



SAFETY OF COMMUNITY BIRTH

Education and training

- Washington State has the most rigorous training and educational requirements for Licensed Midwives (LMs) of any state in the U.S. LMs in Washington are required to attend at least 100 births prior to licensure and are the only profession of regulated obstetrical care providers (e.g. doctors, nurse-midwives) who routinely attend home births. This training and experience ensures high-quality care during pregnancy and birth.
- LMs in Washington have excellent relationships with nurse-midwives, doctors, hospitals, and ambulance personnel. These teams work together to ensure clients have the best care possible. A recent study (Vedam et al., 2018) found that states where midwives were most integrated into the regional healthcare system had the best outcomes for parents and newborns. Washington State was #1 in these rankings.

Midwives Model of Care

- Midwives use a “low-tech, high caring” model that centers the family and their informed choices. The [Midwives Model of Care](#)™ has been found to reduce birth injury, trauma, and surgical interventions while supporting the physical, psychological, and social well-being of pregnant and birthing people.

Monitoring

- LMs are constantly monitoring for early signs of complications during pregnancy and birth and are prepared to manage emergencies and refer to higher levels of care at a moment's notice.
- Each prenatal visit includes a component of risk assessment, such as screening for common infections, measuring the baby's growth, and checking blood pressure.
- During birth, midwives monitor the baby's heart rate, the parent's vital signs, and the progression of labor. They help support a normal labor progression and help families decide when a transfer to the hospital may be an appropriate choice.
- LMs use intermittent auscultation (IA) to monitor babies' heart rates in labor, which means that they monitor the fetal heart rate at periodic intervals instead of continuously. A large meta-analysis found that IA was associated with more spontaneous vaginal births and fewer cesarean births than continuous monitoring (Alfirevic, 2017).
- Midwives are prepared for emergencies at every birth. LMs carry oxygen, medications to prevent and treat hemorrhage, suture equipment for mild-moderate tears, IV supplies, and more.





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Research Supporting the Safety of Home Birth

Years of research have demonstrated excellent outcomes for low-risk people when births are planned at home. Your midwives' summary of this research is below. Please also see [Homebirth: An Annotated Guide to the Literature](#) (Vedam et al., 2013).

- [Johnson & Daviss, 2000](#): This study concluded that intervention rates were significantly lower in planned home births than in planned hospital births. There was no difference in rates of perinatal death.
- [Hutton et al., 2009](#): This study compared births that were attended by midwives in Ontario, Canada. Planned home births were significantly less likely to experience severe postpartum bleeding, severe tears, labor augmentation, and cesarean birth. The study found no differences in rates of perinatal deaths.
- [de Jong et al., 2009](#): This very large study of planned home and hospital births in low-risk people in the Netherlands found that planned home birth was not associated with higher rates of perinatal death or increased rates of NICU admission compared to planned hospital birth.
- [Janssen et al., 2009](#): This large study compared midwife-attended planned home births and planned hospital births in British Columbia, Canada. The authors found that the rates of intervention and complications were significantly less likely in the planned home birth group. Most complications for babies were less likely in those planning home birth, however, babies were *more* likely to be admitted to the hospital in the planned home birth group, usually because of jaundice. Rates of perinatal death were similar in all groups.
- [Cheyney et al., 2014](#): This large study examined data from planned home births in North America. Cesarean section rates in this study were 5.2%, compared to a 32.8% cesarean rate in hospital-based data samples. The authors concluded that for low-risk people, home birth reduces the rate of interventions without leading to increased adverse outcomes.
- [Hutton et al., 2019](#): This large meta-analysis examined data from about 500,000 planned home births. Authors conclude that planned home births are associated with fewer interventions or adverse outcomes. No differences in perinatal or neonatal mortality or mortality were reported.
- [MacDorman & Declercq, 2019](#): National birth certificate data from all 50 United States between 2004 and 2017 found an 85% increase in planned community birth rates in this time period. Overall, over ⅔ of planned home births were self-pay, and the authors argue that lack of insurance and/or Medicaid coverage is a limiting factor for access to community birth.
- [Nethery et al., 2021](#): This large study analyzed over 10,000 planned community births in Washington State (a highly regulated, well-integrated State) between 2015 and 2020. The authors found a low risk of adverse maternal or neonatal outcomes in both planned home and birth center births. About 30% of first-time birthing people transferred to the hospital at some point in labor. Cesarean birth rates were 11.4% for





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first-time birthing people and less than 1% when it was not a first birth. Rates of perinatal mortality were 0.57 per 1000 births, which the authors point out is identical to the rate ACOG cited as a benchmark against which homebirth perinatal mortality should be compared.

- [Grünebaum et al., 2022](#): This large study analyzed CDC data of almost 19 million total births. The authors found that deliveries with risk factors have significantly higher odds of adverse outcomes (the highest risks were for twins and breech) and criticized the conclusions of Nethery et al., 2021. These types of high-risk births were purposefully excluded from Nethery's research because they did not meet their low-risk criteria and were not appropriate candidates for low-risk home births based on Washington State guidelines.
- [Bovbjerg et al., 2024](#): Two large national community birth registries of over 100,000 births compared home birth and birth center data in all 50 states. There were some differences in the two datasets, but overall, the study found comparable or lower rates of hospitalization (both parental and neonatal) in those planning home births compared to birth center births. There were no significant differences in intrapartum or neonatal death. One data set showed higher rates of cesarean birth in those planning home births compared to birth center births. The authors conclude that ACOG's support of birth center birth but not home birth is not supported by the evidence.

The Controversy

The American College of Obstetricians and Gynecologists (ACOG) acknowledges that planned home birth is associated with fewer interventions for the parent but warns families that home birth is associated with double the rates of perinatal death. This sounds alarming, but we know that this claim is due to problematic research.

- **Pang et al., 2002**: This study examined birth certificate data in Washington State and concluded that home births are associated with about twice the rates of neonatal death. The problem is that birth certificate data includes *all* babies who were born at home, whether or not that was the plan. Furthermore, the authors used selective statistical manipulations to make their main outcomes appear statistically significant.
- **Wax et al., 2010**: This meta-analysis also concludes that planned home births are associated with higher rates of perinatal death because the Pang et al., (2002) study made up a large proportion of its data. Unfortunately, meta-analyses are considered to be at the top of the hierarchy of scientific evidence, so these conclusions are often accepted without question, even though they're based on biased research.





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