وزارة الصحة
Ministry of Health

The Saudi Home Birth Standards

Midwifery Units Advisory Committee
Midwifery Department
General Department of Nursing Affairs
Deputyship for Therapeutic Services
October 2021

Preface

The home birth standards were first developed by the Saudi Midwifery Group (SMG) members as a proposal of home birth policy and procedure during the COVID-19 pandemic 2020 and was reviewed by the Saudi Society for Obstetrics and Gynaecology (SSOG) as a response of the call from mothers for home birth. This was submitted to the MOH for final approval.

This document presents the home birth standards in Saudi Arabia recognising the need for evidence-based care, placing the family at the centre. Therefore, the Midwifery Department at the General Department of Nursing Affairs in the Ministry of Health, Saudi Arabia has initiated a Midwifery Units Advisory Committee (MUAC) on February, 2021 under Dr. Tareef Alaama, Deputy Minister for Curative Services and the support of Dr. Mohammed Alghamdi, General Director of Nursing Affairs, with a membership of consultants from Ministry of Health and various sectors. The creation of the home birth standards is the third output of the advisory committee.

This is the first version of the home birth standards, which the committee has made great efforts to accomplish. These standards should be reviewed every 5 years after audit from the time of implementation of these standards.

We would encourage stakeholders and leaders in Saudi Arabia to use this tool as part of local quality improvement and to take the initiative to move maternity care forward.

Chairperson of the Midwifery Units Advisory Committee

Dr Roa Altaweli, PhD, RM

Acknowledgments

The General Department of Nursing Affairs would like to acknowledge and thanks many departments and individuals who have reviewed and provided constructive feedback to the home birth standards. This document could not have been be accomplished without the commitment and contribution of the Midwifery Units Advisory Committee members.

Committee Members

Name	Title and Affiliation	Membership
Dr. Roa Altaweli	**Consultant Midwife** Director of Midwifery Department General Department of Nursing Affairs Ministry of Health, Saudi Arabia	**Chairperson**
Mrs. Samia Alzahrani	**Senior Specialist Midwife** General Department of Nursing Affairs Ministry of Health, Saudi Arabia	**Vice Chairperson**
Dr. Fatma Alshangiti	**Consultant Obstetrics and Gynaecology, Consultant Female Pelvic Reconstructive and Minimal Invasive Gynaecologic Surgeries** Leader of Obstetrics and Gynaecology Development Services Ministry of Health, Saudi Arabia	**Member**
Dr. Fahima AlSomali	**Director of Nursing** Women's Specialised Hospital King Fahad Medical City, Saudi Arabia	**Member**
Dr. Insaf Shaban	**Consultant Midwife; Associated Professor** College of Nursing, Taibah University, Saudi Arabia Princess Salma Faculty of Nursing, All albayt University, Jordan	**Member**
Dr. Mohammed AlQahtani	**Consultant Family Medicine** Deputy of General Director of Primary Health Care Centres Ministry of Health, Saudi Arabia	**Member**
Ms. Nawal Sindi	**Senior Specialist Nurse** Head of Training and Development Department General Department of Home Health Care Ministry of Health, Saudi Arabia	**Member**
Ms. Mona Bukhari	**Midwife** General Department of Nursing Affairs Ministry of Health, Saudi Arabia	**Coordinator**
Dr. Lucia Rocca-Iheanacho	**Lecturer and Programme Director MSc Global Maternal Health,** Centre for Maternal and Child Health Research, School of Health Sciences, City, University of London**, CEO Midwifery Unit Network,** United Kingdom	**External Advisor**

Reviewers	
Name	**Title and Affiliation**
Dr. Alaa Mansoor	Consultant Obstetrics and Gynecology, Maternal fetal medicine specialist Model of care lead at Riyadh Second Health Cluster Chairman of safe birth network
Ms. Eman Mohammed Alturaiki	Director General of Patient Experience Center
Mr. Ahmed Hamad Al Fehaid	Director General of Academic Affairs and Training
Dr. Fahad Samarkandy	Consultant Emergency Medicine Consultant to Vice president at Saudi Red Crescent Authority
Dr. Zolfa AL Rayess	Consultant Family Medicine Surveyor in CBAHI and SCFHS, Member of scientific committee for women's health
Dr. ShakerAbdulaziz Alomary	Consultant of Family Medicine Director General of the General Directorate of Health Programs and Chronic Disease, MOH
Ms. Mona Faia Alsarawi	Director General, Quality and Patient Safety
Dr. Mishary Zaid Almishary	Director General, Primary Health Care Centres

The midwifery units advisory committee would like to acknowledge the members that participated in preparing home birth document. The publication of this document is a result of a collaborative effort between the Saudi Midwifery Group (SMG), Saudi Society of Obstetrics and Genecology (SSOG) and The Saudi Ministry of Health (MOH). This document was first produced in 2020 by the following members:

Saudi Society of Obstetrics and Gynaecology (SSOG)	
Name	**Title and Affiliation**
Prof. Hassan Abduljabar	Consultant Obstetrics and Gynaecology, President of SSOG,
Dr. Fatma Alshangiti	Consultant Obstetrics and Gynaecology, Consultant Female Pelvic Reconstructive and Minimal Invasive Gynaecologic Surgeries

Saudi Midwifery Group (SMG)	
Name	**Title and Affiliation**
Dr. Roa Altaweli	President of SMG; Consultant Midwife
Samia Alzahrani	Vice President of SMG, Senior Specialist Midwife
Dr. Ibtesam Jahlan	Treasurer, of SMG, Senior Specialist Midwife, Assistant Professor
Houada Hammami	Secretary General, SMG, Team Leader Midwife
Taghreed Hawsawi	Head of Scientific Committee, SMG, Senior Nurse Specialist, IBCLC
Patti Paine	Member, SMG, Associate Chief Nurse
Fatimaezzahra Aaynealhayat	International Relations Coordinator in SMG/ Specialist Midwife
Jihane Raad	Member, SMG, Specialist Midwife
Mary Yff	Member, SMG
Mona Bukhari	Head of Media and Public Relations, SMG
Albandari Asiri	Member, SMG, Midwife

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Introduction

Home birth is not new in Saudi Arabia. Before 1952 most women gave birth at home with the help of Traditional Birth Attendants (TBA) or midwives. Home birth with a registered midwife is a safe choice for women who are deemed to be at low risk of complications during pregnancy, labour and birth and the postpartum period.

The Saudi Ministry of Health (MOH) initiated a new model of care for vision 2030 which shifts the focus from curative care to preventive care. The future vision 2030 is to have midwifery-led continuity of maternity care as standard. Uncomplicated births can take place at home or at a birth centre, in addition to hospitals depending on the preference of the woman and her family (MOH, 2017).

Pregnancy and childbirth are considered normal life events and the midwife has been identified as the most suitable and cost-effective healthcare professional to provide care in normal pregnancy and childbirth, including risk assessment, recognition of complications, optimising normal biological, psychological, social, and cultural processes of reproduction and early life; timely prevention and management of complications; consultation with and referral to other services; respect for women's individual circumstances and views; and working in partnership with women to strengthen women's own capabilities to care for themselves and their families (Renfrew et al, 2014). Midwife-led continuity of care has been associated with positive outcomes including reduced maternal and neonatal morbidity, reduced stillbirths, reduced interventions in labour, improved psycho-social outcomes and increased birth spacing and contraceptive use (Sandall, et al., 2016).

The State of the World's Midwifery Report (SoWMy,2021) showed that midwives, when educated, licensed and fully integrated in and supported by interdisciplinary teams, and in an enabling environment, can deliver about 90% of essential Sexual, Reproductive, Maternal, Newborn and Adolescent Health (SRMNAH) interventions across the life course and can provide a wide range of clinical interventions and contribute to broader health goals, such as advancing primary health care, addressing sexual and reproductive rights, promoting self-care interventions and empowering women.

Currently, there is a growing body of evidence demonstrating that continuity of midwife-led care is mostly suitable for healthy women with uncomplicated pregnancies in locations with well-trained midwives and good health systems. When compared to women using hospital based maternity care, midwife-led care in out of hospital settings is associated with maternal reports of more positive pregnancy and birth experiences, better outcomes for healthy women of any parity, along with similar perinatal outcomes, especially for second and subsequent babies. However, to date 2021 there are no home birth services available in Saudi Arabia and this limits the opportunity for provision of optimal, consistent, high quality, safe, cost-effective care for women and their babies.

Aim of Home Birth Standards

The aim of these standards is to promote and support the implementation, development and growth of home birth services which provide holistic care to women and their family throughout Saudi Arabia. In addition, to provide a standard for the conduct of midwives and other healthcare providers providing birth at home services in Saudi Arabia across the full continuum of care; to improve the quality of midwifery care, reduce variation in practices and facilitate a family centred model of care. To ensure that home birth providers will have clear workflow to follow, to regulate and standardise the care provided to women during a home birth in Saudi Arabia to maintain safe practice.

Midwifery Scope of Practice

The scope of midwifery practice is the expected range of roles, functions, responsibilities and activities that a midwife registered with the Saudi Commission for Health Specialities (SCFHS) is educated for and is competent and authorised to perform. It defines the accountability and limits of practice in Saudi Arabia.

The midwife working in home birth services should provide necessary support, care and advice during pregnancy, and postnatal period. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the access of medical care or other appropriate assistance and the carrying out of emergency measures. The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and childcare.

Topic 1: Philosophy and Model of Care

The philosophy and model of care is to work in partnership with women, support the normal physiological process of pregnancy and childbirth, postpartum period and normal physiology of the newborn. In addition, prevention of disease/promotion of health for the woman and newborn, supported of individual responsibility, shared decision-making and self-sufficiency, and a holistic integrated approach to the delivery of health services. Home birth providers use professional knowledge, skills and attitudes to competently support the woman and her baby. They protect and enhance the health of women and babies as a family, which in turn protects and enhances the health and wellbeing of society as well as protection from harm.

Standard 1: The home birth service has a written and public philosophy of care setting out shared values and beliefs

The home birth service has a written philosophy of care document which needs to be mutually agreed among stakeholders. This document needs to be in line with the philosophy of care and values of the wider maternity services and includes a commitment towards:

Supporting a physiological pregnancy, labour, birth and care of the baby

- Supports home birth providers skills and practices that support physiological pregnancy, labour, birth, bonding, neonatal care and transition to parenthood; (MotherBaby-Family Unit).
- States that interventions should be considered and justified in relation to best clinical evidence, on the basis that the potential benefits outweigh the potential harms.

Offering personalised and supportive care that promotes physical and psychological wellbeing

- Considers home birth as a safe option for some births and provides more choice for women;
- Recognises childbirth as a key life event and transition for mothers, babies, families and birth companions;
- Promotes emotional wellbeing in pregnancy, labour and birth and in the early days of motherhood;
- Respects women's human and reproductive rights to dignity, privacy and autonomy;
- Welcomes the woman's chosen companions;
- Commits to providing a positive start to caring for the baby, including baby friendly practices;
- Endorses effective and prompt escalation and transfer to obstetric care, while still focusing on positive experiences and personalised supportive care;
- Acknowledges a clear understanding that caring for home birth providers wellbeing helps to promote caring behaviours.

Promoting a family-centred model of care

- Providing holistic, family-centred care that is responsive to the reality of people's lives and supportive of equal access, equality and cultural diversity;

- Receiving any potential women, by offering information and support relating to pregnancy, birth and the postnatal period;
- Reinforcing an understanding that all home birth providers in the broader maternity care system would benefit from awareness of and training in a social model of care, recognising their impact on the positive experiences of women, families and overall quality of care.

Standard 2: The midwife plans care in partnership with the woman across the continuum of care

The midwife:

- Recommends that the woman engages with maternity care providers across the continuum of care;
- Negotiates care options with the woman that most closely meet the woman's needs and expectations
- Consults with the woman and other maternity care providers where indicated when making recommendations about the care of the woman and/or her baby;
- Established clinical support networks and pathways and utilises these for consultation, referral and/or transfer of care, when indicated;
- Documents all discussions in the clinical record, including the benefits and risks;

Maintains confidentiality and privacy within the woman-midwife relationship in accordance with the MOH standards, codes, policies and guidelines and relevant legislation.

Standard 3: The Home Birth Provider (HBP) assesses the most suitable place for birth in partnership with the woman across the continuum of care

There are benefits and risks associated with all birthplace options. Pregnancy, labour and birth are a dynamic process requiring continual reassessment of the decisions made regarding place of birth. When assisting the woman to make decisions about the most suitable place for birth.

The HBP:

- Considers the woman and baby's health needs and risk factors in relation to the most appropriate place of birth;
- Considers the woman's previous birth experiences;
- Considers the woman's residential location, distance and timely access to the nearest hospital which provides maternity care, and circumstances;
- Assesses the benefits and limitations of each place of birth option and communicates these to the woman;
- Responsible for considering changes in the woman's circumstances, health needs and risk factors, and responding to these by:
    - Re-evaluating the information previously provided to the woman about her birth options;
    - Making recommendations that facilitate the woman's decision making about her planned place of birth;
    - Documenting recommendations, including the benefits and risks, the decision-making process, the plan of care and informed consent of the woman.

Topic 2: Home Birth across Women, Professional and Physical Boundaries

Stakeholders and HBPs should work in a collaborative manner to identify cultural or physical restraints and prioritise cooperation to facilitate smooth, well-integrated, home birth pathways of safe and respectful care, to benefit women and families. HBP is responsible to perform home birth planning with ongoing suitability assessments, safe, evidence-based and appropriate options of care, and facilitate consultations with other healthcare providers for women giving birth at home, and transfer of care to the hospital when this is required.

Standard 4: All routine antenatal and postnatal care including risk assessment for the mother and baby shall be provided as the Ministry of Health (MOH) mother and child health passport

All midwives/obstetricians providing home birth service must have direct access to the results of maternal and neonatal routine screening. Other tests may need to be undertaken depending on the woman's or baby's clinical circumstances.

Antenatal risk assessment

The team linked to the obstetric consultant/midwife consultant (who gave the initial consultation with the woman and approved her request for a home birth) has a clinical responsibility to recognise potential risk and to refer the woman for a hospital birth appropriately. After clearing a woman for home birth and then assigned to a midwife/ physician, it becomes the midwife/ physician's responsibility to follow up the woman regularly till the birth and continue after birth.

The prerequisite for a home birth is that the woman should have:

- An uncomplicated singleton pregnancy.
- A cephalic presentation between 37+0 (259 days), and 42+0 (294 days) weeks of gestation.
- Age of woman is not less than 18 years and not above 40 years.
- Para 0-5 (excluding miscarriages and terminations).
- Body Mass Index (BMI) should be more than 18 and less than 40 on booking.
- Spontaneous onset of labour
- Spontaneous pregnancy.
- Rupture of membranes, must be less than 24 hours and liquor must be clear/non-significant meconium.
- No epidural requested.
- No expected medical, obstetric or neonatal complication.
- No previous significant obstetric history (see standard 7).
- No known history of HIV or Hepatitis B.

- The level of Haemoglobin should be over 11.0g/l and serum ferritin more than 100 ng/ml, even if Haemoglobin is normal.
- Women at 'higher risk' should normally be advised to give birth in a hospital.
- If the woman's status moves from medium or low risk to high risk the eligibility can be withdrawn, and the woman referred immediately to the hospital.

Standard 5: HBP must conduct antenatal initial risk assessment for each pregnant woman

- Individualised risk assessment must be carried out for each pregnant woman at primary health care centre/private polyclinics/birth centre/hospital.
- The midwife/obstetrician and the woman sign and complete the risk assessment tables within the application/consent form for home births and send to the Home birth Team (HBT).
- If there are no risk factors identified, the woman can be offered a supported care pathway and can be provided with an initial confirmation of eligibility for the service based on continual risk assessment.
- If conditions or factors are identified on **Table 1** the woman should be advised that she needs to have an obstetric review. In conducting such a review, the consultant obstetrician/consultant midwife needs to be aware of the criteria against which he/she is reviewing the approval and approve eligibility (or not) based on this assessment. Obstetric review must be documented clearly in the notes and whether the planned home birth can continue or not.
- HBP provides ongoing risk assessment through the observation and monitoring of the mother and baby at each antenatal appointment.
- Risk factors may change and therefore a woman deemed originally to be low-risk, during her pregnancy, can develop a condition that may either deem her high-risk and therefore ineligible, or medium risk requiring review by an obstetrician consultant.
- Ongoing communication between mother, midwife, obstetrician and any other healthcare personnel involved is paramount.
- Any risks identified must be explained to the woman with available supporting written literature.
- The responsible consultant obstetrician/consultant midwife should reconfirm by 36 weeks that the woman is eligible for a home birth; the name/s of the second midwife or obstetric nurse and a birth pack can be organised for the expectant woman. The midwife must reconfirm, at this stage, the woman's contact details, address, and send the directions to the place of birth to the Home birth committee (HBC).
- Ensure that documentation is completed.

Standard 6: The HBPs should conduct a careful assessment and discussion with the woman planning to birth at home during pregnancy

Careful assessment and discussion with the woman planning to birth at home during pregnancy to ensure the woman:

- has an uncomplicated, singleton pregnancy with no foetal or maternal contraindications to birth at home (as specified in standard 7).
- has the capacity to provide informed consent.

- is aware of the midwives involved in the home birth services during her pregnancy.
- is aware of the linked health institution, in case of emergency, with the primary health care/ private polyclinics/ birth centre)
- has a general medical examination by her midwife, general practitioner, family physician or obstetrician early in the pregnancy or on booking visit and notify them of her intention to birth at home.
- is aware that plans to give birth at home may need to be reconsidered at any time, depending on changes in the woman's or foetus/baby's condition during pregnancy, labour, birth or postnatally.
- has the readiness to transfer to the participating health institution should complications arise and transfer is deemed necessary.
- has a birth plan that does not include an epidural during labour and is aware if she requested epidural the transfer to the participating health institution will be necessary.
- has support people intending to be present at the birth and that they have received the appropriate information relating to their roles during labour and birth; ideally, the midwives will have met the support people during pregnancy.
- has someone who can be with her home for the first 24 hours after the birth and her attending support person(s) know how to contact the midwives, ensuring this information covers 24 hours per day, seven days per week.

Standard 7: The woman must be referred to the participating health institution for further assessment if any contraindications to birth at home are identified during pregnancy

The following conditions exclude a woman giving birth at home:

Medical history

- any significant medical condition or pre-existing gynaecological disorder (see Table 1)
- alcohol or illicit drug dependency.
- female genital mutilation Type 2B (i.e. where there is a restriction to the vaginal opening).

Previous obstetric history

- caesarean section (one CS with previous normal birth can be discussed further with the consultant in charge for a home birth permission).
- postpartum haemorrhage over one (1) litre.
- shoulder dystocia requiring internal manoeuvres.
- neonate requiring intensive care for an unexplained reason.
- perinatal death not related to preterm birth.
- unexplained stillbirth/neonatal death or previous death related to intrapartum difficulty.
- previous 3rd/4th degree tears.
- previous baby with neonatal encephalopathy.
- preeclampsia requiring preterm birth.

- placental abruption with adverse outcome.
- eclampsia.
- retained placenta requiring manual removal in theatre.

Current pregnancy

- multiple pregnancy (i.e. other than singleton foetus).
- body mass index (BMI) >40 or maternal weight >100 kgs.
- Gestational Diabetes requiring medication or not controlled well by diet.
- placenta previa.
- placental abruption.
- Pregnancy Induced Hypertension (PIH) and/or pre-eclampsia
- preterm labour or preterm prelabour rupture of membranes before 37 weeks.
- iron deficiency anaemia – Haemoglobin less than 12 g/dl (or serum ferritin less than 100 mg/ml.
- confirmed intrauterine death.
- induction of labour (IOL).
- breech or transverse lie.
- antepartum haemorrhage.
- suspected foetal intrauterine growth restriction or small-for-gestational age (less than fifth centile or reduced growth velocity on ultrasound).
- abnormal foetal heart rate/doppler studies.
- polyhydramnios or oligohydramnios.
- suspected foetal abnormalities that require paediatric attention at birth.
- suspected foetal macrosomia.
- post-term pregnancy (≥ 42 completed weeks; that is, ≥ 294 days)
- identified need for the newborn to be hospitalised following birth.
- extreme psychosocial issues.
- significant mental health issues requiring medication (Note: this is not an absolute contraindication, but further consultation and discussion with the treating practitioner would be required before making the final decision).
- active genital herpes in late pregnancy or at the onset of labour.
- thick meconium stained liquor.
- pyrexia (temperature of 38.0 degrees in Celsius)
- prolonged rupture of membranes more than 18 hours if unknown group B streptococci (GBS) status or if more than 24 hours regardless.
- women with GBS positive or GBS negative or unknown with inadequate intrapartum antibiotic cover. Adequate antibiotic cover defined as:
  - **if GBS positive**: at least 1 dose of penicillin > 4 hours before birth.
  - **if GBS negative or unknown and birth 18-24 hours after ROM:** At least 1 dose of penicillin before birth. Timing of dose is not critical.

if GBS negative or unknown and birth > 24 hours after ROM: At least 1 dose of penicillin >4 hours before birth.

Standard 8: The HBP must visit the woman's home before 37 weeks' gestation to ensure that the home is a safe environment for birth

Consideration and assessment of the suitability and safety of the home environment should be undertaken. HBP must visit the woman's home before 37 weeks' gestation and use the home risk assessment checklist (see Appendix 1).

Home environment that supports home birth

- is less than 30 minutes of traveling time by ambulance from the participating health institution during heavy traffic time.
- has reliable telecommunication access; landline or mobile phone with "coverage".
- has easy access (in case transfer during labour is warranted).
- has easy vehicle access, including parking, if required in an emergency.
- has no evidence of domestic violence.
- has no evidence of illicit recreational drug use.
- the birthing room at home should have privacy, be clean and hygienic environment.
- has clean running water and electricity.
- has suitable heating and lighting.
- If birthing pool is used, it should be placed with an access space for ease of evacuation
- has an environment that supports other dependent members of the household (i.e. the birthing woman must not be responsible for other household members during labour and birth).

Standard 9: The home birth service has a linked lead midwife, a linked obstetrician and neonatologist within a linked health institution

- The linked lead from each professional discipline is consulted for key organisational and clinical decisions;
- The linked professionals provide support to the home birth service;
- The linked health institution should be identified to the women during the third trimester.

Standard 10: The woman's health and wellbeing must remain at the centre of all professional interactions

HBP; when facilitating a home birth, will:

- be aware of potential situational challenges that may arise during birth at home.
- be aware that they have a duty of care to the mother, but also and separately to the newborn.
- have ready access to a means of rapid access telecommunications (landline or mobile phone coverage).
- inform the woman of the precautions necessary, contraindications to birth at home and reasons for transfer to health institution.

- provide the woman with the information brochure on home birth and be confident that the woman has read it (see Appendix 2).
- ensure the woman has had an opportunity to discuss the potential benefits and risks of home birth so that she can make an informed decision.
- ensure the woman intending to have a planned birth at home is booked with the relevant participating health institution early in the pregnancy.

Standard 11: There is a clear policy and procedures for transfers

The policy and procedures for transfer from home to health institution include:

- Indications for transfer
- Ambulance services;
- Operational transfer procedures that promote the integration of services and seamless pathways for women transferring between home and health institutions;
- Joint vision and strategic planning across primary and secondary care settings, and between connecting secondary care services where appropriate.

Transfer to health institution

- Maternal and neonatal complications receive immediate stabilizing interventions then transfer if necessary.

Home birth services should have two levels of transfer:

- Emergency care (level A): transfer within 10-15 minutes to the nearest hospital and must be level 2 hospital (see Appendix 3) that provides maternal and newborn care.
- Urgent care (level B): transfer within 20-30 minutes considering traffic to participating hospital. Direct referral of a woman or her infant to hospital care as a result for a high-risk problem that arose after the eligibility of the woman for home birth.

The following conditions preclude a woman from giving birth at home and/or necessitate transfer to health institution:

Labour, birth and immediate postpartum (4 hours post birth) indications for transfer to health institution:

- changes from low risk to high risk for mother or baby, for example, maternal wellbeing temperature, blood pressure etc.
- preterm labour <37 weeks.
- meconium-stained liquor grade III.
- cord prolapse.
- intrapartum haemorrhage.
- postpartum haemorrhage of one (1) Litre or greater.
- foetal heart rate abnormalities.
- other need for continuous electronic foetal heart rate monitoring.

- evidence of infection or maternal temperature ≥ 38°C for 2 consecutive readings at least 2 hours apart.
- absent (failure) of progress in the established active stage of labour in cervical dilatation or head descends for at least 6 hours providing that membrane is ruptured and inadequate contractions.
- rupture of membranes more or equal to 24hrs.
- active first stage of labour over 18 hours.
- shoulder dystocia requiring internal rotational manoeuvres.
- retained or incomplete placenta.
- third or fourth-degree perineal tear.
- hypertension and/or pre-eclampsia/eclampsia.
- thrombophlebitis or thromboembolism.
- uterine inversion or prolapse.
- acute urinary retention.
- maternal collapse.
- large vulvar or paravaginal haematoma.
- epidural request.

Neonatal indications for transfer to health institution

- Apgar score < 7 at 5 minutes.
- excessive bruising, abrasions, unusual pigmentation and/or lesions.
- excessive moulding and/or cephalohematoma.
- low birth weight (< 2500gms).
- less than three vessels in umbilical cord.
- neonatal convulsions.
- congenital abnormalities.
- vomiting: projectile, excessive, bloody, uncharacteristic for newborn.
- abnormal findings on physical examination.
- birth injuries or trauma.
- temperature instability

Standard 12: HBP must contact and consult a linked staff regarding transfers

In case the woman is not eligible for home birth because of one or more previous conditions, then a referral must be done to the health institution chosen. Source of clinical advice for HBP is labour and delivery ward staff within the participating health institution. When arranging transfer of care, the midwife or obstetrician attending the labour should contact the ambulance service (if appropriate) and the Home Birth Coordinator in the hospital.

Coordination between HBP and hospital.

The Home Birth Coordinator is responsible to:

- alert the relevant healthcare professionals (obstetric, anaesthetic and neonatal) and ambulance services.
- provide ambulance services (red crescent and linked health institution) list of booked women for home birth.

The HBP is responsible to:

- discuss with the woman and her birth companion(s) about the reasons for the transfer and what they can expect, including the time needed for transfer.
- discuss and explain to the women the decision of transfer referral and confirm her agreement and consent about the change of care.
- address any concerns she has and try to allay her anxiety.
- ensure that her wishes are respected, and her informed consent is obtained.
- If a woman is transferred to health institution after the birth ensure that her baby goes with her.

Topic 3: Staffing and Workload

Standard 13: Essential staffing includes HBPs to promote high standards, a sense of ownership and an appropriate philosophy of care

There is a sufficient number of HBP to ensure safe care for mother and baby, including a clear, locally applied escalation policy which includes transfer to a health institution if required:

- A 24/7 service is available.
- Support from a senior midwife/obstetrician is always available (in person, by telephone, or on-call);
- Availability of a second midwife/obstetric nurse during the second stage of labour and present at birth.

Standard 14: HBP must be approved as competent in home birth

To be approved as competent in home birth by HBC, the HBP must:

- have current valid licensure and registration with the Saudi Commission for Health Specialties (SCFHS);
- be certified with BLS and NRP courses;
- have perineal trauma course and (ALSO or BLSO) preferable;
- have malpractice insurance coverage;
- have disclosure of malpractice claims;
- have clearance of health screening;
- be registered on the birth notification online system;
- provide evidence of completion in-person or online training certificate in home birth for professionals.

To be approved as competent in home birth, in addition to the above, the obstetrician must:

- have a minimum level of a registrar with 2 years' experience or a consultant.
- be registered as an obstetrician with the SCFHS.

To be approved as competent in home birth, in addition to the above, the midwife must:

- have participated in at least five (5) home births under supervision of an obstetrician /experienced home birth/ birth centre midwife
- be registered as a midwife with the SCFHS
- work within their scope of practice and per the Guidebook for midwives (MOH, 2019) for consultation and referral, along with their employing health institution's local policies and procedures, referring women and/or their babies for consultation or transfer of care if indicated.

- **have either qualifications as follow:**
  - Technician Midwife (3 years' Associate Diploma): should have a minimum of 7 years' experience in labour and birth/antenatal and postnatal ward with competencies logbook or letter certifying completed competencies from health institution.
  - Specialist/Senior Specialist/Consultant Midwife: should have a minimum of 5 year experience in labour and birth/antenatal and postnatal ward with competencies logbook or letter certifying completed competencies from health institution.

Topic 4: Role and Responsibilities

Standard 15: Health institution management must be responsible for the home birth policy and procedure delineating role and responsibilities

Health institution management in the regional directorate/ cluster/hospital should formulate checklist to ensure the smooth, safe antenatal care, home birth and postpartum care.

Role and responsibilities of Health Institution Director:

- ensure that midwives and obstetricians, who, in their employment have agreed to participate in home births, have an understanding of the home birth standards in Saudi Arabia (see Appendix 4).
- implementing home birth standards and delegating the implementation and monitoring of the standards, policy and procedure to the medical director.
- prepare a clear home birth policy detailing all the information and assign the needed department, staff, and coordinators and facilitate the implementation.
- in charge of monitoring the occurrence variance report (OVR) and the implementation of the home birth standards and procedures with a measurement of the outcome (statistics, key performance indicators (KPI)) including but is not limited to adherence to standards of care, 3rd and 4th degree tear rates, caesarean section rates, foetal growth restriction, Apgar score less than 7 at five minutes, breastfeeding rates, PPH rates.

Role and responsibilities of Health Institution Patient Relationship Director:

- assess the pregnant women and her family experience with home birth and all related issues and facilitate birth registration and notification issue

Role and responsibilities of Health Institution Primary Healthcare Director and Home Healthcare Director:

- ensure the provision of appropriate systems and structures to support the HBP to provide maternity care for women and their families availing of the home birth services and provide all the needed support for the antenatal and postnatal care.

Standard 16: HBPs are responsible for ensuring all maternity care including home birth services, is evidence-based, safe and of high quality

The general role and responsibilities of HBPs are to:

- obtain information about woman's medical and previous obstetric conditions
- study women's history and health assessments
- take women's vital signs
- counsel expectant mothers on birthing plans, including hospital care, home birth and other options such as birthing centres
- provide emotional care for mothers during birth
- arrange prenatal planning and care for mothers
- take vaginorectal GBS swab
- prepare for birthing by following all health and safety standards
- coach mother through the birthing process
- perform vaginal examination
- conduct the birth of low-risk cases
- tend to the health and well-being of both the baby and mother during the process
- provide care for mothers and newborns after birth
- online registration of birth for the birth certificate and co-signed by the attending midwife/ nurse.
- explain and demonstrate breastfeeding techniques
- monitor women during the postpartum period and be available for questions or concerns, including de-briefing of their birth
- perform Cardiopulmonary Resuscitation (CPR) or other emergency measures if needed
- to be aware of the emergency plan and pathway in case of transferring during labour, post-partum and for the newborn.
- take care of the birthing bag and its contents, keeping it stocked for 3 births at all-time with sufficient supply and equipment for appropriate disposal of waste.
- have essential equipment available for the home birth, items necessary in the event of complications, and progress notes for contemporaneous documentation (see Appendix 5).
- documentation of all labour, birth and postpartum visits (maternal and neonatal) by completing files and checklists relevant to them that belong to the hospital where the woman is assigned to for birth
- all of the supplies, equipment and forms will be obtained from each facility the HBP is dealing with, either government or private sector.
- keeping a logbook of all their home birth
- educate women on health, nutrition, and family planning and support the mother with all educational material needed during pregnancy, labour and the postpartum period
- creating a communication group for all her pregnant women during pregnancy and post-partum for support.
- arrange with the home care team for the mother and neonatal screening program with all being documented in her related health institution.

The specific role and responsibilities of Home Birth Team (HBT):

HBT must:

- follow evidence-based practices for the home birth.
- provide a safe working environment at all times by maintaining effective work practices, adopting policy, procedures and practices that comply with the relevant legislative requirements of the MOH or the participating health institution and taking reasonable care to protect their health and safety and that of the woman and the baby.
- complete the mandatory specific competencies.
- NRP and BLS courses are essential for either the obstetrician or the birth attending midwife or the obstetric nurse. One professional in the home birth team present at every birth should have NRP and BLS certificates.
- ensure availability of a lead clinician for advanced neonatal resuscitation requirements (for example intubation), within their scope of practice or the most expert in intubation
- ensure that all portable and non-portable equipment and supplies will be cleaned, disinfected, or sterilized as appropriate.
- maintain equipment according to manufacturer's specifications and calibrated to deliver reliable measurements. Single-use sterile supplies must be in original sealed packaging. Reusable supplies must be properly disinfected.
- midwives and nurses must have access to appropriate communication equipment and means of transportation.
- identify the hospital according to the level of transfer and document in the maternal file and organize it with the Home Birth Coordinator.

The specific role and responsibilities of obstetricians/midwives:

If the home birth will be conducted by an obstetrician whom is approved to attend a home birth then a midwife and or an obstetric nurse should be assigned to the obstetrician for following the woman as below tasks explained for them. If the home birth will be conducted by a midwife then a midwife and or an obstetric nurse should be assigned to the midwife whom is approved to attend a home birth for following the woman as below tasks explained for them.

Obstetricians/midwives must:

- ensure at least one (1) of the midwives of whom is approved to attend a home birth is in attendance at all times from the commencement of **active labour** until at least four (4) hours post-birth of the baby.
- ensure the second midwife or the obstetric nurse are in attendance at all times from the commencement of **active stage of labour**.
- midwife should respect her scope of service and follow the referral regulations in case of need.
- for efficient continuum of care during home birth, HBP may call linked health institution or 997 for Emergency Medical Services (EMS) assistance and transportation during complicated home birth that require intensive care and transport to specialize health facility.

The specifics role and responsibility of paramedics:

- Work with the HBP to ensure safe and effective care of the woman and/or her baby with efficient transfer.
- Take the clinical lead and give direction for care if the situation is not specifically related to the pregnancy or birth such as cardiac arrest, with the assistant of HBPs.
- access to the EMS system shall be through the regional 997 operation center.
- Paramedics shall assist in the overall care provide for the women and her newborn
- Paramedics are in charge of the transportation process.
- The midwife shall continue the care and may ask for any assistance from the paramedics
- The paramedics shall follow the Red Crescent scope of practice and protocols for obstetrics emergency example: resuscitation protocols.
- If necessary dual ambulance response is required when transportation is needed for both mother and the neonate.
- The most responsible person is in-charge of an intensive care procedures
- maintaining medical directions are required for authorization and consultation
- Prepare the advanced ambulance car with following equipment:
  - Incubators with built in ventilator
  - Syringe infusion pumps
  - Monitor with end-tidal co2 (etco2) monitoring
  - Neo-mate paediatric restraint system
  - Medication bag with thermal system

Standard 17: Home birth service should have home birth coordinators available 24/7 with specific role and responsibilities

The specific role and responsibilities of home birth coordinators:

- organise with pregnant woman all needed information and brochures about home birth, HBPs and facilitate her appointments with health institution of her choice, preferable near to her house.
- provide needed information about pregnancy to the HBP.
- provide HBP with needed results such as blood, urine tests and ultrasound scan.
- inform participating health institution and ambulance services of the women having birth at home in active stage of labour and after the birth is completed.
- organise the communication and transfer of the women or newborn according to their emergency level status.
- facilitate the handover of care from the home birth midwife to a health institution midwife/ obstetric nurse when women or her baby transfer from home to health institution.
- organise the mother and baby file and discharge summary after birth.
- follow up the completeness of antenatal, labour, birth and postnatal checklist.

Standard 18: Home Birth Committee (HBC) should be created by MOH as licensing and governing body in collaboration with health institution with specific role and responsibility

HBC will represent the disciplines of the healthcare professionals who practice home birth, prenatal and postpartum care, and newborn care and are required to follow the healthcare professional credentialing and privileging process. The membership is adjusted to reflect the mix of disciplines working at that time. The chairperson will prepare agendas for the committee to consider. **Membership should include:**

- consultant obstetrician
- consultant neonatology
- midwife
- obstetric nurse
- patient relations officer
- quality officer
- infection control personnel
- patient experience officer
- home health care representative
- primary health care (PHC) representative
- human resource representative
- compliance department representative
- investment and promotion representative
- red crescent representative
- 937 representative
- medical coordinator
- administration coordinator

The role and responsibility HBC includes but is not limited to:

- implement and follow up home birth standards with KPIs.
- prepare a checklist and provide it to all applicants for documentation to facilitates and speed up the processing of their application.
- prepare a competency sheet that should be provided to all midwives and nurses who are not fully qualified and under training.
- resolve all home birth service challenges and obstacles faced by health institution and home birth providers.
- approve new or revised credentials and privileges forms and processes.
- review the healthcare professional's credentials at the time privileges are requested and when they are renewed following the processes to ensure that the professionals are qualified to provide home birth, prenatal and postpartum care, and newborn care. They will make recommendations related to the professional's qualifications and the explanation of privileges.
- review, and modify credentialing and privileging related policies and procedures

- determine the appropriate credentialing and privileging processes for new HBP that will provide home birth services. The initial assignment of appropriate privileges for new HBP is determined by the persons' experience, the scope of services that is defined by their license.
- ensure peer reviews are conducted and reports are reviewed.
- review all transfers into hospital, incidents reports, patient experience feedback and complaints.
- review the application within one week of submission.
- review the competencies application within two weeks of submission.
- plan reimbursement for the HBT and payment to the hospitals in case of transfer according to the level of transfer.

Implementation of home birth standards:

Primary health care/ private polyclinic/ birth centre should have a list of hospitals within the catchment area, close the woman home.

Home Birth Committee (HBC) should arrange the following:

- reimbursement for the Home Birth Team (HBT) from the related health institution.
- reimbursement for the participating facility.
- in person or online training in home birth.
- memorandum of understanding with the red crescent regarding transfer.
- the online birth registration system.
- insurance company coverage including health and malpractice.
- hotline for woman and healthcare professionals contact or 937 consultations.
- communicate with the ministry of interior to approve home birth online neonatal birth registrations and notifications.
- educational material that will be needed.
- checklist for the targeted house for home birth to make sure it fits the criteria.
- home birth informed consent form in Arabic/English.
- checklist for the midwife/obstetrician bag for a home birth (see Appendix 5).
- unify documentation of the antenatal follow-up, labour, and postpartum care paperwork.
- clear policy and procedures for a HBPs' credentials and privileges
- clear policy and procedures for a home birth if conducted by physicians or midwives and their roles especially birth documentation and birth notifications.
- clear policy and procedure for home birth model of care and on-call system such as case load midwifery model or team midwifery model.
- follow up for the mother and her baby for the postpartum care period.
- replacement of the home birth supply and equipment.
- postpartum care for maternal and neonatal screening, vaccination, breastfeeding, and documentation.

- home care/ primary health care roles during antenatal care and postpartum care
- the contingency plan for the assigned team who could not be reached and for the transferring woman from home to hospital.
- checklist for the ambulance for mother and neonatal needed equipment for transfer.
- pathway for postpartum home care including mother and her baby.
- clear guidelines for a supply of the birth medications, single-use sterile supply, equipment, disposing waste, sterilization of the equipment.

Topic 5: Leadership

Robust leadership is required within home birth services to ensure that model of care is not only implemented but supported and maintained.

Standard 19: The planning and organising of home birth care takes place through multi-disciplinary collaboration under obstetric and midwifery and neonatal leadership which supports a high quality clinical governance framework that delivers personalised maternity services including home birth

- There must be multi-professional input into the development of evidence based guidelines, policies and procedures that are relevant to clinical practice and subject to regular review.
- There should be a multidisciplinary steering/management group responsible for oversight of clinical care, which meets at least quarterly with published minutes and is directly accountable to the service provider's clinical governance body.

Standard 20: There should be a multidisciplinary and service users' advisory group, which sets out a vision for the home birth service

- The advisory group is composed of service users who are representative of the local population, home birth staff including leader of home birth service and midwives, other clinicians, ambulance services and commissioners. The aim of this group is to enable community engagement and involvement, facilitate co-production with service providers, and support a culture of accountability to the public;
- The advisory group needs to be established while planning the initiating of home birth service;
- The advisory group meets at least quarterly, to be reported to, and to advise on, place of birth bookings and transfer trends, information provided to expectant parents, marketing, relationships with related services and specialties, staff and unit development, service user feedback etc. Other activities and outputs may include: an annual report, multidisciplinary clinical reviews to include best practice cases, clinical and transfers audits, yearly showcase day to the local community.

Topic 6: Policy and Procedure and Training Requirements

Standard 21: The home birth service has a clear policy and procedures, training and skills required of HBP in place

The home birth service has a document in place detailing the policy and procedure, training and skills required of HBPs to attend birth at home include, but is not limited to:

- Comprehensive understanding of physiology and anatomy in relation to pregnancy, birth and the postnatal period;
- History and physical and risk assessment/reassessment of mothers and newborn recognising abnormalities;
- Antenatal and postnatal care including clinical pathways and not limited to perinatal mental health, Patient Health Questionnaire-9 (PHQ-9) in detecting perinatal depression, Venous Thromboembolism (VTE) prophylaxis in pregnancy and postpartum.
- Capacity to provide respectful care;
- Communication skills show the ability to deal with difficult interpersonal situations; (i.e., those involving self and others);
- Communication and supportive techniques for physiological labour and birth;
- Decision-making skills in relation to initial assessment, ongoing assessment and decisions to recommend transfer to the health institution;
- Understanding and application of evidence-based practice;
- Reflective and reflexive skills;
- Foetal Heart Rate (FHR) monitoring (Cardiotocography CTG, Doppler) assessment and interpretation of (CTG) the management of non-reassuring foetal heart rate;
- Use of water and water birth;
- Labour position and comfort measures
- Obstetric emergencies in home birth (including initial care, escalation and transfer);
- Maternal (Basic Life Support BLS) and Neonatal (Neonatal Life Support or Neonatal Resuscitation Program NRP) resuscitation;
- Medication prescription for women and newborn (where available) and administration;
- Anti-D immunoglobulin for Rhesus D prophylaxis
- Intravenous (IV) cannulation (insertion, maintenance, discontinuing)
- Iron intravenous administration
- Phlebotomy
- Perineal trauma and suturing
- Monitoring mother and newborn's vital signs and knowledge of acceptable deviations from the norm
- Eligibility criteria guidance
- Vaginal examination during pregnancy and labour

- Care of women during normal childbirth and conducting normal birth
- Investigations needed for women and newborn
- Early maternal warning signs
- Urinary catheters
- Infection control measures
- Patient falls (assessment of risk and methods to prevent falls)
- Midwifery role in cardiac/respiratory arrest
- Midwifery role in disaster, fire, and other emergencies
- Operation of blood sugar testing equipment
- Emergency measures for obstetric emergency cases such as eclampsia and pre-eclampsia
- Breastfeeding and lactation support
- Postpartum haemorrhage recognition and care
- Immediate newborn care
- Vaccination
- Health education for women and their families
- Detection and reporting of risks, signs and symptoms of mother and child abuse/violence
- Pain assessment
- Metabolic screening test
- Pre-transport assessment guide

Standard 22: Shortly after birth an identified lead midwife, should be responsible for reassessing individual needs and coordinating the postnatal care of all babies and women

- Postnatal follow up appointments should be arranged with the appropriate services.
- Women should have access to their midwife as they require after having had their baby. Those requiring longer care should have appropriate provision and follow up in designated clinics.
- Women should be provided with readily accessible information (including helpline numbers) including but is not limited to support in their chosen method of feeding, access to peer support groups, voluntary organisations, and physiotherapist, etc.
- At each postnatal contact, parents should be offered information and advice to enable them to:
    - Assess their baby's general condition.
    - Report early postnatal warning signs.
    - Identify signs and symptoms of common health problems seen in babies.
    - Contact a healthcare professional or emergency service if required.

Standard 23: The HBP must ensure that all essential equipment, is available in the woman's home at the time of labour and checked and ready for use

- The HBP must ensure that all essential equipment (including resuscitation equipment such as oxygen and suction), is available in the woman's home at the time of labour and checked and ready for use (see Appendix 6).

The HBP is responsible for informing the Home Birth Coordinator:

  - o when they attend the home for the woman's labour.
  - o at the completion of the third stage of labour.
  - o when they leave the woman's house.

- The midwife and obstetric nurse are recommended to stay for 4 hours after the birth of the baby, undertaking a clinical assessment of both mother and baby immediately before leaving and finishing all maternal/neonatal documentation of birth (see Standard 25).
- The midwife and /or the obstetric nurse should manage and dispose of the placenta safely as per local policies and procedures for the management of medical waste.
- The midwife must provide information and education regards infant feeding and maternal and neonatal wellbeing, including when and how to contact the midwife.
- The midwife must provide the mother with details of how and who to contact to seek support and advice
- The midwife must organise a home visit to review the mother's and baby's condition within 24 hours of the birth and then in accordance with the participating health institution's protocols.
- The midwife or obstetric nurse must organize with the home care or the health institution to collect mother Complete Blood Count (CBC) and perform newborn screening within 24-48 hours postpartum as per the MOH national newborn screening programme.
- The HBP must advise the parents of the newborn to have their baby examined by a general practitioner, family physician or paediatrician of their choice between day seven (7) and day ten (10) after the birth to perform newborn check-up and review newborn screening results.
- The midwife/obstetrician must register and notify about the birth using the electronic system for birth notification with a witness from the second midwife or obstetric nurse.
- The attending midwife is responsible to submit mother and newborn documentation to the participating hospital.

Topic 7: Clinical Governance

Standard 24: The home birth service has specific referral pathways and protocols

The home birth service has specific referral pathways and protocols for:

- primary health care/ private polyclinics/ birth centre for the linked hospitals in case of emergency situation;
- the indications and the process of transfer to a hospital (labour and birth room or neonatal unit) (with a clear statement of acknowledgement of a woman's autonomy);
- local health and social care;
- multi-disciplinary and inter-agency referrals;
- referrals to primary care, family physicians or general practitioners for postpartum care.

Standard 25: The HBP collects information about and documents care of the woman and baby across the continuum of care

The HBP must:

- collects and documents information about the woman's social, emotional, mental, physical and cultural circumstances to facilitate maternity care that is suited to her and her baby's needs;
- maintains contemporaneous clinical documentation, recording all care, recommendations to the woman, decision-making processes and ongoing plans for care;
- makes the woman's clinical records available for the purpose of consultation, referral, transs fer of care, and clinical review with the consent of the woman.
- provides postnatal documentation and forms to the parents according to the requirements of jurisdictions and/or organisations.
- adheres to reporting requirements to perinatal data collections.
- ensures the woman has read the home birth information brochure for women and discussed this with the midwife(s) and signed the consent form for home Birth (Appendix 7).
- ensures that the woman has signed the two (2) copies of the Consent Form for Home Birth and that one of these is filed in the woman's medical record at the participating hospital prior to birth.
- completes the checklist which forms part of the Planned Home Birth Consent Form.
- completes the Identification, Situation, Background, Assessment, Recommendation (ISBAR) communication tool in case of medical consultation or referral. The tool must document clearly the name and I.D number of the midwife, medical healthcare professionals, date and time for consultation, reason for consultation, the decision made, and woman medical record number. Also, in case of referral a copy of woman's medical records and results of investigations should be given to the receiving hospital.
- complete a transferal form, this should be done and attached with the document.
- documents the decision to transfer should include the following details:
    - referring HBP name, contact details.
    - date and time at which decision to transfer was taken.
    - reasons and level of transfer.

- mother's and newborn clinical status and vital parameters before, during and after transfer should be documented, so also the medical management during the transport.
- medical records and results of investigations should be given to the receiving hospital.

Documentation required for home birth:

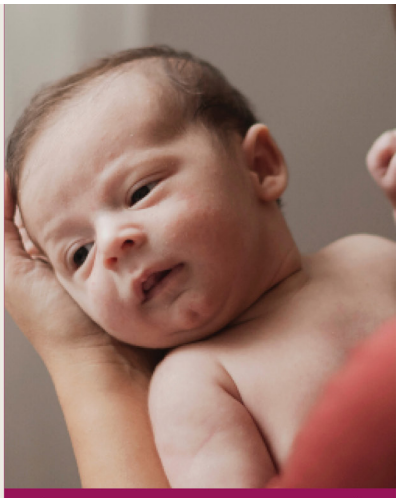
- **Mother's Records Form**: this form should contain all the mother's details; age, parity and date of last menstrual cycle, history and any useful data for the HBP attending home birth.
- **Risk Assessment Form**: this might include all the background of the previous pregnancies, current history and diagnosis of any family members abnormalities to rule out any risk for home birth.
- **Antenatal Record's**: this form is stating the whole journey of the current pregnancy.
- **Consultation Form**: this will used if any other specialty opinion is required.
- **Labour Assessment:** this form is crucial as it includes all the detailed information about the labour e.g. the Partogram, Vital Signs, Vaginal Examination, Intermittent Auscultation, Procedures performed during labour etc.
- **Birth Data**: this is stating all information related to the birth; time of birth, cord around the neck, sex of the baby, APGAR scoring, blood loss, perineal tears, and the initial assessment of the newborn.
- **Postpartum Sheet:** this should describe the immediate post-partum status of the women -third stage of labour- including lochia, contractility of the fundus, any perineal or vaginal trauma and repair, Estimated Blood Loss (EBL) after repair.
- **Newborn Assessment and Breastfeeding:** this is the first assessment of the newborn's status and it is very important and will reflect that the birth took place at home, contain initial height and weight of the newborn, vital signs, initial examination**.**
- **Referral Form:** whenever required and should contain the name of the hospital for referral, 997 or linked hospital for ambulance services**,** location of the home and phone number of the HBP who conducted the birth and to be signed by the HBP.
- **Birth Registration/Notification:** this is for the father/guardian of the newborn to register at Ministerial Agency of Civil Affairs with complete names of both mother and father, date and time of birth and the newborn initial ID that will provided by the registration system of the MOH.
- **Prescription form:** this will include any medication needed to be provided by the midwife/ obstetrician.
- All of the above forms will be obtained from each facility the HBP is dealing with, either government or private sector.
- The forms should be filed as required by physician/midwife who attended the home birth as clearly stated in the role and responsibilities section.

Appendix 1: Home Risk Assessment Checklist

Mother name		**Midwife name**	
Home address		**Assessment date**	
Phone number		**Visit number**	

	Home Risk Assessment	**Yes**	**No**	**Note**
1	**Location Factors**			
	Participating hospital location less than 30min			
	Nearest Hospital location less than 15min \ peak time			
	Accessibility for an ambulance			
	Availability of working elevator (detect floor number)			
	Adequate phone signal			
	Adequate network coverage			
	No specific location risk			
2	**Environment Factors**			
	Area is clean			
	Adequate heating supply			
	Adequate lighting			
	Availability of clean water supply			
	Electricity supply with an appropriate electrical outlet for the room birth			
	Stretcher access for the birth room			
	Access to wheelchair			
	Accessibility of the bathroom and toilet			
	Pets \ animals should be secure away from the birth area			
	Food and water supply			
	Safe general structure			
3	**Social Factors**			
	Supporter healthy adult availability during labour and the first 24 hr after birth			
	A caring person for other children if exist			
	Emergency contact availability			
	Midwife Name and Signature:			

Appendix 2: Home Birth Brochure



الولادة المنزلية

مجموعة القبالة السعودية
بالتعاون مع
الجمعية السعودية لأمراض النساء
والولادة

لماذا
الولادة المنزلية؟

الولادة هي الحدث الأجمل والحميمي لكل أم وللعائلة بكاملها حيث تفضل العديد من الأمهات وضع طفلها في أجواء من الراحة والخصوصية.

وفي ظل جائحة كورونا قد تبدو الولادة المنزلية هي الخيار الأفضل للأمهات ذوات الحمل منخفض الخطورة لتقليص انتشار العدوى وتوفير العناية المثلى بك وبطفلك!

ولأن صحتك وصحة وليدك أولوية فقد قامت وزارة الصحة باعتماد برنامج الولادة المنزلية والذي يخضع لأعلى معايير الصحة والسلامة ويستند على البحوث العلمية الأحدث في هذا المجال.

تقدم خدمات الولادة المنزلية من قبل فريق طبي مؤهل ومرخص مكون من استشاريّ النساء والتوليد، القابلات والممرضات.

تشمل خدمات الولادة المنزلية:

- **استشارات الحمل المنزلية**
- **الولادة في المنزل**
- **استشارات ما بعد الولادة المنزلية**

أظهرت البحوث

أن السيدات اللواتي يخترن الولادة في المنزل للحمل منخفض الخطورة مقارنة باللواتي يخترن الولادة في المستشفى هن:

- أقل عرضة للتدخلات الطبية مثل شق العجان، الولادة مع الشفط أو القيصرية
- أقل عرضة لتمزقات العجان أو النزيف ما بعد الولادة
- أكثر اتجاها نحو الرضاعة الطبيعية والبدء بها مبكرا ولمدة أطول

مواليد الولادة المنزلية هم:

- أقل حاجة للدخول للحاضنة
- لا تختلف نسب الوفاة بين الولادة المنزلية والولادة في المستشفى

قد تحتاجين إلى أن يتم نقلك للمستشفى قبل، خلال او ما بعد الولادة المنزلية في حال:

- عدم تقدم المخاض
- حدوث أي مضاعفات لك قبل، أثناء او ما بعد الولادة
- إذا كان هناك تخوف على صحة طفلك قبل، أثناء أو ما بعد الولادة.

الطبيب/ القابلة المتابع/ة لولادتك على كفاءة عالية لتحديد المخاطر واشعارك بضرورة النقل عند الحاجة.

لمزيد من المعلومات الرجاء التواصل على:

937

هل ينطبق على منزلك المعايير التالية؟

يجب أن يحقق منزلك المعايير التالية:

- يبعد أقل من ١٥ دقيقة عن المستشفى التي تتابعين بها
- الارسال لشبكة الهاتف في المنزل جيدة
- امكانية دخول الاسعاف بشكل سلس
- توفر الكهرباء ومصدر نظيف للماء
- بيئة المنزل نظيفة
- الوصول لدورة المياه سهل وقريب من الغرفة المخصصة للولادة
- وجود مرافق لمساعدتك خاصة في ال ٢٤ ساعة الاولى ما بعد الولادة
- وجود مرافق للعناية بالأطفال الآخرين في حال وجودهم.

يمكنك التقدم بطلب الولادة المنزلية إذا كنت تحققين المعايير التالية:

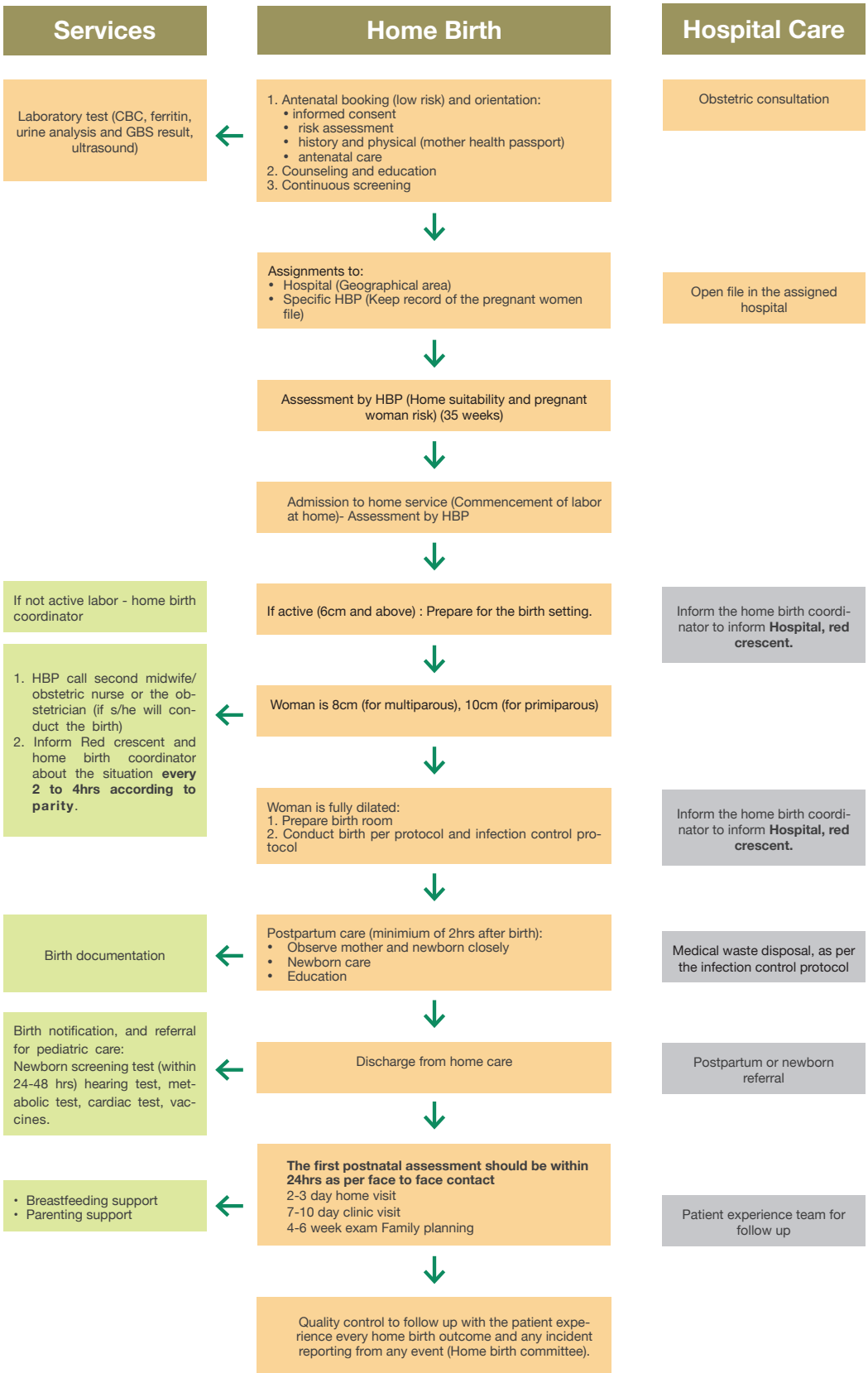
- حاملا بطفل واحد
- لا يوجد لديك تاريخ طبي أو جراحي يمنعك من الولادة في المنزل
- وزنك ضمن المعدل الطبيعي مع مؤشر كتلة الجسم أقل من ٤٠ كيلو\ متر
- ليس لديك قيصرية سابقة
- لم تحصل لك مضاعفات في الحمل أو الولادة السابقة
- لا تعانين من سكر الحمل
- فحص السونار للجنين الطبيعي
- مسار حملك الحالي طبيعي دون أي مضاعفات
- لا تخططي لأخذ ابرة الظهر
- جنينك بصحة جيدة ولا يحتاج أي تدخلات طبية خاصة عند الولادة
- جوازك الصحي مكتمل شامل لجميع المراجعات المطلوبة مع الطبيب\القابلة
- التقدم بطلب الولادة المنزلية يحمل توقيعك الشخصي

Appendix 3: Maternity Unit/Hospital Levels

Maternity Units/Hospital Levels

Levels IV (Regional)	Levels III (Subspecialty)	Levels II (Specialty)	Levels I (Basic)	
Obstetric Provider to perform emergency and elective CS	Obstetric Provider to perform emergency and elective CS	Obstetric Provider to perform emergency and elective CS	Obstetric Provider to perform emergency CS	**Minimum care provider available**
Obstetric Anesthesia available	Obstetric Anesthesia available	Available all the time	Available all the time	**Anesthesia**
Available all the time	Available all the time	Available all the time	Specialist available 24 hours / consultant accessible when needed	**OBGYN**
Onsite for 24 hours	Onsite for consult	Accessible for consult by phone / part time	Accessible for consult by phone	**MFM**
Onsite	Onsite	Accessible	Accessible	**Blood bank**
Onsite	Onsite	Onsite	Accessible by referral	**Ultrasound service**
Available with subspecialties	Available	HDU	No	**ICU**
Medical subspecialties onsite	Medical subspecialties accessible	Internist	No	**Medical Specialist**
Surgical subspecialties Onsite	Subspecialties accessible	General surgeon accessible	No	**Surgical Specialist**
Onsite	Onsite	Onsite	Accessible	**Laboratory**

Appendix 4: Clinical Pathway for Home Birth



Appendix 5: Home Birth Essential Equipment, Supplies and Medications

The following list is the minimum required equipment, supplies and medications necessary for the provision of safe and appropriate care in home birth setting.

Equipment/supplies/medications	Quantity	Y	N
Maternal Pack			
Fetoscope	1		
Pinard stethoscope	1		
Electronic foetal sonic aid (doppler) and	1		
Adult Stethoscope	1		
Sphygmomanometer with adequate Sized cuffs	1		
Thermometer	1		
Sterile or disposable speculum different sizes	1		
Aqua gel	1		
Sterile gloves- different sizes	6		
Non-sterile gloves – different sizes	1 box		
Amnihook	3		
Amnicator or suitable method for assessing amniotic fluid	3		
Sterile lubricant, KY Jelly	2		
Swabs for microbiology	1		
MSU universal container	2		
Urinalysis supplies	1		
Antiseptic solution	2		
Alcohol hand cleaner	1		
Birth Pack			
Cord clamp or artery forceps	2		
Cord clamp remover	2		
Cord scissors	2		
Sterile episiotomy scissor or curved Mayo	2		
Sterile catheterisation pack	1		
Receiving bowl/dish (able to be autoclaved)	1		

Equipment/supplies/medications	Quantity	Y	N
Disposable in/out urinary catheter size 12	1		
Self-retaining urinary catheter size 12	1		
Urine collection bag	1		
Inco pads 40x60 cm inches (minimal size)	10		
Bed pads (under pad-incontinence pads)	2		
Basic delivery pack; includes sterile bowls, drapes	1		
Sanitary towels	10		
Torch/good light	1		
Medical waste bags	3		
Medical waste hazard bags (for placenta)	3		
Suitable time-keeping device	1		
Newborn Pack			
Paediatric stethoscope	1		
Paediatric thermometer	1		
Baby weighing scale	1		
Disposable tape measure	3		
Newborn screening equipment	1		
Transcutaneous bilirubin meter	1		
Perineal Suturing Pack			
Clean drape or dressing towel	2		
Mosquito forceps	2		
Ring forceps	2		
Hemostats or needle holder	4		
Dissecting forceps	2		
Scissor for suturing	2		
Vicryl Rapide2-0 for vaginal repair	3		
Vicryl Rapide 3-0 for labial and skin repairs	2		
Apron	5		
Goggles	1		
Mask	5		
Headcovers	5		
Shoe cover	5		

Equipment/supplies/medications	Quantity	Y	N
Sharps container/bin	**2**		
Adequate light source	**1**		
Sterile large swabs	**5**		
Syringes 10 ml	**5**		
Syringes 20 ml	**5**		
Intramuscular needles	**5**		
Drawing up needles	**5**		
IV equipment and supplies			
Cannula size 20 G	**2**		
Cannula size 18 g	**2**		
Cannula size 16 g	**2**		
Selection of disposable syringes 5cc, 10cc, 20cc	**5 each**		
IV dressings	**2**		
Needles	**5**		
Vacutainers	**2**		
Tourniquet	**1**		
Plasters	**5**		
Alcohol swabs	**1 box**		
Gauze	**5**		
Mepore tape	**1**		
IV giving set	**2**		
Blood drawing supplies (Venepuncture equipment)	**1**		
Blood bottles	**1**		
Resuscitation Pack (Maternal and Infant)			
Maternal non-rebreathing Oxygen mask	**2**		
Cord blood gas tubes	**2**		
Feeding tubes	**2**		
Endotracheal tubes	**2**		
Meconium aspirators	**2**		
Suction tubing	**2**		
Heat source for the baby (e.g. heating pad)	**1**		
Self-inflating newborn resuscitation bag and appropriate sized masks	**2**		

Equipment/supplies/medications	Quantity	Y	N
Newborn laryngeal mask airway	**2**		
Infant oral airway (appropriate sizes 0, 00 & 000)	**2**		
Compressed gas regulator and flow metre	**1**		
Portable suction equipment (compatible with intubation)	**1**		
Neonatal bulb suction	**2**		
Scissors for intubation tubing	**2**		
Newborn intubation equipment including laryngoscope, appropriate sized blades, light, stylet	**2 each**		
Newborn portable pulse oximeter	**1**		
CO2 detector	**1**		
PEEP valve- A PEEP valve is not required if the HBP carries an additional device with PEEP capability (e.g., flow inflating bag or T-piece resuscitator)	**1**		
Scalpels for UVC	**1**		
Equipment for administering epinephrine and/or fluids for volume expansion via umbilical vein	**1**		
Disposable mouthpiece	**1**		
Adult self-inflating resuscitation 'ambu' bag with facemask	**1**		
O2 tubing	**1**		
Bulbs and batteries for laryngoscope			
Spare batteries for sonic aid/torch/weighing scales			
Medications Pack (should be stored in a secure container in the woman's home)			
Papal	**2**		
Oxytocin 10 units	**8**		
Methergine	**2**		
Cytotec	**8**		
Hepatitis B vaccination	**1 bottle**		
Antiseptic preparation (preferably Chlorhexidine)	**1 Bottle**		
Paediatric Vitamin K	**2**		
IVI fluids (Ringer Lactate, D5NS, NS)	**2**		
IVI Gelofusin 500ml	**2**		
IVI Hartmann's solution 1 litre	**2**		
IVI NaCl 500mls	**2**		
Oxygen cylinder enough for transport mother and baby	**1**		
Sterile water 10 ml	**2**		

Equipment/supplies/medications	Quantity	Y	N
Normal saline 10 ml	**2**		
Entonox cylinder and connector	**1**		
Xylocaine spray	**1**		
Local anaesthetic (Lidocaine 1% 10 ml without epinephrine	**2**		
Local anaesthetic (Lignocaine ampoule 1 % 20 ml with Adrenaline 1: 200,000)	**2**		
Epinephrine hydrochloride (maternal and newborn doses)	**1**		
Diphenhydramine hydrochloride (Benadryl)	**1**		
Paracetamol IV 1gm	**4**		
Voltarin suppositories 100 mg	**2**		
Antibiotics- as required	**1**		
Documents			
Midwifery progress notes			
Blood forms and labels			
Venepuncture forms			
Drug additive labels			

Appendix 6: Gas Cylinder Safety

Safety is of the utmost importance in the handling and use of a gas cylinder. It is important that the HBP always read the label on the cylinder and the accompanying Material Safety Data Sheet before use.

The HBP responsible for storing or using a gas cylinder should be trained and familiar with both the current cylinder manual handling regulations and the procedures to be followed in case of an emergency (see manufacturer's instructions). It is especially advisable that the following precautions are applied when handling gas cylinders:

1. The cylinder should not be knocked violently and should be prevented from falling;
2. Force should never be used when opening or closing valves;
3. Cylinder valves must be closed before moving the cylinder; all equipment must be detached; and the valve should be checked to ensure that it has not been inadvertently turned on;
4. The cylinder should be firmly secured in a vehicle during transport;
5. The key should be kept in a safe place, separate from the cylinder, but easily available;
6. The cylinder should be checked regularly for leaks and faults; and
7. The cylinder should be stored upright in a cool, dry and well-ventilated place away from heat sources, sources of ignition and combustible materials (especially flammable gases), and out of the reach of children.

Appendix 7: Consent Form

Written consent for home birth	موافقة خطية على الولادة المنزلية
I ..... give consent to home birth.	اقر انا ..... بالموافقة على الولادة المنزلية.
• The midwife has explained to me the nature of the birth at home/ my health condition after the birth/the consequences of following up on the condition of the baby during the first hours after birth, the risks and possible complications after the birth and the procedures followed at the time or the suggested alternative options.	• قد أوضحت لي الطبيب/ة /القابلة طبيعة الولادة في المنزل/ حالتي الصحية بعدها/ حالة المولود/ الأمور المترتبة لمتابعة حالتي وحالة المولود خلال الساعات الأولى بعد الولادة، المخاطر والمضاعفات المحتملة بعد الولادة والإجراءات المتبعة حينها أو الخيارات البديلة المقترحة.
• the midwife or her assistants are authorized to provide any additional service to me when they deem it appropriate or reasonable, including but not limited to suturing vaginal tears arising from childbirth and performing services such as physiological analysis for me and the newborn.	• القابلة المسؤلة أو معاونيها مفوضون بتقديم أية خدمة اضافية لي حين يرون ذلك مناسبا أو معقولا، بما في ذلك على سبيل المثال لا الحصر، خياطة التشققات الناشئة من الولادة وأداء خدمات مثل التحاليل البولوجية لي وللمولود.
• The benefits of giving birth at home and its safety for low-risk pregnancies were explained, and the risks resulting in severe bleeding and a transfer mechanism to the nearest hospital were clarified.	• تم توضيح فوائد الولادة في المنزل وأمانها بالنسبة للحمل القليل الخطورة، كما تم توضيح المخاطر الناتجة في حال حصل النزيف الشديد وآلية نقلي لأقرب مستشفى.
• The mechanism of my transfer to the nearest hospital to my home after communicating and preparing between them in advance, based on the names in the list of cadres and hospitals approved by the Ministry of Health to deal with home birth.	• تم توضيح آلية نقلي لأقرب مستشفى لمنزلي بعد التواصل والتحضير بينهما مسبقا، بناءا على الأسماء المتواجدة في قائمة الكوادر والمستشفيات المعتمدة من وزارة الصحة للتعامل مع الولادة المنزلية.
• I also authorize the obstetrican/ midwife to take any action that is in my interest and in accordance with the regulations and laws in force in Saudi Arabia.	• كما أفوض الطبيب/ة / القابلة المسؤلة باتخاذ أي اجراء يتم لمصلحتي وتبعا للأنظمة والقوانين السارية في المملكة العربية السعودية.
• I had the opportunity to ask all my inquiries and they were answered clearly. **Mother's signature:** ..... In the presence of the husband, the above matters are explained to him and he is shown his name below, who has agreed to the written permission. Name and Signature: ..... Obstetrican/midwife ID Number and signature: .... Date:	• وقد سنحت لي الفرصة لطرح جميع استفساراتي وقد تم الإجابة عليها بوضوح تام. **توقيع الأم:** ..... في حاة تواجد الزوج، يتم توضيح الأمور الموضحة اعلاه له وهو الموضح اسمه أدناهوالذي وافق على الإذن الخطي. الاسم والتوقيع: ..... اسم الطبيب/ القابلة والتوقيع: .... التاريخ: .....

Table 1: Medical Condition or Pre-existing Gynaecological Disorder

Disease area	Exclusion Criteria
Cardiovascular	• Confirmed cardiac disease • Hypertensive disorders • Cardiac disease without intrapartum implications
Respiratory	• Asthma requiring an increase in treatment or hospital treatment • Cystic fibrosis
Haematological	• Haemoglobinopathies – sickle cell disease, betathalassemia major • History of thromboembolic disorders • Immune thrombocytopenia purpura or another platelet disorder or platelet count below 100×10^9/liter • Von Willebrand's disease • Bleeding disorder in the woman or unborn baby • Atypical antibodies which carry a risk of haemolytic disease of the newborn • Atypical antibodies not putting the baby at risk of haemolytic disease
Endocrine	• Hyperthyroidism • Unstable hypothyroidism such that a change in treatment is required • Diabetes Mellitus
Infective	• Risk factors associated with group B streptococcus whereby antibiotics in labour would be recommended • Hepatitis B/C with normal or abnormal liver function tests • Carrier of/infected with HIV • Toxoplasmosis – women receiving treatment • Current active infection of chicken pox/rubella/genital herpes in the woman or baby • Tuberculosis under treatment
Immune	• Systemic lupus erythematosus • Scleroderma • Nonspecific connective tissue disorders
Renal	• Abnormal renal function • Renal disease requiring supervision by a renal specialist
Neurological	• Epilepsy • Myasthenia gravis • Previous cerebrovascular accident
Skeletal	• Spinal abnormalities • Previous fractured pelvis • Neurological deficits
Gastrointestinal	• Liver disease associated with current abnormal liver function tests • Liver disease without current abnormal liver function • Crohn's disease • Ulcerative colitis
Psychiatric	• Psychiatric disorder requiring current inpatient care

Glossary/Definitions

Home Birth: is a birth that takes place in a residence rather than in a hospital.

Home Birth Providers (HBPs): either a midwife or obstetrician who is certified by the Home Birth Committee.

Home Birth Coordinator: is a person assigned by the participating hospital to facilitates the home birth.

Home Birth Team (HBT): consists of 1 obstetrician, midwife, and nurse or 2 midwives, or 1 midwife and 1 obstetric nurse.

Home Birth Committee (HBC): is a group of experienced healthcare professionals who are qualified to oversee the home birth services and to review other professionals credentials and privilege to determine if their qualifications and experience are sufficient to provide clinical services (home birth, prenatal and postpartum care, and newborn care). They set in the Regional health affairs directorate and report to the MOH.

Credentialing: is the process of determining the accuracy of a qualification reported by an individual including licensing, relevant education, training or experience, current competence and ability to perform requested privileges.

Privileging: the process of authorizing a healthcare professional to provide care within a defined scope. Privileging is performed in conjunction with the evaluation of an individual's clinical qualifications and/or performance and after a thorough review and validation of their credentials.

Participating Health Institution: will have an agreement with MOH to provide a home birth service consistent with this standard and will have written approval.

Reimbursement: the act of compensating healthcare professionals per home birth either money or a day off.

Midwifery caseload: A model of maternity care where women have a primary midwife assigned to them throughout pregnancy, labour and birth and the postnatal period. Each midwife has an agreed number (caseload) of women per year and acts as a second or "back-up" midwife for women who have another midwife as their primary carer. Caseload midwives usually work on a 24-hour on-call basis (this may be organised within a group) and may be employed on an annualised salary. This is also known as a midwifery continuity of carer model of care and may be a private or public arrangement. Midwifery caseload may be managed within a midwifery group practice model where a small number of midwives join together in a group with each midwife

having their own caseload and providing backup for the other midwives in the group practice.

A key aspect of caseload midwifery practice that differentiates it from 'team midwifery' models is that women have a named midwife, caseload midwives have a self-managed workload that is outside of a traditional roster structure and provides a high level of continuity of a known carer across the continuum of maternity care. Note that this is different to team midwifery.

Midwifery Group Practice caseload care: Antenatal, intrapartum and postnatal care is provided within a publicly-funded caseload model by a known primary midwife with secondary backup midwife/midwives providing cover and assistance with collaboration with physicians in the event of identified risk factors. Antenatal care and postnatal care is usually provided in the hospital, community or home with intrapartum care in a hospital, birth centre or home.

Team midwifery care: Antenatal, intrapartum and postnatal care is provided by a small team of rostered midwives (no more than eight) in collaboration with physicians in the event of identified risk factors. Intrapartum care is usually provided in a hospital or birth centre. Postnatal care may continue in the home or community by the team midwives.

Abbreviations

BMI: Body Mass Index
EBPs: Evidence Based Practices
ISBAR: Identification, Situation, Background, Assessment, Recommendation
KPI: Key Performance Indicators
L&D: Labour and Delivery
MOH: Ministry of Health
OVR: Occurrence Variance Report
ROM: Rupture of Membrane
TBA: Traditional Birth Attendants
SCFHS: Saudi Commission for Health Specialties
CPR: Cardiopulmonary Resuscitation
NRP: Neonatal Resuscitation Program
BLS: Basic Life Support

References

Australian Institute of Health and Welfare (2014) Foundations for enhanced maternity data collection and reporting in Australia: National Maternity Data Development Project Stage 1. Cat. no. PER 60. Canberra: AIHW.

Australian College of Midwives (2016) Birth at home midwifery practice standards. Available at: https://www.midwives.org.au/birth-home-standards accessed July 12, 2021

College of Midwives of Ontario (2015) Essential Equipment, Supplies and Medications. [online]. Available from: www.cmo.on.ca accessed July 12, 2021

Cheyney M, Bovbjerg M, Everson C, Gordon W, Hannibal D, & Vedam S. (2014) Outcomes of care for 16,984 planned home births in the United States: The Midwives Alliance of North America Statistics Project, 2004-2009.

Health Service Executive (2018) Midwifery Practice Guidelines HSE Home Birth Service. [online]. Available at: www.hse.ie/eng/services/list/3/maternity/hb004-midwifery-practice-guidelines-hse-home-birth-service-2018.pdf accessed July 12, 2021

MacDonald, M. & Bourgeault, I. L. (2009) 'The Ontario Midwifery Model of Care', in R E Davis-Floyd et al. (eds.) Birth Models That Work. London: University of California press. pp. 89–117.

Ministry of Health (MOH) (2019) Guidebook for Midwives. Riyadh, Saudi Arabia: [online]. Available at: https://www.moh.gov.sa/Documents/Book-2019-04-24-001.pdf accessed July 12, 2021

Ministry of Health (MOH) (2017) Model of Care: Pathway Manual Women and Children.

Sandall J, Soltani H, Gates S, Shennan A, Devane D. Midwife-led continuity models versus other models of care for childbearing women. Cochrane Database of Systematic Reviews 2016, Issue 4. Art. No.: CD004667. DOI: 10.1002/14651858.CD004667.pub5. Accessed 12 July 2021.

Homer C, Brodie P & Leap N. 2008. Getting started: what is midwifery continuity of care? in Midwifery Continuity of Care. Chatswood: Elsevier Australia, 1-24

The Royal College of Obstetricians and Gynaecologists (2016) Providing quality care for women: A framework for maternity service standards**. Available at:** https://www.rcog.org.uk/globalassets/documents/guidelines/working-party-reports/maternitystandards.pdf accessed July 12, 2021

Safer Care Victoria (2021) Home birth: Clinical guidance. State of Victoria, Australia, https://www.bettersafercare.vic.gov.au/sites/default/files/2021-05/GUIDANCE_Homebirth.pdf

United Nations Population Fund, World Health Organization, International Confederation of Midwives (2021) State of the world's midwifery: a universal pathway. A woman's right to health. New York: United Nations Population Fund. Available at:
https://www.unfpa.org/sites/default/files/pub-pdf/21-038-UNFPA-SoWMy2021-Report-ENv4302_0.pdf accessed Oct 10, 2021