Planned home birth

INTRODUCTION — Planned home birth is a subject of ongoing controversy. The American College of Obstetricians and Gynecologists' (ACOG) Committee on Obstetric Practice states that hospitals and birthing centers are the safest setting for birth, but they respect the right of women to make medically informed decisions about their delivery site [1]. The American College of Nurse Midwives [2] and the American Public Health Association [3] have policy statements supporting the practice of planned out-of-hospital birth in select populations of women. The World Health Organization (WHO) has released a statement indicating women can choose to deliver at home if they have low-risk pregnancies, receive the appropriate level of care, and formulate contingency plans for transfer to a properly-staffed/equipped delivery unit if problems arise [4]. In the Dutch system, pregnant women without medical complications are asked to choose where they want to give birth: at home or in a short-stay hospital setting. The home birth rate in the Netherlands is the highest in the developed world, although it has declined from 35 percent of all births in 1997-2000 to 29 percent of all births in 2005-2008 [5].

This topic will discuss planned home birth. Delivery at birth centers and unplanned home birth are reviewed separately.

- (See "Birth centers".)
- (See "Precipitous birth not occurring on a labor and delivery unit").

US NATALITY DATA

Prevalence of home birth — The United States National Center for Health Statistics reports birth data based on state vital statistics records, which are determined from the Standard Certificate of a Live Birth (ie, birth certificate). Prior to 1989, births were identified as either occurring in or out of a hospital (eg, home, car, office). Since 1989, a specific category for home births was included on the Standard Certificate. Since 2003, some states have changed their Standard Certificate to identify planned versus unplanned home births and, by 2008, there were 27 states which reported planning status, accounting for 68 percent of all home births.

In 2008 (the most recent complete figures available), there were 42,746 out-of-hospital births in the US: 28,357 were home births and 12,014 occurred in free standing birthing centers [6]. Thirteen percent of the home births were unplanned in 2008 (range 1 to 33 percent among the 27 states reporting these data). From 1989 to 2003, the overall rate of home births in the United States declined from 0.69 to 0.57 percent of births, or by an average of 0.01 percent annually. The 2008 figures represent a substantial increase in both absolute numbers and rate, reaching 0.67 percent of all births, the highest US home birth rate since 1990 [7,8]. This rate is comparable to that in other industrialized countries with two exceptions: England has experienced a slight rise in its home birth rate from 1.0...
percent in 1989 to 2.9 percent in 2008 [9], while the Netherlands has maintained rates of home birth of approximately 30 percent [10].

In the United States, 10 states had home birth rates at least double the US national average, including: Montana (2.2 percent), Vermont (2.0 percent), Alaska (1.6 percent), Idaho (1.5 percent), and Utah (1.4 percent). These states are predominantly rural; however, some nonrural states also have relatively high rates of home birth: Oregon (1.9 percent), Wisconsin (1.6 percent), Pennsylvania (1.5 percent), and Washington (1.5 percent). In Wisconsin, the home births were disproportionately located in rural counties. In Pennsylvania, the high rate of home birth was due, at least in part, to a large Amish population, which has traditionally relied on home birth. Lancaster County, for example, had the highest home birth rate of any county in the US: 12.9 percent.

**Birth attendant** — The proportion of home births in the US provided by different types of birth attendants is shown in the table (table 1) [6]. The qualifications of the different types of midwives are described below (see ‘Provider’ below).

Physicians and certified nurse midwives (the two dominant birth attendants for hospital births) attend fewer than 25 percent of home births, with "other midwives" (primarily certified professional midwives) attending 43 percent and "other" attendants attending 33 percent. The "other" category is a residual category for attendants (eg, fathers) not meeting the criteria for the categories provided. In some cases, fathers may sign the birth certificate to protect birth attendants (eg, direct entry midwives) in states with legal restrictions on planned home birth or type of provider for home birth. In other cases, the woman has planned an unassisted birth [11].

The type of birth attendant varies widely by race/ethnicity. Black non-Hispanic mothers were usually attended by either "other" (53 percent) or a physician (26 percent), while white non-Hispanic mothers were primarily attended by other midwives (46 percent) or "other" (30 percent). Hispanic mothers relied on "other" (44 percent) and other midwives (37 percent). The higher rate of physician attendance at home births for black non-Hispanic mothers is, in part, a reflection of the higher rate of unplanned home births among these mothers combined with the higher rate of physician attendance at unplanned home births. When physicians were recorded as home birth attendants, it was usually (69 percent) an unplanned home birth [12].

**WOMEN WHO CHOOSE HOME BIRTH** — Little systematic research has been performed on the motivation of US mothers who plan home birth; most studies report survey data from select groups of women. These women tend to be self-reliant, more comfortable with their own intuition than with professional advice, adverse to medical intervention and technology, confident about the normality of childbirth, and they have a belief in their bodies' inherent ability to give birth without interference [13,14].

**Demographics** — The table shows demographic data of mothers who gave birth at home (planned and unplanned) in the United States in 2009 (table 2) [15]. Approximately one out of every 140 births in the United States overall was a home birth, while for non-Hispanic white women, approximately one out of every 90 births was a home birth [16]. In addition to being predominantly white non-Hispanic, women who had home births were more likely to be older, multiparous, native born, living in a nonmetropolitan county, and nonsmokers. They were much more likely to report not having had prenatal care than women who delivered in a hospital. Educational levels were comparable for women who gave birth at home and those who delivered in a hospital.

**Reasons for choosing home birth** — Studies have identified many different reasons women choose to give birth at home, including [14,17-22]:

- A desire for a low-intervention birth, in particular the avoidance of oxytocin, epidural analgesia, pharmacologic pain relief, episiotomy, instrumental vaginal delivery, and cesarean birth
• Cultural or religious concerns (e.g., the Amish, religions that proscribe male birth attendants)
• A concern about iatrogenic complications of hospital birth; fear of and dissatisfaction with hospital care
• A desire for freedom and control in the birth process
• A desire to give birth in a comfortable, familiar environment surrounded by family and friends
• Lack of access to transportation (rural areas)
• Economic concerns

OUTCOMES OF HOME BIRTH — Multiple studies have reported the maternal and neonatal outcomes of home birth [23-36]. Generally these studies have found that, compared to planned hospital birth, planned home birth is associated with reduced rates of cesarean birth and medical interventions, and similar rates of maternal and perinatal morbidity and mortality. However, there are significant limitations to the quality of population data available for systematic analysis and, in some cases, on the methodological quality of the studies themselves [37].

Limitations of available data — The use of birth certificate data to assess outcomes of home birth limits interpretation of findings because birth certificates prior to 2003 did not distinguish between planned and unplanned home births or cases where a home birth resulted in a transfer to a hospital. These omissions created biases in opposite directions. The failure to identify planned home births meant a portion of the home births were the result of emergencies, perhaps involving precipitous labor, which might result in a poorer than average outcome when occurring in a setting unprepared for a delivery. Such cases are not uncommon. As noted above, 2007 birth certificate data from 21 US states revealed that 14 percent of recorded home births were unplanned. In contrast, not accounting for hospital transfers meant those planned home births with potentially the worst outcomes were counted as hospital births. These issues were partially addressed in 2003 when birth certificates were changed to identify planned versus unplanned home births, but states have been slow to adopt the new certificate (as of 2007, 56 percent of birth certificates included planning status of home birth).

Several reviews have attempted to summarize studies on the perinatal and maternal outcomes associated with home births. Such studies are very difficult to compare because of the lack of data on planning status and/or transfers to hospitals, use of different outcome measures (e.g., neonatal or perinatal death rates), alternative approaches to classification of deaths associated with congenital anomalies, and lack of a similar population of appropriately screened hospital births to use as controls. Confounders that affect comparisons of reported outcomes include differences in: the medical/obstetrical risk status of the parturients, parity (nulliparous versus parous), competence of birth attendants, and birth practices [13]. As an example, a study from Southern Australia found that home birth was associated with a significantly higher rate of intrapartum death from asphyxia than hospital birth [35]. Review of the perinatal deaths in the planned home birth group identified inappropriate inclusion of women with risk factors for home birth and inadequate fetal surveillance during labor, which highlights the importance of assessing patient and provider factors in home birth outcome.

Many of the higher quality studies have been from industrialized countries other than the US. These countries can have approaches to maternity care very different from that in the US, and often have much more integrated support systems for women/infants who must be transferred from the home setting to the hospital.

Evidence

Meta-analysis — A meta-analysis of 12 English-language peer reviewed publications from
developed Western nations evaluated maternal and newborn outcomes associated with planned home or planned hospital birth [38]. The challenges in systematically studying home birth outcomes are illustrated by this analysis. It was dominated by a retrospective population-based cohort study from the Netherlands with more than one half million women [27], but also included a failed attempt at a randomized trial that involved only 11 women [39] and several prospective studies ranging in size from 200 to more than 1000 women. Only two studies from the United States met the inclusion criteria: one involved data from 1976 to 1982 [40] and the other relied on birth certificate data that could only infer planning status [23]. The largest US study that has been performed (described below [29]) was excluded because it did not include a linked comparison group of low risk hospital births. Subsequent analyses have raised further methodological questions concerning this meta-analysis [41].

In this meta-analysis, planned home birth was associated with significant reductions in intrapartum interventions (epidural anesthesia, electronic fetal heart rate monitoring, episiotomy, operative vaginal delivery, cesarean delivery); odds ratios ranged from 0.1 to 0.42. Planned home birth was also associated with significant reductions in maternal morbidity (3rd degree laceration, infection, postpartum bleeding, perineal laceration, vaginal laceration, retained placenta); odds ratios ranged from 0.27 to 0.85. There were no maternal deaths.

Perinatal mortality, which encompasses both fetal deaths and early (up to seven days) neonatal deaths, was similar for both planned home births and planned hospital births. The meta-analysis authors chose to exclude the Dutch study from their analysis of neonatal death because this study only examined early neonatal death, rather than the 28-day standard they chose for the meta-analysis. The Dutch study found no difference between groups in deaths up to seven days; however, when these data were excluded, neonatal death up to 28 days was significantly higher in the planned home birth group: all neonatal deaths OR 1.98 (95% CI 1.19-3.28) and nonanomalous neonatal deaths OR 2.87 (95% CI 1.32-6.25).

The authors could not determine the reason for the two- to three-fold higher 28 day neonatal death rate in planned home births. They hypothesized that it might be due to less maternal intervention and/or a higher risk of respiratory distress and failed neonatal resuscitation in the planned home delivery group.

**Prospective studies** — The following findings illustrate data from two large prospective studies.

- The largest contemporary prospective study of home births in the US and Canada involved 5418 women who utilized a certified professional midwife as their primary caregiver and planned to deliver at home [29]. Women who became high risk intrapartum were transferred to the hospital. Major findings were:

  Rates of medical intervention for home births were consistently less than half those for hospital births, whether compared with a relatively low risk group or the general obstetric population of hospital births. For the planned home and planned hospital birth groups, the episiotomy rate was 2.1 versus 33.0 percent in hospital, the cesarean delivery rate was 3.7 versus 19.0 percent in hospital, the rate of forceps delivery was 1.0 versus 2.2 percent in hospital, the induction rate was 9.6 versus 21 percent in hospital, and the electronic fetal monitoring rate was 9.6 versus 84.3 percent in hospital.

  However, it is difficult, if not impossible, to match planned home birth patients to planned hospital birth patients since both groups are self-selected. In particular, the home birth population tends to be healthy, multiparous, of above average education and means, and adverse to intervention.

  12.1 percent of patients were transferred to a hospital intrapartum or postpartum. Five out of
every six women transferred (83.4 percent) were transferred before delivery, half of these transfers were for failure to progress, pain relief, or exhaustion. After delivery, 1.3 percent of mothers and 0.7 percent of newborns were transferred to a hospital, usually because of maternal hemorrhage (0.6 percent of births), retained placenta (0.5 percent of births), or newborn respiratory problems (0.6 percent of births).

There were no maternal deaths.

Intrapartum and neonatal mortality in pregnancies at low risk at start of labor, excluding deaths from life threatening congenital anomalies, was 1.7 deaths per 1000 planned home births, which was similar to the rate in other studies of low risk home and hospital births in North America. In the planned home birth group, there were five intrapartum fetal deaths (one cord prolapse, two breech presentations, one intracranial hemorrhage, one true knot with six nuchal cords), seven infant deaths in the week after birth (3/7 were related to lethal congenital anomalies), and two other infant deaths within 28 days of birth.

- A subsequent prospective cohort study of home births in Canada also reported maternal and neonatal outcomes in planned home births were similar to, or lower than, rates in planned hospital births [31]. Strengths of this study were that the same midwives performed both in hospital and home births, the planned hospital birth group was limited to women who met eligibility criteria for planned home birth, and high ascertainment of outcome data. Specific findings were:

  The rates of perinatal death for the planned home birth and planned hospital birth were 0.35 and 0.57 per 1000 births, respectively (perinatal death defined as stillbirth after 20 weeks of gestation or death in the first seven days of life).

  Women in the planned home birth group were significantly less likely than women in the planned midwife-attended hospital birth group to have obstetric interventions or adverse maternal outcomes (third- or fourth-degree perineal tear, postpartum hemorrhage).

  Newborns in the home birth group were significantly less likely than those in the midwife attended hospital birth group to require resuscitation at birth or oxygen therapy beyond 24 hours and they were less likely to have meconium aspiration.

  Since the same group of midwives attended the home births and the hospital births, the differences in newborn outcomes are unlikely to be related to differences in skills or management of newborn resuscitation. It is possible that hospital protocols about newborn resuscitation and use of oxygen may explain some of these differences. It is also possible that the lack of pharmacologic pain relief and lack of labor augmentation in home births explain the lower need for newborn resuscitation, but there is no information in the article to support or refute this.

- A large prospective study, “Birthplace in England,” compared the outcomes of low risk mothers planning to deliver at an alternative birth site (home, freestanding midwifery units, midwifery run units within hospitals) to those of a comparable population planning to deliver in obstetrical units throughout England [42,43]. The final sample consisted of 64,538 women with singleton, term births from 2008 to 2010. The primary composite outcome consisted of stillbirth after the start of labor, early neonatal death, neonatal encephalopathy, meconium aspiration syndrome, brachial plexus injury, and fractured humerus or clavicle. Mortality alone was too rare for useful statistical analysis. Major findings were:

  There were only 250 primary adverse outcome events, giving an overall weighted incidence of 4.3 per 1000 births in this low-risk population.
Overall, the odds (adjusted) of the composite outcome were similar for the three alternative birth settings and the obstetrical units.

When analyzed by parity, first time mothers planning to deliver at an alternative birth setting were significantly more likely to experience transfer to hospital than multiparous mothers (44 versus 9.2 percent).

First time mothers planning to deliver in an alternative birth setting had a significantly higher occurrence of the composite outcome (0.93 percent) than first time mothers planning to deliver in an obstetrical unit (0.53 percent), even after adjustment for maternal characteristics. In multiparous women, there was no significant difference in the odds of the composite outcome between planned alternative setting and planned hospital births.

The rates of cesarean delivery, augmentation of labor, and epidural anesthesia were significantly lower in planned alternative setting births than in births planned for obstetrical units: intrapartum cesarean delivery (2.8 percent versus 11.1 percent); augmentation (5.4 versus 23.5 percent); epidural anesthesia (8.3 percent versus 30.7 percent).

By analyzing data according to parity, this study provides an important new insight about the risk of home birth. Although planned home births have fewer interventions, for nulliparous women, these births are associated with poorer perinatal outcomes.

**Retrospective studies** — Retrospective studies comparing the outcomes of women who planned home birth to matched women who planned hospital births have generally found that intrapartum and early neonatal mortality rates for the planned home birth group were as low as, or lower than, those in the hospital group [24,26,27,32-34,36,44].

**MANAGEMENT** — Home birth can be a viable option for carefully screened low risk mothers with good labor support and a back-up plan to facilitate transfer, if needed. While other countries have developed such integrated plans for care, few such examples exist in the United States.

**Counseling** — Women considering planned home birth should be informed of its risks and benefits based on the meta-analysis discussed above [38] that planned home birth appears to be associated with a two-fold to three-fold increased risk of late neonatal death when compared with planned hospital birth, although the absolute risk may be low [1]. The provider’s ethical obligations regarding discussing home birth with patients have been the subject of commentaries elsewhere [45,46].

**Provider** — In the US, access to quality out-of-hospital birth services varies greatly by geographic locale. Most home births are attended by midwives, although a few physicians are also willing to attend home births. There are three different categories of midwife, which vary by the amount of training, oversight and credentialing they receive:

- **Direct-entry midwife (DEM):** a health care professional who may or may not have a college degree or certification. Direct-entry midwives train through some combination of apprenticeship, workshops, and formal instruction. DEMs usually practice in homes or freestanding birth centers. The legal status of DEMs varies from state to state.

- **Certified nurse-midwife (CNM):** a health care professional who has received a degree as a registered nurse (RN) followed by additional graduate-level training in pregnancy and birth. CNMs work in collaboration with physicians.

- **Certified professional midwife (CPM):** a health care professional certified by the North American Registry of Midwives after passing written exams, as well as hands-on skill evaluations. Both direct-entry midwives and certified nurse-midwives can apply for this certification. CPMs are required to have out-of-hospital birth experience, and usually practice in homes and birth
centers. Their legal status varies according to state with 25 states recognizing them in some form (licensure, certification, registration) as of May, 2010.

There is no consensus on what constitutes the optimal qualifications for a home birth attendant in the US. Women may find assistance in seeking a qualified provider by contacting one of the following organizations:

- American College of Nurse-Midwives: [www.midwife.org](http://www.midwife.org)
- Midwives Alliance of North America: [www.mana.org](http://www.mana.org)
- Childbirth Connection: [www.childbirthconnection.org](http://www.childbirthconnection.org)
- DONA International: [www.dona.org](http://www.dona.org)

**Patient selection** — There is considerable controversy over the specific patient characteristics and risks that might compromise the safety of out-of-hospital birth. Many countries have established such lists based on expert panel recommendations, as well as local and international outcomes data [47], but no such list exists for the United States. While determining the appropriate birth setting ultimately falls upon the woman and her birth provider, women who may be good candidates for an out-of-hospital birth include the following (this should not be considered a complete list):

- A woman who has chosen home birth on the basis of informed consent
- Singleton, cephalic fetus at term
- Absence of preexisting serious medical conditions (eg, cardiac, renal disease, coagulopathy, diabetes mellitus managed with insulin)
- Absence of serious obstetrical conditions (eg, preeclampsia, antepartum bleeding)
- No prior cesarean deliveries
- Absence of contraindications to vaginal birth (eg, placenta previa, active genital herpes)
- Spontaneous labor

Some guidelines also include women with one prior low transverse cesarean delivery or who are being induced [31].

**Organization** — The Dutch system is probably the best model of planned home birth for an industrialized country, given the large number of successful home births in the Netherlands. The continued high rate of home births in the Netherlands is unique among industrialized countries and is a legacy of a strong reliance on independent direct entry midwives, a widespread view among families that birth is a natural process, a generalized questioning of the use of technological interventions in medicine, a view of obstetricians as specialists in high risk births only, and a pride in the uniqueness of their status as center for home birth in the industrialized world [10]. This system has several important features:

- A highly organized system of midwifery care. Dutch midwives are trained in a four-year program that prepares them to practice in the hospital or in the home and to recognize and manage some pregnancy complications. Early pregnancy care is primarily delivered by independently practicing midwives. If complications occur or threaten to occur, the midwife refers the woman to an obstetrician at the secondary or tertiary care level. At that point, the woman is no longer eligible for home birth.
- Formal agreements for collaboration between professional groups that have been specified in the Verloskundig Vademecum (Obstetric Manual), which also includes a list of obstetric indications for
referral from primary to secondary care, based on best evidence or consensus. This provides a clear distinction between women at low risk and those at high risk of problems during pregnancy, labor, and delivery.

- A timely transfer system where the average distance to the hospital is relatively short. In Amsterdam, 85 percent of urgent obstetric referrals arrived in the hospital within half an hour. In addition, the midwife is able to provide some interventions herself in the woman's home, such as the administration of an intravenous infusion and provision of basic life support.

- Lack of intervention, eg, pharmacologic methods of pain relief are not offered to women laboring at home.

Periodic measurement of temperature, pulse, blood pressure, and fetal heart rate is part of the ongoing assessment of labor, not interventions, and should be performed [4]. A clean delivery kit should be available. Instruments that come into contact with mucous membranes or non-intact skin, or penetrate the skin or mucous membranes, should be sterile.

**Newborn care** — Standards for newborn care in the home birth setting should be consistent with state and federal regulations. For example, administration of vitamin K and eye prophylaxis and metabolic screening should be explained and offered, but parents have a right to refuse.

**Hospital transfer** — Seven to 20.4 percent of women attempting out-of-hospital birth will be transferred to the hospital either intrapartum or postpartum [26,42]. As discussed above, the largest prospective study of US home births reported 12.1 percent of cases required transfer, and about 25 percent of these were classified as urgent [29].

Ideally, the back-up hospital should provide 24-hour maternity care and should be within 15 minutes of the home, but this may not be possible, especially in some geographic areas where home birth is more common precisely because of the lack of nearby hospitals. In such settings, home birth providers should have a lower threshold for transferring patients to the hospital and must consider the transfer time when caring for patients in labor. Women delivering in homes that are remote from a hospital should be informed by their home birth provider during prenatal care that in the case of an unforeseen catastrophic complication (eg, abruption, cord prolapse), they may not be able to transfer to the hospital in time to avoid maternal or neonatal injury or death.

An optimum outcome is facilitated when hospital providers, including nurses, physicians, and hospital-based midwives, communicate in a respectful manner with home birth providers and their clients during the transfer process. Home birth providers and their clients sometimes report that they are treated "punitively" or disrespectfully by hospital staff when a transfer occurs [17,48]. This perception may lead to a delay in a needed transfer, thereby increasing the risks of morbidity to mother and baby. Perceived antagonism from hospital staff may also lead to the patient's refusal and resultant delay of recommended medical interventions [48,49].

Hospital staff should be aware that most home birth providers keep detailed antenatal and intrapartum records and such information may be crucial for patient care after hospital transfer. Good communication between home birth providers and hospital staff will allow conveyance of this information and a smoother transition for the patient.

Providers should also be aware that women transferred to the hospital after an attempted home birth may be very disappointed and/or fearful of hospital transfer; putting such patients at ease may facilitate patient care. The use of the expression "failed home birth" is discouraged, as it is unnecessarily negative, as opposed to a neutral expression such as "home birth transfer."

**SUMMARY AND RECOMMENDATIONS**
• Planned home birth is uncommon in the United States (0.67 percent of births). After remaining fairly stable over recent years, the rate appears to be rising, suggesting ongoing interest in this approach to childbirth. The Netherlands have the highest rate of planned home birth (30 percent of births). (See 'Prevalence of home birth' above.)

• Women who opt for home birth are predominantly white non-Hispanic, older, and multiparous. Some common reasons for choosing home birth include a desire for a low-intervention birth with family and friends in a familiar environment, more control of the birth process, and dissatisfaction with hospital care. (See 'Women who choose home birth' above.)

• Large cohort studies using intent-to-treat analysis of midwife-attended, planned, out-of-hospital birth of low risk women in developed countries have reported reduced rates of cesarean birth, perineal lacerations, and medical interventions, and similar rates of maternal and early perinatal morbidity and mortality compared to planned hospital birth. However, there may be a higher rate of late neonatal mortality with planned home birth. (See 'Outcomes of home birth' above.)

• The following are suggested minimum criteria for planning a home birth:

  informed consent
  singleton cephalic fetus at term
  absence of preexisting serious medical or obstetrical conditions
  absence of contraindications to vaginal birth

  The prenatal care, labor, birth, and postpartum care should be attended by a licensed obstetrical caregiver and there should be a transport plan in case a hospital providing obstetrical care becomes necessary. Ideally, the back-up hospital should provide 24-hour maternity care and should be within 15 minutes of the home. (See 'Management' above.)

• Good communication and mutual respect between home birth providers and hospital staff are essential for patient care and safety when a woman is transferred from home to hospital. (See 'Hospital transfer' above.)

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REFERENCES


Med 2003; 56:1911.


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## GRAPHICS

### Birth attendant and race/ethnicity, US residential births, 2009

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<th>Attendant Type</th>
<th>Medical doctor or doctor of osteopathy (percent)</th>
<th>Certified nurse midwife (percent)</th>
<th>Other midwife (percent)</th>
<th>Other (percent)</th>
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### Characteristics of mothers giving birth in home and hospitals, US, 2009

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<th>Characteristics</th>
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<th>Hospital (percent)</th>
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