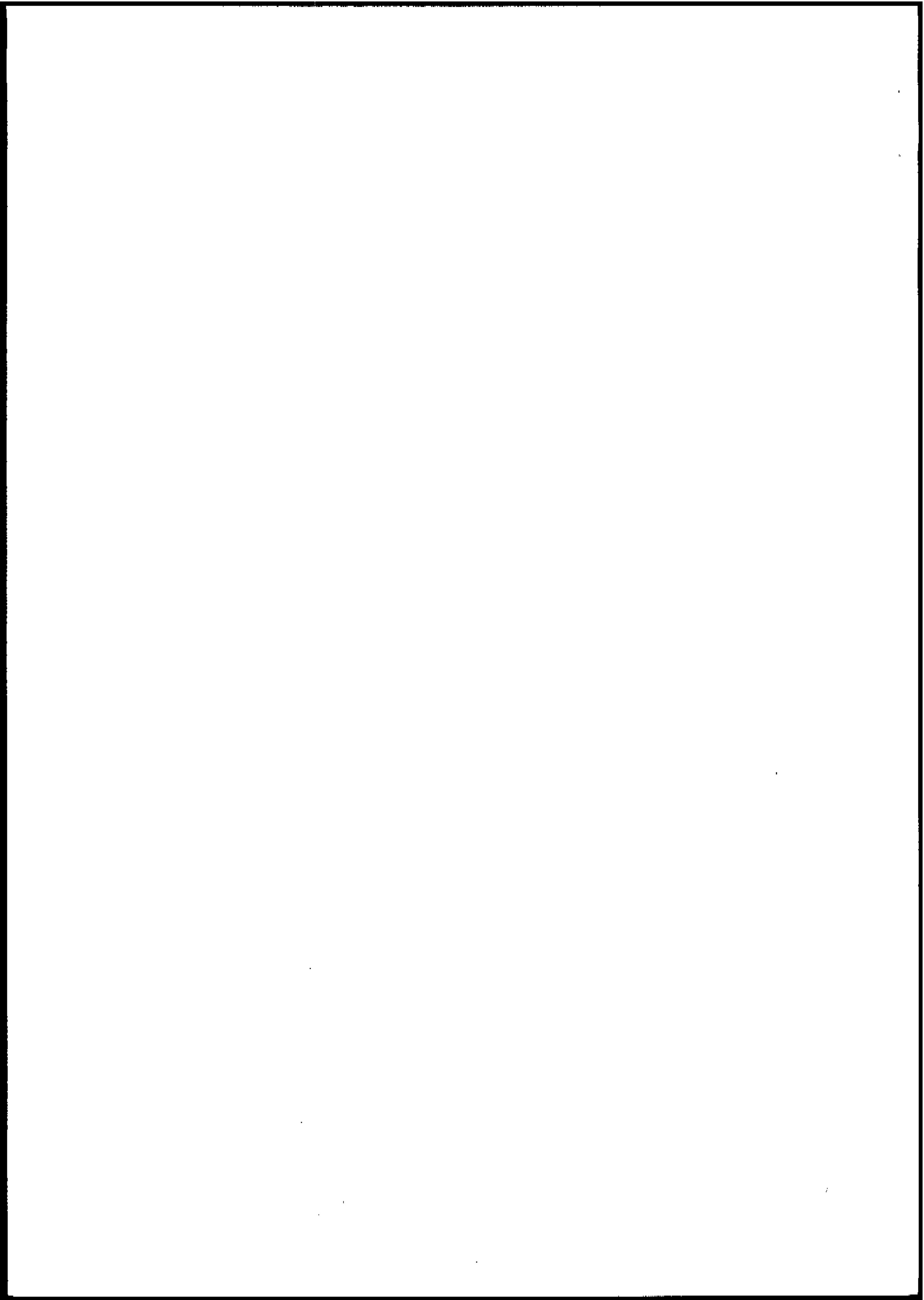

DURATION OF THE ENQUIRIES

The study was undertaken over a period of five years, from January 1986 to December 1990. The personal background of the writer includes being in charge of the maternity unit in a French State Hospital (Pithiviers) from 1962 until 1985. In this hospital, great importance has been attached to the effects of environmental factors in the perinatal period ("bringing the home into the hospital"). The evolution of obstetrics in Pithiviers has been widely documented in medical literature.

METHODS

Two groups of methods have been combined.

First method of enquiry

This involved meetings with midwives, doctors, childbirth educators, parents and medical students in different parts of the world.

A preliminary distinction should be made between what is happening in the Netherlands, where the rate of home birth has always been above 30%, and the rest of the developed world where the rate of home birth is below 2%. I have visited the Netherlands several times and met many Dutch midwives and doctors.

European countries

United Kingdom — I have had numerous meetings with community midwives and general practitioners attending home births within the framework of the National Health Service (NHS); with independent midwives, antenatal teachers, consumer groups, midwifery students and medical students.

France — I have had several meetings with home birth groups, especially in Paris, Toulouse, Millau, Marmande, Angers and Perigueux.

Spain — I have had meetings with the homebirth groups in Valencia and San Sebastian; participated in the "l Jornadas mediterraneas de embarazo y parto" (Valencia 3-5 February 1985) and in the "III Jornadas nacionales y internacionales para matronas" (Alicante 23-24 November 1990).

Italy — Meeting midwives with experience of home birth in 19 different cities. I have had special contacts with the groups in Modena and Catania. Less than 1000 home births a year are shared by 22 different groups of midwives.

Malta — I have contacts with local groups made during the launch of the St James Natural Birth Centre (June 1988).

Switzerland — I have had meetings with midwives, doctors, and consumer groups in the districts of Geneva, Lausanne and Zurich.

Germany — I have had meetings with home birth midwives and childbirth educators, especially in Munich, Berlin and Regensburg.

Austria — I have had meetings in Vienna with professionals and parents.

Greece — I have visited Thessaloniki and had meetings with different professionals.

Belgium — I participated in a public debate at Liege University (16/17 March 1987) which included a presentation by Dr Gisela De Ridder about "Home birth in Belgium'. I have contact with the Aquarius group in Ostende.

Denmark — I have contacts with home birth midwives.

Norway — I have had several meetings in Oslo and Tonsberg with midwives and other professionals. Meetings also with some isolated midwives doing home births.

Sweden — I spent a day in Uppsala with the Stockholm-Uppsala Home Birth Group as well as some meetings with other isolated home birth midwives in Goteborg.

Poland — A week spent between Warsaw and Poznan, including lecturing at the midwifery schools.

Finland — I have contacts made possible by Leena Valvane, President of the Finnish Midwifery Association.

United States of America

I have made numerous contacts by participating in conferences organised by La Leche League International (LLLI), the International Childbirth Education Association (ICEA), the National Organisation of Parents and Professionals for Safe Alternatives in Childbirth (NAPSAC), the Cesarean Prevention Movement (CPM), the Pre- and Perinatal Psychology Association of North America (PPPANA), the Midwifery Alliance of North America (MANA), and the magazine 'Birth'.

I have had numerous private meetings sponsored by Doris Haire, President of the American Foundation for Maternal and Child Health (New York).

I have had meetings with home birth groups, midwives, childbirth educators and parents in several American states.

Alaska — Annual meeting of the Midwives Association of Alaska (Fairbanks, July 1987).

Hawaii — The home birth group in Maui.

Arizona — Several visits to Phoenix, Tucson, Bisbee.

I am a member of the advisory board of the Midwifery School of North Arizona

California I have made several visits to the main cities, especially Santa Barbara where a home birth midwife is practising after having been partly trained in Pithiviers.

Idaho The annual meeting of the Midwifery Association of Idaho (Bonners Ferry, 1987).

Illinois (Chicago), Maine (Portland), Washington DC, Massachusetts (Boston area, Leominster, Amherst), Minnesota (Minneapolis), Missouri (St. Louis), Montana (Missoula), New Jersey (CPM of New Jersey), New York (New York City, Rochester, Syracuse, Scarsdale, Long Island), New Mexico (Albuquerque), North Carolina (meeting in Charlotte with the only legal midwife in the state), North Dakota (having special contacts with the midwifery alliance of North Dakota and visits to Bismark, Minot Fargo, Grand Forks), Ohio (Cleveland), Oregon (Portland), Pennsylvania (Philadelphia), Tennessee (Knoxville), Texas (Dallas, Houston, and special contacts with the home birth midwives in Austin), Washington (as a member of the professional advisory board of the midwifery school in Seattle), Wisconsin (two days spent in La Crosse).

Canada

I have had meetings with home birth groups in the cities of Quebec, Montreal, Toronto, Winnipeg, Regina, Calgary, Vancouver, Victoria. In Montreal, I appeared before a court as an expert witness in a case of a neonatal death after a home birth attended by a lay midwife.

Israel

I have contacts with local groups made during the International Conference on Childbearing and Perinatal Care (Jerusalem, March 1987).

Australia

I have had meetings with home birth midwives, doctors, childbirth educators, parents, students in New South Wales (Sydney, Canberra, Wagga Wagga, Tamworth, Lismore, Dubbo); Victoria (Melbourne); Tasmania (Launceston); Queensland (Brisbane and several places on the sunshine coast); the Northern Territory (Darwin); South Australia (Adelaide); Western Australia (Perth, Bunbury).

New Zealand

I have had meetings with home birth midwives, doctors, childbirth educators, parents, in Auckland, Tauranga, Wellington, Dunedin, and Christchurch.

In addition to these visits to different countries, the First International Conference on Home Birth (Wembley, London, October 1987) was an opportunity to meet representatives from Latin America, India, Japan and Hungary.

Second method of enquiry

I have taken up the role of a birth attendant at home, working in the London area (United Kingdom), that is to say in a country where the rate of home birth (1%) is close to the rate generally in the industrialized world. All these births have taken place less than thirty minutes away from a hospital (the typical situation for the majority of women living in the industrialized world). When attending a home birth, I am the only experienced professional in the house.

During the period of enquiry I have been called to attend 100 births. In 95 cases I did not refuse a trial of labour at home in advance, assuming that the first stage of labour is the right time to do the screening. In many cases I had seen the pregnant woman only once before the birth, in cases where it was a last minute decision to stay at home, or the woman had been refused by other birth attendants for medical reasons, etc.

With regard to the 84 deliveries that finally happened at home, 36 of the mothers were primiparas (including one breech presentation and three women aged around 40); three women had had a previous caesarean; one woman had had a fibroid removed (myomectomy), and one woman had had a post-partum haemorrhage and manual removal of the placenta after her previous delivery in a hospital. Nine women gave birth twice in my presence.

Among those 84 home births there were no episiotomies and only one second degree tear; none of the babies had to be suctioned or ventilated; there was no incidence of post-partum haemorrhage.

On five occasions I have refused a trial of labour at home: once I was called at the same time for two births; once I advised the mother to go to the hospital on the basis of information given on the telephone (bleeding in the middle of the night in a distant district while I was attending another birth (the outcome was a normal birth); on another occasion it was a transverse lie and the indication for a caesarean was indisputable; I once refused the principle of a home birth six days after the premature rupture of the membranes (the baby was born normally in hospital); and on yet another occasion I refused the principle of a home birth three weeks after the due date (again, the baby was born normally in hospital).

When I have advised transferring to the hospital during labour, it has always been before a clear case of complication had occurred. Once a caesarean was performed soon after arrival at hospital (there were signs of fetal distress during the first stage).

All the mothers and babies have been visited by national health service community midwives after notification of the birth to the health authority. Two babies were sent to a hospital by the midwives after a few days for benign jaundice. One post-term baby born after a fast labour (secundipara) was transferred to a paediatric unit in the first week for digestive problems - a mild form of necrotizing enterocolitis was hypothesized and the recovery was complete in a few days.

CONCLUSIONS

By combining the two methods of enquiry, some conclusions can be drawn.

Conclusion I

A statistical approach has only a limited value at the present time (except in the Netherlands) to evaluate the potential advantages of home birth in the industrialized countries.

A It is impossible to draw general conclusions from a small self-selected group. Within this small group the motivations are not the same, and are not representative of the whole population (exceptional self confidence, or exceptional phobia of hospitals, or an intellectual analysis of the risks and benefits, etc.).

B Statistics cannot easily take account of the effects of the current dominant beliefs about the process of birth. The dominant beliefs regarding home birth are the same everywhere in the industrialized world (except the Netherlands) and easy to summarize: "home birth is dangerous". This belief is shared by many hospital trained European midwives, many American nurse midwives, by the majority of the general public, by many career women who hold key roles in journalism, and (still more) by medical students and practising doctors.

Everywhere in the world, whenever a pregnant woman mentions home birth in front of her doctor (general practitioner or obstetrician) the most common reaction is "It is a return to the past. What will you do if ....?"

Many doctors do not hesitate to reinforce the fear of childbirth without taking any account of fear being the main obstacle to an easy birth. Moreover, as long as home birth is a marginal phenomenon many birth attendants feel especially vulnerable to legal action. This situation triggers another aspect of fear surrounding birth, the effect of which is difficult to evaluate in terms of statistics.

The current medical attitude is deeply entrenched. Most of the medical students I have met could never imagine that the environment might influence the physiological processes in the perinatal period and that environmental factors might be taken into account. Very few doctors around the world mention that birth in a familiar place and in privacy might be a way to avoid complications, and very few doctors have looked into the statistics from the Netherlands, the only western country where home birth with the backup of a hospital is commonplace.

Very few doctors mention that a newborn has been sharing its mother's antibodies (IGg) and is therefore specifically adapted to the domestic microorganisms.

The current beliefs surrounding home birth can also be reinforced by the media. The story of a stillbirth in France has been reported all over the world and conclusions drawn without any statistical reference.

C Statistically, it is difficult to evaluate the effects of an atmosphere of conflict surrounding home birth. In some countries this antagonism cannot be dissociated from the conflict between obstetrics and the art of midwifery. This is more open in countries where midwives are outnumbered by obstetricians (Canada, USA, Brazil, Italy).

D The criteria for selection vary enormously from one birth attendant to another, ranging from accepting only those women who have had an easy previous birth, up to accepting almost everybody.

In spite of all the difficulties there have been many attempts to express the outcomes of home birth in the industrialized world in statistical terms.

In the United Kingdom, Marjorie Tew stumbled into the subject in 1975 when she was teaching epidemiology to medical students in Nottingham. Whilst doing some "epidemiological exercises", she discovered by chance that no statistics could support the widely accepted hypothesis that the increased hospitalisation of birth had caused the decline by then achieved in the perinatal and maternal mortality rates (3-5).

In France, the medical team in Millau presented its own statistics in 1986 (300 births) in a rural area which is not typical of an urban society. Other documents were put forward by groups of midwives and general practitioners who had understood that the statistics concerning one particular birth attendant are too small to be significant (e.g. Toronto).

Statistical studies have been conducted in a number of American states (6-9).

A report about neonatal mortality in Missouri home births (10) including 3067 planned home births, provided evidence that nearly all the mortality excess for planned home births occurred in association with less experienced attendants. This is the main conclusion shared by all the home birth practitioners who follow up their own outcomes: the statistics tend to improve according to their experience (the statistics from Millau in 1986 with 300 births were better than the statistics in 1984 with 180 births).

We should bear in mind that very experienced birth attendants in the Third World (e.g. Malawi) have records which would be acceptable in the industrialized world (11,12), where, as long as home birth remains marginal, many birth attendants will lack experience. In turn, the home birth attendants' lack of experience further compromises any statistical evaluation of the potential of home birth.

<u>Conclusion II</u>

Some mistakes appear to be common everywhere in the world in the context of an urban society (home birth with hospital backup).

A The most common mistake is to accept a home birth after a long and difficult first stage. in other words the first stage of labour should be considered the best time to select women who can give birth at home. From informal conversations with hundreds of birth attendants it appears that most complications (newborn baby in need of resuscitation, post-partum haemorrhage, etc.) are preceded by a long and difficult first stage. On the one hand, a transfer during labour is not associated with

special risks. This has been demonstrated in the Netherlands in the "Wormerver Study" where the perinatal mortality rate after transfer during labour was the same as the overall national rate during the same period (11 per 1000) (13). On the other hand if the first stage of labour is considered to be the elective time for screening, fewer pregnant women have to carry the label "high risk" for several months of pregnancy which is, itself, a cause of dangerous anxiety.
In the Wormerver Study, referral by the midwife to an obstetrician during pregnancy was associated with a very high perinatal mortality rate (51 per 1000).

B A second common mistake among home birth attendants is to underestimate the importance of privacy during labour. It is commonplace in the home birth movements to emphasize the mother's need for support, emotional help, assistance etc. The word "privacy" comes far down the list. Friends are invited to share a home birth. This attitude is at odds with the concept of "natural childbirth". Among all the mammals "natural childbirth" is birth in privacy.

C A third common mistake is to introduce the rules established by professionals who have no experience of home birth. For example, midwives working under different health systems have to repeat a certain number of vaginal exams and record the progress of the dilation of the cervix on a graph. In fact midwives who go beyond their hospital training and have good experience of home birth in complete privacy do not need to disturb the labouring woman with many vaginal examinations. They can easily assess the progress of labour by the noise the woman is making, the way she is breathing, her position, etc.

Another example is the rule which obliges community midwives in some British health districts to attend a home birth with a colleague. This requirement is inspired by the practice of obstetrics in the framework of a medical team. Practising the art of midwifery is a solitary experience. It is counterproductive to introduce two birth attendants while the main role of the midwife is to assess now and then the rhythm of the baby's heartbeat or detect in good time any reason for making a transfer to hospital.

Not only is it often a mistake to follow the guidelines laid down by hospital teams in the context of a home birth but it would also be a mistake to apply the conclusions of studies conducted in another environment to home birth. For example, a so-called "physiological third stage of labour" in a teaching hospital has nothing in common with what it can be like in a familiar place and in complete privacy (in a small, dark room; well-heated; no observers; no suggestions; no interference with the skin-to-skin contact and eye-to-eye contact between mother and baby during the first hour following birth, etc.).

Conclusion III

There are also financial reasons why home birth is not a real option in the developed countries. The economic obstacles are not the same in every country. For example, in the United Kingdom women who want to have the option of a home birth often want to know in advance who will be their birth attendant. They therefore pay an independent midwife although medicine is free in the United Kingdom through the NHS. In France, the independent

midwives ("Sages femmes liberales") have difficulty making a living. The "securite sociale" estimates that the fees for assisting at a home birth are FrFr. 830 (including the postnatal visits!).

Conclusion IV

The development of home birth on a large scale will be easier in the countries where midwives outnumber obstetricians. From conversations with Scandinavian midwives it appears that home birth networks might be easily introduced in cities like Stockholm or Goteborg although the rate of home births is below 1% at present, in Sweden.

In the United Kingdom the development of home birth should be facilitated by the productive competition between community midwives working in the NHS and independent midwives. On the other hand it will be more difficult in a country like Canada (where the training of midwives is still at the project stage), or Spain (where the training of midwives has been interrupted for five years).

RECOMMENDATIONS AND SUGGESTIONS

1. Since the main obstacle to our modern society adapting to home birth is in the realm of beliefs the priority must be to challenge the universal propaganda that home birth is dangerous and is just a return to the past. The best means by which to challenge the current beliefs are the statistics from the Netherlands (14). But these statistics must be simplified and summarized to be easily understood. For example, "the Netherlands is the only industrialized country where one third of all births happen at home. The Netherlands is also the only country where they can reconcile a perinatal mortality rate lower than 10 per 1000, a maternal mortality rate lower than 1 per 10 000, and a rate of caesarean section of around 6%".

2. While there is no serious reason to discourage the development of home birth with the back-up of a modern hospital, an excessive amount of organization in home birth networks, on the other hand, might be counterproductive. Most women who want to give birth at home wish to know in advance the person who will be their birth attendant. The art of midwifery cannot be systematized like obstetrics.

3. From a long-term point of view it should be beneficial to try to control the ratio between the number of midwives and the number of obstetricians, and to introduce the concept of quota to regulate this ratio. We suggest that countries such as the Netherlands or Sweden might be used as references. In these countries the rate of caesarean section and other interventions has been pretty stable for the last twelve years (15).

4. The effect of environmental factors on human parturition and other physiological processes in the perinatal period should be a topic introduced into the curriculum of medical students. This would lead students and their teachers to raise new questions and would challenge dominant beliefs.

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