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EVALUATING THE SAFETY OF HOME BIRTH IN THE MODERN HEALTHCARE CONTEXT: EVIDENCE FROM INTERNATIONAL RESEARCH

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ABSTRACT

The choice between home birth and hospital birth remains a topic of considerable discussion within contemporary obstetrics. The choice of birth setting and the characteristics of women opting for home birth vary across different regions of the world. In developed countries, hospitals are the default place of birth, whereas in developing countries, childbirth more often occurs at home. One of the most important criteria for comparing home and hospital births is the safety of both the mother and the newborn.

The comparison of home and hospital births among low-risk women shows similar neonatal safety, with lower NICU (Neonatal Intensive Care Unit) admissions and intervention rates in home births. Mothers delivering at home experience fewer cesarean sections, episiotomies, and postpartum complications. However, outcomes vary regionally, with U.S. studies reporting higher neonatal risks in planned home births.

Transfer to hospital rates range from 10-30%, mainly due to slow labour. VBACs (Vaginal Birth After Cesarean) at home are associated with lower cesarean rates but higher non-urgent transfers. Postpartum outcomes, including breastfeeding success, are superior after home birth. Evidence suggests that, in integrated systems, home birth can be a safe and informed choice.

KEYWORDS

Home Birth, Hospital Birth, Maternal Outcomes, Neonatal Outcomes, Low-Risk Pregnancy, Childbirth Safety

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Introduction

Childbirth is one of the most important events in a woman's life. (Galera-Barbero & Aguilera-Manrique, 2021, p.1) The birth of a child evokes a wide range of emotions both during and after childbirth. On the one hand, a positive childbirth experience can have a long-lasting effect on women's self-efficacy and self-esteem. On the other hand, a negative childbirth experience may lead to negative outcomes, such as fear of childbirth, maternal distress, depression, and post-traumatic stress disorder (PTSD) (Green, Tesler, & Marques, 2022, p.1) Given the significance of this event, the choice of birth setting appears to be highly important.

Home birth is a widely practised norm among women in most developing countries. (Said & Ibrahim, 2022, p. 63) The prevalence of home births is 23.8% among women in East African countries; it was highest among women in Ethiopia (72.5%), Kenya (53%), and Tanzania (33.5%), and lowest among women in Mozambique (2.8%). However, a greater prevalence of home deliveries were reported in the West African region - Ghana (7,9%), Nigeria (59%), Cameroon (33,8%), Chad (78%) and Niger (70%) - and the Southwest Africa region - Namibia(40%). (Akokuwebe & Idemudia, 2023, p. 32-33)

The majority of women living in high- and middle-income countries have given birth in hospitals since the middle of the 20th century. (Olsen & Clausen, 2023, p.5) Significantly fewer births occur in birth homes or home settings. According to data from the Central Statistical Office of Poland in 2023, home births accounted for only 0,34% of all deliveries. In Europe, the highest rates of home births are observed in the Netherlands (16,3%), Denmark (1,4%), and Germany (1,3%) (Galková et al, 2022) The notably high rate in the Netherlands, not observed in other developed countries, likely reflects the population's trust in a healthcare system that supports the option of home birth. Despite the overall low prevalence of home births in European countries, an increasing trend is currently observed, with more women opting for home as the place of delivery. A similar pattern is evident in the United States, where the number of home births increased from 35,578 in 2004 to 62,228 in 2017 (Daviss, Anderson & Johnson, 2021, p.3) Consequently, the choice of home versus

hospital birth is increasingly being discussed in the context of maternal safety, medicalization, and women's perceived sense of security.

This paper presents a literature review addressing the reasons for choosing home as the place of birth and the safety of this option. The article attempts to examine whether home birth represents a safe alternative for both mother and neonate compared to hospital delivery. A separate section is dedicated to women with a previous cesarean section and the attempt of VBAC (Vaginal Birth After Cesarean) at home - HBAC (Home Birth After Cesarean).

Methodology

The article is a review of scientific studies on home births worldwide. Its aim was to collect the most recent data from various countries, including the USA, Australia, the Netherlands, Poland, Germany, Ethiopia, and South Africa. Particular attention was given to meta-analyses available on Google Scholar and PubMed.

Reason for Choosing Home as the Birth Setting

Choice of birth setting may be influenced by health, pregnancy status, family needs, and religious or cultural values. (Lang, Farnell & Quinlan, 2021, p. 673) For women in most developed nations, the choice of where to give birth is not really a consideration, because birthing in a hospital is the cultural norm. (Zielinski, Ackerson & Kane Low 2015, p. 361) Consequently, this article primarily examined the motivations of women who chose an out-of-hospital birth.

A central consideration in discussions about home birth is safety and risk. An insightful analysis of this topic among women opting for home birth was published in Midwifery in May 2025, with data collected mainly from high-income, English-speaking countries. The study found that women choosing home birth often perceive hospital environments as disruptive to the natural physiology of labor, potentially causing complications or unnecessary interventions. Additionally, hospitals were viewed as lacking emotional and psychological support and as posing potential risks to human rights. Regarding risks associated with home birth, women most commonly expressed concerns about judgment from others regarding their decision, worst-case scenario outcomes, and limited access to a midwife (Chauncy, Dawson & Bayes, 2025).

Similar findings were reported in a July 2021 study on reasons for choosing home birth among Australian women. Women opted for home birth not only to avoid medical interventions but also to escape time pressure and perceived lack of support for natural labor in hospitals. Motivating factors included access to continuous midwifery care, immediate and uninterrupted skin-to-skin contact with the newborn, early breastfeeding, availability of water birth, and the ability to choose labor positions (Sassine, Burns, Ormsby & Dahlen, 2021).

As can be observed, among the reasons for choosing home as the birthplace, the primary motivation for women appears to be the desire to experience the most natural birth possible, without unnecessary medical interventions. As noted by the WHO, increasing medicalization of childbirth processes tends to undermine the woman's own capability to give birth and negatively impacts her childbirth experience. (World Health Organization, 2018, p. 1) However, Rossi and Prefumo (2018, p.107)) state that "if the reduction of medical interventions is advantageous for women and fetal wellbeing, is still to be determined. Labor augmentation with either oxytocin or amniorrhexis shortens duration of labor, epidural analgesia allows pain relief, leading to more collaboration from women, and benefits of episiotomy are the never-ending debate."

The COVID-19 pandemic was a major driver of changes in healthcare organization worldwide. It also affected perinatal care and, consequently, women's decisions regarding the place of birth, making them more likely to consider alternatives to hospital delivery (Lang et al., 2021). In Poland, the number of home births doubled during the COVID-19 pandemic, as women opted for home delivery due to concerns about giving birth without the support of their husband or partner (Damentko, Damra, Dąbrowska, Kiersnowska & Bączek, 2023). Other factors influencing the decision to deliver at home during the pandemic included fear of infection and separation from the newborn after birth (Nelson & Romanis, 2021).

At this point, it is important to distinguish home birth from "freebirth," which is defined as "the deliberate decision to give birth without a regulated healthcare professional". (Higueras, Douglas & Kennedy, 2024)

Characteristics of women choosing home birth

British study shown, that compared with the obstetric unit group, women planning to give birth at home were more likely to be older, white, have a fluent understanding of English, and live in a more socioeconomically advantaged area. (Birthplace in England Collaborative Group, 2011, p. 3) Similar patterns are observed in the USA, where home births are more commonly chosen by older, white, well-educated, married women (Fleming et al., 2016).

In contrast, the situation in African countries differs. In Ethiopia, where home births account for approximately 74% of all deliveries, they are more often chosen by women with lower education levels, residing in rural areas far from healthcare facilities, and multiparous women (Weldegiorgis & Feyisa, 2021).

Safety

The main focus of this article remains the comparison of safety - for both mother and child - between home births and hospital births. The presented studies predominantly involve women with low-risk pregnancies, as guidelines on home births state that only low-risk women should be accepted for, or have recommended, home birth. “Low-risk women” are defined as women without medical diseases or conditions that may influence outcomes of pregnancy, without serious complications in previous pregnancies, with a single foetus in the cephalic position, and with a spontaneous onset of labour at term. (Blix, Kumle, Kjærgaard, Øian & Lindgren 2014, p.1)

Neonatal safety

A systematic review and meta-analysis focusing on low-risk pregnancies in high-income countries showed no significant difference in stillbirth risk based on the planned place of birth. Similarly, no significant differences were observed in early neonatal mortality. Infants born at home were less likely to be admitted to the Neonatal Intensive Care Unit (NICU) (Scarf et al., 2018, pp. 251–252).

A comprehensive Canadian meta-analysis, including studies from the Netherlands, England, and the USA, also found no differences in neonatal mortality outcomes between planned home births for low-risk pregnancies and hospital births. However, unlike the Scarf meta-analysis, no differences were noted in NICU admissions. Apgar scores and the need for neonatal resuscitation were also similar across birth settings (Hutton, Reitsma, Simioni, Brunton, & Kaufman, 2019, p.60).

An Australian study on planned home births reported comparable findings: there were no statistically significant differences in rates of stillbirth, neonatal mortality, low 5-minute Apgar scores, or intrauterine hypoxia between home and hospital births among low-risk women. Among high-risk pregnancies, stillbirth rates did not differ significantly between planned home and hospital births, but neonatal mortality was 7,2 times higher and NICU admissions four times higher in the home birth group. Interestingly, rates of birth trauma, intrauterine hypoxia, and complex perinatal morbidity were lower among planned home births (Davies-Tuck, Wallace, Davey, Veitch, & Oats, 2018).

Rossi and Prefumo (2018) state that infants from planned home births had a lower risk of shoulder dystocia compared with planned hospital births. They also noted that the risk of perinatal death, neonatal asphyxia, and low Apgar scores was similar between groups. The authors emphasized that Apgar scores may be an unreliable measure and suggested using umbilical cord blood pH, which provides more precise and less subjective information regarding neonatal hypoxia.

In the studies cited so far, neonatal safety in planned home births was comparable to hospital births. However, different findings have been reported in U.S.-based research. There is an obvious ‘Atlantic Divide’ over the role of home birth in modern obstetrics. There is agreement that for medically complicated pregnancies, outstanding care can only be provided in an obstetric unit, but for low-risk pregnancies, US obstetricians are more against home birth than their European counterparts. (Walker 2017, p.82) A U.S. case-control study indicated an increased risk of hypoxic-ischemic encephalopathy (HIE) among neonates born in planned home births (Buchanan et al., 2022). Another American analysis reported higher neonatal mortality in planned home births (Grünebaum, McCullough, Orosz, & Chervenak, 2020).

Beyond the basic safety parameters, another important aspect to consider is the difference in microbiota between infants born at home and those born in hospitals. It is now widely recognized that the microbiota can influence human physiological function in multiple ways. Hospital-born infants were found to have lower levels of *Bacteroides*, *Bifidobacterium*, *Streptococcus*, and *Lactobacillus*, and higher levels of *Clostridium* and members of the *Enterobacteriaceae* family. Stool samples from hospital-born infants at one month of age induced higher expression of proinflammatory genes (TLR4, IL-8, occludin, and TGFβ) in human colonic epithelial HT-29 cells (Combellick et al., 2018).

Maternal safety

A Canadian meta-analysis of data from high-income countries shows that women in well integrated settings who intended to give birth at home compared with those planning a hospital birth were >40% less likely to give birth by caesarean section; >50% less likely to have an operative vaginal birth; 70% less likely to use epidural analgesia; 55% less likely to have an episiotomy; >40% less likely to experience a 3rd or 4th degree perineal tear and >60% less likely to receive oxytocin augmentation of labour. Adverse maternal outcomes were also less frequent among those intending to give birth at home with: >75% fewer reporting maternal infection and >30% fewer reporting postpartum haemorrhage. (Reitsma, Simioni, Brunton, Kaufman, & Hutton, 2020, p.4) The findings of the Scarf meta-analysis are similar: women planning home births were nearly three times more likely to achieve an unassisted vaginal delivery compared with those planning hospital births. Additionally, women giving birth at home had significantly lower risks of severe perineal trauma and major postpartum hemorrhage (≥1000 ml). (Scarf et al, 2018) The Australian study previously cited in the context of neonatal results shows that low-risk women planning a home birth have a significantly higher likelihood of spontaneous vaginal delivery, lower rates of neonatal intensive care admission, severe perineal trauma, intrapartum and postpartum hemorrhage, blood transfusion, and manual placenta removal. They also have significantly lower rates of unplanned cesarean sections, epidural analgesia, and episiotomy. Similarly, home births among high-risk women are associated with higher chances of spontaneous vaginal delivery and lower rates of obstetric interventions (Davies-Tuck et al, 2018).

Similar results are observed in the Netherlands, where women giving birth at home had a lower risk of operative delivery and cesarean section. (Van der Kooy, Birnie, Denktas, Steegers & Bonsel, 2017) Rossi & Prefumo similarly report that low-risk pregnancies planned for home birth have twice the likelihood of spontaneous vaginal delivery, whereas women planning hospital births more frequently underwent operative delivery. Home birth was also associated with reduced medical interventions, including labor augmentation, epidural analgesia, and episiotomy. Interestingly, women planning home births in this analysis had a higher risk of perineal tears of any degree.

Transfers to hospital

One of the most important criteria providing an accurate picture of the safety of home births is the analysis of transfers from home to hospital. The most general classification of transfer reasons divides them into maternal and neonatal causes. It is also crucial to distinguish whether the transfer occurred during labor or postpartum, and whether it was an emergency transfer to save life or prompted by the need for further maternal or neonatal assessment. (Lisowska & Dobrzycka, 2025, p.97).

The proportion of home births requiring transfer to a hospital varies depending on the source. Rossi & Prefumo (2018) state that 4-10% of women planning a home birth required transfer to a hospital during or after labor. In a Hungarian study, this rate was 11,77%. (Wami et al, 2022) In the USA, among women who planned a home birth, 89,1% delivered at home, with most intrapartum transfers occurring due to slow progress in labor. (Cheyney et al, 2014)

In the review by Blix et al. (2014), the rate of transfer from home to hospital during and after planned home birth ranged from 9,9% to 31,9%. Among primiparas, this rate ranged from 23,4% to 45,4%, and among multiparas from 5,8% to 12,0%. The most common indication for transfer was labour dystocia (slow progress in labour), occurring in 5,2% to 9,8% of all women planning a home birth. Indications for transfer due to fetal compromise ranged from 1,0% to 3,6%, due to postpartum hemorrhage from 0% to 0,2%, and due to neonatal respiratory problems from 0,3% to 1,4%. The rate of emergency transfers ranged from 0% to 5,4%.

Similar results are observed among Scandinavian women. There, transport from home to hospital usually takes approximately 15-20 minutes. According to a systematic review (Blix et al., 2016) involving women in Norway, Sweden, Denmark, and Iceland, 32,7% of primiparas and 8,0% of multiparas were transferred to the hospital during labour. The most common reasons for transfer were slow progress in labour, the need for analgesia, and suspected fetal compromise. Overall, 28,9% of transfers, representing 3,8% of all births, were classified as potentially urgent.

Regarding women who previously had a cesarean section and are now attempting an out-of-hospital VBAC, the rate of transfer to hospital is higher (38,3%) compared to women who previously delivered vaginally (4,6%). Interestingly, the rate of emergency transfers is twice as high among women with prior vaginal births compared to those with prior cesareans. The higher rate of non-urgent transfers for women attempting VBAC might mean that midwives are more cautious when attending women with a prior cesarean in out-of-hospital settings. (Beckmann, Barger, Dorin, Metzing & Hellmers, 2014, p. 309)

Apgar scores at 5 and 10 minutes among neonates transferred from home or midwife-led units were significantly lower. Similarly, infants from home births and midwife-led births who were transferred to hospital also exhibited lower umbilical cord pH values (<7.0). (Schildberger, Riedmann, Leitner & Stelzl, 2024) In the Netherlands, neonates of women planning home births who required intrapartum interventions (operative vaginal delivery and/or cesarean section) demonstrated an increased risk of perinatal mortality (intrapartum and early neonatal mortality up to 7 days postpartum). (van der Kooy et al, 2017)

VBAC – Vaginal Birth After Cesarean and HBAC – Home Birth After Cesarean

Vaginal birth after cesarean (VBAC) is associated with fewer complications for both mother and neonate compared to a repeat cesarean section. (Parslow & Rayment-Jones, 2024). In general, offering VBAC in out-of-hospital settings is considered controversial. (Beckmann, Barger, Dorin, Metzing & Hellmers, 2014, p. 309) Therefore, it is important to examine the potential risks and benefits associated with home birth after cesarean (HBAC).

Regarding neonatal safety, Bayrampour et al. (2021) state that the risk of neonatal mortality and severe morbidity is significantly lower among women planning HBAC compared to those attempting VBAC in a hospital setting. After adjusting for potential confounders, no significant associations were found between the birth setting and neonatal mortality or severe morbidity. Similarly, there were no statistically significant differences in the incidence of 5-minute Apgar scores below 7, frequency of admissions to the neonatal intensive care unit and intermittent positive pressure ventilation (IPV) between infants born via planned home birth after cesarean (HBAC) and those born via VBAC in hospital. In contrast, U.S. studies report differing findings: Tilden et al. (2017) note that out-of-hospital VBAC is associated with a higher risk of neonatal seizures and lower Apgar scores compared to hospital VBAC. However, a meta-analysis by Parslow & Rayment-Jones (2024) found that NICU admissions and low Apgar scores were similar between VBAC births in hospital and out-of-hospital settings.

The rate of cesarean delivery is lower among women planning a VBAC outside of the hospital, at 13%, compared with 30% among women planning a VBAC in obstetric units. A primary concern that comes to mind when considering VBAC is the risk of uterine rupture. However, Parslow & Rayment-Jones (2024) found no differences in the incidence of uterine rupture between women in both groups in their meta-analysis.

Overall, 37,2% of women planning a vaginal birth after cesarean (VBAC) at home were transferred to a maternity unit during labor or immediately postpartum. Transfer rates varied significantly depending on parity; 56,8% of women with one prior cesarean who had not previously delivered vaginally were transferred, compared with 24,6% of women for whom this was their third or subsequent birth. (Rowe, Li, Knight, Brocklehurst & Hollowell, 2016, p. 1127) Another study reported that 77,8% of out-of-hospital VBACs (at home or in independent midwife-led birth centers) were successful. Among women planning a home birth after cesarean (HBAC) who were transferred to a hospital, 42,2% still delivered vaginally. (Beckmann et al, 2014)

After delivery

Satisfaction with childbirth correlates with the quality of care, personal characteristics, and stress experienced during labor. It has been observed that women who planned a home birth or a birth in a “birth centre” report higher satisfaction compared with those planning a hospital birth. (Fleming et al, 2016) This is likely influenced by the fact that during home births, women experienced significantly greater trust in their care providers, felt better informed, and were more actively involved in decision-making. (Gregory, Caffrey & Daly, 2023)

Regarding the postpartum period, it is essential to mention breastfeeding, which “is critical for child survival, nutrition and development, and maternal health”. (WHO, 2018) Spanish data indicate that among women choosing home birth, there was a favorable breastfeeding rate, with 99% of mothers opting for exclusive breastfeeding during the first 6 months, and 96,3% continuing to breastfeed for more than a year (Galera-Barbero & Aguilera-Manrique, 2021, p. 9) On the other hand, a study conducted in Ireland and the UK found that home birthed infants were overall twice as likely to be breast fed and sustained breast feeding was consistently associated with home birth at various time points. (Quigley et al, 2016, p. 3)

At this stage, it is also important to highlight the experiences of fathers during childbirth. Research shows that there are no significant differences between men who participated exclusively in hospital births and those who also experienced home births - in terms of feeling needed, providing support, feeling appreciated, coping with the challenges of labor, or perceiving it as a “test of masculinity.” Contrary to expectations, participation in a home birth was not associated with a stronger sense of involvement or appreciation. (Stępkowska, Bogusz & Stępkowska, 2022)

Summary

Home birth in developed countries is often perceived as highly risky and irresponsible. However, as the presented scientific evidence demonstrates, this is not necessarily the case. According to the Cochrane Review, for low-risk women, evidence from observational studies favors home birth, and this body of evidence appears to be steadily increasing. It is important to regularly conduct systematic reviews encompassing such studies. Given that both women and healthcare professionals can be aware of the evidence, conducting randomized controlled trials in this context seems impractical and ethically questionable. (Olsen & Clausen, 2023)

Home birth is not a dangerous trend, but it can represent a well-considered and safe strategy for childbirth in specific groups. Women who wish to plan a home birth should have the opportunity to consult healthcare professionals to discuss the potential benefits and risks in their individual circumstances. It is essential that the physicians and midwives engaging in these discussions are familiar with the latest scientific evidence on home births, allowing them to base their guidance on research findings rather than solely on subjective opinions. This paper aims to compile the most recent scientific evidence regarding the benefits and risks associated with choosing a home birth.

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