ISCTE IUL
Instituto Universitário de Lisboa

School of Sociology and Public Policy

Department of Sociology

Knowledge, power and new professional dynamics in Portuguese home births

Mário João Duarte da Silva Santos

Thesis presented in partial fulfilment of the requirements for the degree of

Doctor in Sociology

Supervisor:
Doctor Amélia Augusto
Integrated Researcher, Centre for Research and Studies in Sociology
ISCTE – University Institute of Lisbon
Auxiliary Professor, Universidade da Beira Interior

Co-supervisor:
Doctor Jette Aaroe Clausen
Senior Lecturer, Faculty of Health
University College Copenhagen

September 2019

ISCTE IUL
Instituto Universitário de Lisboa

School of Sociology and Public Policy
Department of Sociology

Knowledge, power and new professional dynamics in Portuguese home births

Mário João Duarte da Silva Santos

Thesis presented in partial fulfilment of the requirements for the degree of

Doctor in Sociology

Jury:

Doctor Madalena Ramos, Associate Professor, ISCTE – University Institute of Lisbon
Doctor Helena Serra, Associate Professor with Aggregation, FCSH – UNL
Doctor Felismina Mendes, Coordinator Professor, Universidade de Évora
Doctor Teresa Joaquim, Auxiliary Professor, Universidade Aberta
Doctor Sónia Pintassilgo, Auxiliary Professor, ISCTE – University Institute of Lisbon
Doctor Amélia Augusto, Auxiliary Professor, Universidade da Beira Interior
Doctor Jette Aaroe Clausen, Senior Lecturer, University College Copenhagen

September 2019

This work was funded by a doctoral grant (SFRH/BD/99993/2014) from the Portuguese Foundation for Science and Technology [Fundação para a Ciência e Tecnologia] – FCT.

Acknowledgements

The research trajectory that led to this thesis was, for me, much more than a long and demanding academic exercise. It was a transforming process. And I became a father, which by itself deconstructed and reconstructed me. There is no combination of words that captures how much all this has transformed me. I am filled with gratitude when I realise how much I received along this journey. To Brígida, with whom I did all this path, hand in hand, and heart in heart. To my daughters, for all they taught me, even before they were born. To my friends, for constantly showing to me that it is safe to be who I am. To my family, for all the love I received and still receive, in original and surprising ways. To all the people that I have met because of this research, many of which I now have as true friends. To everyone who generously and altruistically opened their home, their intimacy, and their heart to make this work possible. To Luís, Miguel, Anaís, Luís, Carolina, Miguel, and Lucas, for giving me this much, this early. To the doulas, midwives, and doctors, who accept the radical challenge of respecting human rights, at the hospital or at home. To my colleagues from the doula courses, for fostering our difference and for recognising what we have in common, after all. To Amélia, for the lucidity, the critical and vigilant sociological eye, To Jette, for the constant unravelling. To Sara, Barbara, and Francesca, for the precious contribution in different chapters of this thesis. To UIBI, for being my home in part of this journey. To ISCTE and CIES, for hosting my project. To the colleagues of my PhD class, because there was never a class like this one. To my office colleagues, for the subversive occupation adventures and for being an example of persistence. To Sónia and Dulce, for believing in the sociology of childbirth, and to all other colleagues who believe. To my colleagues and friends at COST, for taking me to another level. To the Portuguese Association for the Rights of Women in Pregnancy and Childbirth, for proving me that you can actually make change happen. To my colleagues at SAMS, to whom I owe many working hours. To the ISCTE Choir, for being a shelter. And, last, to the SAMS hospital, for the flexibility and the unpaid leave, which allowed me to be dedicated to this project full time; and to FCT for the funding.

Agradecimentos

O percurso de investigação que deu origem a esta tese representou, para mim, bem mais do que um exercício académico longo e exigente. Foi um processo transformador. E tornei-me pai, o que por si só me desconstruiu e reconstruiu. Não há uma escolha de palavras que acerte na descrição de como tudo isto me transformou. Enche-me de gratidão o reconhecimento de tudo o que recebi ao longo deste percurso. À Brígida, com quem fiz todo este caminho, de mão dada e de coração no coração. Às minhas filhas, por tudo o que me ensinaram, mesmo antes de nascerem. Aos meus amigos e amigas, por me mostrarem tantas vezes que é seguro ser quem sou. À minha família, por todo o amor que recebi e recebo, de formas originais e surpreendentes. A todas as pessoas que conheci por causa desta pesquisa, muitas das quais agora tenho como verdadeiras amigas. E a quem generosa e altruisticamente abriu a sua casa, a sua intimidade e o seu coração para tornar este trabalho possível. Ao Luís, ao Miguel, à Anaís, ao Luís, à Carolina, ao Miguel e ao Lucas, por me trazerem tanto desde tão cedo. Às doulas, parteiras/os e médicas/os, que aceitam o desafio radical de respeitar os direitos humanos, no hospital ou em casa. Às colegas dos cursos de doula, pelo acolhimento da diferença e pelo reconhecimento do que afinal temos de tão igual. À Amélia, pela lucidez, pelo olhar sociológico crítico e atento, pela disponibilidade e pela amizade. À Jette, pelo constante desvendamento. À Sara, à Barbara e à Francesca, pelos preciosos contributos em diferentes capítulos desta tese. À UIBI, por ter sido a minha casa durante uma parte deste percurso. Ao ISCTE e ao CIES, pelo acolhimento. Aos/às colegas de turma do doutoramento, porque nunca houve uma turma assim. Aos/às colegas de gabinete, pelas aventuras de ocupação subversiva e por serem exemplo de resistência. À Sónia e à Dulce, por acreditarem na sociologia do nascimento, e a todas/os as/os outras/os que acreditam. Aos/às colegas e amigos/as da COST, por me levarem a voos mais altos. À APDMGP, por me provar que se pode de facto fazer a mudança acontecer. Às/aos colegas do SAMS, a quem devo muitas horas de trabalho. Ao Coro ISCTE, por ser um refúgio. E, por fim, ao SAMS pela flexibilidade e pela licença sem vencimento que me permitiu dedicar-me a este projeto em exclusivo; e à FCT pelo financiamento concedido.

Abstract

The contemporary option of an out-of-hospital birth confronts different risk perceptions, questions established organisational dynamics, and challenges medical power and expertise. Looking at the Portuguese context, this research is thus focused on home birth as a social phenomenon, where different professional actors define their own fields of knowledge and power, mostly without a formal organisation or an institutional structure. The diffuse distribution of home birth called for the use of a multi-sited ethnography, in order to understand the connections between the formal and the informal, the public and the private, the regulated and the unregulatable. The four essays that constitute this thesis propose an original and integrative sociological perspective on home birth. The first essay offers a sociohistorical analysis of the extinct figure of the community midwife. This sets the stage for the analysis of midwifery today, in the second essay, which looks at the contemporary circulation of knowledge and power among home birth professionals. In the third essay, "natural" childbirth initiatives and home births, more broadly, are analysed for its particular features regarding how gender is conceived and enacted. And the four essay presents a critical analysis of the organisation of contemporary home births in Portugal, proposing a set of recommendations for improving maternity care. Beyond the academic and sociological relevance of this research, it is expected that it can have a wider social impact, by informing the definition of maternal health policies that are sensitive to the rather invisible but relevant reality of home birth.

Keywords: home childbirth, Portugal, sociology of health, sociology of childbirth, midwife, doula, ethnography

Resumo

A opção contemporânea por um parto fora do hospital confronta diferentes perceções de risco, questiona dinâmicas organizacionais estabelecidas e desafia o poder e a pericialidade médica. Observando o contexto português, esta pesquisa centra-se no parto em casa enquanto fenómeno social, onde diferentes atores profissionais definem os seus campos de saber e de poder, maioritariamente sem uma organização formal ou uma estrutura institucional. Sendo um objeto difuso, elegeu-se uma etnografia multissituada, de forma a compreender as conexões entre o formal e o informal, entre o público e o privado, o regular e o irregulável. Os quatro ensaios que compõem esta tese propõem uma perspetiva sociológica original e integrada sobre o parto em casa. O primeiro ensaio apresenta uma análise socio-histórica da figura extinta da parteira comunitária, o que serve de base ao segundo ensaio, onde é feita uma análise da atual profissão de parteira e se discute a circulação contemporânea de saberes e poderes entre profissionais do parto domiciliário. No terceiro ensaio, é discutida a forma como o género é concebido e posto em prática no parto em casa e em contextos a ele associados. E o quarto ensaio apresenta uma análise crítica da organização do parto em casa contemporâneo em Portugal, propondo um conjunto de recomendações para a melhoria dos cuidados de saúde materna. Além da sua relevância académica e sociológica, é esperado que esta pesquisa possa ter um impacto social mais abrangente, informando a definição de políticas de saúde materna que sejam sensíveis à realidade pouco visível, mas relevante do parto em casa.

Palavras chave: parto domiciliário, Portugal, sociologia da saúde, sociologia do nascimento, parteira, doula, etnografia

CONTENTS

1. GENERAL INTRODUCTION

Home birth is far more than the birth of a child at a domestic and familiar place. It is a complex social event that goes beyond its biological or clinical dimensions. The contemporary option of an out-of-hospital birth confronts different risk perceptions, plays with powers and knowledge with different levels of social legitimacy, and challenges formalised professional and organisational dynamics. An in-depth sociological look at home births requires the deconstruction of these power relations, ways of knowing, and productions of meaning. In a previous research on women's experiences of home birth in Portugal (Santos, 2012), planned home births revealed to be part of a wider reflexive search for a sense of identity coherence, where medicine loses its centrality and part of its power. Home birth represented a manifesto against the hegemonic dominance of medicine over birth, as it symbolises the rejection of the context and the technology where obstetrics became an authoritative medical specialty and where its power is reproduced.

In fact, each hospital ward illustrates typical forms of exercising medical knowledge and medical power (Carapinheiro, 1993; Serra, 2008). Following Foucault (1975), obstetric units can be analysed as a medical and medicalising panoptic, with a structure that allows a permanent and conscious visibility status which assures an automatic exercise of power (Newnham, McKellar, & Pincombe, 2018; Rothman, 2007). Knowledge and power of the health professions constitute a fluid system with creative potential. While maintaining an organised action, power is highly relational (Crozier & Friedberg, 1977), so that within the hospital one cannot objectify one professional power, but a set of power-knowledge in circulation (Carapinheiro, 1993).

Home births, however, escape the permanent surveillance of this medical panoptic and remain largely hidden from the public eye. In some cases, among many, it seems a pragmatic and coherent option. In other cases, it seems part of a subculture where femininity and womanhood are celebrated, in a particular way of performing gender. But this does not mean that they are demedicalised events (Santos & Augusto, 2016) or that they are neutral in regard to the construction and legitimation of professional powers. The specific

organisational features of home birth in each country may vary, depending on the local status of this option at the social, legal, and cultural levels. The organisation of home birth care in Europe is extremely diverse – from being part of the formal health system to being illegal. In Portugal, informal networks and a lack of dedicated regulation are a common feature. Without the formal structure of a health institution, we find an unstable set of rules, codes, and meanings, nevertheless coexisting with persisting elements of medical rationality. This demands a reflexive and in-depth sociological approach into the practices and the mechanisms that structure the power relations and the circulation of knowledge in these particular settings, as well as the effects of these mechanisms in women, families, and home birth professionals.

There is a growing body of literature focused on pregnancy, childbirth and motherhood within the social sciences. Its main contributors have been dedicated to the socio-historical analysis of care in childbirth, to the critical discussion of the medicalisation of women's health, to the role of technologies in the experience of being pregnant and giving birth, and to how knowledge and power circulate among women and health professionals in maternity care, to name just a few. Home birth, as a contemporary phenomenon, has been mainly analysed as a paradigmatic case of reaction to medicalisation of childbirth and to institutionalised obstetric practices (Cheyney, 2008; Mansfield, 2008; Rothman, 1982). Framed by the theories of modernity, home births emerge as a reflexive rejection of medical hegemony, with specific patterns of interaction with medical and non-medical technologies (Santos & Augusto, 2016). Home birth may also be regarded as a particular field of professional interaction, yet this has been less explored in the available literature.

Looking at the Portuguese case and building on previous work, this present research is focused on the rather invisible professional dynamics surrounding home births. Among home birth practitioners – midwives and doulas, but also obstetricians, general practitioners, and other professionals directly involved in home birth care – there are permanent tensions suggesting active social dynamics, where different kinds of knowledge circulate. How do all these actors interact, communicate and work? How do doulas and midwives define their professional boundaries? Which trajectories shape the professional socialisation of nurse-midwives who are trained under the logics of hospital caregiving, but decide to start attending

home births? Do these actors search for the legitimation of their practice through scientific objectivity or, conversely, through subjugated forms of knowledge, such as (feminine) intuition? How is gender perceived and enacted, and how it modulates the childbirth experience for women and for professionals? Is home birth a new pathway for the affirmation of professional power for nurse-midwives and midwives?

This research was designed having these questions as a starting point. It aimed to (1) identify which professional and non-professional actors are part of the set of resources mobilised during pregnancy and birth; (2) to observe the features and dynamics of the informal networks of support and care; and (3) to describe and characterise the strategies of power-knowledge of these different social actors. Beyond its sociological and broader academic relevance, the research was developed expecting that the recognition and the analysis of these social dynamics can have a wider impact at the national level, by informing the definition of inclusive, participated, and evidence-based public policies in maternity care.

1.1. SITUATING THIS RESEARCH – THE MEDICALISATION OF CHILDBIRTH AND ITS RESISTANCE

Despite being epistemically anchored on the sociology of health and illness and on the literature dedicated to the critical analysis of the medicalisation of childbirth, the multidimensionality of home births required a permanent dialogue with other fields of knowledge, particularly the sociology of professions, medical anthropology, midwifery, legal studies, history of medicine, and gender studies more broadly.

Looking at the social processes that have surrounded women's health in the past decades was an essential step to better contextualise and understand pregnancy and childbirth as contemporary social events. In the western world, from the 19th century onwards, the field of medicine considerably expanded its frontiers, reaching more dimensions of human life, including pregnancy and childbirth, in a gradual process of medicalisation (Conrad 2007). Health professions, and medicine in particular, became a patriarchal authority legitimised by science, with the power to label the normal and abnormal in individual bodies, in family social relations, and in the whole population (Carapinheiro,

1993). Women's bodies – and pregnant women's bodies in particular – were studied by medicine for its contrasts with the norm, the male body, and were described as mere production units demanding standardised control systems (Martin 1992; Rothman 2016).

Medicine has proved to regard women's reproductive processes as particularly suited for the introduction of new technologies (Oakley 1980) while men's reproductive processes have been rather invisible (Annandale and Clark 1996). The historical success of these multiple forms of violence against women is largely due to the dynamic feedback process of biologising the social and socialising the biological: the identification of and the emphasis on the biological – yet, socially constructed – features that distinguish all men from all women and, at the same time, a dissemination of biology-based arguments where the male unarguably stand as better prepared, as the dominant (Bourdieu, 1998).

The history of childbirth across societies and cultures recalls how, since ancient times, birth was kept within the women's scope of care, at home, in a gynaeceum (Carneiro, 2008, p. 308), either within the family, through neighbourly relationships, or with the proto-professional or professional aid of a midwife (Donnison, 1977). Yet, as science emerged as the only valid form of knowledge (Carneiro, 2008; Donnison, 1977), and as medicine replaced the Church in the definition of morality (Lupton, 1994), lay women from lower classes who occasionally attended births – given their experience-based knowledge and as part of their neighbourly relationships – progressively lost their legitimacy to practice. Donnison (1977) provides examples of how, among the European medical community, there was a general disbelief in the ability of women to learn such a practice. Women were described by many medical men as ignorant, while few publicly advocated the potential role of educated midwives to the public health. Obstetrics and gynaecology were thus "developed as challenges to female modes of reproductive care, its ideology has historical roots in anti-feminism, in a mythology of women that represents them as a marginal group" (Oakley, 1980, p. 45). Although childbirth remained biologically female, the experience, knowledge, and practices that were imposed in the birth scenario were the ones of male obstetricians. The medicalisation of childbirth was, thus, also a process of masculinisation (Cahill, 2001).

However, similar to the process of medicalisation of many other areas of human life, the medicalisation of childbirth has been dynamic and multidirectional. Multiple factors were

the starting point for women to be portrayed by medicine as naturally incapable of giving birth, as having a defective body, as being inapt for childbirth without the expertise and the intervention of obstetrics. This process was not linear, but a product of a complex interaction of different positions and ideologies among women and within medicine itself (Treichler, 1990). Analysing the medicalisation of childbirth requires acknowledging these dynamics. Childbirth has been and still is a contested site, not a place of passive femininity under the control of male obstetricians (Annandale & Clark, 1996). Notably, midwives' professional development also contributed to the medicalisation of childbirth. In Portugal, as in other settings, there was strong regulatory pressure on both lay and certified community midwives, with the advent of obstetrics. In their own search for recognition and legitimacy, Portuguese certified midwives were committed with distancing themselves from lay midwives, the *curiosas*. They engaged in formal training in medical schools, where female, lower-class midwifery was clearly placed under the control and dependence of male, higher-class obstetrics (Carneiro, 2008). In this process, the obstetrical understanding of childbirth was gradually imposed as the only legitimate form of knowledge and practice (Davis-Floyd & Davis, 1996). This reinforced the role of the obstetrician as the leading expert in maternity care, regardless of the level of risk identified in pregnancy; and firmly established the hospital as the right place to give birth. In some countries or regions, there were higher mortality rates associated with the first years of the universalisation of hospital maternity care (Loudon, 1992), but this did not halt this process. Women with low or high-risk pregnancies alike were deemed to be safer at the hospital, giving birth under the supervision of an obstetrician.

Likewise, women and families also contributed and are contributing to the medicalisation of childbirth, demanding physiological reproductive processes to be consensually legitimised as medical problems and treated accordingly, in a dynamic fit of interests (Augusto, 2004; Fox & Worts, 1999; Riessman, 1992). Inscribed in the normal order of things, the obstetrical management of childbirth became embedded in the social experience of birth, and the clinical interventions in healthy women with straightforward pregnancies came to be broadly perceived by doctors and the society, in general, as something natural, necessary, and legitimate, even if lacking scientific validation or if configuring acts of disrespect and abuse (Sadler et al., 2016).

In her documentary film “The Motherhood Archives”, Irene Lusztig (2013) portraits childbirth in the industrialised era, in the United States and Europe. Through archival footages, she recalls how pregnancy, labour, and birth ceased to be family events and became medical conditions managed by male doctors, strongly mediated by technology, and with the compliance of women. Early “natural” childbirth movements that followed Lamaze’s psychoprophylactic method, for example, are portrayed through their compliance with the medical establishment, with their focus on training women to self-control labour pain, particularly middle-class, educated women, deepening existing social inequalities. Despite promoting the participation of women, these movements discretely reinforced the naturalised masculine domination, by paternalistically training the otherwise unprepared women’s bodies for birth and educating their male partners to act like coaches (Segal, 2007).

Plus, few other women’s movements have been led and inspired by so many men as the movements for humanising childbirth – which is by itself worthy of analysis. Grant Dick-Read, Fernand Lamaze and, more recently, Michel Odent, Marsden Wagner, and others are men who influenced and still influence the resistance to the overmedicalisation of childbirth internationally. Also in Portugal, many of the leading personalities in this area are men: the first nurse-midwife to publicly stand for home births in the media, the obstetrician who led the reduction of national caesarean rates, the nurse-midwife who brought back the birth stool to the hospital practice, and the nurse-midwife who led the project for introducing water births in a public hospital, who was later nominated chair of the Midwifery College of the Order of Nurses. This puzzling overrepresentation of men may be interpreted as a plain reproduction of the patriarchal structure of society, where men in equal roles to women are given more credit and visibility, again bringing men to the public arena and pushing women to the private sphere.

Consumers’ movements unarguably made relevant contributions to the discussion and improvement of maternity care internationally. Nevertheless, it also created further asymmetries. The closing scenes of “The Motherhood Archives” bring the viewers back to the social context surrounding childbirth today, focusing on the ontology of the birth-centre – a hybrid setting, a chimera between home and hospital, a home away from home. Lusztig (2013) notes:

> The archive is circular. Here we are in the present tense. We find ourselves preoccupied with nostalgic ideas of the natural. Pain presents itself as a portal into some kind of authentic moment. We no longer simply give birth – we now have birth experiences.
>
> Our own birth has become a consumer choice, an index of privilege. Like the hotel room, the birthing suite is precisely production designed – its anonymous domestic details reassure the visitor and promise a predictable experience in a controlled environment. The empty birthing suite bears no trace of medical equipment, blood, or fluid. On these images of tumbled-river-rock birthing tubs, throw pillows, and tasteful wall art, we are encouraged to project the perfect authentic birth. The archive tells us that birth is both natural and pathological: two opposite things inside of one that intertwine through history.

Indeed, childbirth as a social event and the social movements around it have grown in number and complexity in the last decades. Yet, contemporary forms of resistance to medicalised childbirth are still a matter of privilege. Although the rhetoric of humanisation and women's choice conveys the idea that most women are able to decide the circumstances of their birth experience, too frequently there seems to be little choice to be made (Oakley, 2016; Sadler et al., 2016), especially among less advantaged social groups (Johnson, 2016). In many contexts, the demands of consumers' movements for the 'humanisation' of childbirth has been shrunk to the sole focus on improving the environment of hospital birthing rooms, far from being demedicalised, which reinforces the disadvantage of poorer women, with less access to these privileged settings (Annandale & Clark, 1996; Riessman, 1992). Similarly, when planned home births are only available in the private sector, they are demanded mainly by middle and upper-class women – which is the case of Portugal (Pintassilgo & Carvalho, 2017) – making way for an asymmetric distribution of quality care.

Regardless of being publicly-funded or private, home births remain a minority choice across Europe, representing less than 1% of all births in most countries (Euro-Peristat, 2013). Still, they are considered one of the most relevant challenges to the medicalisation of childbirth, a systems-challenging practice (Cheyney, 2008). This does not mean that home births are demedicalised events. Among home birth families, medicine loses part of its

charisma and power, as it is placed side by side with other resources deemed to be equally or more legitimate, amid midwifery, the support of a doula, homeopathy, and others (Fedele, 2016; Mansfield, 2008; Santos & Augusto, 2016). But research in different countries illustrates how medicine prevails: women's subjective risk perceptions, and the perception of a moral risk – the risk of being morally condemned – make medicine stand as one of the most important resources in the management of risks and complications (Santos & Augusto, 2016; Viisainen, 2000). There may be a selective use of medical technologies throughout antenatal care, labour, and birth – blood tests, ultrasounds, foetal auscultation, medication – which in some cases approaches the logics of consumerism; and the number of medical appointments and medical specialties involved in the antenatal care of a person planning a home birth may be greater than in mainstream antenatal care for low-risk pregnancies (Santos & Augusto, 2016). Even in planned, unassisted home births, where people choose to birth without any sort of professional birth attendant, medicalisation seems to, at least, condition discourses and expectations (A. Miller, 2009). Contemporary home births seem to be a good example of how western societies, despite being a fertile ground for demedicalisation processes, tend to arrive to different expertise and legitimacy frameworks, instead of truly achieving more authentic processes of subjectivity and embodiment (Lupton, 1994).

1.2. THE RESEARCH SETTING – CHILDBIRTH AND MATERNITY CARE IN PORTUGAL TODAY

Home births are on the fringe of a wider maternity care setting, highly structured by the hospital and centred on the medical profession. Currently, it is not possible to accurately calculate the number of planned home births in Portugal. There are no direct data, and the official statistics only report the actual and not the planned place of birth. As such, a planned hospital birth that accidently happened at home will be registered as a home birth, and a planned home birth that was later transferred to the hospital will be registered as a hospital birth. Although research from other countries show that home births can be as safe as hospital births (Hutton, Reitsma, Simioni, Brunton, & Kaufman, 2019; Olsen & Clausen,

2012), replicating such research in the Portuguese setting would be challenging. Pintassilgo & Carvalho (2017), in a population-based analysis of the social features of childbirth in Portugal, combine the social position of mothers and the type of birth attendant with the place of birth, indirectly estimating the actual percentage of planned home births. The authors note that most home births are experienced by women of higher social position and that, of these, the majority were attended by a health professional. Based on their estimation, approximately 25% of all registered home births may be unintended or accidental.

But if planned home births represent such a tiny part of all births, why are they worth of such an in-depth analysis? Choosing a home birth in Portugal is not always a matter of linear preference for a more intimate setting. It usually is a difficult choice for women and families, who are often morally condemned (Santos & Augusto, 2016; Viisainen, 2000). It thus takes a high level of motivation for deciding a home birth, which, not rarely, derives from a previous experience of disrespectful care at the hospital. In many cases among home birth families, the hospital is regarded as a hostile setting where women's right to informed consent and refusal are jeopardised (Santos & Augusto, 2016). In a social setting that is hostile for home births, their prevalence may be regarded as a sentinel phenomenon of disrespectful hospital care.

The fact that Portuguese maternity care is highly structured by the hospital is not necessarily problematic. The centrality of the hospital in the overall organisation of Portuguese healthcare is one of its main features (Carapinheiro, 2006). However, given the physiological (i.e. non-pathological) nature of pregnancy and birth, in most high-income countries and remarkably in Portugal, the centrality of the hospital culture in maternity care seems to have a pervasive effect on childbirth. There are remarkable variations in intervention rates that persist between countries with similar populations at the social, economic and biologic levels (Euro-Peristat, 2013, 2018). While in many low-income settings there are less resources than needed, in high-income countries there are too much unnecessary interventions performed to pregnant women, many lacking scientific validation (S. Miller et al., 2016), configuring a form of systemic violence against women (Sadler et al., 2016).

The effects of childbirth medicalisation in Portugal is particularly visible when looking at the growing rates of intrapartum interventions in the country or the discrepancy on the frequency of births per day of the week, lower on weekends, which exposes the medical interference with the onset of labour through induction or caesarean section (Pintassilgo & Carvalho, 2017). Today, Portugal has one of the highest European rates of episiotomy, caesarean section, and vaginal instrumental deliveries (Euro-Peristat, 2013, 2018). Given that other countries have similar perinatal mortality rates with lower rates of intervention, it becomes evident that many women in Portugal are being submitted to non-evidence-based, iatrogenic, unnecessary, and potentially harmful interventions. It is indeed the time to ask whether hospital births are a safe option for women with straightforward pregnancies and babies (Dahlen, 2019). We must, thus, go beyond mortality rates when assessing the overall quality and safety of maternity care, by considering and adequately collecting data on the slippery phenomenon of maternal morbidity (Pintassilgo, 2014), and by including the subjective childbirth experiences of women as an indicator (World Health Organization, 2018).

In recent years, there have been some progresses made in women's rights in childbirth, yet these progresses seem largely insufficient to tackle the full dimension of the problem (APDMGP, 2019). Medicine proves to be particularly resistant to any forms of regulation external to the profession (Carapinheiro, 1993). As in Brazil (Diniz et al., 2015), shifting the discourse from a "need for humanising childbirth" to a "fight against the violation human rights" may have strengthen the impact of consumers' demands in Portugal, but the structural nature of obstetric violence demands further action at the legal, economic, organisational, educational, and research levels, without blaming the health professionals as a group (Sadler et al., 2016). Concrete changes are taking place, such as the lowering of caesarean section rates (Ayres-De-Campos, Cruz, Medeiros-Borges, Costa-Santos, & Vicente, 2015). Nevertheless, a narrow approach focused on one single intervention will unlikely produce an effective structural change in the culture of maternity care, as we risk to solely replacing one intervention by the other (Topçu, 2019), instead of truly promoting positive birth experiences and building on the capacity of supporting women in labour and birth in a respectful way.

Designing and conducting a study on planned home births therefore required acknowledging these broader scenarios in which they take place. Within the overall system of maternity care, home birth may seem to have a negligible expression, when in fact it maintains a permanent dialogue with mainstream maternity care and its regulatory bodies. As an empirical object, home birth revealed to be a moving social phenomenon. Home birth hides behind an apparent stability and homogeneousness, when in fact it is a changing object, shaped by a permanent tension between gaining visibility and legitimacy, and concealing it so it is safeguarded as an option for women. Different social actors push and configure home birth in different directions, in accordance to their social position and their personal, professional, or institutional motivations and interests. Not only is home birth part of the wider system of maternity care, as it proves to be an important gateway for an in-depth sociological understanding of how this system is configured and organised.

1.3. DOING HOME BIRTH ETHNOGRAPHY

Given the aims of this research and its focus on intra and interprofessional dynamics, the most suited methodological strategy would unquestionably be qualitative, with an in-depth approach to the production of data and a direct involvement of the research with the research setting, through ethnography. This choice was strengthened by the contributions of Carapinheiro (1993) and Correia (2012), who reported, from their research experience on Portuguese health settings, that the common defensiveness of health professionals would hardly allow obtaining sufficient data about professional relationships if the researcher relied solely on standardized instruments or interviews disconnected from real contexts of interaction. Acknowledging the relative invisibility of home births and the lack of an institutional structure, the initial research design loosely projected a multi-sited ethnography.

According to Hannerz (2003), establishing a multi-sited field requires understanding trans-local connections: the relationships that are established between the different locations are as relevant to research as the relationships established in each of the locations. There are important and necessary distinctions between classical ethnography, in one place, and

multi-sited. On the first, there is usually the presence of a researcher in a defined place for a long period in an attempt to achieve a complete immersion and in-depth knowledge of the reality under study (Costa, 1987; Hannerz, 2003). In the case of multi-sited ethnography, where the object is dispersed, there is no intention of a holistic and totalitarian understanding of a given social setting (Marcus, 1995). Instead, the aim is to understand the local ecology of each setting, positioning the researcher in the trans-local network of relationships (Desmond, 2014; Hannerz, 2003). Home births, as a diffuse social phenomenon, could then be captured in several different settings and beyond home birth itself, namely in public events promoting or discussing a physiological approach to birth, or in places where home birth families meet, or where professionals discuss and train, or in antenatal or postpartum care consultations, or in online interactions. Multi-sited ethnography involves a gradual, cumulative selection of observation sites among many potentially eligible. While some authors would advoke on the role of serendipity in the selection of observable situations (Hannerz, 2003), others highlight the relational links behind this ongoing construction of the field (Amit, 2000; Desmond, 2014). In fact, this ethnography would happen intermittently, studying "fields rather than places; boundaries rather than bounded groups; processes rather than processed people; and cultural conflict rather than group culture (Desmond, 2014, p. 562). This would allow assembling the different pieces that compose the bigger picture of home births in Portugal.

Ethnographic research in health care settings may be challenging, considering the level of intimacy needed, the frequent bodily exposure, the common contact with individuals in vulnerable situations, and the eventual abundance of smells, sounds, and sights that are usually kept private. On this account, reflecting on her entrance in a hospital ward, Noémia Lopes (2001, p. 93, original in Portuguese) notes:

> [T]he sociologist equipped with an observation grid and a notebook would believe having the sufficient instruments to, when entering the field, start their work. However, soon will be compelled to forget them, until they can move beyond the disturbance caused by the sudden and prolonged contact with the intense scenarios of physical and psychic suffering, and even of death, that are gathered in these places.

Disgust and other emotions may be an intrinsic part of ethnographic work (Durham, 2011), but for any researcher who is not familiar with health settings, this may become physical and emotionally demanding, and can even compromise the progress of the research.

Furthermore, formal institutional barriers to health care ethnography are widely described, and these are more significative in the Western world and when the researcher is not a health professional (Van Der Geest & Finkler, 2004). But for those who are health professionals, it may not be easy to combine their simultaneous roles of ethnographers and practitioners (Clausen & Santos, 2017; Wind, 2008). In my case, six months before starting fieldwork I was working as a general nurse in an obstetric unit, where I practiced for almost seven years. Recognising the productiveness of this interfusion of roles (Amit, 2000), I believed the experience interacting with women in labour could act in my favour, although the context at home was significantly different.

But home births are not an easily accessible field for ethnographic research. Geneviève Pruvost, a sociologist studying home birth in France, decided to use secondary data, through the analysis of online home birth narratives, as the direct observation would conflict with the ethos of home birth: trust and intimacy, limiting the number of unfamiliar presences (Pruvost, 2016). Emily Burns, in Australia, tried an ethnographic approach to home birth but their potential informants refused to participate, which was in itself useful because it revealed features of the research field (Burns, 2015). Similarly, Teresa Martínez-Mollá, a Spanish midwife who carried a qualitative study on home births, planned the inclusion of direct observation of antenatal consultations with a home birth obstetrician, but the obstetrician considered this was not a feasible strategy (Martínez-Mollá, 2015). Colm OBoyle, a male midwife from Ireland, developed an ethnography of home births, which progressively became interestingly autoethnographic as he himself engaged in home birth midwifery for the first time. More than fulfilling his professional interest with this kind of practice, becoming a home birth midwife revealed to be the way to access the field and to collect data on midwives' independent practice (OBoyle, 2009). Being a midwife and keeping an unengaged observation of home births could unintentionally convey the message that he

did not really believed in home birth midwifery, jeopardising his access and permanence to the field (C. OBoyle, personal communication, June, 2018).

Despite considering home birth as a social phenomenon that goes beyond labour and birth at home, observing this circumscribed event was still central to this research. Intimate settings, such as consultations with midwives, doula sessions, and certainly labour and birth at home would likely pose additional challenges for me as ethnographer, as well. I had previously led research on home births where I interviewed home birth families (Santos, 2012). Interviewing require a lower level of embodiment and engagement, but it helped gaining familiarity with part of the field. Some home birth professionals already knew me and my work and this would be an advantage. However, being a male researcher would be an additional challenge for accessing the field. Personal traits of the researcher, such as gender identity and expression, can influence not only the access to the field but also the actual data production and collection, especially in highly gendered settings (Thomas, 2017). From previous research, it was clear that men could be involved in home births but being a man and an almost stranger to the family seemed a problematic combination. Also, I was unable to locate families planning a home birth. If some are comfortable making this option publicly visible after the birth takes place, even in social media, many prefer to be discrete and not to disclose their plans during pregnancy (Santos, 2012).

For this research, I had planned a set of semi-structured interviews to home birth professionals – midwives and doulas – in order to capture their trajectories, their views on the present and future regulation and organisation of the home birth care network. I interviewed 13 home birth midwives and 7 doulas (of which, 3 were also doula trainers and 1 was also a birth photographer). Interviews had an average length of 96 minutes. Having in mind these methodological challenges, I asked my interviewees to mediate and to facilitate my access to more intimate settings, namely, to ask their clients if they would accept having my presence at birth. This strategy had little success. The first interviews were conducted in October 2015. The first months went by and, at this stage, only one home birth professional actually introduced me to a family, who consented my presence in their home birth, in early 2016.

Yet, another interviewee who was also a doula trainer granted my access to a 120-

hour doula course, in which I enrolled from November 2015 to April 2016, carrying out participant observation. Some doulas are clearly opposed to the involvement of men in a doula practice. Still, although my (male) presence within that group of trainees was odd and disturbing at the beginning, it became natural in later stages of the course:

> When my presence seemed less strange, the trainer proposed a circle so I could introduce myself. I did, and I stressed the idea that I could leave whenever necessary. I talked about my position and my role. The following personal introductions had common features: "I came to this course to work on my feminine"; "This is how I feel good, in a circle of women"; "We [women] sit down and we immediately start to share and talk". […] One of the trainees said that my presence, as a man, was a challenge, because she has difficulties being in the presence of men. However, everyone said they were grateful for the fact that I was there. My presence there as a man is more notorious than my presence as a stranger or as a researcher. (Fieldnotes, December 2015)

As in Gareth M. Thomas' ethnography of prenatal clinics, having a man in a setting mostly frequented by women gave a permanent visibility and otherness to the researcher, but it also opened way for unexpected interactions and dynamics that would not be visible otherwise (Thomas, 2017). The presence in the course required a high level of engagement, with a direct involvement in all course activities. Actually, in this kind of setting, similarly to what was described by Clausen, (2010), Clausen & Santos, (2017), and Favret-Saada (1980) there was no room for an unengaged observer. As such, accepting the multiple possibilities within ethnographic work, and the likely variability of the ethnographer's role and engagement (Winkler, 2017), this fieldwork gradually developed into an autoethnography of becoming a doula. Besides the rich set of data produced throughout the course, I ended up being certified as a doula, which proved to be useful at later stages of fieldwork.

Simultaneously to this doula course, me and my partner were experiencing our own transition to parenthood, with the pregnancy and birth of our first child. We decided to plan a home birth and my partner suggested that I kept autoethnographic fieldnotes, so I could assimilate my lived experience into this research. I did, keeping a reflexive attitude when

interacting with the professionals supporting us, and the baby was born in June 2016. This was an exceptional opportunity, and much of the professional and organisational dynamics around home births, as well as the constrains felt by home birth families when in contact with hospital care, were made visible through this experience.

In October 2016, I enrolled in another doula course with the same team of trainers, but with a different group of trainees. This time, the familiarity with the context in which the course takes place allowed a less autoethnographic approach. At this stage, I already had a relevant amount of data from conversations and other social interactions at scientific events, informal meetings, and the doula course, and also from the two home births I observed. Still, these data mainly reported discursive practices and not much other facets of social interaction and professional practice. In early 2017, almost one year and a half from the starting of fieldwork and having interviewed eleven home birth professionals, I still have not gained further access to consultations or home births. Thus, in March 2017, I disseminated a call for participants via Facebook, where the background, the aims, and the research methods where clearly stated, with a disclosure of my personal experience as a nurse, my recent doula training, and me and my partner's option of a home birth[1]. The call had wide visibility and many people who I met or interviewed contributed to the dissemination, saying that I was trustworthy. Moreover, the fact that I was now a doula and that I had also embodied the experience of planning and experiencing a home birth may have added legitimacy to my request. In order to access the field, I needed to be there already. Shortly after the publication of this call, eight women planning a home birth granted consent. Of these, one woman later removed her consent, and other decided to give birth at the hospital. In all other cases, I participated in at least one antenatal care consultation with a midwife, besides being present during labour and birth at home. One woman consented the attendance in all antenatal consultations with her midwife and all sessions with her doula, throughout the pregnancy. These six home births happened between July 2017 and July 2018.

Altogether, from October 2015 to December 2018, I carried out 20 semi-structured interviews and participated in 27 midwifery consultations, 15 doula sessions, and 8 home

[1] This call may be accessed at https://www.facebook.com/photo.php?fbid=1535983343109290.

births across the country, with different lengths, different sets of professionals, and different levels of engagement from my behalf, apart from the two doula courses and the many spontaneous interactions in formal and informal settings.

While writing about the methodological trajectory of this study, trying to describe the options taken and the challenges faced in an honest way, it becomes clear how, with ethnography, they can only be analysed retrospectively. Before and during fieldwork, I relied on research methods handbooks to guide my entrance on the field, searching for tips on how to become an ethnographer. Now unsurprisingly, these handbooks seemed unspecific, giving some concrete advices but insisting on the flexibility and the broad nature of ethnographic work. Still, regarding the research *method*, I wanted to be methodical. I was concerned with being consistent and systematic, producing reliable and valid data. However, moving between settings required having diverse approaches towards ethnography and, more often than not, the advices and rules from the handbooks seemed difficult to follow. I ended up relying mostly on my personal judgement, my good sense, and my sensibility to make decisions regarding my role(s) in the field, and this certainly did not seem very methodical. In the first home birth I observed, adopting an almost non-participating attitude seemed the most adequate strategy. I sat silently and discreetly, and I preferred not to take a notebook with me to avoid the potential interference caused by the visible act of taking notes. However, it was exactly the absence of my notebook that was visible and noisy, with the woman in labour curiously asking for it, as it contrasted with her expectations of what an ethnographer would do. In another home birth, however, non-participation was problematic. I arrived early in labour and the midwife advised me to take some sleep. When I woke up, the woman was in front of me, her partner and the midwife were supporting her, and labour seemed to be progressing. For moments, I believed I could be in the perfect observing position, unnoticed and unengaged:

> Around 5 a.m., I definitely woke up and I remained lying in the bed, observing. I was not sure what my role should be, if I should get up and participate more actively or if I should be lying down observing what was happening from the outside. When [midwife] got up [to prepare some material] and interrupted her physical support to [pregnant woman], I felt I should get up

> and participate. […] I saw that [midwife] was massaging [pregnant woman]'s back, applying a cold gel pack on her back, and I got up and did the same: I applied cold, I massaged, and I did double hip squeeze. And I asked [pregnant woman] if it was comfortable or not. From that moment onward, my roles got more confused. [...] I believe it would have been strange if I was in that place, in that circumstance, but decided not to go, if I had really stayed at the corner as an observer. I think it would have been strange at least in this situation. (Fieldnotes, July 2017)

It is clearer, now, how insisting in an unengaged position could have been problematic and even ethically wrong. Interestingly, after engaging in the direct support to the woman in labour, there was no turning back. It seemed appropriate to move from an unengaged to an engaged presence when it was deemed necessary, yet it would have been highly disruptive to move back to a passive, non-participant observer.

The unpredictability of this and many other research settings demanded critical epistemic surveillance and methodological reflexivity throughout fieldwork, but actually I was only able to truly reflect on the most adequate strategy for each of these moments as they took place. Planning ethnographic work and deciding on the role of the researcher beforehand was impossible. Like Desmond (2016), thinking of ethnography as a method was not useful. Instead, ethnography unfolded itself as a process of embodying (Chadwick, 2017), as something deeply inscribed in one's way of being in the world (Desmond, 2016). Overcoming the expectations of systematicity and methodological rigour, I was able to recognise the relational nature of this ethnographic work: each step taken in the field was less of a methodological decision and more of a move towards the construction of a relational object of research (Desmond, 2014).

In becoming an ethnographer, I also became part of this complex network of relations and my presence in the field became natural. In the end, confronting the need to focus on analysing and writing instead of collecting data, I faced the difficult task of concluding the fieldwork without actually being able to leave the field. Most opportunities for the production of data were fuelled by an immense generosity that goes beyond the willingness to be heard or to contribute to the visibility of home births. I built strong and lasting relationships with

some of the people I met and interacted with. This ethnography changed who I am. As Desmond (2016, p. 336) notes, "[t]he harder feat for any fieldworker is not getting in; it's leaving. And the more difficult ethical dilemma is not how to respond when asked to help but how to respond when you are given so much".

1.4. THE ORGANISATION OF THIS THESIS

The following chapters are dedicated to the presentation of the research's findings and to its discussion. Although interlinked and forming a coherent corpus, each chapter is an independent essay dedicated to a specific topic and may be read separately. All essays were prepared for individual dissemination in the form of an academic journal article and are either already published or submitted for publication. As such, beyond presenting the findings, each essay offers a dedicated theoretical background that anchors the empirical discussion, and closes with a specific set of conclusions. Chapter 2 builds on historical and secondary data, while chapters 3 to 5 are based on primary data. All quoted excepts from documents, interviews, and fieldnotes, originally in Portuguese, are presented translated to English.

The first essay (chapter 2) deals with the early professionalisation dynamics of midwifery and the emergence of science in childbirth care, which altogether led to the disappearance of community midwifery in Portugal. In the first part, the reference to midwives in Portuguese literature is presented as a means to illustrate the social role of community midwives from pre-modernity to the 19th century. In the second part, the analysis is focused on the medical handbooks of Joaquim da Rocha Mazarem. Mazarem was a Portuguese surgeon who promoted the formal training of midwifes in medical schools in the first half of the 19th century. In the advent of medical obstetrics, his handbook for female candidates attending the Course of Births serves as an example of the many factors that contributed to the reconfiguration of midwifery practice, from art to science.

The second essay (chapter 3) looks at midwifery today and presents an analysis of home birth midwives' professional trajectory and professional identity. Research of how different types of knowledge are distributed and how they frame maternity care sets the

background for this analysis of Portuguese home birth midwives' practices. By looking at the way these midwives train, practice, and interact with families and other professionals, this essay reveals the fluid and dynamic nature of home birth midwifery. Their status as experts in the birth scenario proves to be conquered not much solely through their reliance in scientific knowledge, but through their personal and personalised combination of different types of knowledge, in a particular case of epistemic syncretism.

The third essay (chapter 4) offers an analysis of gender in and around home births. Pregnancy and childbirth are of the least consensual matters within feminist debates, for being a fertile ground for essentialist perspectives that tend to define women based on their biological features. Biological essentialism has the potential to control and constrain both women and men. Acknowledging the social dimension of human reproductive processes, this essay presents an analysis of how gender is perceived and enacted in home births and associated settings. At first, home births appeared to be surrounded by an essentialist rhetoric. However, a deep immersion in the field revealed a complex interaction of essentialist and non-essentialist perspectives that prove not to be incompatible. The essentialist discourse thus serves as an alternative to the medical lexicon, creating new and exclusive spaces for communicating and interacting, producing opportunities for emancipation.

The fourth essay (chapter 5) provides a broad account on the organisation of home birth care in Portugal. From the legal and regulatory aspects to individual practices, this last essay maps and characterises home births from an organisational yet critical perspective. The existing legal void and the unspecificness of the available regulations make way for a set of uncertainties that surround home birth practitioners and families. If some level of flexibility is desired, these uncertainties end up limiting midwifery care at home – especially when they face the need to interact with institutional settings, such as in a hospital transfer. The lack of a dedicated guideline for home birth practice also hinders the adequate assessment of home birth care, fuelling the pervasive prejudice that home births are inherently dangerous. Based on these findings, this essay closes with a set of six country-specific recommendations that could potentially improve the quality of maternity care for those who opt for a home birth.

These four essays, globally, offer an original and integrative perspective on the social

features of home births and, foremost, on its main professional and organisational dynamics. Altogether, they meet the research aims, contributing to fill-in the knowledge gap about home birth and home birth care in Portugal. There are, however, some aspects that were left out of this analysis, either due to insufficient data or insufficient resources. These aspects could benefit from a more detailed analysis elsewhere. The professional trajectories of doulas and their broader professionalisation strategies were only briefly discussed, but these frame complex social processes that deserve a dedicated sociological discussion. Also, the role and the discourses of other professionals with a less expressive representation within home births, such as birth photographers and doctors, could be further explored in future research. Looking at the practices that emerge exclusively in home births, such as the contemporary uses of the placenta, is something that has also been little explored in the scientific literature. Placenta consumption, placenta and umbilical cord keepsakes, and other symbolic or therapeutic uses by professionals and families illustrate particular forms of objectification and consumption, and an interesting dialogue between scientific evidence and individual experiences and beliefs that deserved a thorough study.

At a broader level, there is a need for research that rends visible the inconsistency of policies and practices regarding out-of-hospital births across Europe. Contrasting with the common European frameworks that aim to harmonise rights and regulations in the European Union, there are persisting differences between countries in respect to the free exercise of the right to choose the place of birth. Micro-level and country-specific studies, such as this one, may surely be useful as a platform for comparative analysis, but a more extensive mapping that includes these minority – yet legitimate – choices in maternity care remains to be done.

1.5. REFERENCES

Amit, V. (2000). Introduction - Constructing the field. In V. Amit (Ed.), *Constructing the Field. Etnographic Fieldwork in the Contemporary World*. London: Routledge.

Annandale, E., & Clark, J. (1996). What is gender? Feminist theory and the sociology of human reproduction. *Sociology of Health & Illness*, *18*(1), 17–44. https://doi.org/10.1111/1467-

9566.ep10934409

APDMGP. (2019). *Submission of Associação Portuguesa pelos Direitos da Mulher na Gravidez e Parto (APDMGP) to the United Nations Special Rapporteur on violence against women*. Retrieved from United Nations Office of the High Commissioner on Human Rights website: https://www.ohchr.org/EN/Issues/Women/SRWomen/Pages/Mistreatment.aspx

Augusto, A. (2004). *Infertilidade e reprodução medicamente assistida em Portugal: dos problemas privados aos assuntos públicos* (Unpublished doctoral dissertation). Universidade da Beira Interior, Covilhã, Portugal.

Ayres-De-Campos, D., Cruz, J., Medeiros-Borges, C., Costa-Santos, C., & Vicente, L. (2015). Lowered national cesarean section rates after a concerted action. *Acta Obstetricia et Gynecologica Scandinavica*, *94*(4), 391–398. https://doi.org/10.1111/aogs.12582

Bourdieu, P. (1998). *La domination masculine*. Paris: Éditions du Seuil.

Burns, E. (2015). "Thanks, but no thanks": Ethnographic Fieldwork and the Experience of Rejection from a New Religious Movement. *Fieldwork in Religion*, *10*(2), 190–208. https://doi.org/10.1558/firn.v10i2.27236

Cahill, H. A. (2001). Male appropriation and medicalization of childbirth: An historical analysis. *Journal of Advanced Nursing*, *33*(3), 334–342. https://doi.org/10.1046/j.1365-2648.2001.01669.x

Carapinheiro, G. (1993). *Saberes e poderes no hospital - Uma sociologia dos serviços hospitalares*. Porto: Edições Afrontamento.

Carapinheiro, G. (2006). A saúde enquanto matéria política. In G. Carapinheiro (Ed.), *Sociologia da saúde: Estudos e perspectivas* (pp. 137–164). Coimbra: Pé de Página.

Carneiro, M. (2008). *Ajudar a nascer: parteiras, saberes obstétricos e modelos de formação: séculos XV-XX*. Porto: UP.

Chadwick, R. (2017). Embodied methodologies: challenges, reflections and strategies. *Qualitative Research*, *17*(1), 54–74. https://doi.org/10.1177/1468794116656035

Cheyney, M. J. (2008). Homebirth as systems-challenging praxis: knowledge, power, and intimacy in the birthplace. *Qualitative Health Research*, *18*(2), 254–267. https://doi.org/10.1177/1049732307312393

Clausen, J. A. (2010). *How does materiality shape childbirth? An explorative journey into evidence , childbirth practices and Science and Technology Studies* (Doctoral dissertation, Aarhus University, Denmark). Retrieved from http://sts.imv.au.dk/jette-phd-defence

Clausen, J. A., & Santos, M. J. (2017). Capturing the complexity of practice as an insider: in-labour ethnography. In S. Church, L. Frith, M.-C. Balaam, M. Berg, V. Smith, C. van der Walt, … E. van Teijlingen (Eds.), *New thinking on improving maternity care - international perspectives* (pp. 73–89). London: Pinter and Martin.

Correia, T. (2012). *Medicina - O agir numa saúde em mudança*. Lisboa: Mundos Sociais.

Costa, A. F. da. (1987). A pesquisa de terreno em Sociologia. In A. Santos Silva & J. Madureira Pinto (Eds.), *Metodologia Em Ciências Sociais* (pp. 129–48). Porto: Afrontamento.

Crozier, M., & Friedberg, E. (1977). *L'acteur et le système*. Paris: Éditions du Seuil.

Dahlen, H. G. (2019). Is it Time to Ask Whether Facility Based Birth is Safe for Low Risk Women and Their Babies? *EClinicalMedicine*, (xxxx), 1–2. https://doi.org/10.1016/j.eclinm.2019.08.003

Davis-Floyd, R., & Davis, E. (1996). Intuition as authoritative knowledge in midwifery and homebirth. *Medical Anthropology Quarterly*, *10*(2), 237–269. Retrieved from

http://www.ncbi.nlm.nih.gov/pubmed/8744086

Desmond, M. (2014). Relational ethnography. *Theory and Society*, *43*(5), 547–579. https://doi.org/10.1007/s11186-014-9232-5

Desmond, M. (2016). *Evicted - Poverty and profit in the American city*. New York: Crown.

Diniz, S. G., Salgado, H. D. O., Andrezzo, H. F. de A., Carvalho, P. G. C. de, Carvalho, P. C. A., Aguiar, C. de A., & Niy, D. Y. (2015). Abuse and disrespect in childbirth care as a public health issue in Brazil: Origins, definitions, impacts on maternal health, and proposals for its prevention. *Journal of Human Growth and Development*, *25*(3), 377–384. https://doi.org/http://dx.doi.org/10.7322/jhgd.106080

Donnison, J. (1977). *Midwives and medical men. A history of inter-professional rivalries and women's rights*. London: Heinemman.

Durham, D. (2011). Disgust and the anthropological imagination. *Ethnos*, *76*(2), 131–156. https://doi.org/10.1080/00141844.2010.547941

Euro-Peristat. (2013). *European Perinatal Health Report - Health and Care of Pregnant Women and Babies in Europe in 2010*. Retrieved from http://www.europeristat.com

Euro-Peristat. (2018). *European Perinatal Health Report. Core indicators of the health and care of pregnant women and babies in Europe in 2015*. Retrieved from www.europeristat.com

Favret-Saada, J. (1980). *Deadly Words – Witchcraft in the Bocage*. Cambridge: Cambridge University Press.

Fedele, A. (2016). 'Holistic Mothers' or 'Bad Mothers'? Challenging Biomedical Models of the Body in Portugal. *Religion and Gender*, *6*(1), 95–111. https://doi.org/10.18352/rg.10128

Foucault, M. (1975). *Surveiller et punir : naissance de la prison*. Paris: Gallimard.

Fox, B., & Worts, D. (1999). Revisiting the critique of medicalized childbirth: A Contribution to the Sociology of Birth. *Gender & Society*, *13*(3), 326–346. https://doi.org/10.1177/089124399013003004

Hannerz, U. (2003). Being there... and there... and there!: Reflections on Multi-Site Ethnography. *Ethnography*, *4*, 201–216. https://doi.org/10.1177/14661381030042003

Hutton, E. K., Reitsma, A., Simioni, J., Brunton, G., & Kaufman, K. (2019). Perinatal or neonatal mortality among women who intend at the onset of labour to give birth at home compared to women of low obstetrical risk who intend to give birth in hospital: A systematic review and meta-analyses. *EClinicalMedicine*. https://doi.org/10.1016/j.eclinm.2019.07.005

Johnson, C. (2016). *Maternal Transition: A North-South Politics of Pregnancy and Childbirth*. New York: Routledge.

Lopes, N. M. (2001). *Recomposição profissional da enfermagem*. Coimbra: Quarteto Editora.

Loudon, I. (1992). *Death in Childbirth: An international study of maternal care and maternal mortality 1800-1950*. Oxford: Oxford University Press.

Lupton, D. (1994). *Medicine as Culture. Illness, Disease and the Body in Western Societies.* London: Sage.

Lusztig, I. (2013). *The motherhood archives*. Retrieved from http://motherhoodarchives.net/

Mansfield, B. (2008). The social nature of natural childbirth. *Social Science and Medicine*, *66*(5), 1084–1094. https://doi.org/10.1016/j.socscimed.2007.11.025

Marcus, G. E. (1995). Ethnography In/Of the World System: The Emergence of Multi-Sited Ethnography. *Annual Review of Anthropology*, *24*, 95–117.

https://doi.org/10.1146/annurev.anthro.24.1.95

Martínez-Mollá, T. M. (2015). *Etnografía sobre la decisión del parto en el domicilio* (Doctoral dissertation, University of Alicante, Spain). Retrieved from https://rua.ua.es/dspace/bitstream/10045/46250/1/tesis_martinez_molla.pdf

Miller, A. C. (2009). "Midwife to Myself": Birth Narratives among Women Choosing Unassisted Homebirth. *Sociological Inquiry*, *79*(1), 51–74. https://doi.org/10.1111/j.1475-682X.2008.00272.x

Miller, S., Abalos, E., Chamillard, M., Ciapponi, A., Colaci, D., Comandé, D., … Althabe, F. (2016). Beyond too little, too late and too much, too soon: a pathway towards evidence-based, respectful maternity care worldwide. *The Lancet*, *6736*(16), 1–17. https://doi.org/10.1016/S0140-6736(16)31472-6

Newnham, E., McKellar, L., & Pincombe, J. (2018). *Towards the humanization of birth: A study of epidural analgesia & hospital birth culture*. https://doi.org/10.1007/978-3-319-69962-2

Oakley, A. (1980). *Women confined - Towards a sociology of childbirth*. Oxford: Martin Robertson.

Oakley, A. (2016). The sociology of childbirth: an autobiographical journey through four decades of research. *Sociology of Health & Illness*, *38*(5), 689–705. https://doi.org/10.1111/1467-9566.12400

OBoyle, C. (2009). *An Ethnography of Independent Midwifery in Ireland* (Doctoral dissertation, University of Dublin, Ireland). Retrieved from http://hdl.handle.net/2262/70390

Olsen, O., & Clausen, J. (2012). Planned hospital birth versus planned home birth. *Cochrane Database of Systematic Reviews*, *2012*(9). Retrieved from http://almenpraksis.ku.dk/nyheder/oleolsen/Hjemmef_dsel.pdf

Pintassilgo, S. (2014). *O Risco e as Condições Sociais e Assistenciais da Maternidade em Portugal* (Doctoral dissertation, ISCTE-IUL, Portugal). Retrieved from http://hdl.handle.net/10071/7898

Pintassilgo, S., & Carvalho, H. (2017). Trends and consequences of the technocratic paradigm of childbirth in Portugal: A population-based analysis of birth conditions and social characteristics of parents. *Sexual & Reproductive Healthcare*, *13*, 58–67. https://doi.org/10.1016/j.srhc.2017.06.003

Pruvost, G. (2016). Qui accouche qui? Etude de 134 récits d'accouchement à domicile. *Genre, Sexualité & Societé*, (16). https://doi.org/10.4000/gss.3849

Riessman, C. (1992). Women and medicalization: a new perspective. In G. Kirkup & S. Keller (Eds.), *Inventing women* (pp. 123–144). Cambridge: Polity Press.

Rothman, B. K. (1982). *In labour: women and power in the birth place*. London: Junction Books.

Rothman, B. K. (2007). Introduction. In W. Simonds, B. K. Rothman, & B. M. Norman (Eds.), *Laboring On: Birth in Transition in the United States* (pp. XI–XXII). New York: Routledge.

Sadler, M., Santos, M. J. D. S. J., Ruiz-Berdún, D., Rojas, G. L., Skoko, E., Gillen, P., & Clausen, J. A. (2016). Moving beyond disrespect and abuse: addressing the structural dimensions of obstetric violence. *Reproductive Health Matters*, *24*(47), 47–55. https://doi.org/10.1016/j.rhm.2016.04.002

Santos, M. (2012). *Nascer em casa: a desinstitucionalização reflexiva do parto no contexto português* (Master's thesis). Retrieved from http://repositorio-iul.iscte.pt/handle/10071/4684

Santos, M., & Augusto, A. (2016). "Se estava tudo bem, porque é que eu havia de ir a uma obstetra?" - Identidade, risco e consumo de tecnologia médica no parto domiciliar em Portugal. *Sociologia, Problemas e Práticas*, (82), 49–67. https://doi.org/10.7458/SPP2016825922

Segal, S. (2007). The masculinization project of hospital birth practices and Hollywood comedies. *ESharp*, (9), 1–18. Retrieved from https://www.gla.ac.uk/media/media_41220_en.pdf

Serra, H. (2008). *Médicos e poder - Transplantação hepática e tecnocracias*. Lisboa: Almedina.

Thomas, G. M. (2017). Doing gender in a hospital setting: Reflections of a male researcher. *Sociological Research Online*, *22*(2), 1–14. https://doi.org/10.5153/sro.4307

Topçu, S. (2019). Caesarean or vaginarean epidemics? Techno-birth, risk and obstetric practice in Turkey. *Health, Risk & Society*, *21*(00), 1–23. https://doi.org/10.1080/13698575.2019.1641588

Treichler, P. A. (1990). Feminism, Medicine and the Meaning of Childbirth. In M. Jacobus, E. F. Keller, & S. Shuttleworth (Eds.), *Body/politics: Women and the Discourses of Science* (pp. 113–138). New York: Routledge.

Van Der Geest, S., & Finkler, K. (2004). Hospital ethnography: Introduction. *Social Science and Medicine*, *59*(10 SPEC. ISS.), 1995–2001. https://doi.org/10.1016/j.socscimed.2004.03.004

Viisainen, K. (2000). The moral dangers of home birth: parents' perceptions of risks in home birth in Finland. *Sociology of Health and Illness*, *22*(6), 792–814. https://doi.org/10.1111/1467-9566.00231

Wind, G. (2008). Negotiated interactive observation: Doing fieldwork in hospital settings. *Anthropology & Medicine*, *15*(2), 79–89. https://doi.org/10.1080/13648470802127098

Winkler, I. (2017). Doing Autoethnography: Facing Challenges, Taking Choices, Accepting Responsibilities. *Qualitative Inquiry*, 107780041772895. https://doi.org/10.1177/1077800417728956

World Health Organization. (2018). *Intrapartum care for a positive childbirth experience*. Retrieved from http://www.who.int/reproductivehealth/publications/intrapartum-care-guidelines/en/

2. CHARISMA, AUTONOMY, AND SCIENCE: THE HANDBOOKS OF JOAQUIM DA ROCHA MAZAREM AND THE DISAPPEARANCE OF COMMUNITY MIDWIVES IN PORTUGAL

In Portugal, the professionalisation of community midwifery led to its disappearance. This essay[2] provides an analysis of the identity, roles, and practices of midwives from pre-modern times until today. The representation of community midwives in the literature and in the medical handbooks of Mazarem are brought to this analysis to illustrate these social transformations in childbirth care.

2.1. INTRODUCTION

Portuguese midwifery ceased to be a truly autonomous profession in the early 20th century due to the increasing social value of medicine and its early professionalisation, which cemented it as a ubiquitous field of knowledge and practice. Birth, regarded since ancient times as part of intimate and private life, the domestic sphere, moved into the public and the professional arena with modernity. As with apothecaries and other traditional occupations, the emergence of scientific knowledge – first articulated as a separate field of knowledge or discipline in the eighteenth and early nineteenth centuries – led traditional midwives to renounce their charismatic and holistic knowledge, grounded on experience, and to accept science, and medical science in particular, as the only truth.

Accepting health as a set of complex, interacting systems has more recently encouraged professionals to examine the field through the lens of complexity theory, and thus consider the value of a trans-disciplinary approach, and the opening of the social sciences (Byrne & Callaghan, 2013). Following this train of thought, and in analysing some of

[2] This essay benefited from the contributions of Francesca Scott and was submitted to publication in the form of a book chapter in a volume on Science and Literature edited also by Francesca Scott.

the most relevant publications on the Portuguese history of midwifery, this essay reflects on the social processes behind the disappearance of midwifery in Portugal, evoking the image of the community midwife in Portuguese literature (developing Gomes, 1955[3]), and recapturing the work of the 19th century surgeon Joaquim da Rocha Mazarem (1775-1849), author of several obstetric and midwifery handbooks which mark the beginning of a new era in childbirth care in the country. While it can be said Mazarem contributed positively to the education, professionalisation, and autonomy of midwives, he can paradoxically also be seen as part of a wider process by which midwives lost part of their character, their charisma[4] and autonomy, attributes which were subordinated to scientific knowledge and medicine. Complexity theory raises awareness of the difference between the value and interpretation of these social dynamics at the time these texts were written, and considers the way in which such texts are influenced by social and personal contexts. The irreversibility of the past, as well as the uncertainty of current and future contexts, also cannot be left out of the analysis (Heat, 2013), as they, too, have bearing on the meaning that emerges from the text. Thus, these contexts are recognised throughout this essay, and while this analysis is positioned in a particular social time and space, it is mindful that a potentially different reading and analysis could be offered in a different contemporary social context. Past and current social realities are therefore put into dialogue when exploring these historical texts, and this complex interaction can be observed across this essay.

By examining a selection of literary and medical works preceding Mazarem's work from the early to mid-nineteenth century, and analysing two of Mazarem's most relevant publications, it is possible to follow a gradual transformation from the *art* of assisting births to the establishment of the *science* of obstetrics, and ultimately captured in its complexity in the Portuguese context by Mazarem. In this new paradigm, as seen across swaths of Europe, trained midwives were embedded in the hospital model of care, where medical knowledge was structural. In Portuguese hospital wards, midwives had a diffuse identity – neither a

[3] Gerarda Gomes, a certified nurse-midwife, published a one-of-a-kind article on the role of midwives in art and literature, with excerpts from Portuguese literary works where midwives are mentioned. This essay recaptures her contribution and brings excerpts both from literary and medical works.

[4] A set of legitimating characteristics that midwives would possess, framed within the complex matrix of fear, knowledge, and skills surrounding birth, which will be further explored.

doctor nor a nurse – but with spaces and competences in common with both (Carneiro, 2008). In 1919, when a nursing degree, grounded on biomedical knowledge, was established as a pre-requisite to midwifery courses, the coexistence of obstetric-nurses and midwives in the hospital became progressively redundant, and this foregrounded the disappearance of midwifery in Portugal. Although in the current situation, in both professional and informal contexts, the title of midwife is still applied to obstetric-nurses as an equivalent, this exploration of the complex social history beneath these professional transformations around childbirth clarifies the significance of this transformation.

2.2. MATRONS AND CO-MOTHERS: FROM PRE-MODERNITY TO THE 19TH CENTURY

The history of childbirth care in Portugal has been remarkably non-linear in terms of the spaces where it occurred and the actors, professional or otherwise, who were called to participate. From ancient times, women were the caretakers not only of their families, but also of other women. In Portugal, and elsewhere, childbirth care happened mainly within a feminine sphere, without the father, at home, in a gynoecium composed by female family members, neighbours, and lay midwives (Carneiro, 2008; Joaquim, 1983). These midwives were commonly called *matronas* 'matrons' or, more often, *comadres,* meaning literally co-mother – a designation originally used between both mothers of a married couple, or between the mother and godmother of a child. The midwife's presence went far beyond the sole act of assisting birth. While the use of *comadre* has not been completely clarified, some suggest lay midwives were generally invited to take part in the child's baptism, frequently as godmothers, addressing the child's parents as *comadre* and *compadre*, her co-mother and co-father (da Silva Carvalho, 1931).

With their respected empirical and somewhat mystical knowledge, lay midwives were central figures and moral authorities within their communities (Carneiro, 2008; Collière, 1982). Gil Vicente (1465-1537), a Renaissance playwright, and father of Portuguese drama, left us this portrait of Rubena and a community midwife, with a combination of elements from religion and empirical knowledge, together with some ungracious remarks:

Vem hũa parteira, e diz:

P. *Bento he o Sancto Spirito,*
Bento he o San Miguel,
Bento he o Padre, bento he o Filho,
Benta he a Virgem do Lorito,
E o anjo San Gabriel.
E vós, donzella,
Que fazedes, minha estrella?
R. *Estouy mucho afatigada.*
P. *Não hajades vós aquella*
Bem vejo que estais pejada
Isto he cousa natural
E muito acontecedeira.
Se nunca fôra outra tal,
Disseramos que era mal
Por serdes vós a primeira.
Somos eira de cangrejos;
Há hi homens tão sobejos,
Que, ma trama que lhes nasça,
Com enganos, com despejos,
Lá buscão ma ora ensejos
Pera elles tomarem caça.
Reira de morte apertada
Lhes salte nas ilhargadas;
Caganeira esforricada,
Que não sáião da privada
A enganar as coitadas.

(Vicente, 1562, pp. 88–89)

A midwife enters, and says:

M. Blessed is the Holly Spirit,
Blessed is the Saint Michael,
Blessed is the Father, blessed is the Son,
Blessed is the Virgin of Lorito,
And the angel Saint Gabriel.
And you, milady,
What are you doing, my star?
R. I am very fatigued.
M. You have no such thing
I can see you are pregnant.
This is a natural thing
And very frequent.
If there was no other alike,
We should say it was of harm
Being you the first.
We are floor of crabs;
There are men so daring,
That, bad faith upon them,
With deception, with eviction,
There they search the chance
For them to take hunt.
Rear of a stroking death
Jumps out of their sides;
Tattered diarrhoea,
Makes them stay in the toilet
Rather than deceiving the poor ladies.

Not all women could help at birth; maturity and a previous experience of childbirth were necessary to legitimise their knowledge during pregnancy, birth and after birth, with the newborn (Joaquim, 1983). Given the heterogeneous and cultural diversity grounding their practices, it is thus more accurate to address the diversity of *midwives*, as opposed to a hypothetical well-defined profile of the *midwife*. In Portuguese literature, lay midwives were portrayed as older, low-class women, wise and mystic, and frequently in movement, in transit, being called with urgency to attend a sudden birth, coming and going, as opposed to the static presence of other figures. In a baroque play from Francisco Manuel de Melo (1608-1666), Gil, the insecure apprentice of noblemen, faces a lay midwife, dressed in white, and accompanied by the stressed, expectant father who went to call for her, covered by a dark cloak:

[Gil suspeita de dois vultos, um negro		[Gil suspects of two shadows, one dark	
e um branco, que se aproximam]		and one white, coming closer]	
Gil	*Cousa má eu te requeiro*	Gil	Evil thing, I wish
	que te vás para outra vida.		thou go to the afterlife.
V. branco	*Falai compadre.*	White sh.	Speak co-father.
V. negro	*Não posso*	Dark sh.	I cannot
	que o medo me tem cortado		the fear has cut me
	dizei vós.		you speak.
V. branco	*Sois um cuitado.*	White sh.	You're a poor man.
V. negro	*Tenho medo Padre Nosso.*	Dark sh.	I am afraid Our Father.
V. branco	*Senhor não sou cousa má*	White sh.	Sir I am no mean thing
	sou Guimar Lopes parteira		I am Guiomar Lopes midwife
	vou para cás da padeira		heading to the house of the baker
	que de parto diz que está		in travail she claims to be
	este pobre é o marido		this poor man is the husband
	que vai tal que é para ver.		which goes as it can be seen.

(Melo, 1665, pp. 252–253)

The practices were passed on orally (Joaquim, 1983), as younger women learned the art of caring for the human body and human reproduction by following matrons, and this informal service had a utility value in the community, within the subsistence economy of the time, based on the exchange of goods and services (Collière, 1982). However, in wealthier families, if a boy was born, traditionally the midwife would give *alvíssaras* 'good news' to the father and he was expected to reciprocate with a treat, like a small piece in gold. A novel from Teófilo Braga (1843-1924), plays with this dynamic referring to an early period, before 1761 when slavery was abolished in Portugal:

A Rainha está pejada	The Queen is pregnant
A escrava também o vinha	The slave came as well
Quis a boa ou má fortuna	By the will of good or bad fortune
Que ambas parissem num dia.	Both gave birth on a day.
Filho varão teve a escrava,	A son had the slave,
E uma filha a Rainha,	And a daughter had the Queen,
Mas as perras das comadres,	But the stubborn co-mothers
Para ganharem alvíssaras,	To earn the good-news,
Deram à Rainha o filho,	Gave to the Queen the son,
E à escrava a filha. (Braga, 1867, p. 104)	And to the slave the daughter.

Birth itself was, and still is, seen as both a private and social event influencing the future of all communities and of mankind. As such, the charisma of lay midwives was grounded in the aforementioned complex matrix of social relationships, fear, knowledge, and skill. The fear of death had (and has) an insidious presence in every childbirth, which is reflected in popular traditions and beliefs (Joaquim, 1983), as well as in the mysticism and religiosity that surrounded midwives. Because of this, the frontier between witchcraft and knowing the art of birth was not always clear. In a time marked by very low levels of literacy in the adult population, being able to influence this extraordinary event with bare hands was seen to be magical. In line with Weber's (1978) definition, this power of charisma was outside and beyond the formal administrative system, and relied on proofs – the recognition of

midwives' individual skills and characteristics by others – for the (ephemeral) legitimation of power and knowledge held by midwives over childbirth. Moreover, the midwives' presence allowed the female scream to be a way for women to travel within their consciousness, in a body-to-body relationship and a re-birth process. This led to a certain aura of mystery around the art, and the moments around birth. This is an image also described by the writer Júlio Dantas (1876-1962) in one of his tales, set in the 18th century:

Um dia, depois do terço, foi chamada à pressa a comadre. Entrou rebuçada num bioco. Fecharam-se as janelas por causa dos vizinhos. Acenderam-se as luzes. A criada negra passava descalça, ajoujada, com panelas de água quente. Cortou o silêncio um vagido de criança.
(Dantas, 1915, pp. 18–19)

One day, after the rosary, in a hurry was called the co-mother. She came in wrapped in a scarf. Windows were closed because of the neighbours. Lights were lit. The black maid walked, bear-footed, overwhelmed with hot water pans. Silence was cut by the cry of a child.

This figure of the co-mother or the lay midwife, prevalent at the advent of modernity, was contemporary to the emergence of the educated or trained midwife. In fact, after the Middle Ages, and all across Europe, the political, social and economic relevance of birth placed reproduction under the norms of the Church, the state and medicine, submitting midwives to external control. According to existing documents, the regulation of midwifery under the supervision of medicine has existed in Portugal since at least the 16th century, from which point no midwife could *formally* use her crafts without being examined by the town physician to certify her knowledge, and without an oath before the town hall to attest to her moral virtues (Carneiro, 2008). Alongside midwifery, other health-related crafts were merged, professionalised, and submitted to medical control, progressively enforcing a system that emphasised intervention in the health and diseases of the population – a sanitary system, which confronted different kinds of knowledge, with medicine as the central axis (Carneiro, 2008; Freidson, 1984; Hugman, 1991).

Medical treatises published in Portugal reflected concern over the deregulation of childbirth care – such as the *Luz da Medicina* (Light of Medicine) by Morato Roma, written in

the 17th century, and the *Tratado da Feliz Parida* (Treatise of the Happy New Mother) by Silva Leitão, written in the 18th century – and were addressed to lay people in order to draw scientific knowledge into the ubiquitous community-based and informal care (Joaquim, 1983). Medical handbooks of the time often denounce an uneven understanding of male and female bodies, describing the female body as soft and sensitive, whose imbalance is established by the excess or lack of menstruation blood, while male bodies are seen as more resistant to illness (*ibid.*). Likewise, women were understood to be socially inferior, with less capability than men to learn and perform complex tasks – handbooks and medical treatises proclaimed the scarce capacities of (feminine) midwives and were crucial to establish the (masculine) surgery's authority over birth, diminishing the autonomy of midwives and placing midwifery under the control of medicine (Barreto, 2011).

In 1631, it was decided that the craft of midwifery would now require an exam assessed by the Royal Grand-Surgeon (Carneiro, 2008). Following the new drive to centralise control over the diversity of the healing arts, the Royal Grand-Surgeon was mandated to fight the coexistence of examined and non-examined practitioners across the territory, especially outside Lisbon. However, the subsequent reformulations of this regulation in the following years, hint at its inefficacy (*ibid.*). Surgery was still distinct from medicine – surgeons descended professionally from barbers and were skilled in the art of curing certain illnesses by the use of cutting metallic tools. Around 1750, birth entered the surgeons' scope of activity across Europe, with particular consequences in the French context, and although their scope of action was generally limited to a foetotomy or a caesarean if the mother or the foetus were dead, this was a strategy for surgeons to acquire clinical legitimacy and a higher professional status that could bring them closer to physicians (Barreto, 2011; Carneiro, 2008). As a result, for the first time, midwifery care had a formal, economic value and was paid. Matrons and co-mothers were gradually excluded, following the ongoing rupture with traditional and profane knowledge. Examined midwives were scarce and worked mainly in urban centres: the cost of the exam, the difficulties for the Grand-Surgeon to control remote areas, and the strategies used by midwives to bypass the system, resulted in a lasting predominance of lay and non-examined midwives across the country. Most births were still attended by lay midwives and there were no significant differences between the care of

examined and non-examined midwives (Carneiro, 2008; Joaquim, 1983). The knowledge and the techniques introduced by medicine were applied unevenly in different contexts, and the persistence of traditional practices and beliefs varied across social classes and urban or rural settings. Thus, while innovative practices transformed and replaced existent practices, a certain degree of the old practices remained. Long after the beginning of the regulation of midwifery, there were symbols, meanings and practices that persisted, echoes of the valuable role of the lay midwife in the community.

The relationship between the community and the professional midwife was captured in Gervásio Lobato's (1850-1895) novel *Lisboa em Camisa* (Lisbon in Shirt), in which the social relations of a family from the *petite bourgeoisie* of 19th century Lisbon are described and satirised. Despite being examined and educated, the character of Leonarda da Purificação, a wise, middle-aged midwife, is described as having a dark moustache, which positions her as from a lower social class. She is first mentioned helping a birth, at the family's home, during the night:

Ás duas horas d'essa noite, a sr.ª Leonarda da Purificação depositava nos braços desastrados do Justino, o primeiro fructo do seu matrimonio. […] Antes do sol sair, saiu a sr.ª Leonarda da Purificação, e toda a familia extenuada pela noite perdida foi-se deitar.	At two o'clock of that night, Mrs Leonarda da Purificação placed in the clumsy arms of Justino, the first fruit of his matrimony. […] Before the sun came up, Mrs Leonarda da Purificação left, and all the family exhausted by the lost night went to bed.

(Lobato, 1890, pp. 24–29)

Later, Lobato adds details about Mrs Leonarda's participation in a baptism, and more than one baptism on the same day. This was a tradition that was becoming less and less common as midwifery became more professionalised (Gomes, 1955). The community midwife, with enigmatic skills and a salary depending on the family's gratitude, shows both differences and similarities with the professional midwife:

A entrada da sr.ª Leonarda da Purificação veio interromper a falla do conselheiro. Leonarda vinha vestida modestamente, sem o espalhafato proprio dos baptisados: entrou muito mesureira, muito desembaraçada, dizendo os ditos da sua profissão e foi vestir o pequeno que chorava com uma ancia, com que realmente choraria o verdadeiro Moysés, se alguem se lembrasse de o fazer baptisar em S. Nicolau. […] Eram tres horas quando chegaram a casa, vindos da solemnidade religiosa. A Leonarda da Purificação, a comadre, estava sobre brasas. Ás duas e meia tinha que estar em casa do commendador Rocha, e já eram tres. Estava vendo que se zangavam com ella, e que perdia aquelle freguez. E que freguez! O commendador Rocha! Um homem que tinha pelo menos quatro filhos em tres anos!... (Lobato, 1890, pp. 74, 95)

The entrance of Mrs Leonarda da Purificação interrupted the counsellor speech. Leonarda was dressed modestly, without the usual baptism hullabaloo: she entered full of niceties, very agile, saying the sayings of her profession and went to dress the baby who cried in such a feeling, really like the true Moses would cry, if someone thought of baptising him in Saint Nicolas. […] It was three o'clock when they got home, coming from the religious celebration. Leonarda da Purificação, the co-mother, was afire. At half past two she had to be at commander Rocha's house, and it was already three o'clock. They could get mad with her, or she could lose that costumer. And what a costumer! Commander Rocha! A man that had at least four children in three years!...

"Lisbon in Shirt" gives a good example of the community value of the midwife, which persisted, despite the professionalisation process, in picturing the frequent return of the midwife into the family's life. Leonarda played a part in family celebrations and can even be seen here to accept a role in a community play. She was a *sui generis* but dear member of the neighbourhood:

A D. Angelica foi á porta e d'ali a momentos entrava na sala a D. Leonarda da Purificação, com um grande ruido, de gargalhadas, de exclamações, fallando muito, com um grande barulho, uma gritaria enorme, de quem tem por

Mrs Angelica went to the door and within few moments Mrs Leonarda da Purificação was entering the living-room, with loudness, laughing, shouting, talking a lot, with great noise, an enormous yelling, coming from who has a

officio falar com pessoas que não podem ouvir bulha. […] – A sr.ª D. Sabina está já noiva, está para casar com o sr. dr. Fromigal. – Ah! Bravo! disse logo a Leonarda pondo-se em pé e indo a elles: muitos parabens. Não sabia! Sim senhor, casem e tenham muitos filhos como se diz nos romances, que eu cá estou.

(Lobato, 1890, pp. 254–255)

craft of speaking to people who can't hear bustle. […] – Mrs Sabina is engaged; she will marry Dr. Fromigal. – Ah! Bravo! said Leonarda rising up and walking towards them: congratulations. I didn't know! Yes sir, get married and have many children like it is said in the novels, and here I am.

However, the professional tension between midwives and surgeons regarding the dominance of childbirth care led to an uneven debate about the (in)competence and ignorance of midwives, which slowly but steadily gave more power and legitimacy to surgeons and physicians. Under medical control, birth was less of a community event, in which all members directly or indirectly took part, and more a doctor-patient encounter, which imposed formalities and a greater distance between the carer and the body of birthing woman (Joaquim, 1983). The project of replacing midwives' empirical knowledge with medical and scientific knowledge shrank the social value of midwives. Thus, the midwife's role in caring for the pregnant and birthing woman, based on her experience, empathy and sensitivity, was placed within the scientific and medical jurisdiction, controlled, and converted into the medical paradigm.

Sexuality and maternity can be regarded as central issues in the discrete mechanisms to discipline the body, towards a normalised global population whose practices are conditioned – excluded or legitimated – by the institutionalised discourse of Medicine (Foucault, 1989). The development of sanitary policies, asepsis, surgery, and the will to reduce infant and perinatal mortality through medical techniques, together with the expanding medicalisation of women's health, set the ground for medical specialisation in obstetrics. Obstetrics was one of the medical specialisations that first conquered its own curricular discipline, first taught in 1825, with the foundation of the *Escola Régia* (the Royal School) (Garnel, 2013). Besides reflecting concern over the health of birthing women and newborn, it also illustrates a will to conquer the authority over a knowledge and practice

which was not easy to access. Physicians and surgeons were still rarely called to the moment of birth, which still happened mainly at home without professional assistance. Doctors had the theoretical knowledge but could rarely practice in clinical settings.

Broadly speaking, Portuguese academic medicine evolved alongside German, British and French academies (Barreto, 2011), with some notable differences. From 1836 onwards, obstetrics was formally separated from surgery in medical schools (Barreto, 2011) and the first midwifery course was established – an important step towards the medical monopoly of childbirth care. The course was biannual, free of charge, and the candidates had to know how to read and to write, be at least twenty years old, and be certified as having good morals and good manners (Mazarem, 1838), to prevent the knowledge and practice of abortion from spreading. In the first year of the course, there were lessons about the theory and practice of the Obstetric Art, and in the second year, all lessons were repeated in the same order. Midwifery students had some of the theory lessons with students of medicine and surgery, although these were conducted in a separate area (Mazarem, 1838), and they practiced in hospital wards in 24 hours shifts, supervised by the surgeon, the Professor of Births, or a senior midwife. Besides doing everything that related to the admitted, pregnant women, candidates had to keep a diary for the registration and identification of each woman, a description of the labour and birth, and all relevant incidents. It could be said that these midwives had thus better training than physicians and surgeons, who had difficult access to the intimate setting of a woman in labour, even on a labour ward.

The emergence of modern obstetrics was, in fact, alluded to in an earlier period, in a text by the physician Domingos de Lima e Mello, who in 1725 translated and published the outdated 17th century book *Luz das Comadres ou Parteiras* (Light of Co-mothers or Midwives) under the pseudonym Sebastian de Souza. This provided only a very limited view of childbirth, with no mention of anatomy or physiology. Although some historians and social scientists have considered that this book reflects the obscurantism that Portuguese medicine and surgery were facing in the 18th century, a wider analysis (Barreto, 2007) reveals several other works from the 18th and 19th centuries, such as those by Joaquim da Rocha Mazarem, that were much more relevant, influencing the emergence of modern obstetrics in Portugal and the transition from the art to the science of birth.

By the nineteenth century, the coexistence of an array of professional identities within the field of midwifery across the country, and the tensions between traditional occupations, the state, and medicine, as institutions of social control, meant that midwives were in a fragile situation – yet they still often played a central role in the community, and persisted in many of their endeavours. Even so, childbirth was progressively framed within the rules of scientific rationality, leaving little space for subjectivity and undermining charismatic authority. Seemingly, only *converting* midwives to the scientific rationality of medicine, reframing their space in the social scenery of the emerging sanitary system, could allow them to avoid complete exclusion.

2.3. THE SURGEON MAZAREM: MIDWIFERY BETWEEN ART AND SCIENCE

Thus, as observed, based on the rising degree of formality and the professionalisation of care in birth settings that marked the early period of obstetrics, it is possible to identify two paradigms: the art and the science of birth. As previously mentioned, the shift between the paradigms cannot, however, be seen as linear, as many forms of formal and informal assistance were able to coexist. There was, however, a transition period, between the 18th and the 19th centuries, where a set of social, political and professional factors strongly defined this shift, marking its irreversibility. For the novelty, uniqueness, and entrepreneurship of his work in this period, Mazarem has been highlighted as a key player in this transition. He had an influent position within the medical sciences in Brazil and in Portugal, and the relevance of his work was recognised by royalty. In the rather heterogeneous context of childbirth, he seemed to have pursued a balance between art and science in obstetrics, in which midwives were an essential element. Nevertheless, this radical inclusion of midwives in his proposal of a modern conception of childbirth care ultimately led to the relegation of traditional rationalities and subjective knowledge, and reinforced the submission of midwives to the scientific paradigm. The long-term repercussions of this transition to midwifery can be observed until today and are, indeed, found at the centre of the ontological debate around physiological birth and the ontogenesis of midwifery.

Joaquim da Rocha Mazarem (1775-1849) was a Portuguese surgeon graduated from a central hospital in Lisbon in 1806. He spent the first years of his professional life in Brazil, from 1807 to 1821, working as a surgeon and teaching surgery, obstetrics and physiology. After returning to Portugal, he dedicated a part of his life to teaching obstetrics to medical and midwifery students in the Royal School of Surgery (Barreto 2011). At the beginning of the 19th century, studies of anatomy, chemistry and pharmacy were included in new obstetric handbooks. Recognising the fast progression of the discipline, in his Compendium of Obstetrics (Mazarem, 1823), written for medical students, Mazarem questioned if it was of any use to publish an elementary compendium regarding a new medical science that was embedded in a permanent evolution and therefore constantly changing.

As Barreto (2011) demonstrates, from the list of works published by Mazarem, one is of clear significance: *Recopilação da arte dos partos, ou Quadro elementar obstetricio para instrucção das Aspirantes, que frequentão o Curso de Partos* (Recompilation of the art of births, or elementary obstetric framework for the instruction of the [female] candidates who attend the Course of Births). It was published in 1838, when Mazarem was already quite prominent within the fields of surgery and obstetrics in Portugal. Contrary to what was typical of the time, this work does not reflect a sense of the superiority of surgeons or the subordination of midwives to surgeons and physicians, or even the common belief that the work of traditional and lay midwives should be replaced by the work of surgeons. Surprisingly, he mentions midwifery as a field of medicine and elaborates on the potential scientific virtues of this profession, recognising certain similarities between surgeons and midwives, rather than conflicts and tensions. He reacts to the negative opinions of midwives that were common across Europe, and defends formal midwifery training supported by scientific evidence. In his book, Mazarem makes a brief introduction where he explains the social and political relevance of educating midwives, condemning those who consider midwives and women in general incapable of assisting pregnant and birthing women. The inexistence of midwifery courses is considered by Mazarem as a form of neglect:

As Parteiras, entre nós, tem tido contra uma especie de indisposição moral, que geralmente	Midwives, amongst us, have had against them a kind of moral indisposition, generally giving them

lhes tem grangeado o epitheto proverbial de ignorantes, que talvez restrictamente lhes não devêra competir. Este opprobrio não deve recair sobre ellas, mas sim sobre aquelles, que lhes tem vedado os meios de adquirirem a necessária instrucção, e pelo menos o indispensavel para o exercicio da sua arte. Em Portugal, até hoje, jámais existio estabelecimento algum onde as Parteiras podessem ter o prévio ensino elementar da Arte dos Partos; e este desleixo não he esclusivamente nosso, muitos paizes da Europa o tem partilhado comnosco, e de tal modo, que alguns ainda hoje não possuem taes estabelecimentos, em quanto que em outros, sómente no meio do seculo passado he que forão instituidos. Muita gente talvez se persuada, que as mulheres são inhabeis para exercerem com distincção a profissão de Parteira; porém esta persuasão he vã, pois que muitas tem existido, e existem ainda na França e na Prussia, que muito tem excedido os ordinarios limites da sua arte, e de hum modo tão notavel, que seus nomes distinctos farão epoca nos annaes da Sciencia. Taes preconceitos não devem prevalecer, visto que hoje se tem facilitado os meios de poderem adquirir os precisos conhecimentos para exercerem a profissão de Parteiras com discernimento, todas aquellas mulheres que se

the epithets of ignorant, which maybe restrictedly should not be assigned to them. This opprobrium should not fall upon them, but upon those, who have foreclosed the means to acquire the necessary instruction, and at least the indispensable for the exercise of their art. In Portugal, until today, there never was an institution where Midwives could have the previous elementary education of the Art of Births; and this neglect is not exclusively ours; many countries of Europe have been sharing it with us, and in such a way, that some still today do not have such institutions, while others, only in the middle of the past century were established. Perhaps many people are persuaded, that women are unable to practice with distinction the profession of Midwife; however, this persuasion is vain, because many have existed, and still exist in France and Prussia, that have largely exceeded the ordinary limits of their art, and in a such remarkable way, that their distinct names will take part in the annals of Science. Such prejudice should not prevail, as today it has been made easier to gain the needed knowledge to practice the profession of Midwife with discernment, all those who would want to be dedicated to this field of Medicine.

quizerem dedicar a este ramo da Medicina.
(Mazarem, 1838, pp. 3–4)

The attitude and values reflected in his book, and particularly in this excerpt promoting midwifery courses, mitigates the so-called conflict between surgeons and midwives in Portugal (Barreto, 2011). Mazarem mediated the art and the science of birth, between the expertise of midwives and the knowledge of surgeons, giving this broad and inclusive definition of the Art of Birth, grounded in scientific elements: "[b]y Art of Births one understands, a collection of precepts and rules, intended to give, with them, the due help to the woman in the occasion of birth" (Mazarem, 1838, p. 11). These quotes seem to reinforce the legitimacy of midwifery practice, alongside the legitimacy of surgeons operating in this field, grounded not on *a priori* and exclusive assumptions, but on a realist framework, balancing the severity of each case and the degree of intervention needed, in order to obtain the optimal assistance for each birth.

Despite being addressed to midwives, Mazarem used scientific language in his book, instead of a lighter, informal language, mentioning, for example, an extensive and detailed description of the anatomy of the pelvic bones, its relations, distances and dimensions, over the course of several pages:

Nas partes lateraes do estreito abdominal existe de cada lado os musculos psoas *e* iliaco*, e os vasos e nervos iliacos, que alguma couse lhe diminue o diametro transversal. Na escavação os musculos* pyramidaes*, os vasos e os nervos* gluteos *e* sciaticos*, passando pelo grande buraco* sacro-sciatico*, enchem este espaço, e completão, posterior e lateralmente, as paredes da excavação.* (Mazarem, 1838, p. 21)

In the lateral parts of the abdominal strait there are on each side the *psoas* and *iliac* muscles, and the iliac nerves and vases, which somewhat reduce its transversal diameter. In the excavation of the *pyramidal* muscles, the *gluteus* and *sciatic* nerves and vases, passing through the great *sacroiliac* foramen, fill in this space and complete, posterior and laterally, the walls of the excavation.

Contrary to other medical handbooks, in the “Recompilation of the arts of births” there are no drawings, nor is metaphorical language used to describe the reproductive system or the physiology of birth, which could reflect gender-biases and patriarchal views of reproductive processes (Martin, 1992). Nevertheless, the female body is objectified; it is addressed as the object of study and practice. This style of writing followed some of the surgical and medical handbooks written for medical students in the 19th century in England (Barreto, 2011). In the first chapters of the book, as noted above, Mazarem provides an extensive and detailed description of the anatomy of the pelvic structures. He also describes the several layers of tissues covering the pelvis, building up a picture of it layer by layer. The emphasis given to the pelvis is particularly significant, revealing Mazarem’s fascination with this particular structure. The process of copulation and conception is, however, absent in this description, although it is explored and described in an earlier book (Mazarem, 1823), written for medical students:

A geração, opera-se pelo ajuntamento de dois individuos de sexo differente; a este ajuntamento se dá o nome de coito*, ou* copula carnal*. O phenómeno subsequente ao coito, he a* concepção*, ou* fecundação *do* Ser *que se hade desenvolver no útero. A consumação do coito, he effectuada pela correspondencia, e communicação dos orgãos genitaes de individuos dos dois sexos. [...] Na acção do coito, o fluido seminal, he emitido dos orgãos genitaes do homem, para os da mulher; a vagina o recebe primeiro, depois o útero, excitado pelo* orgasmo venereo*, se apodéra da parte mais subtil delle.*

(Mazarem, 1823, pp. 2–3)

The generation is operated by the assembly of two individuals of different sexes; this assembly is called the *coitus*, or the *carnal copula*. The phenomenon subsequent to the coitus, is the *conception*, or the *fecundation* of the *Being* which will develop in the uterus. The consummation of the coitus, is made by the correspondence, and communication of the genital organs of individuals of both sexes. [...] In the action of the coitus, the seminal fluid, is sent from the man's genital organs, to the woman's; the vagina receives it first, then the uterus, excited by the *venereal orgasm*, takes its subtlest part.

Although it could be said that the midwives' main focus would, naturally, be on pregnancy and birth itself, the gender of the target audience of each of these two books should not be ignored as a possible determining factor for this distinction. The absence of an explanation of coitus in the book written for midwives can be interpreted as a sign of Mazarem's attention to decorum. Nevertheless, it is a good example of how scientific knowledge and scientific models of explaining the body were unequally made accessible for men and women. In the case of pregnancy and birth, this gap was notorious, and contributed to the social definition of a hierarchy (Newnham, 2014). While (female) midwives had easier access to the labouring female body, as mentioned before, (male) surgeons had an easier access to theory, but also to the observation of the internal anatomy of women, through the dissection of bodies, which supported the reproduction and development of scientific (thus valid and legitimate) knowledge on the mechanisms of labour and birth. Different natures of knowledge were developed and flowed through these actors in distinct rhythms, giving shape to the social dynamics of dominance.

In the "Recompilation of the art of births", Mazarem differentiated normal births from difficult births, but both were within the midwives' scope of practice. He specifically distinguished *parturição*, which could be translated as "giving birth", from *partejamento* "helping at birth":

Chama-se parturição*, quando essencialmente o utero expulsa o feto: denomina-se* partejamento*, quando o feto he extrahido por meio de hum processo operatorio, manual, ou instrumental.* (Mazarem, 1838, p. 11)	We call "*parturição"*, when essentially the uterus expels the foetus: we denominate "*partejamento*", when the foetus is extracted by means of an operation, manual or instrumental.

This distinction allows him to limit, throughout the books, the surgeon's scope of practice, the instrumental help of a birth. Normal birth occurs spontaneously to women, ideally with the assistance of a midwife, and difficult births might dispense with the use of instrumental operations – and thus the surgeon – if the midwife knows how to operate manually (Mazarem, 1823, 1838).

With a normal birth, the description mentions a process without intervention, based on the forces of nature, and the focus is set on the body of the birthing woman. No intervention is advised for this kind of birth – which contrasts with the contemporary predominance of an interventionist culture at birth:

Pelas subsequentes dores, a parte do feto que se apresente, avança, franquêa o orificio uterino e estreito abdominal, até vir entrar na vagina, a qual se alarga e alonga. O pavimento inferior da bacia começa então a ser distendido; os grandes e pequenos labios desfazem-se, o monte de Venus distende-se; a vulva alarga-se; o perineo alonga-se e se adelgaça, e o ano se dilata. Succede algumas vezes haver a sahida involuntaria da urina e das materias fecaes. Os esforços se activão, acompanhados de tremores convulsivos e de gemidos da parturiente. Ha finalmente huma contracção muito prolongada, ou duas sucessivas, em consequencia do que a cabeça do feto he expulsada para fóra da vulva; e depois de hum pequeno intervallo outra dor se declara, poré, menos vehemente, que expelle o corpo do feto com o restante das aguas, que o utero continha dentro de si. A parturiente goza então hum suave socego, que pouco depois he interrompido por novas contracções uterinas, com as quaes são expulsadas as secundinas. Não he possivel designar o tempo prefixo que dura o trabalho de parto natural; porém os seus limites são pouco mais ou menos entre quatro e

In the subsequent pains, the foetal part presenting, comes forward, opens the uterine orifice and abdominal strait, until entering in the vagina, which extends and stretches. The inferior floor of the pelvis starts to be distended; the outer lips and inner lips vanish, the mount of Venus distends, the vulva extends, the perineum stretches and narrows, and the anus dilates. Sometimes an involuntary loss of urine and faeces happens. The efforts are activated, together with convulsive tremors and groans of the birthing woman. Finally, there is a very long contraction, or two successive, having as consequence the expulsion of the head of the foetus outside the vulva; and after a short interval another pain is declared, yet less strongly, which expels the body of the foetus with the rest of the water, the uterus still had in it. The birthing woman then enjoys a soft quietness, which is shortly interrupted by new uterine contractions, with which the placenta and membranes are expelled. It is not possible to designate the predetermined time a normal labour lasts; yet its limits are more or less between four and eight hours.

oito horas. (Mazarem, 1838, pp. 59–60)

A Parteira sentada em huma cadeira de sufficiente altura, posta ao lado direito da cama, no nivel da bacia da parturiente, introduz a mão por baixo das coberturas da cama, por entre a coxa e a perna direita da paciente, o que habilita a Parteira a exercer todas as acções convenientes sem a descobrir. Estas acções consistem em explorar as partes genitaes, quando for preciso, e sustentar o períneo, quando for impellido pela cabeça do feto (Mazarem, 1838, p. 94).

The Midwife, sitting in a chair sufficiently high, on the right side of the bed, at the level of the pelvis of the birthing woman, places her hand underneath the bed linen, between the thigh and the right leg of the patient, which allows the Midwife to exercise all actions without uncovering her. These actions consist in exploring the genital parts, when needed, and sustaining the perineum, when it is impelled by the head of the foetus.

Later in the book, the author details the duties of a midwife towards a woman in normal labour and birth, and makes several recommendations regarding the moral and emotional attitudes of the midwife. This was highly innovative, as there was no reference to the psychological and emotional aspects of childbirth in the most important handbooks of that time (Barreto, 2011). He also recognises and promotes the importance of the environment during labour:

[A parteira] Deve regular a temperatura do ar atmosferico do quarto em que a mulher pare; o excesso de calor, frio, e humidade póde causar prejuizo; os cheiros activos pódem ser nocivos á parturiente. Com o vestuario também a Parteira deve ter toda a contemplação, para que elle não cause constrangimento á mulher em trabalho. [...] As impressões moraes, tristes, ou mesmo

[A midwife] Should regulate the temperature of the atmospheric air in the room where the woman gives birth; the excess of heat, cold, and humidity can cause damage; the active odours can be harmful to the birthing woman. With the clothing should also the Midwife have all contemplation, so it does not cause constrains to the woman in labour. […] The moral, sad, or

excessivamente alegres, serão poupadas á parturiente (Mazarem, 1838, pp. 92–93)

even excessively happy impressions, should be spared to the birthing women.

One of the last chapters explores difficult birth or dystocia. Mazarem outlines his interpretation of the law, according to which midwives were allowed to use instruments only under the direct supervision of a professor, but in difficult births they can intervene autonomously as long as they apply manual and non-instrumental operations. The instruments midwives could use were the forceps and the obstetric lever, but only in the presence of a professor. But Mazarem also recognises the hands as the most valuable instrument of a midwife, and the respect for the rhythms of nature emerges as an important attribute:

Em quanto aos primeiros [partos instrumentados] a lei só permitte á parteira usar de instrumentos cirurgicos na presença dos Professores; porém em quanto aos segundos a lei não lhe veda o exerce-los livremente. (Mazarem, 1838, p. 103)

While to the first [the instrumental delivery] the law only allows the midwife to use surgical instruments in the presence of Professors; however to the second [manual delivery] the law does not prohibit its free execution.

Toda esta serie de movimentos e de tracções serão executados pela Parteira de hum modo regular e uniforme, assimilhando os, quando for possivel, áquelles produzidos pela natureza nos partos espontaneos.
(Mazarem, 1838, pp. 108–109)

All this series of movements and tractions shall be executed by the midwife in a regular and uniform way, resembling, when possible, the ones produced by nature on spontaneous births.

[Num parto complicado e manual, a parteira] obterá melhor resultado, se puxar por ambos os pés ao mesmo tempo, e se na extracção do feto

[In a complicated and thus manual birth, the midwife] will get a better result, if she pushes by both feet at the same time, and if in the

proceder do mesmo modo como a natureza opéra quando por si só o expulsa.
(Mazarem, 1838, p. 114)

extraction of the foetus she proceeds the same way as the nature operates when by itself expels it.

[A parteira usa o fórceps] imitando neste processo aquelle, que a natureza executa no parto espontaneo [...] e o extrahe para fóra da vulva pelo mesmo modo como a natureza o expelle no parto natural.
(Mazarem, 1838, pp. 119–120)

[The midwife uses the forceps] imitating in this process the one, which nature performs in spontaneous birth [...] and extracts him out of the vulva by the same way nature expels him on natural birth.

[Em partos pélvicos] termina a extracção da cabeça, adoptando na direcção e nos movimentos que executa, a marcha que a natureza segue quando espontaneamente obra.
(Mazarem, 1838, p. 121)

[On pelvic births] she ends the extraction of the head, adopting in the direction and the movements she performs, the march that nature follows when spontaneously works.

As stated, Mazarem distinguishes the midwifery scope of practice from the surgery scope of practice by examining the existing legal limits for the use of surgical instruments in difficult births. But the scientific criteria are not always sufficient to define limits between the two professional activities, and subjective criteria, reliant on intuition, maturity and good judgement, are also mentioned, providing a balance between art and science. For instance, in the chapter dealing with placenta delivery – the spontaneous and the manual – the umbilical cord traction is described as part of the midwife's scope of practice. Here, Mazarem specifically mentions the limitations of midwifery practice, clarifying what midwives could perform autonomously and what should be referred to an obstetrician:

Se pelos meios indicados a extracção das secundinas não póde ser effectuada, a Parteira não proseguirá nas tentativas. A retenção das

If by the indicated means the placenta extraction cannot be performed, the Midwife will not continue the efforts. The retention of the

secundinas provindo talvez da completa inacção do utero, da restricção do seu orificio interno, do excessivo volume da placenta, ou da sua íntima adhesão ao utero, neste caso he necessario recorrer a hum Parteiro para emprehender meios mais efficazes, ou confiar á natureza o cuidado de as expulsar. (Mazarem, 1838, p. 88)

placenta coming maybe from the complete inaction of the uterus, of the restriction of its internal hole, of the excessive volume of the placenta, or its intimate adherence to the uterus, in this case it is necessary to call an Obstetrician to undertake more effective means, or to trust the nature with the care of expelling it.

Nevertheless, during normal labour and normal birth, the referral criteria are more diffuse and subjective, leaving unclear limits as to the midwives' independent domain of action. The risk perception, the experience and the setting would greatly influence this referral:

Pelo que respeita aos esforços expulsivos, os factos mostrão; que humas vezes a mulher os expende com muita violencia, ordinariamente proportcionada ao seu vigor, ou á resistencia que a cabeça do feto encontra, esforços causados pelo sentimento da oppressão da cabeça do mesmo feto no orificio do utero, na vagina e intestino recto; outras vezes, pelo contrário, as contracções uterinas afrouxão e avagorão. No primeiro caso a Parteira deve recear, que algum accidente grave se desenvolva, como o rompimento do utero, as hemorrhagias, as hernias, &c.; e como as insinuações para que a parturiente os modere nada servem, porque elles se fazem independentes da vontade della; a Parteira invocará o soccorro de hum habil Parteiro, para

In what concerns the expulsive efforts, the facts show; that sometimes the woman spends them with great violence, ordinarily proportionate to her vigour, or to the resistance found by the foetus' head, efforts caused by the feeling of oppression of the same foetus' head in the hole of the uterus, in the vagina and rectum; other times, on the contrary, the uterine contractions loosen and slow down. In the first case the midwife should fear, that some severe accident develops, like the rupture of the uterus, the bleedings, the hernias, etc.; and as the suggestions for the birthing woman to moderate them are useless, because they happened independently of her will; the midwife will ask the help of a skilled obstetrician, so such accidents are avoided.

que sejão evitados taes accidentes.

(Mazarem, 1838, pp. 94–95)

In the advent of modern Portuguese obstetrics, the work of Mazarem reveals the emerging relevance of scientific knowledge in the education and practice of health workers. He describes subjective phenomena objectively, and praises the legitimatisation of midwives' practice through science. At the same time, however, he consecrates the value of experience within midwifery, with reference to the manual expertise of wise midwives, and to the natural and physiological processes they can follow and mimic. Further, beyond directly assisting births, Mazarem advocates that midwives should understand the signs of extra-uterine pregnancies and be able to diagnose this condition by touching and palpating, although there was not much for them to do beyond that in the early 19th century. He also states midwives should know how to perform bloodletting, to apply leeches and to vaccinate, techniques usually understood as part of the medical scope of practice at that time.

By analysing Mazarem's legacy, registered in his book, and bearing in mind his social relevance to Portuguese academic medicine, there are significant departures from the common idea of a permanent tension between midwives and surgeons once professionalisation had begun. Even though his individual principles might not have represented all surgeons (and midwives), his leading position and his vision gave way to the settlement of a new order of midwives who did not reject the value of subjectivity, but rather incorporated it alongside scientific knowledge, balancing – at least to some extent – art and science.

2.4. THE DISAPPEARANCE OF MODERN MIDWIFERY

One can see that Mazarem ideally pictured every birth being autonomously attended by an educated midwife, adhering to a natural timing and process for normal births, and referring to an obstetrician when appropriate, based on scientific criteria or her experience and sensibility. However, over time, the hospital-based education of midwives, where medical

culture was and is hegemonic (Carapinheiro, 1993; Carpenter, 1993), reinforced the medical monopoly over midwifery. In early 20th century, in the hospital, midwives were strange elements, neither nurses nor doctors, with contradictory forces and movements guiding their practice (Carneiro, 2008; Weitz & Sullivan, 1985). They had to integrate the technical and scientific paradigm of health into their practice, renouncing a holistic orientation, and losing what could have been an important part of their professionalisation potential: occupying their own field of esoteric knowledge, unintelligible to other professional groups, with an exclusive theoretical ground and conditions to its reproduction (Benoit, 1989; Carneiro, 2008).

The definition of the professional limits of midwifery and surgery can be analysed as a tension between feminine and masculine values or between male and female dominance over childbirth care. Gender was indeed structural to the definition of boundaries between midwifery and obstetrics, and a pervasive sense of decency somewhat limited obstetricians' actions to what was necessary. Interestingly, Mazarem used the same word, but with different genders – *parteira* and *parteiro* – to refer to midwives and obstetricians. Even though this might be in keeping with what was common at the time, it can also be seen as his reaffirmation of the complementarity between the professions, with gender as their distinguishing axis. Nevertheless, the prevalent idea of biological differences between men and women which determined women's inferior social status and scientific competence held back the development of midwives' training and the enlargement of their scope of practice to more complex situations. Their limited formal competences remained, and surgeons continued to be called to more complicated situations, preserving and strengthening their indispensability at birth. As more and more situations were defined as complicated and demanded the use of forceps or other instruments, the scope of practice and social relevance of midwives simultaneously shrank. The high degree of social relevance obstetricians have at birth today in the Portuguese context, compared to midwives, has almost certainly come from these early stages in the development of the two professions, when the use of instruments and emerging medical technology were defining elements of the social division of labour between surgeons and midwives (Barreto, 2011; Carneiro, 2008).

In mid-1880s, following a physician's report about the low quality of care delivered by (low-class and under-educated) trained midwives, the first women (who were of a high class

and well-educated) were allowed into medical schools and could enrol in Medicine courses – something which was not free from controversy within the scientific community at the time (Garnel, 2013). For these female doctors, there were no gender barriers around the private setting of birth. Thus, they were commonly referred to the speciality of obstetrics, finally clearing the way to wider reproduction of medical knowledge in the practice of obstetrics (Garnel, 2013). Female obstetricians could unabashedly access all birth settings and explore women's bodies, on the one hand expanding medical knowledge to areas which were, until then, out of reach, and on the other hand, blurring the frontiers between midwifery and obstetrics and narrowing the scope of practice of independent midwives. Moreover, formally, the double sense in the word *midwife*, adopted by Mazarem, continued, and has persisted until today, and *midwife* in Portuguese has different dictionary meanings for the masculine and feminine gender: the feminine word *parteira* means midwife or a woman that assists births, the masculine word *parteiro* means a physician specialist in obstetrics. Although it seems difficult to map when this change occurred, *parteiro* and *parteira* are now solely used to name male and female nurse-midwives, and *parteiro* is no longer used for obstetricians.

In spite of this, long after the beginning of the education and professionalisation of midwives, many births still happened without professional assistance, and lay midwives continued to informally help childbirth within communities (Pombo, 2010). Educated midwives were incompatible with lay midwives, as the diploma was not always enough to legitimate their practice and grant paid work, especially in rural areas, places where the role of lay midwives was more deeply established (Barreto, 2011). Newly educated midwives strived to be distinguished from co-mothers and lay midwives, renewing the image of midwives as a more cultured and more scientific figure, competent to the challenges and the duties of the profession. As Gomes (1955, p. 5) states, "[t]oday's midwife has to be a person well instructed and well educated, never the rude midwife from past times".

In his realist novels *O Crime do Padre Amaro* (The Crime of Father Amaro) – which is considered the first work of the Portuguese Realism – and *Primo Basílio* (Cousin Basílio), Eça de Queirós (1845-1900), describes Dionysia and Vitória as women who, besides having other values for the local community, were lay midwives. Both actions take place in the 19th century:

Agora engomava para fora, encarregava-se de empenhar objectos, entendia muito de partos, protegia o "rico adulteriozinho", segundo a singular expressão de D. Luís da Barrosa, cognominando o "infame", fornecia lavadeirinhas aos senhores empregados públicos, sabia toda a história amorosa do distrito.

(Queirós, 1875, p. 165)

Now she took in other people's ironing, acted as an intermediary with pawnbrokers, she understood a lot about births, protected the «odd little adultery» […] she procured young countrywomen for gentlemen civil servants, and knew everything about the love life of everyone in the district.

A tia Vitória era uma grande utilidade; tornara-se um centro! A criadagem reles, mesmo a criadagem fina, tinha ali para tudo o seu despacho. Emprestava dinheiro aos desempregados; guardava as economias dos poupados; fazia escrever pelo Sr. Gouveia as correspondências amorosas ou domésticas dos que não tinham ido à escola; vendia vestidos em segunda mão; alugava casaca; aconselhava colocações; recebia confidências, dirigia intrigas, entendia de partos.

(Queirós, 1878, pp. 257–258)

Aunt Vitória was a great utility, she has become a centre! The petty servants, even the fine servants, had there the solution for all. She loaned money to the unemployed; kept the economies of those who save more money; asked Mr Gouveia to write love or domestic letters for those who had not been to school; sold second-hand dresses; rented coats; advised nominations; heard confessions, directed intrigues, knew about births.

At the beginning of the 20th century, the development of obstetrics, surgery and anaesthesia, with the improvement of infection control and of the use of forceps, and the establishment of maternity hospitals in Portugal, significantly increased medical intervention in pregnancy and birth. Midwifery, in turn, was progressively opened to a wider but diverse field of practice by exogenous pressures, as carer of the population, educator of women and families, guardian of good hygiene, and fighter against voluntary abortion, thus acting on the individual, communal and political level. Moreover, as the hospital organisation became more

complex, with the development of medical-surgical specialities and the wider use of technological elements, some of the less prestigious tasks were delegated to nurses and nurse-midwives, enlarging the gap between head-midwives and midwives, and between midwives and surgeons (Carpenter, 1993; Hugman, 1991). This narrowed the differences between nurses and midwives, ultimately leading to these occupations being merged. In fact, in 1919, a nursing course was defined as a pre-requisite for the midwifery course, creating the new profession of the nurse-midwife, with a common basic training in general nursing care and hospital culture, with added specialised knowledge and skills related to birth (Carneiro, 2008). This brought closer and agglomerated elements within the same gender and social class: nurses and midwives were generally part of a lower social class, their practice and identity was surrounded by feminine social values of intuition, care and maternity, while surgeons and physicians belonged to higher social classes and had the masculine social values of rationality and problem-solving (Carneiro, 2008; Collière, 1982; Hugman, 1991).

This professionalisation led to a lower average age for midwives and reduced the importance of experience. Today, nurse-midwives' professional assistance of a birth is mainly grounded in theory: empathy, *experience* of childbirth, and embodied knowledge, although relevant, particularly to women, seem to have residual importance at the formal level (Borrelli, 2014; Carneiro, 2008; Collière, 1982; Newnham, 2014). Although nursing now pursues its autonomy through the ideology of caring, both in Portugal and internationally, nursing and midwifery practices often differ from this ideology, subjugated by the dominant medical culture (Foley & Faircloth, 2003; Lopes, 2001; Newnham, 2014). Technocratic obstetrics still confines the practice of midwives and nurse-midwives, leading to passive agreement with hospital and medical norms and obstructing the appropriation of their autonomous scope of practice (Hyde & Roche-Reid, 2004; Tereso, 2005). The social-anthropologist Teresa Joaquim, concluding her study of Portuguese lay knowledge and traditional practices around pregnancy and childbirth, reflects on this striking difference with "those women" she studied, given the absence of charisma and of esoteric elements in the hospital setting in her own experience of childbirth:

[E]ra eu, o médico e a enfermeira – mas tudo ausente, tudo distante, em regras que me deixavam pouco espaço para o meu corpo se alterar à medida ao receber este corpo que criava. Eu já não era a mesma que todas essas mulheres, sem crenças nem superstições, num corpo vazio de filho, num mundo onde os outros não são nem maus nem bons, onde ninguém se define pela força que tem, a força do bem e do mal, que atua nos outros corpos e os põe entre a vida e a morte. Que mundo se alterou, se modificou entre mim e essas mulheres, entre o meu corpo e o destas mulheres? Que visão nos foi imposta que o olhar não é o mesmo?

E o olhar nada provoca, e o olhar não olha. (Joaquim, 1983, p. 224)

[I]t was me, the doctor and the nurse – but all absent, all distant, in rules that gave little space for my body to change while receiving this body I was creating. I was no longer the same as all of those women, I had no beliefs or superstitions, in a body emptied of son, in a world where others are neither bad or good, where no one is defined by its strength, the strength of good and evil, which acts in other bodies and places them between life and death. Which world was changed, modified between me and those women, between my body and the body of those women? Which vision was imposed to us, now that the gaze is not the same?

And the gaze causes nothing, and the gaze does not gaze.

Reconfigured and tangled in the multiple tasks of hospital work, Portuguese contemporary nurse-midwives have less time with the birthing woman, compared to the lay midwives of the past, owners of an exclusive culture and identity. The contradictory logics of the advanced professionalisation of community midwives in Portugal, with successive reconfigurations in their professional identity, have ultimately led to the disconcerting paradox of their disappearance.

More recently, at the end of the 20th century, doulas (from the Greek, meaning slave or servant) entered the field of childbirth in Portugal. Doulas emerged together with a return to the promotion of “natural” childbirth (Badinter, 2011). Their holistic approach seems to meet several of the charismatic values of lay midwives, and contrasts with the current formal role of nurse-midwives, filling the void they left after professionalisation (Everson & Cheyney, 2015). On the other hand, contemporary home birth offers new opportunities for nurse-midwives to recover their lost role in the community. Yet, in a new social and historical

setting, the role of home birth midwives today is far more than a linear recovery of the knowledge and charisma of the midwives of the past. Instead of bringing back ancient midwives, contemporary home births seem to be re-signifying midwifery itself.

2.5. REFERENCES

Badinter, E. (2011). *The conflict: How modern moderhood undermines the status of women*. New York: Metropolitan Books.

Barreto, R. (2007). A ciência do parto nos manuais portugueses de obstetricia. *Gênero*, *7*(2). https://doi.org/10.22409/rg.v7i2.152

Barreto, R. (2011). A «ciência do parto» e a atuação de Joaquim da Rocha Mazarém (século XIX). In C. Bastos & R. Barreto (Eds.), *A circulação do conhecimento: Medicina, Redes e Impérios* (pp. 51–80). Lisboa: ICS.

Benoit, C. (1989). The professional socialisation of midwives: balancing art and science. *Sociology of Health & Illness*, *11*(2), 160–180. https://doi.org/10.1111/1467-9566.ep10844338

Borrelli, S. E. (2014). What is a good midwife? Insights from the literature. *Midwifery*, *30*(1), 3–10. https://doi.org/10.1016/j.midw.2013.06.019

Braga, T. (1867). *Romanceiro Geral*. Coimbra: Imprensa da Universidade.

Byrne, D., & Callaghan, G. (2013). *Complexity Theory: The State of the Art*. Taylor & Francis.

Carapinheiro, G. (1993). *Saberes e poderes no hospital - Uma sociologia dos serviços hospitalares*. Porto: Edições Afrontamento.

Carneiro, M. (2008). *Ajudar a nascer: parteiras, saberes obstétricos e modelos de formação: séculos XV-XX*. Porto: UP.

Carpenter, M. (1993). The subordination of nurses in health care: towards a social divisions approach. In E. Riska & K. Wegar (Eds.), *Gender, Work and Medicine: Women and the medical division of labour*. London: Sage.

Collière, M.-F. (1982). *Promouvoir la vie*. Paris: InterEditions/Masson.

da Silva Carvalho, A. (1931). *Subsidios para a historia das parteiras portuguesas*. Lisboa: Tip. Labor.

Dantas, J. (1915). *Ao ouvido de Mme. X*. Porto: Livraria Chardron.

Everson, C., & Cheyney, M. (2015). Between Two Worlds: Doula Care, Liminality, and the Power of Mandorla Spaces. In A. N. Castañeda & J. J. Searcy (Eds.), *Doulas and intimate labour: boundaries, bodies, and birth* (pp. 203–225). Bradford: Demeter Press.

Foley, L., & Faircloth, C. a. (2003). Medicine as discursive resource: legitimation in the work narratives of midwives. *Sociology of Health & Illness*, *25*(2), 165–184. https://doi.org/10.1111/1467-9566.00330

Foucault, M. (1989). *The Birth of the Clinic*. London: Routledge.

Freidson, E. (1984). *La profession médicale*. Paris: Payot.

Garnel, M. R. (2013). Da Régia Escola de Cirurgia à Faculdade de Medicina de Lisboa - O ensino médico: 1825-1950. In S. C. Matos & J. Ramos do Ó (Eds.), *A Universidade de Lisboa, séculos*

XIX-XX: *Vol. II* (pp. 538–650). Lisboa: Tinta da China.
Gomes, G. (1955). As parteiras na Literatura e na Arte. *Revista de Enfermagem*, (6–7).
Hugman, R. (1991). *Power in caring professions*. Houndmills: Macmillan Press.
Hyde, A., & Roche-Reid, B. (2004). Midwifery practice and the crisis of modernity: implications for the role of the midwife. *Social Science & Medicine*, *58*(12), 2613–2623. https://doi.org/10.1016/j.socscimed.2003.09.014
Joaquim, T. (1983). *Dar à luz: Ensaio sobre as práticas e as crenças da gravidez, parto e pós-parto em Portugal*. Lisboa: D. Quixote.
Lobato, G. (1890). *Lisboa em Camisa*. Lisboa: Empreza Litteraria de Lisboa.
Lopes, N. M. (2001). *Recomposição profissional da enfermagem*. In *Labirintos)*. Coimbra: Quarteto Editora.
Martin, E. (1992). *The Woman in the Body: A Cultural Analysis of Reproduction*. Boston: Beacon Press.
Mazarem, J. da R. (1823). *Compendio de obstetricia*. Lisboa: A Nova Impressão da Viuva Neves e Filhos.
Mazarem, J. da R. (1838). *Recopilação da arte dos partos ou Quadro elementar obstetricio para instrucção das Aspirantes, que frequentão o Curso de Partos*. Lisboa: J. M. R. e Castro.
Melo, F. M. de. (1665). *Obras metricas*. Leon: Horacio Boessat y George Remeus.
Newnham, E. C. (2014). Birth control: Power/knowledge in the politics of birth. *Health Sociology Review*, *23*(3), 254–268. https://doi.org/10.1080/14461242.2014.11081978
Pombo, D. (2010). *Modelos terapêuticos em movimento no Portugal do século XIX: actores, discursos e controvérsias* (Master's thesis). Retrieved from http://hdl.handle.net/10071/3836
Queirós, E. de. (1875). *O Crime do Padre Amaro*. Porto: Livraria Chardron.
Queirós, E. de. (1878). *O Primo Basílio*. Porto: Livraria Chardron.
Tereso, A. (2005). *Coagir ou emancipar*. Lisboa: Formasau.
Vicente, G. (1562). *Obras completas* (Ed. fac si). Lisboa: Biblioteca Nacional.
Weber, M. (1978). *Economy and society: an outline of interpretive sociology* (G. Roth & C. Wittich, Eds.). Berkeley: University of California Press.
Weitz, R., & Sullivan, D. (1985). Licensed lay midwifery and the medical model of childbirth. *Sociology of Health & Illness*, *7*(1), 36–54. https://doi.org/10.1111/1467-9566.ep10831346

3. BECOMING TRUE MIDWIVES: KNOWLEDGE, CHARISMA, AND NEW PROFESSIONAL DYNAMICS IN PORTUGUESE HOME BIRTHS

Home birth seems to be a privileged setting for the development of midwives' independent scope of practice. In this essay[5], we explore the ways of becoming a home birth midwife in Portugal, and how they reconfigure their profession through their practice. We analyse the role of knowledge in the definition of midwives' status as experts and authorities, and how this authority is managed in their relationship with families and in interprofessional interactions with doulas.

3.1. INTRODUCTION

The professionalisation of midwifery has been the result of a set of movements either towards, either away from medical knowledge and practice. While, in some countries, midwifery is now recognised as an autonomous profession, in other countries it was almost erased by medicine. Annandale and Clark (1996) argued that obstetrics and midwifery were built as self-referential, in which modern midwifery was defined as the opposite of obstetrics, offering what obstetrics does not instead of constituting a true original alternative. However, in practice, we argue, this opposition is not clear. The formal recognition of modern midwifery as a profession was – and still is, in many settings – levered by the training of midwives in medical or medicine-centred schools (Carneiro, 2008; Donnison, 1977); by the adherence of midwifery training and practice to the dynamics of hospital intrapartum care, where obstetrics reproduces its authority over childbirth (Rothman, 1982); and by the use of a discourse

[5] This essay benefited from the contributions of Amélia Augusto, Jette Aaroe Clausen, and Barbara Katz Rothman, and was submitted to publication in the form of an article in the journal *Sociology of Health and Illness*.

strongly framed by medical knowledge, even among midwives working outside the hospital setting (Foley & Faircloth, 2003).

Nevertheless, research indicates that contemporary midwives also combine the use of intuition and other forms of embodied knowledge in their practice, strengthening their professional identity and authority (Cheyney, 2008; Davis-Floyd & Davis, 1996; Sjöblom, Lundgren, Idvall, & Lindgren, 2015). Subjective understandings of the world have been largely suppressed and stigmatized in modern societies, placed beyond the line of what could be considered proper knowledge (Sousa Santos, 2014). They constitute knowledge which is not verifiable by science and, as such, has always posed a challenge to the authoritative position of scientific and medical practices, namely in maternity care (Jordan, 1997). Yet, neither medical science nor their practitioners are neutral and objective. Medicine and other health professions do not exist apart from culture (Rothman, 1982) and there are beliefs and perceptions influencing and constructing contemporary "conventional" care in health facilities. However, mainstream maternity care still tends to formally reject any practice that is not considered "scientific" (Downe, 2010). In turn, midwives, through the combination of medical-scientific and embodied knowledge, seem to have the potential to challenge this socially established divide between valid and invalid forms of knowledge (Cheyney, 2008; Davis-Floyd & Davis, 1996; Newnham, 2014).

Midwifery, however, is not homogenous, and analysing midwives' autonomous scope of practice requires a strong degree of abstraction and simplification. Actually, the heterogeneity and ever-changing nature of midwifery is well recognised. Over time, the profession of midwifery has been commonly addressed as being in movement, in transformation, and in search for a clearer definition of their professional boundaries. There are different degrees of professionalisation across countries (DeVries, 1993), even in Europe where there are common frameworks and guidelines for training and practice. And, within each setting, midwives' practices may also vary along a continuum between the most medical and the most women-centred care (Rothman, 1982; Teijlingen, 2005). A dichotomic definition of the medical and the midwifery model of care, as initially proposed by Rothman (1982), offers a useful set of analytical tools for the social study of childbirth and maternity care but, in their practice, midwives may grasp ideological assumptions from both models.

This has been analysed either as posing a practical dilemma for the definition of the professional identity of midwives (Rothman, 1982) or, conversely, as a potential opportunity for their professional development (Newnham, 2014, p. 265):

> [M]idwives are in a unique position to identify and develop theories of embodied knowledge in childbirth, regenerating a distinct body of knowledge that, while providing a balancing argument to medical discourse, does not need to detract from safety measures, nor worldwide efforts to increase the visibility and professional status of midwifery.

In the same line of argument, Santos and Augusto (2016) identify that home birth couples recognise a certain charisma in their midwives, given their combination of scientific knowledge with a lasting experience; but the authors fail to offer an explaining hypothesis for this.

Nonetheless, medical discourse and knowledge remain dominant in maternity care, and the potential for the professional development of midwifery if often limited. As a consequence, in most contemporary systems of maternity care – as is the case of Portugal – midwives' embeddedness in the hospital system also meant that the objective, technical, and measurable dimensions of their practice have been prioritised over the more subjective dimensions, fragmenting and undermining midwifery care (Dahlen, Jackson, & Stevens, 2011; Teijlingen, 2005), even when attending physiological labour and birth, and despite the existing scientific evidence supporting the benefits of these subjective dimensions of care for the promotion of a positive birth experience (World Health Organization, 2018).

Without these subjective dimensions, we could argue maternity care becomes somewhat dehumanised, empty of care itself. In fact, one of the consequence of devaluing these subjective dimensions of midwifery through hospital practice is the emergence of doulas[6] in maternity care (Dahlen et al., 2011; Everson & Cheyney, 2015; Hunter & Hurst, 2016; Norman & Rothman, 2007). Beyond offering what midwives have left behind, doulas'

[6] Doulas offer informal but paid physical, emotional, and informational support during pregnancy, labour and birth. The doula's role does not include the full midwife's role, given that they do not qualify as skilled birth attendants; while midwives' role may include the full doula's role (Everson & Cheyney, 2015).

role has been held as an example of the widely disseminated loss of confidence in the lay ability to care and the consequent commodification of informal support in childbirth (Rothman, 2016; Torres, 2015), in line with what Hochschild (2012) has described as the "outsourced self". Everson and Cheyney (2015) further argue that the role of doulas in the hospital is actually positioned within the space of intersection between the medical and the midwifery models of care, encompassing the neglected dimensions of both of these models.

3.1.1. PRACTICING AT HOME

Later developing on her definition of the medical and the midwifery model of care, Rothman recognised how they were not necessarily bounded to a specific setting (home vs hospital), nor to a specific professional group (midwives vs obstetricians). Yet, she stressed that the major distinctions are usually drawn between home and hospital settings of practice, and not so much between the professionals involved (Rothman, 2007). In fact, despite not being necessarily demedicalised events (Santos & Augusto, 2016; Viisainen, 2000), planning and experience birth at home represents the most remarkable challenge to the medicalisation of childbirth (Mansfield, 2008; Rothman, 1982). Home births stand as an anti-obstetric manifesto, as they symbolise a rejection of the setting where this medical specialty emerged and where its authority is reinforced and reproduced. Similarly to other medical specialties (Serra, 2010), the power of obstetricians, at the hospital, is sustained mainly through the use of medical technology. Conversely, at home, there is a valorisation of alternative forms of knowledge – intuition and embodied knowledge – challenging medical knowledge as the norm (Cheyney 2008). Thus, avoiding or rejecting the hospital setting generally implies more than a mere preference for an alternative place of birth: it reflects an adherence to a mother-centred ideology (Teijlingen, 2005), and a counterculture (Rothman, 2016).

Women and couples who opt for home births seem to integrate this choice into their biographies along with other options in their lifestyle that allow them to have meaningful experiences and to reach a sense of identity coherence (Santos & Augusto, 2016). Likewise, midwives who opt-out from hospital-based into a community-based childbirth care report

being able to better reach the full scope of their practice (Ahl & Lundgren, 2018; Coddington, Catling, & Homer, 2017; Davis & Homer, 2016), feeling an emancipation from the constrains found at the hospital, and a sense of coherence between their practice and their ideology (Aune, Hoston, Kolshus, & Larsen, 2017; Sjöblom et al., 2015). However, it is not clear if there are common triggers to this shift in their professional trajectory – from mainstream midwifery at the hospital to home birth midwifery – and how this shift impacts and transforms their midwifery practice.

In this article, we explore the ways of becoming a home birth midwife in Portugal, and how they reconfigure their profession through their practice. Furthermore, we analyse the role of knowledge in the definition of midwives' status as experts and authorities, and how this authority is managed in their relationship with families and in interprofessional interactions with doulas.

3.2. METHODS

This article is part of a wider research project dedicated to the study of home births as a stage for professional interactions strongly shaped by power relations. Fieldwork was carried by M. S: between October 2015 and December 2018, in Portugal, with a multi-sited ethnographic approach (Hannerz, 2003; Marcus, 1995). Portuguese home births are rare and disperse phenomena, generally surrounded by intimacy, trust relations, and even some secrecy (Santos & Augusto, 2016). Thus, without a circumscribed space, fieldwork was gradually constructed through the cumulative production of thick reflections upon each situation experienced by the ethnographer while entering the field, with a high degree of personal engagement. Aligned with Desmond's (2014, p. 548) concept of *relational ethnography*, data production focused on "studying fields rather than places, boundaries rather than bounded groups, processes rather than processed people, and cultural conflict rather than group culture". More than comparing different places or situations, fieldwork was developed through the reflexive navigation of a growing network of interpersonal relationships with families who opted for a home birth, activists for human rights in childbirth,

home birth midwives, and doulas, which enabled an in-dept understanding of home births as a wider and multidimensional social phenomena.

3.2.1. ENTERING THE FIELD

At first, fieldwork was generally restricted to formal and structured settings, such as meetings and public or semi-public events where natural or home births were relevant topics. Besides being a sociologist, M. S. was member of a childbirth activist group and had previous experience as a nurse in an obstetric unit. This simplified the access to such settings, which enabled numerous opportunities for engaging in informal conversations with home birth families and professionals. Also, at this stage, 20 semi-structured interviews with an average length of 96 minutes were conducted to pragmatically chosen professionals linked to home births, namely 13 home birth midwives; 1 birth photographer; and 6 doulas, 3 of which regularly organised doula courses. This allowed capturing different professional trajectories drawn around home births and contributed to the draft of a map of collaborations and conflicts within the network of home birth professionals.

In the later stages of the ethnographic fieldwork, a total of two 120-hour doula courses, 27 midwifery consultations, 15 doula sessions, and 8 home births were observed across the country, with different lengths, different sets of professionals, and different levels of engagement of the ethnographer. In all cases, there was the need to prior establish trust relations with the woman and her family, and also with the professionals involved. Many of these relations lasted long after each home birth, granting the ethnographer with a privileged and naturalised position within the network of home birth families and professionals. Therefore, leaving the field proved to be as challenging as entering it. As Desmond (2016) notes, the commonly debated ethical problems of (over-)participating, helping, and engaging in the lives of those who contribute to our fieldwork are, by far, less serious than the dilemma of knowing how to react to their generosity and to their place in our own lives, once the research is set to be finished.

3.2.2. DATA MANAGEMENT AND ANALYSIS

During and, most frequently, after each relevant situation experienced throughout fieldwork, detailed fieldnotes were taken in order to keep track of the facts and the related reflections, across the broad diversity of settings. Interviews were recorded and verbatim transcribed. The sizeable qualitative dataset produced was then organised according to the type of situation reported, and further analysed thematically, using an inductive approach to build a system of themes and sub-themes, with the assistance of MaxQDA (2017), version 12. Five major themes emerged, which loosely guide the following presentation of findings: (1) *engaging in home births*, (2) *characteristics of training*, (3) *home-hospital conciliation*, (4) *types of knowledge and power*, and (5) *the role of doulas and midwives at home*.

Quoted excepts from interviews and fieldnotes, originally in Portuguese, are presented translated to English. Quotes assigned with a name are taken from interviews, and all names are pseudonymous. Almost all professionals who attend home births are female midwives, but there are at least 2 male midwives and 2 female doctors directly involved in home birth care. Identifying them as such would potentially disclose their personal identity. Being a male or being a doctor did not mark any relevant distinction for the present discussion. In this essay, we do not aim to explore neither the role of gender in home births (discussed in chapter 4), nor the role of doctors in home births. As such, in two of all quotes here presented, these professionals are identified with female pseudonymous and as midwives, for the sake of data anonymity.

3.3. FINDINGS AND DISCUSSION

3.3.1. REINVENTING MIDWIFERY THROUGH HOME BIRTHS

Despite the diversity of professional trajectories, all home birth midwives shared a conflict with the dominant model of care found at the hospital. As with home birth families (Santos &

Augusto, 2016), reflexivity and the ability to question social norms seems to play a part in creating what may become an incompatibility with mainstream childbirth care. Attending home births was more than a job; it was a matter of activism and resistance. In line with the literature (Aune et al., 2017; Santos & Augusto, 2016; Sjöblom et al., 2015), midwives regarded home births as an opportunity to accomplish a sense of coherence within their professional identities, where they were able to practice aligned with their values and their knowledge. Home birth midwives, except for few who trained abroad, enrolled in the Portuguese official midwifery education[7], which they recognised as being focused on intervention, and subsequently had their first clinical practices strongly structured by the hospital organisation of care. The formal and bureaucratic recognition of their authority – granted by the Order of Nurses, the regulatory body of the profession – seems not to be enough for these midwives to feel able to legitimately attend a home birth. Most felt they "didn't know how to be a midwife" (Olga, midwife) when they finished their degree, as it did not prepare them to attend physiological labour and birth, regardless of place of birth:

> We have classes on monitoring, pharmacology, we have nothing that tells us the art of midwifery. Healthy pregnancy, we don't have that. We always learn everything in the logic of preventing complications, never to optimise the healthy side. Our training should be oriented to the other side. It is always the biomedical model and the prevention of problems and it should be the other way around. (Núria, midwife)

> During the training, I was really disappointed with the school curriculum because it was mainly based in pathology. […] They briefly mentioned natural birth, but as if it was something that was not from here, from our country, but from other contexts. And that here, actually, we would have to follow [the rules and routines of the hospital]. […] No one taught us to attend births like this. (Tânia, midwife)

[7] Midwifery education, in Portugal, is a 1,5-year course and requires a previous 4-year nursing degree, plus 2 years of professional experience as a nurse.

Surprisingly, this void of knowledge regarding spontaneous and physiological labour and birth contrasts with the legal definition of the midwives' independent scope of practice in Portugal, described as "all low risk situations, understood as those in which the physiological processes and the normal life processes of women's reproductive cycle are involved" (Ordem dos Enfermeiros, 2019). To acquire the skills they believe are necessary to safely attend low-risk labour and birth, home birth midwives often complement their training, frequently in other countries. Although this investment in complementary training emerged as one of the most recurrent elements in the trajectories of home birth midwives, it may happen even before they consider attending home births.

Facing the dissonance between their ideologies of care and the kind of care they are allowed to offer at the hospital, some decided to opt-out of the labour ward, either by choosing an alternative position within a health institution or by becoming fully dedicated to their home birth practice:

> I had attended some home births, […] and when returning to the hospital, in the labour ward, I couldn't bare seeing the things they were doing there, so I started getting sick. […] I didn't want to be in the delivery room, and I felt really revolted because all things done there were against what I believed. […] I couldn't be "water" on one place and "land" on the other. I couldn't. I couldn't split myself. So, I ended up asking to leave the labour ward. (Rute, midwife)

Others, however, kept their position at the labour ward, navigating between what they believe is good practice and what they are able to perform, either by applying a pragmatic strategy of defining distinct practices for home and hospital or, on the contrary, by actively promoting normal birth in the hospital setting, struggling to reduce the use of unnecessary interventions in women with straightforward pregnancies. A similar rationale of "keeping normal births normal at the hospital" has been identified in other settings where hospital midwives also deliver home birth care, in Denmark (Santos, 2018a), and in Italy (Quattrocchi, 2014).

This new set of competences and knowledge, beyond individually transforming these midwives' practice, led to a resignification of what "being a midwife" means. One midwife

describes how attending home births enabled her access to specific knowledge which was not available elsewhere:

> When the dilation is complete, for example, the leg gets cold from the knee to the ankle. We get a purple line between the buttocks. Indirect signs. The sacrum area gets somewhat dull, it's a sign that things are getting there, we don't need to manipulate. We end up observing labour in a different way, which is interesting. […] *[Q: Do you see that happening at the hospital, as well?]* No. There is a lot of things interfering with it. […] In terms of the hospital, this doesn't have much interest. For those who don't work anywhere else, it doesn't have much interest. (Sílvia, midwife)

If, on the one hand, the new practice of these home birth midwives positioned them closer to the formal definition of midwifery, on the other hand it distanced them from mainstream (hospital) midwifery practice. In his cross-national analysis of midwifery, DeVries (1993) notes how there are important differences between countries and cultures, in a way that it may seem difficult to recognise midwives from different settings as being members of the same profession. Yet, in Portugal, despite broadly being within the same macrosocial context, the different types of knowledge and the skills distinctively used by these home birth midwives and by hospital midwives it enough for make it substantially difficult to recognise them as being part of the same profession. As other have asserted (Ahl & Lundgren, 2018; Coddington et al., 2017; Davis & Homer, 2016), home births were then seen as an opportunity for these midwives to exercise the full scope of this redesigned midwifery practice.

3.3.2. EPISTEMIC SYNCRETISM

While community midwives, in their early stages of professionalisation, commonly relied on medical knowledge to formally legitimate their practice (Carneiro, 2008; Donnison, 1977), these trajectories of contemporary home birth midwives in Portugal portrayed a movement in

the opposite direction, from a practice that reproduces the authoritative position of medical knowledge to one where different types of knowledge are horizontally embedded. More than either recognising the use of intuition as authoritative knowledge (Davis-Floyd & Davis, 1996), or the use of medical knowledge as a legitimation resource (Foley & Faircloth, 2003), we identified an epistemic syncretism among home birth midwives, who move beyond what is formally defined as their scope of practice and integrate different types of knowledge, without a clear hierarchy.

In many antenatal consultations and home births, medical knowledge was a common resource, but its relative importance compared to other types of knowledge was not static, but dynamic and situational:

> Results from blood tests were discreetly transcribed to the clinical records by [midwife A] while she talked. Not of big importance. While listening to what [pregnant woman] and [midwife A] talked, [midwife B] took [pregnant woman]'s pulse and blood pressure. […] But palpating the belly and listening to the baby's hearth beat is surrounded by a certain ritual, a certain ceremonial. It seems it is not only because it implies changing [pregnant woman]'s position but also because it is part of the midwives' own, unique, lost, and esoteric knowledge. There is a reverence to these moments, and usually both midwives stop and pay attention. It is not something considered minor or secondary. (Fieldnotes, July 2017)

Medical technology usually associated with interdependent interventions and with processes of delegation from medical doctors, e.g. taking the blood pressure, was regarded necessary, yet secondary. The ways of using medical knowledge and technology did not reflect the centrality commonly found in the interaction between users and health professionals, particularly in maternity care settings (Clausen, 2010). On the other hand, the practices deemed independent or those revealing a detachment from hospital-centred midwifery, even if involving the use of medical technology, seemed to be fundamental to the reconstruction of the role of the home birth midwife. These vary considerably, given the lack of national guidelines or consensus, and may also include the competences formally defined as the midwifery scope of practice, e.g. monitoring the foetal heart rate; but also an array of

procedures drawn from types of knowledge that are not consensually recognised as legitimate, such as the knowledge of complementary and alternative medicines, e.g. aromatherapy or homeopathy; or traditional or neo-traditional knowledge, e.g. the use of *rebozo*[8] in labour; or intuition and other embodied forms of knowledge.

Epistemic syncretism thus refers to this diverse nature of the knowledge assembled and applied by home birth midwives. Each midwife autonomously established a personal combination of knowledge, individually redefining the boundaries of their midwifery practice.

In the discourse of some of the midwives, there may have been an authoritative position not that much of the medical, but of the scientific knowledge. This seemed particularly important in the process of conquering further public legitimacy, beyond the formal legitimacy granted by the Order of Nurses, particularly to "the outside", to those who are not familiar with home births, in a country where home birth is generally deemed to be a marginalised practice:

> [My work is guided by] scientific methodology. Good practices based on international guidance. Period. (Filipa, midwife)

> For now we have a group of midwives […] and we try to do a little of that [exchanging information], quite informally, but [we say] "we have this situation, what do you think?", and everyone sends what they have, the research they have, the evidence they have, and the experience they have, and that's it. (Paula, midwife)

> Perhaps it didn't matter to others, but for me it was really important the position paper [regarding home births] from the Order of Nurses. […] They were really based on evidence and they published their statement, and how it should be, and somehow I felt that if I have any trouble, at least I have someone here that will defend me based on science, instead of defending me based on prejudice. (Olga, midwife)

[8] A *rebozo* is a long scarf traditionally worn by women in Latin America, and also used as a technology by local traditional midwives. These wrapping techniques during labour are gaining popularity in other parts of the World, namely in Europe (Iversen, Midtgaard, Ekelin, & Hegaard, 2017).

Similarly to what Akrich et al. (2014) discussed on the legitimising role of evidence in childbirth activism, also here, among home birth midwives, scientific evidence effectively added legitimacy to their practice, and thus was mentioned as the most important type of knowledge. But this was mostly rhetoric.

Some home birth midwives claimed to have a stricter approach in their practice, maintaining a closer and permanent dialogue with the available evidence. Vested with scientific legitimacy, these midwives usually had higher public visibility, as they seemed less resistant to disclosing their professional identity in public fora. However, most home birth midwives' practice reflected the integration of a wider spectrum of knowledge with different natures, integrating science, intuition, experience, traditional knowledge, medical knowledge, and knowledge rooted in complementary and alternative medicines. The midwives who more openly combined science with less accepted types of knowledge usually had lower public visibility.

In cases where intervention was needed due to an unexpected pathological event, it seemed generally accepted that one could not solely rely on non-verifiable forms of knowledge to guide their intervention:

> Home births, although commonly linked to a mystical dimension, and they may have one – even knowing we can also have this mystical part at the hospital or not – as a professional, I am there to guarantee quite practical things as well. I have to guarantee. That's why I am hired. I can't simply say "no, all will go well, there are no transfers, the Great Mother is with us, amen, let's play some drums." It makes no sense. (Isa, midwife)

But intuition and other embodied types of knowledge were commonly mobilised by home birth midwives, even when facing the need to intervene. However, in cases where severe complications arose, these would be generally used as complementary to medical and scientific knowledge which, in these situations, clearly stood at an authoritative position.

It is worth noting that all home birth midwives were quite invisible to the general public and that all integrated different types of knowledge – constantly moving along a continuum

rather than remaining static in one of its poles – but the visibility of some of these midwives who claim to rely mostly on science somewhat reinforces the importance of scientific evidence as a legitimation resource.

Epistemic syncretism encompasses this dynamic diversity of accepted types of knowledge. Despite the prominence of scientific knowledge in particular situations, it seems it was not science alone that endowed home birth midwives with legitimacy, but the ability to integrate different techniques and a wide spectrum of knowledge in their practice, mobilising them in a meaningful way for women and families under their care. By doing so, midwives were making way to the recovery of the mystic and symbolic meanings of childbirth, and to bringing back the esoterism of helping at birth. Altogether, this syncretism seemed to endow home birth midwives of a certain charismatic authority.

3.3.3. MIDWIVES' CHARISMATIC POWER

Drawing on Weber's (1978) work, charisma is defined as being informal, extra-institutional, conquered not through the bureaucratic nomination or formal recognition of competences, but through the acknowledgment of an intrinsic ability to perform something extraordinary, proposing a transformation from within. And, in fact, home birth midwives' ownership of such diverse set of specific knowledge, with the incorporation of subjugated types of knowledge, seemed to reinforce their status of experts, with a less distinct yet persistent position of power.

> A friend told me, "my sister is going to be a midwife" and I had never been aware of this profession before, but inside of me I thought that this was for cool people and not for me. […] One of my first clinical practices was with an independent midwife, and I felt butterflies in my stomach, and she was a one-of-a-kind woman. A midwife that is still inside me as a I believe a midwife is, a model. Really sweet and, of course, also using homeopathy and herbs. She said so many words that I never heard of, in such a funny way. […] I thought [...] she is a witch; she makes up words as she wishes. (Vera, midwife)

> [In antenatal care, pregnant woman] complained about some pain in her knee when she kneels. […] We all tried to understand what it was and recommended different alternative positions. But after the physical evaluation, [midwife], without having promised it and without further introduction to what was about to happen, as if there was an unspoken coincidence of wills, asks [pregnant women] to get up, palpates her left knee and makes a manoeuvre in her left groin, firmly pressing her finger. She held herself some time in this manoeuvre. Then she also pressed the nape of the neck with a vigorous massage. […] After these manoeuvres, the pain had ceased. [Pregnant women] said she knew she should have come earlier. [Midwife] stressed that the pain might return. (Fieldnotes, May 2018)

The dominant position of home birth midwives as experts in their relationship with families or doulas was not translated into a coercive or subjugating authority. Co-decision-making and informed consent was common practice, and the power relation between midwives, women, partners, and doulas was definitely more balanced than what would be generally found at the hospital. In one home birth, facing the absence of signs of labour development, everyone present was involved in the process of decision-making, but the final decision was carried by the pregnant woman:

> [At home,] we all set down in the room and, in a way, [midwife A] and [midwife B] came up for the first time with the possibility of going to the hospital. There was a talk involving everyone about this, [pregnant woman] cried and said she did not want to go to the hospital. [Midwife A] suggested the couple would stay alone to talk about this. And we went to the living room. After a while, [pregnant woman] and [partner] came back and she said, with a sad face, “let’s go to the hospital”. My perception was that we had reached the moment from which [midwife A] was no longer comfortable in continuing supporting this labour at home. But then [midwife A] asked them to sit down and explained quite the contrary, saying everything was alright, that she was still comfortable in supporting them there, but this had to be their [pregnant women and partner] decision. She asked them not to interpret her words as an indication for transfer, because at that moment there was nothing telling her that a transfer was needed, but it had to

> be their decision. [Pregnant woman] asks [partner] what he thinks, and he says, “it’s like I said inside, we do as you want”. After thinking for a while, [pregnant woman] changed her mind and declared she wanted to continue at home. (Fieldnotes November 2017)

The women’s ability to decide and to stay in charge is actually one of the motivations for opting for a home birth in Portugal (Santos & Augusto, 2016). Yet, somewhat contradicting Cheyney (2008) and Davis-Floyd and Davis (1996), we recognised how this did not always meant that there were equal power relations between women and midwives, nor a permanent co-construction of knowledge by midwife, mother, and significant others.

In fact, home birth midwives maintained their authority in the birth setting, but this had particular features. Santos and Augusto (2016) note that one of the most remarkable elements emerging from the trajectories of home birth families is the building of trust relations with the professionals who will attend the birth at home. These authors further assert that trust – and, we add, not the formal recognition of competences – was mentioned by women as the main condition for others, namely midwives, to be granted access to the intimate setting of their home birth. Nevertheless, the authors acknowledged how this trust was sometimes jeopardised if, for example, a midwife’s intervention at home was regarded by the woman as unconsented or unnecessary.

Accordingly, we recognised this fragile status of midwives’ charismatic authority in situations where there was a conflict or a latent disagreement between the woman’s will and the midwife’s recommendation:

> [I]n prenatal care, I ask them, and we talk about home care and why do you want to have home care and mostly the word is "I want to be in charge, I want to have the right to decide myself". And sometimes, that was funny for me to know, because, as a professional, after 3 hours [or labour without progressing] or whatever, I said "well, I think it is time to go to the hospital, this won’t succeed at home". And then the doula said to me, which was curious to me, "you don't decide when she’s going to the hospital, she decides when she’s going to the hospital." Huh? [a surprise sound] That was stunning... "Ok, ok, I thought I was a professional and I know when we have to go. – No, no. She decides when to go." So, I had to explain to

> her, it was a very good moment for me to learn, […] because […] I was used to be the person that was trusted and so on, but in here you have a different team. And I was explaining to her "well, let's see, tarararara, so I think it is better to go to hospital. Do you agree?" And then she said yes. But, I mean, I was too short. I said "oh, we have to go to hospital" and then the doula restricted me "you have to... she is in charge. – You're right." (Elisabete, midwife)

The single fact of being a formally endorsed professional was not sufficient for the establishment of this midwife's authority. Invested by charismatic authority, in Weber's (1978, p. 1114) terms, the power of home birth midwives relies on their ability to "prove [their] powers in practice" and to be recognised by their followers. By shifting from the role of researcher to the role of user, M. S. accounts how this also transformed the image of the midwife's office and of the midwife herself:

> It was interesting to be there as a researcher and now as a client. The spaces and my relationship with [midwife] now gained a different configuration. Now I faced her as my potential midwife, the person who could help us experience birth at home with safety and trust, the professional, the expert, the one who legitimates our choice, the wise woman, the midwife. The room where she took us for the consultation was now different, warmer, more colourful. [My partner] and I stayed in the sofa and [midwife] stayed in a chair, in front of us, in the opposite corner, among books, flyers, chests, and photos or paintings. Everything there seems to have some story behind, even the chair where she sits on. (Fieldnotes, autoethnography, June 2016)

Here, in the relationship established between families and home birth midwives, and in the users' recognition of charisma, laid the keystone of home birth midwives' power. In their practice, home birth midwives tried to maintain the delicate balance that needs to be met between the sustainability of the trust relationship with each woman and family, established around co-decision-making and informed consent; and their unstable and thus vulnerable position as midwives in construction.

3.3.4. MIDWIVES' AUTHORITY IN INTERPROFESSIONAL INTERACTIONS WITH DOULAS

Beyond the professional development of midwives, home births were also a stage for interprofessional interaction. Doulas commit to the overlooked components of maternity care (Everson & Cheyney, 2015). Considering home birth midwives' distinct opportunity to reach the full scope of their practice, it would be expected that, at home, doulas would have a less relevant role. But this was not the case.

Doulas took part in 5 of the 8 home births observed, and this seems far from circumstantial. Doulas occupied a key position in the home birth scenario, to which three factors may have contributed: doulas' role as gatekeepers, the persisting separation between technical and emotional work in home birth midwifery; and the commodification of lay support in labour and birth.

When this research began, home birth midwives were even less visible and, for women who desired a home birth, a doula would frequently act as a gatekeeper – a point of entry who grants access to health care (Gérvas, Ferna, & Starfield, 1994):

> I have three ways of labelling midwives: those with whom I team up with, and with whom I love to work and I get really excited each time we have a birth together, because it really makes want to be there. There are those whose practices, for some reason, are so dangerous that I don't work with them. […] They're not even on my list. […] Then I have the ones in the middle, with whom I am not that fond of working with, but I have no objections either. I mean… They're to interventive, they talk too much, this and that. So, what's my role in this? [To advise:] "hey, ask them the right questions". (Leonor, doula)

Doulas' knew the field, and their support to women navigating the rather hidden pathways for home birth was one of the many components of their care (Torres, 2015). Without formal recognition or a formal status as professionals, doulas where somewhat immune to the hindrances found by home birth midwives when disclosing their professional identity. Before 2017, there were no publicly available lists of home birth midwives, neither in

pro-home-birth movements, nor in the Order of Nurses as the formal regulatory body. The secrecy around the identity of these midwives led many families to meet doulas at a first instance, who publicly advertised and promoted their services. The available lists of home births midwives would be passed on privately between doulas and families, with an implicit non-disclosure agreement:

> If a mother asks us for contacts [of home birth midwives], we have a list of professionals and I give her this list. But it's the mother who contacts them. It's not us, as doulas, who will contact a professional to work with that mother. […] So, this list is only given to those who really want a home birth. *[Q: And can I ask you to send me this list, by email?]* Yes, yes, I may then… I can… (Ana, doula)

Doulas, in a way, enabled the flourishing of contemporary home birth midwifery in Portugal. If, on the one hand, doulas were invested with the power to control the access to certified home birth professionals; on the other hand, the fact that doulas offered lists of midwives, but midwives did not need to offer lists of doulas highlights the dominant position of home birth midwives in these relationships. In 2015, in a conference of the Order of Nurses, the president of the Portuguese Association of Obstetric Nurses (APEO) declared that they would host a list of certified midwives who attend home births, to improve the families' access to these professionals. This never happened. However, by the final years of this research, between 2017 and 2018, a growing group of home birth midwives started to publicly advertise their services for the first time, and there are now different lists available on doulas and users' movements websites[9]. It is not clear what triggered this change, but it definitely dimmed doulas' power as gatekeepers. Nevertheless, doulas kept their place in home births, namely for practical reasons. Some midwives simply recognised they are not always able to fully respond to the needs of emotional support of a woman in labour, in order to adequately monitor labour and birth, particularly if there is not another midwife present:

[9] At least three websites offer such list at http://www.associacaogravidezeparto.pt/wp-content/uploads/2018/11/Lista-de-Profissionais-de-Saúde-Parto-Domiciliar.pdf, https://www.redeportuguesadedoulas.com/profissionais-de-sauacutede.html, http://maesdagua.org/quero-ter-um-parto-na-agua/lista-de-parteiras/ (accessed May 29, 2019).

> I know some doulas. I spoke with some of them and I think their work is important. I am not one of those who believes their work will take over our role. On the contrary. I even believe we were the ones who lost some things that we couldn't have lost, particularly in our training. But I think it's important that each one has their own space. One does not overrule the other. On the contrary. *[Q: What do you mean, what were those things that somehow midwives lost?]* The care, the touch, being concerned with the woman's emotional well-being, which we end up talking broadly during our training. And then we end up not doing anything. The truth is that, if we are monitoring labour, we are not as available for the woman as the doula. It's different, it ends up being different. But being two [midwives], there is always one who can offer this emotional support, but not as effective as a doula, because they are better prepared than us. I'll think about taking this [doula] course, one day. (Núria, midwife)

Emotional support in labour is part of the formal competences of Portuguese midwives (Ordem dos Enfermeiros, 2019), regardless of place of birth. Still, here there is an acknowledgement of the potentially high level of engagement required for offering emotional support in a home birth, which may result incompatible with an adequate *technical* monitoring of labour.

Emotional support unintentionally drifted away from this reconfigured midwifery practice, although in varying degrees. In some extreme cases, there was an explicit separation between the technical work, and the emotional and logistical support:

> Many couples who come to me are looking for professionals with competencies. What they want is to safely have that baby. Yes, at home, but what they want – with all the existing pressure [upon them], right? – is a professional with whom they connect and who can offer them that guarantee. Let's say that I can combine the more technical, more professional side of home birth assistance. Because, fortunately, for this more emotive, more psychological, more sensorial side, that's why doulas are there. (Filipa, midwife)

The role of doulas thus emerges not only from the separation between "the brain and heart" (Rothman, 2016, p. 44) that seems to prevail in home birth midwifery, but also from the increasing recognition of doulas as experts in delivering emotional support to women in labour. This separation varied immensely. While the technical work of midwives had well established boundaries, the division of emotional support was contextually established. And while, in some home births, an overarching approach from the midwife was counterbalanced by having the doula in the background, focused on logistic support; in many cases both doula and midwife offered emotional and logistic support. Boundaries[10] were tacitly established, according to each situation. But, in any case, the midwives' autonomy seemed unaffected, and their authoritative position persisted.

Building on the work of Hochschild (2012), Rothman (2016), and Torres (2015), we add that, also in home labour and birth, people seem to be searching for the support of a hired expert – the doula – who can bring intimacy and emotional reassurance into the contemporary "birth experiences" (Lusztig, 2013). Doulas today, like the first Portuguese certified and educated midwives of the early 20th century (Carneiro, 2008), represent a professional and thus adequate support, while the truly lay support from friends, relatives, or neighbours represents an uncertainty. And in parallel with early obstetrics, whose broader scope of practice and higher degree of professionalisation contributed to reproducing their authority, also here – in contemporary home births – the same factors seem to operate in preserving the authority of these midwives.

3.4. CONCLUSION

Portuguese midwives seemed to conquer a higher degree of professional autonomy and, more broadly, to reach a higher level of professional development through home births. The new practice of these midwives positioned them closer to the formal definition of midwifery, but it also distanced them from mainstream midwifery. In Portugal, the formal and informal

[10] How doulas themselves define the boundaries of their work and other aspects of the professionalisation of doulas was left out of this analysis.

subordination of nurses and midwives to medical authority at the hospital hinders the true recognition of midwives as experts in childbirth. By contrast, these home births enabled the full exercise of midwives' autonomous scope of practice, recovering the mystic and symbolic meanings of childbirth, and bringing back the esoterism of helping at birth.

The authority of Portuguese home birth midwives thus showed important differences from the authority of health professionals in the hospital setting. The legitimacy of medicine's authoritative position relies foremost on the control of an esoteric technoscientific field of practice, at the hospital. But, in fact, the slow translation of the ever-changing nature of science to maternity care has been contributing, globally, to a growing body of concerns and critiques regarding the prevalence of consented and naturalised delivery of inadequate care in health facilities (D'Oliveira, Diniz, & Schraiber, 2002; Sadler et al., 2016; World Health Organization, 2014). On the contrary, the authoritative position of Portuguese home birth midwives was not coercive. It was found to be more complex, driven by their fluid epistemic syncretism and by the users and doulas' recognition of midwives' charismatic power. The nature of midwifery, in constant reconfiguration, may well be interpreted not as a sign of a low degree of professionalisation, but as a useful feature contributing to the long-term sustainability of their key position in respectful maternity care.

3.5. REFERENCES

Ahl, M., & Lundgren, I. (2018). Working with home birth – Swedish midwives' experiences. *Sexual and Reproductive Healthcare*, *18*(August), 24–29. https://doi.org/10.1016/j.srhc.2018.08.006

Akrich, M., Leane, M., Roberts, C., & Arriscado Nunes, J. (2014). Practising childbirth activism: A politics of evidence. *BioSocieties*, *9*(2), 129–152. https://doi.org/10.1057/biosoc.2014.5

Annandale, E., & Clark, J. (1996). What is gender? Feminist theory and the sociology of human reproduction. *Sociology of Health & Illness*, *18*(1), 17–44. https://doi.org/10.1111/1467-9566.ep10934409

Aune, I., Hoston, M. A., Kolshus, N. J., & Larsen, C. E. G. (2017). Nature works best when allowed to run its course. The experience of midwives promoting normal births in a home birth setting. *Midwifery*, *0*(0), 21–26. https://doi.org/10.1016/j.midw.2017.03.020

Carneiro, M. (2008). *Ajudar a nascer: parteiras, saberes obstétricos e modelos de formação: séculos XV-XX*. Porto: UP.

Cheyney, M. J. (2008). Homebirth as systems-challenging praxis: knowledge, power, and intimacy in

the birthplace. *Qualitative Health Research*, *18*(2), 254–267. https://doi.org/10.1177/1049732307312393

Clausen, J. A. (2010). *How does materiality shape childbirth? An explorative journey into evidence , childbirth practices and Science and Technology Studies* (Doctoral dissertation, Aarhus University, Denmark). Retrieved from http://sts.imv.au.dk/jette-phd-defence

Coddington, R., Catling, C., & Homer, C. S. E. (2017). From hospital to home: Australian midwives' experiences of transitioning into publicly-funded homebirth programs. *Women and Birth*, *30*(1), 70–76. https://doi.org/10.1016/j.wombi.2016.08.001

D'Oliveira, A. F. P. L., Diniz, S. G., & Schraiber, L. B. (2002). Violence against women in health-care institutions: an emerging problem. *Lancet*, *359*(9318), 1681–1685. https://doi.org/10.1016/S0140-6736(02)08592-6

Dahlen, H. G., Jackson, M., & Stevens, J. (2011). Homebirth, freebirth and doulas: Casualty and consequences of a broken maternity system. *Women and Birth*, *24*(1), 47–50. https://doi.org/10.1016/j.wombi.2010.11.002

Davis-Floyd, R., & Davis, E. (1996). Intuition as authoritative knowledge in midwifery and homebirth. *Medical Anthropology Quarterly*, *10*(2), 237–269. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/8744086

Davis, D. L., & Homer, C. S. E. (2016). Birthplace as the midwife's work place: How does place of birth impact on midwives? *Women and Birth*, *29*(5), 343–119. https://doi.org/10.1016/j.wombi.2016.02.004

Desmond, M. (2014). Relational ethnography. *Theory and Society*, *43*(5), 547–579. https://doi.org/10.1007/s11186-014-9232-5

Desmond, M. (2016). *Evicted - Poverty and profit in the American city*. New York: Crown.

DeVries, R. (1993). A cross-national view of the status of midwives. In E. Riska & K. Wegar (Eds.), *Gender, Work and Medicine: Women and the medical division of labour* (pp. 131–146). London: Sage.

Donnison, J. (1977). *Midwives and medical men. A history of inter-professional rivalries and women's rights*. London: Heinemman.

Downe, S. (2010). Beyond evidence-based medicine: complexity and stories of maternity care. *Journal of Evaluation in Clinical Practice*, *16*(1), 232–237. https://doi.org/10.1111/j.1365-2753.2009.01357.x

Everson, C., & Cheyney, M. (2015). Between Two Worlds: Doula Care, Liminality, and the Power of Mandorla Spaces. In A. N. Castañeda & J. J. Searcy (Eds.), *Doulas and intimate labour: boundaries, bodies, and birth* (pp. 203–225). Bradford: Demeter Press.

Foley, L., & Faircloth, C. a. (2003). Medicine as discursive resource: legitimation in the work narratives of midwives. *Sociology of Health & Illness*, *25*(2), 165–184. https://doi.org/10.1111/1467-9566.00330

Gérvas, J., Ferna, M. P., & Starfield, B. H. (1994). Primary Care, Financing and Gatekeeping in Western Europe. *Family Practice*, *11*(3), 307–317. https://doi.org/10.1093/fampra/11.3.307

Hannerz, U. (2003). Being there... and there... and there!: Reflections on Multi-Site Ethnography. *Ethnography*, *4*, 201–216. https://doi.org/10.1177/14661381030042003

Hochschild, A. (2012). *The outsourced self: Intimate life in market times*. New York: Metropolitan Books.

Hunter, C. A., & Hurst, A. (2016). *Understanding doulas and childbirth - Women, love and advocacy*. New York: Palgrave Macmillan.

Iversen, M. L., Midtgaard, J., Ekelin, M., & Hegaard, H. K. (2017). Danish women's experiences of the rebozo technique during labour: A qualitative explorative study. *Sexual and Reproductive Healthcare*, *11*, 79–85. https://doi.org/10.1016/j.srhc.2016.10.005

Jordan, B. (1997). Authoritative knowledge and its construction. In Robbie Davis-Floyd & C. F. Sargent (Eds.), *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives* (pp. 55–79). Berkeley and Los Angeles: University of California Press.

Lusztig, I. (2013). *The motherhood archives*. Retrieved from http://motherhoodarchives.net/

Mansfield, B. (2008). The social nature of natural childbirth. *Social Science and Medicine*, *66*(5), 1084–1094. https://doi.org/10.1016/j.socscimed.2007.11.025

Marcus, G. E. (1995). Ethnography In/Of the World System: The Emergence of Multi-Sited Ethnography. *Annual Review of Anthropology*, *24*, 95–117. https://doi.org/10.1146/annurev.anthro.24.1.95

MaxQDA. (2017). *software for qualitative data analysis*. Retrieved from http://www.maxqda.com/

Newnham, E. C. (2014). Birth control: Power/knowledge in the politics of birth. *Health Sociology Review*, *23*(3), 254–268. https://doi.org/10.1080/14461242.2014.11081978

Norman, B. M., & Rothman, B. K. (2007). The new arrival: labor doulas and the fragmentation of midwifery and caregiving. In W. Simonds, B. K. Rothman, & B. M. Norman (Eds.), *Laboring On: Birth in Transition in the United States* (pp. 251–282). New York: Routledge.

Ordem dos Enfermeiros. *Regulamento n.º 391/2019 - Regulamento das competências específicas do enfermeiro especialista de saúde materna e obstétrica*. (2019).

Quattrocchi, P. (2014). Homebirth and the NHS in Italy. *Canadian Journal of Midwifery Research and Practice*, *13*(3), 32–39.

Rothman, B. K. (1982). *In labour: women and power in the birth place*. London: Junction Books.

Rothman, B. K. (2007). Introduction. In W. Simonds, B. K. Rothman, & B. M. Norman (Eds.), *Laboring On: Birth in Transition in the United States* (pp. XI–XXII). New York: Routledge.

Rothman, B. K. (2016). *A bun in the oven: how food and birth movements resist industrialization*. New York: NYU Press.

Sadler, M., Santos, M. JDS., Ruiz-Berdún, D., Rojas, G. L., Skoko, E., Gillen, P., & Clausen, J. A. (2016). Moving beyond disrespect and abuse: addressing the structural dimensions of obstetric violence. *Reproductive Health Matters*, *24*(47), 47–55. https://doi.org/10.1016/j.rhm.2016.04.002

Santos, M. (2018). Can the unequal access to home birth be framed as a source of inequalities? A comparison between Portugal and Denmark. *Portuguese Journal of Social Science*, *17*(3), 335–347. https://doi.org/10.1386/pjss.17.3.335_1

Santos, M., & Augusto, A. (2016). "Se estava tudo bem, porque é que eu havia de ir a uma obstetra?" - Identidade, risco e consumo de tecnologia médica no parto domiciliar em Portugal. *Sociologia, Problemas e Práticas*, (82), 49–67. https://doi.org/10.7458/SPP2016825922

Serra, H. (2010). Medical technocracies in liver transplantation: Drawing boundaries in medical practices. *Health*, *14*(2), 162–177. https://doi.org/10.1177/1363459309353297

Sjöblom, I., Lundgren, I., Idvall, E., & Lindgren, H. (2015). Being a homebirth midwife in the Nordic countries – a phenomenological study. *Sexual & Reproductive Healthcare*, *6*(3), 126–131. https://doi.org/10.1016/j.srhc.2015.02.004

Sousa Santos, B. de (2014). *Epistemologies of the South: justice against epistemicide*. New York: Routledge.

Teijlingen, E. van. (2005). A critical analysis of the medical model as used in the study of pregnancy and childbirth. *Sociological Research Online*, *10*(2). https://doi.org/10.5153/sro.1034

Torres, J. M. C. (2015). Families, Markets, and Medicalization: The Role of Paid Support for Childbirth and Breastfeeding. *Qualitative Health Research*, *25*(7), 899–911. https://doi.org/10.1177/1049732314553991

Viisainen, K. (2000). The moral dangers of home birth: parents' perceptions of risks in home birth in Finland. *Sociology of Health and Illness*, *22*(6), 792–814. https://doi.org/10.1111/1467-9566.00231

Weber, M. (1978). *Economy and society: an outline of interpretive sociology* (G. Roth & C. Wittich, Eds.). Berkeley: University of California Press.

World Health Organization. (2014). *The prevention and elimination of disrespect and abuse during facility-based childbirth: WHO statement*. https://doi.org/WHO/RHR/14.23

World Health Organization. (2018). *Intrapartum care for a positive childbirth experience*. Retrieved from http://www.who.int/reproductivehealth/publications/intrapartum-care-guidelines/en/

4. ESSENTIALISM AS A FORM OF RESISTANCE: AN ETHNOGRAPHY OF GENDER DYNAMICS IN CONTEMPORARY HOME BIRTHS

Feminist scholars have criticised the essentialist construction of femininity associated with "natural" childbirth. In this essay[11], we present data from a multi-sited ethnography on Portuguese home births where we analyse how gender ideologies are reproduced and operationalised by families and home birth professionals. Given the androcentric references of modern obstetrics and the marginal position of home birth, we argue that essentialism was constructed as a form of resistance.

4.1. INTRODUCTION

The critiques of medicalised childbirth entered the agenda of feminist research and activism rather late, from the 1970s' onward, when the second wave movement already had its momentum (Macintyre, 1980; Oakley, 2016). Since then, planned home births have been considered the typical representation of a counterculture and a resistance to childbirth medicalisation and masculinisation (Mansfield, 2008). But in fact, by looking at how gender is performed in contemporary home births, they seem to be more than the plain expression of a demasculinisation movement. In this article, grounded in the growing body of knowledge on childbirth and gender, we report findings from a multi-sited ethnography on Portuguese planned home births, and analyse how gender ideologies are reproduced and operationalised by home birth professionals and by families.

[11] This essay benefited from the contributions of Amélia Augusto, Jette Aaroe Clausen, and Sara Cohen Shabot, and was published in the form of an article in the *Journal of Gender Studies* (available at https://doi.org/10.1080/09589236.2019.1650256).

4.2. GENDER, DEMEDICALISATION, AND HOME BIRTH

Since its early stages, feminist approaches focusing on women's roles in childbirth were far from being consensual, and the debate remains unfinished (Annandale & Clark, 1996; Beckett, 2005; Oakley, 2016). These approaches are often criticised for having an underlying conception of women as a homogenous group, and different from all men, based on their reproductive functions (Amélia Augusto, 2013; Beckett, 2005); for representing a step back in women's achievements, particularly by limiting their social lives back to their private, family life (Badinter, 2011); and for failing to recognise the diversity of women as a social group across the intersections of place, race, class, and many other social markers, excluding transgender and non-binary gender persons, falling into biological essentialism. On the other hand, the mere act of talking about gender without essentialising may be challenging (DeFrancisco, 1997), and even feminist scholars who reject essentialism are often unintendedly trapped in "the notion of a 'raw material' that women hold in common" (Annandale & Clark, 1996, p. 27).

Still, gender surely remains central when discussing the medicalisation and demedicalisation of childbirth. Traditional gender roles in childbirth seem to be broadly internalised. Martin (2003), analysing gender identities in hospital births, concluded that white, middle-class, heterosexual, cisgender women demonstrated a concern with their behaviour during labour and birth, trying to be discrete, contradicting the culturally dominant image of a lack of emotional control, and demonstrating how *internalised gender technologies* control the body in the interactions with all other actors in childbirth. Martin highlights how the control mechanisms of the female body are not only external, institutional, and interactional, but are also related to a traditional gender identity internalised by the woman, that leads her to remain calm, docile and quiet during birth. Cohen Shabot (2016) also highlights the gendered nature of the medical management of childbirth. She develops how the labouring body holds a strong erotic meaning that defies the hegemonic ideal of passive and docile femininity prevailing in patriarchal societies. Childbirth is, at the same time, the opposite of femininity, and the archetype of femininity. The hospital structure, the

control mechanisms, and the medical interventions are thus needed to domesticate this disquieting, erotic female potential.

Home births, in particular, stand as one of the most significant countercultures to obstetrics, but retain several characters of medicalisation. How is then gender operationalised and configured? Although stressing the need for further research, Martin (2003, pp. 67–68) notes how internalised gender technologies seemed to operate differently on two of the women she interviewed, who chose and experienced a home birth. There were minimum references to traditional gender roles when these women described their labour and birth experiences:

> Two of these women also described interactions that might be seen as challenging gender norms. For example, Andrea took pleasure in her own, out-of-the ordinary cursing and ordering. [...] Jill, who gave birth at home, described taking charge of the labor and telling others what she needed them to do. She did this without reservation and without apology. [...] She also describes holding up her finger several times to signal to her birth attendants that she needed quiet to get through a contraction. At another point, she told her husband to stop reading a book and to pay attention to her and her contractions. She does all of this without apology. No other interviewees told such stories.

The oppressive power of internalised gender technologies might have been differently expressed in these women because they had home births, with several contextual differences from hospital labour rooms. However, Martin notes that further research is needed before establishing causal relations, to know whether women with lower degrees of internalised gender technologies are more likely to choose a home birth, or if actually home births free women from these technologies.

Drawing on Martin's work, Carter (2009) analysed interviews and birth stories posted on the internet from women who choose out-of-hospital births (at home or in midwifery-led units). She illustrates how their behaviours during labour and birth were not aligned with traditional gender roles, although they were coherent with the traditional feminine role in the private sphere, where women are in charge and delegate tasks. But Carter notes how this is

one of many possible interpretations, and stresses that it is not clear if women were, in fact, adhering or defying gender norms. In fact, when people who do not belong to the household are present – as is the case of a home birth with professional assistance – the boundaries between public and private sphere at home are less clear. Plus, the focus on women's behaviour during labour and birth seems not to be enough to understand how gender is operationalised and reproduced in home births more broadly, before and after the birth takes place, and through the practices of home birth professionals.

In a research on Portuguese home births, Santos (2012) also highlights how gender seems to mediate the birth experience. The author states how, from the women's description of their hospital and home births, there were forms of resistance to external and internalised control mechanisms in both settings. In some cases of hospital births, there were no significant internalised gender technologies, but an external control by the hospital staff. One of the interviewees had her second birth at home, after a first hospital birth, and she described how being at home allowed escaping both from external and internalised gender technologies (Santos 2012, p. 25–6, our translation):

> Because, in the hospital, we kind of feel that a woman who screams is a woman who disturbs, isn't it? In the hospital, I was always saying sorry! I didn't want to bother. I just wanted them to like me! […] And there [at home], I knew they [the midwife and the doula] wouldn't judge me, they wouldn't point their fingers at me, they wouldn't, you know? And I could do what I wanted! I could embody the woman giving birth that I was, you know? Freely. Screaming. I screamed. Basically, that was my scream, my war scream.

For Santos, the experience of a home birth does not grant an autonomy from internalised and external control mechanisms. It is in the context of each home birth that a set of conditions may allow exercising and experiencing such an emancipation. Santos notes how access to the home birth setting, in late modernity, is mainly conditioned by reflexivity[12] and the birthing woman's trust-based relationships, and not so much by gender, expertise, or

[12] Santos uses Giddens' concept of reflexivity: the rupture with traditions, the active search for knowledge, and the ability to reflect upon that knowledge and upon reflection itself.

family ties. On the other hand, the author reports the re-emergence of a gender ideology apparently rooted on essentialism within the discourse of women who had a home birth, where birthing without control mechanisms and in the desired setting is said to be an opportunity to fully experience femininity. However, this femininity is not always built on traditional gender roles. Gender is stated as an important feature of home births, but its role remained unclear.

Fedele (2016) goes further, analysing the connections between home births and gender in what she calls “holistic mothering” in Portugal. She notes how holistic mothers share, in different degrees, attributes found on the rather diffuse Goddess spirituality movement, were female reproductive processes are sacralised and celebrated. Among the women she interviewed, the ones who gave birth at home recalled the women’s socially devalued and oppressed abilities to give birth without medical interference. Yet, Fedele stresses how there is an underresearched political dimension underlying their claims, where gender stands as a cornerstone for social critique. These women generally acknowledged the pitfalls of reproducing traditional gender roles and searched for conciliating solutions to challenge patriarchal models.

Following these works of Santos and of Fedele, we propose an in-dept analysis of gender in the home birth setting, focusing on how birthing women and both established and emerging home birth practitioners – midwives and doulas – operationalise and reproduce gender ideologies and control mechanisms through their discourse, their birthing experiences, and their care giving.

4.3. METHOD

This article draws from an ethnographic research aiming at observing the dynamics of Portuguese home birth practices, throughout pregnancy, birth and postpartum. Practices related to home birth happen intermittently in several spaces, and there is not an institution serving as an integrative stage for the organised action of different social actors. Therefore, we developed a multi-sited approach (Hannerz, 2003; Marcus, 1995), and by observing the

singularities of each situation, searching for its *local ecology* (Hannerz, 2003, p. 208), we were able to learn their common features. This led to an in-depth understanding of the social dynamics surrounding home births, more broadly.

Ethical approval for this study was granted by the Institutional Review Board of the PhD Programme in Sociology of the University Institute of Lisbon (ISCTE-IUL), and all names are pseudonyms. Fieldwork was carried by M. S. in Portugal from October 2015 to July 2018. Because there was no formal home birth network in the country, entering the field was driven by existing personal relations, at first mainly in structured and formal fields, such as conferences, activists' meetings, women's circles, and doula courses. Gaining direct access to home births was less common in the first stages of research. The fact that the ethnographer was a man may have had some implications in gaining deeper access to the field at these stages. But as stronger trust-based relations were built, both with families and professionals, being a man became less relevant, and more opportunities for accessing intimate settings were granted. In the end, the ethnographer took part in 27 consultations with midwives, 15 doula sessions, and 8 home births, with varying degrees of engagement, apart from numerous spontaneous conversations with professionals and families.

Further data was produced from auto-ethnography of M. S. home birth experience in June 2016, and from 20 semi-structured interviews to home birth professionals, including nearly all active Portuguese home birth midwives. A total of 13 midwives, 1 birth photographer, and 6 doulas were interviewed. From these doulas, 3 were also doula trainers. Interviews lasted an average of 96 minutes. Data was also produced from ethnography of online interactions on social media (Bryman, 2012; Kozinets, 2010), and from the media coverage of events or debates associated with home births, in Portugal.

4.4. RESULTS AND DISCUSSION

4.4.1. GENDER IN THE INNER AND OUTER LAYERS OF HOME BIRTHS

Doing ethnography in and around home births allowed a privileged analysis of gender dynamics. At home, there are no formal or institutional rules regarding the access to and the stay in the birth setting. Despite the likely gendered context of the home, gender dynamics emerge independently from the constrains found at the hospital. Gender and any control mechanism may be then analysed in the interplay between how gender is individually enacted and how it is conditioned and reproduced through interaction. While at the hospital, apart from the external and internalised gender technologies, there are overarching institutional norms formally conditioning the access, the stay, and the behaviour in the birth setting.

Although home births were at the centre of this research, broadening the fieldwork to the "outer layer" of home births – other settings and activities where people talk, train and elaborate on home and natural childbirth – allowed the ethnographer to interact and to gain intimacy with more people, and to get further access to more private settings, such as midwifery consultations, doula sessions, and labour and birth at home – the "inner layer" of home birth. At first, interviewing some of the home birth practitioners, attending public or semi-public events dedicated to natural birth or home birth, and reviewing on-line information on doulas' websites showed an abundance of essentialist perspectives. These were structuring elements of the discourses produced around home birth. Yet, as the access to the inner layers of home birth was granted, a more complex picture started to be drawn on how gender ideologies are integrated and reproduced in more intimate interactions. During the analysis, three main categories emerged: *rhetoric essentialism*; *gender as energy*; and *essentialism as emancipation*. These will guide the following discussion. To a certain extent, they are presented diachronically, roughly representing three stages of immersion in the field.

4.4.2. RHETORIC ESSENTIALISM

In the outer layer of home birth, the role of women is strongly conditioned by the biological nature of their reproductive processes. A rhetoric essentialism was found in different public and semi-public settings, offline and online. There was a certain consensus regarding the relative position of women and men in childbirth in the discourse of women and midwives, doulas, or other professionals linked to home birth. The medical management of birth was described as a form of patriarchy and thus the processes of demedicalisation were mentioned as a form of gender re-appropriation, of recovering the feminine in childbirth, as described here by Beatriz, a doula and doula trainer, in an interview:

> [On the content of a doula course:] Many times it's not a matter of "I read" or "I studied", but "I intuitively knew" or "I always knew this [medical management of birth] was not the normal thing to happen". It is that rescue of that feminine wisdom that we do [in the course], right? Giving the leading role back to the woman, and improving her self-esteem, because a woman with a strong self-esteem is not easily deceived, she is not. She is responsible for her choices, for her decisions, and if necessary she says "no" to her doctor, or changes doctor, or has no doctor, or no obstetrician.

Home birth emerged as the option where a woman can truly free herself from the masculine dominance: with women back in charge of the birth setting and without the presence of men, an ancient feminine knowledge about birth could be reclaimed. In some situations, there was a strong reference to witches, who symbolised this subjugated knowledge. There was a homogenising rhetoric of women as a group, bonded by their exclusive experiences of motherhood, often translated into a celebration of reproductive processes that are biologically female. This is well represented in this interview to a doula, conducted by another doula and posted on her blog on 10 October 2015 (accessed 10 November 2015):

> Q: When a mother is born, we discover an inner strength that we did not know of. Don't you agree?
>
> A: Certainly! It's one of the things I most appreciate, seeing how much a Woman grows when she can give the best birth to her son. It is a double birth. It is a kind of growth that has a glow in the Women's eyes, they change, and with them changes the world around them. A contagious chain is produced. I am surrounded by a feminine strength which is an incredible chain. I am grateful to all these Women, for the strength with which we are feeding each other.

This narrative conveys a straight association between being a woman and being a mother. Similar discourses contributed to reproduce the idea of motherhood as enabling a more complete fulfilment of womanhood. This resembles some of the contours of the concept of holistic mothering proposed by Fedele (2016), where being a mother legitimises women's authority over their bodies.

In this outer layer of home births, at the discourse level, other elements of holistic mothering could be identified, such as emphasising the importance of the female lineage, or referencing Mother Earth; as reflected in the discourse of Andreia, an obstetrician, at a Portuguese conference on normal childbirth, in May 2016, when she was explaining her alternative approach to antenatal care:

> The first part of the pregnancy is to work on the feminine, 'me and the mother'; the second will be like adolescence; the third is to work the masculine, to be ready for choices, to decide when and where the birth is going to happen. [...] The mother is the Earth [where life is created], the father is the Universe [with its masculine ability of protection].

Having a home birth was frequently described as a way of keeping birth feminine. Part of the information channelled by women and professionals reflected the relevance of living and sharing the experience of pregnancy and childbirth within a circle of women, in a feminine protective environment. Pregnancy was sometimes referred to as a phase when repressed issues with the women's mother, or issues dating further back in the maternal

lineage, surface; representing an opportunity to "heal the feminine", either metaphorically or through specific practices focused on female body parts, such as the "blessing of the uterus".

Being a cisgender woman and, in some cases, having the embodied experience of childbirth was thus rhetorically recognised as a form of authoritative knowledge in the support given to other women throughout pregnancy, labour, birth and postpartum. This was particularly evident in the definitions of the role of the doula found on two of the Portuguese websites advertising doula services and doula training (accessed 27 October 2016):

> [A doula is someone who] ... has lived the experience of motherhood and recognises this stage as one of the most important stages of a woman's life, if not the most important, which she will save in her memory forever. [Website A]

> Birth is part of the feminine universe and, until recently in history, it has always been "a women's thing". Women protected and helped each other, because they are bond by the miracle of giving birth. The role of the doula, in a way, rescues this cooperation between women, this intuitive feminine wisdom, and thus a doula is, by nature and tradition, a woman, and usually has the experience of motherhood. However, there are some women who do not have children *yet* but already feel within them the will and the vocation to help other women in this moment of their lives. Some men may have in them the sensitivity and the understanding of the feminine that allows them to accompany a woman in her birth, especially their partner, but it is not usual that they would want to dedicate their life to this. [Website B, our emphasis]

Doulas are not a monolithic and homogenous group. But, in general, their role was the most intrinsically connected to this line of rhetoric essentialism. Most home birth professionals are women, but while it was generally accepted that a minority of home birth midwives were men, many doulas and mothers were clearly against the existence of male doulas.

Yet, among midwives, essentialism also had particular features. More than rhetorically recognising childbirth as a feminine territory, some expressed a fascination with the "feminine" and with the uniqueness of women's bodies, which required a specific set of

knowledge that they have neglected through their hospital midwifery practice. Engaging in home birth midwifery was, then, a way of reconnecting with this feminine knowledge. Midwives acknowledged how, through their home birth practice, they were somewhat recovering part of the lost charisma of lay midwives, wise women who helped other women in childbirth using their embodied experience of childbirth and their "feminine intuition" before the hospitalisation process begun. This is in line with what has been described by other authors internationally, regarding the valuation of intuition in home birth midwifery (Davis-Floyd & Davis, 1996; Sjöblom et al., 2015). However, as Beckett (2005) notes, some of these arguments have underlying essentialist notions of the nature of intuition, where women are more naturally capable of being sensitive and intuitive than men.

Essentialism, at least rhetorically, notably surrounded home births. From public speeches to online information, and across different social actors and settings, the homogeneity of women and the natural differences between women and men were convened and celebrated. However, in more private and intimate situations, there were circumstances that somewhat contradicted the seemingly essentialist foundations of home birth experience and care. Beyond recognising that gender is in fact attenuated when defining the access (of others) to the home birth setting, as described by Santos (2012), several interactions drawn attention to a more complex and dynamic framework, built around the notion of gender as energy, and as independent from biology, even among the same individuals who expressed essentialist views.

4.4.3. GENDER AS ENERGY

As the ethnographer accessed inner layers of home births, a surprising recognition of the social construction of gender identity emerged, through an energy discourse. It was distinct from what Fedele (2016) has described regarding holistic mothering, where energy is linked to spirituality. Holistic mothers are said to share, in different degrees, the attributes of the members of the Goddess spirituality movement, including the use of an energy discourse to describe the theory and practice of experiencing a connection with a spiritual or divine force

(Fedele, 2013). Here, despite some infrequent references to energy as a component of one's spirituality, the energy discourse generally emerged as linked to the definition of the gender identity of a person or of a certain setting.

This had implications when defining how much "rescuing the feminine" in the birth setting actually meant that it should be (re)established as a place exclusive for women. Beatriz, a doula trainer, clarified how finding the desired feminine support within a group (of women) was not necessarily determined by nature:

> Q: So, you think that, at the same time, [women relying on other women] it's a feminine thing, but also something inherited from society?
>
> A: I don't think it's something naturally feminine. I think we learned to do that, you know? [...]
>
> Q: My question is why is it possible [to have a "feminine" circle of trust] in a circle of women and not in a circle of women and men, or a circle of men.
>
> A: But of course it is possible in a circle of women and men, of men and cats, and dogs, and giraffes, and crocodiles. I don't know, I don't work with men [laughter]. I don't work with men. But more and more I am starting to be surrounded by men with a completely extraordinary energy.

These results show important parallels with some of the debates on gender as non-determinist, as non-binary, as fluid. And, in some cases, there were accounts of the interplay between structure and agency, in so much gender was recognised not only as a social construct, but also as a set of individual features performed in the context of each social interaction, as discussed by Connell (1987), West and Zimmerman (1987), and Butler (1990). This is well illustrated by this excerpt of Ana's interview, discussing the interaction with a man in a doula course:

> A: We [doulas in training] didn't feel "ok, a man just came in, now we have to..." That issue of patriarchy. "We have to do what he tells us, we have to..." No, no way. We didn't feel that submission, or an oppressive energy, let's put it this way. We didn't feel that. It was like if he

was part of the circle. “Ok, we are among peers, we are all on the same line”, so we didn’t feel any big differences.

Q: It was almost like if... you were talking about energy and I understood it almost like if you were saying that he had a feminine energy.

A: Yes, he does. And so do you [as a man]. A part of you is also feminine. Yes, he had a sort of energy which was more feminine than masculine, yes.

Likewise, aligned with Connell’s work, femininity and masculinity were widely conceived as fluid forms of energy, and everyone could have coexisting traits of femininity and masculinity, in varying degrees.

We note that there is some degree of essentialism in the definitions of what constitutes feminine and masculine energy, some of them clearly connected to traditional gender roles (feminine as listening, being, feeling; and masculine as doing, intervening, oppressing). Yet some conceptions of femininity (though not that much of masculinity) overcome these traditional definitions. Women’s femininity in the birth place was also constituted by being powerful, strong, loud, untamable, determined. This was not seen as innate, and not even only a product of socialisation. Gender as energy and the degree of masculinity and femininity in one’s self were said to be modulated by each social situation, which is particularly relevant in the birth place. Júlia, a home birth midwife, gives further account of this in her interview:

Wherever a birth is happening, the energy is feminine, clearly. And you must get in, either if you’re a man or a woman, you must enter in the feminine energy. Which is an energy of welcoming, an energy of mission, an energy of service, and an energy of presence, you know? You are there to be on service. And an energy strongly intuitive.

Again, this was not identified in every setting, but generally the presence of men was not incompatible with the feminisation of the birth place. Building on one of the arguments of the famous French obstetrician Michel Odent, who promoted undisturbed birth, Leonor, a

doula and doula trainer, develops in her interview how she conceives birth as a place also for men:

> Do you remember an interview to Michel Odent, one of the last, to a Portuguese magazine, and that was completely controversial, saying birth is no place for men? And everyone though this guy had gone crazy, but I completely understand that, you see? I think he used some inadequate terminology. Because, my perception is that birth is not a place for masculine energy, at all. It's a place for feminine energy. And in my work with couples and with men, this is my focus: everyone can be present at birth, if you have the right energy. Knowing the minimum about how a birth happens, and how it develops, you can be in a certain energy. If you go to the church, if you know what are the proper manners to be in the church, you can behave adequately. It's the same thing. And I think there are women that, at birth, even if they are mothers and have a bunch of kids, they have such a strong masculine energy that birth is not a place for them. It's not about sex or about having kids or not, it's about your attitude there.

As such, not only the presence of men may promote the femininity of the birth place, but also the presence of women may well interfere with it, depending on how one interacts and performs.

4.4.4. ESSENTIALISM AS EMANCIPATION

The results above, roughly describing two levels of immersion in the field – the inner and outer layer of home births – may unintendedly induce in the reader a sense of two discrepant dimensions of home birth: public discourses and private practices. However, we acknowledge that discourse is not separable from other forms of social practice (Connell, 1987; Wodak, 1997). In fact, deepening our analysis we see how, despite the essentialist rhetoric, "masculine energy" may also be welcomed in a home birth; and how, despite the non-binary gender ideology, being a man or a woman is not completely indifferent and has

practical implications in the home birth setting. By looking at the wider context in which home births are happening – how home births and home birth practitioners are socially positioned, and how the role of women and men in childbirth is configured in Western societies today – we can then have a more comprehensive understanding of how gender is shaped in the home birth setting.

Home birth is an alternative, marginal, system challenging praxis (Cheyney, 2008). As such, although the embodied experience of being a woman and being a mother was relevant to the establishment of home birth professional practices, it was not enough. The legitimation of these practices (among families and among other professionals) was first granted by the fact that they were based in scientific and medical knowledge and evidence. Isa, a midwife, in her antenatal consultations, frequently drew on the evidence upon which her advices and practices were based, carefully noting when an advice was based only on her experience.

In general, solely having an embodied experience as a woman did not grant legitimacy to the professional practices in home births, either as midwife or doula. Plus, men in the birthplace, other than the partner, did also use of their embodied experience to inform actions, to discuss options, and to exemplify possibilities. While talking on the phone with Nádia, a pregnant woman, about the ethnographer's presence in her planned home birth, she explained how having another man in the birth place will be an advantage, particularly because of his previous experience of a home birth:

> I think it will be interesting that you're here, because my husband will be here surrounded by women and you're a man, so it will be great. He was very happy to know you would be coming, because he will feel supported and you had that experience already, which is also good in case we want to ask you something.

These home births reflected the emerging diversity in the role of men in pregnancy and childbirth earlier discussed by Daniels and Chadwick (2017, p. 11) where men also explored the "containing, receptive and nurturing possibilities of the masculine". Similarly, here male partners acted in many ways in a home birth, from those who gave direct physical support, to others who remained waiting in a different room for the labour to progress while

others offered direct support. And these different levels of engagement also varied during labour.

Moreover, we do not ignore that there are specific rules for social interaction in the birth setting and that being a woman does seem to give way to exclusive forms of social interaction. Elisabeth Challinor (2018), in an autoethnographic narrative of her hospital birth experience, mentions how a kiss in the forehead by the female midwife who attended her birth was meaningful in making the experience more positive. Yet she acknowledged that the kiss would have been experienced differently if it were from a man (Ibid. personal communication, September, 2015). Likewise, in most of the observed home births, touching and establishing a more intimate physical contact was easier and more welcomed if it was performed by women. Men, other than the partner, giving physical support to the labouring women was less common, and when it happened it was less immediate, happening in later stages of labour.

Also, beyond the "women and men divide", the couple, as a singular system or entity, emerged as relevant. "Pregnant couple", i.e. (mainly) a heterosexual couple of cisgender man and woman where only the woman is in fact pregnant, is a term with growing acceptability among doulas and health professionals in Portugal. Some home birth professionals also integrated this in their practice, focusing on the couple rather than on the women. This was especially clear during antenatal care. The purpose of celebrating reproductive functions of women, rooted in an essentialist ideology, became even less evident.

But why then an essentialist rhetoric, in the first place? We argue that, given the androcentric references of modern obstetrics and the marginal position of home birth, essentialism was constructed as a form of resistance. Júlia, home birth midwife, mentions in her interview:

> [O]bstetrics today has the need to control, so it adopts a masculine role of controlling. [...] Because you have the power to intervene. So, it's the power of the masculine, completely wrong, in a context that should be feminine, of redemption, and of presence. Nothing else. And of wait. [...] It's the sacred energy of the feminine that is there [at birth], at its peak. You

> can't find it anywhere else. You see? And that's the reason for this eternal fight. Because when you go fighting, to win a war you must fight. And this is a lost fight from the start, because the feminine doesn't fight. So, you can't fight. The feminine energy is not an energy of fighting. [...] Unless it is not a battle, were we rest our weapons completely, and start demanding, but without fighting, what is ours by right.

Resistance through discourse may be ephemeral and have multiple shapes, but at its core is the Foucauldian proposal of power as the social control of knowledge and perception (DeFrancisco, 1997). Today, scientific obstetrics and the medical management of childbirth are the norm, and they allegedly exist free from culture. Facing this as a form of oppression, home birth practitioners and families seemed to have found here an opportunity for emancipation, using a discourse strongly rooted in the power of women, in nature, and in emotions, intuitions and other oppressed forms of knowledge. Essentialism offered an exclusive language, clearly distinguishing and distancing home birth practitioners from hospital birth practitioners, securing their own identity as independent from the medical hegemony.

In this line of argument, rhetoric essentialism becomes compatible with the other practices in home births described above, where gender is performed rather than innate, and masculinity and femininity are understood as fluid concepts varying according to each person, each setting, and each interaction. Recovering Martin's (2003) research on internalised gender technologies in the birth place, and the apparent gender non-conformity of Martin's respondents who had a home birth, we are now able to say that those respondents were probably not incidental outliers. While we cannot say if hospital births are, in fact, what produces and reinforces the technologies of gender Martin describes, we can say home births do seem to open way for women to resist to or to be freed from these technologies. In general, the way women and men behaved at their child's birth at home did not seem to reflect traditional gender roles. Through their behaviour, women and men varied their position within the gender spectrum.

Yet, there was a certain notion of what women in labour (at home) should be and should do: strong, decided, in control, informed, reflexive, aware of their choices and their

trajectory, and emotionally developed. This notion was not convened in a repressive way, it was not prescriptive, and women did behave differently without apology on their account or censure by others. But even so, this shared notion did not always have an empowering and positive influence on the women's experience. Despite not being rooted in an essentialist ideology of gender, to some extent this shared ideal conditioned the personal experience of and the professional practice at home births. Some practitioners shared their views on how, in some very specific moments where a labouring woman was "whining too much", they had to "shake her", or yell, or be directive, so the woman could "put herself together"; after what, often, the practitioners returned to their usual caring and supportive behaviour. In Liliana's home birth, at a stage when labour apparently stopped progressing after developing quickly, the midwife paused the physical support she was offering, created direct eye contact with Liliana, and said she needed to stop behaving like a baby and to behave like an adult woman, so she could help labour to move forward. Liliana nodded, and the midwife continued offering physical support.

Also, for some women, not having been completely "in control" could sometimes be felt like a failure. This was the case in Rosário's home birth, when the birth attendant ended up having to be in command, and the woman felt she was not "strong enough". This was recently developed further by Fedele (2018) regarding women who had to have a home-to-hospital transfer, e.g. due to prolonged labour or the need for pharmacological labour pain relief. Nevertheless, we highlight that these occasional internalised and external control mechanisms were more conditioned by this shared notion of what a person giving birth should be than by traditional gender norms. In general, there seemed to be a liberation from internalised and external gender technologies in these home births.

4.5. CONCLUSION

Gender matters in home birth. But its features are far more complex than what is usually conveyed by the simple association of home birth – and natural childbirth in general – with nature and biological essentialism. In the social framework where this research was

conducted, in and around Portuguese home births, gender dynamics were a central dimension of personal and professional experiences and interactions.

Contrasting with the dominant discourse around childbirth, strongly conditioned by the hegemonic medical lexicon, there was an essentialist rhetoric around home births, celebrating women as mothers and conceiving birth as an opportunity to reconnect with the oppressed feminine dimensions of childbirth. And contrasting with the internalised and external gender technologies that may be found in hospital births, home births enclosed non-binary gender ideologies, where femininity and masculinity were conceived as fluid forms of energy that everyone has in different degrees, varying across situations; and where men are potentially welcomed in the birth setting, either as fathers or as professionals. These, we argue, set a rather disperse but coherent form of resistance to the androcentric framework of modern maternity care, that goes beyond the rejection of the hospital as the ideal place for birth, or of the obstetrician as the lead birth expert.

In these home births, in general, there were no internalised or external gender technologies. There seems to be a shared vision of some of the traits a person giving birth should have, but they were not aligned with a specific gender ideology, and they were mostly not prescriptive. These home births, while representing a minority and rather privileged option, can be framed as emancipatory.

4.6. REFERENCES

Altheide, D. L., & Schneider, C. J. (2013). *Qualitative media analysis* (2nd ed.). Thousand Oaks: Sage.

Annandale, E., & Clark, J. (1996). What is gender? Feminist theory and the sociology of human reproduction. *Sociology of Health & Illness*, *18*(1), 17–44. https://doi.org/10.1111/1467-9566.ep10934409

Augusto, A. (2013). Género e Saúde. In F. Alves (Ed.), *Saúde, Medicina e Sociedade: uma visão sociológica* (pp. 29–34). Lisboa: Pactor.

Badinter, E. (2011). *The conflict: How modern moderhood undermines the status of women*. New York: Metropolitan Books.

Beckett, K. (2005). Choosing cesarean: Feminism and the politics of childbirth in the United States. *Feminist Theory*, *6*(3), 251–275. https://doi.org/10.1177/1464700105057363

Bryman, A. (2012). *Social research methods* (4th Ed.). New York: Oxford University Press.

Butler, J. (1990). *Gender Trouble: Feminism and the Subversion of Identity*. New York and London:

Routledge.

Cahill, H. A. (2001). Male appropriation and medicalization of childbirth: An historical analysis. *Journal of Advanced Nursing, 33*(3), 334–342. https://doi.org/10.1046/j.1365-2648.2001.01669.x

Carter, S. K. (2009). Gender performances during labor and birth in the midwives model of care. *Gender Issues*, *26*(3–4), 205–223. https://doi.org/10.1007/s12147-009-9084-x

Challinor, E. P. (2018). Exploring the power of the written word: on hospital birth and the production of birth narratives. *Etnográfica*, *22*(3), 669–690. https://doi.org/10.4000/etnografica.6077

Cheyney, M. J. (2008). Homebirth as systems-challenging praxis: knowledge, power, and intimacy in the birthplace. *Qualitative Health Research*, *18*(2), 254–267. https://doi.org/10.1177/1049732307312393

Cohen Shabot, S. (2016). Making Loud Bodies "Feminine": A Feminist-Phenomenological Analysis of Obstetric Violence. *Human Studies*, *39*, 231–247. https://doi.org/10.1007/s10746-015-9369-x

Cohen Shabot, S. (2017). Constructing subjectivity through labour pain: A Beauvoirian analysis. *European Journal of Women's Studies*, *24*(2), 128–142. https://doi.org/10.1177/1350506815617792

Connell, R. W. (1987). *Gender and Power: Society, the Person, and Sexual Politics.* Oxford: Polity Press.

Daniels, N. M., & Chadwick, R. J. (2017). Doing homebirth like a man? Constructions of masculinity in South African men's narratives of homebirth. *Journal of Gender Studies*, *27*(6), 1–15. https://doi.org/10.1080/09589236.2017.1301811

Davis-Floyd, R., & Davis, E. (1996). Intuition as authoritative knowledge in midwifery and homebirth. *Medical Anthropology Quarterly*, *10*(2), 237–269. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/8744086

DeFrancisco, V. (1997). Gender, power and practice: or putting your money (and your research) where your mouth is. In R. Wodak (Ed.), *Gender and Discourse* (pp. 37–56). London: Sage.

Fedele, A. (2013). *Looking for Mary Magdalene: Alternative Pilgrimage and Ritual Creativity at Catholic Shrines in France*. New York: Oxford University Press.

Fedele, A. (2016). 'Holistic Mothers' or 'Bad Mothers'? Challenging Biomedical Models of the Body in Portugal. *Religion and Gender*, *6*(1), 95–111. https://doi.org/10.18352/rg.10128

Fedele, A. (2018). When homebirth "goes wrong": holistic mothers who end up giving birth in a Portuguese hospital. *Etnográfica*, *22*(3), 691–714. https://doi.org/10.4000/ etnografica.6099

Hannerz, U. (2003). Being there... and there... and there!: Reflections on Multi-Site Ethnography. *Ethnography*, *4*, 201–216. https://doi.org/10.1177/14661381030042003

Kozinets, R. V. (2010). *Netnography: Doing ethnographic research online*. London: Sage.

Macintyre, S. (1980). The Sociology of Reproduction. *Sociology of Health and Illness*, *2*(2), 215–222. https://doi.org/10.1111/1467-9566.ep10487797

Mansfield, B. (2008). The social nature of natural childbirth. *Social Science and Medicine*, *66*(5), 1084–1094. https://doi.org/10.1016/j.socscimed.2007.11.025

Marcus, G. E. (1995). Ethnography In/Of the World System: The Emergence of Multi-Sited Ethnography. *Annual Review of Anthropology*, *24*, 95–117. https://doi.org/10.1146/annurev.anthro.24.1.95

Martin, E. (1992). *The Woman in the Body: A Cultural Analysis of Reproduction.* Boston: Beacon Press.

Martin, K. A. (2003). Giving Birth Like A Girl. *Gender & Society*, *17*(1), 54–72.

https://doi.org/10.1177/0891243202238978

Oakley, A. (2016). The sociology of childbirth: an autobiographical journey through four decades of research. *Sociology of Health & Illness*, *38*(5), 689–705. https://doi.org/10.1111/1467-9566.12400

Pintassilgo, S., & Carvalho, H. (2017). Trends and consequences of the technocratic paradigm of childbirth in Portugal: A population-based analysis of birth conditions and social characteristics of parents. *Sexual & Reproductive Healthcare*, *13*, 58–67. https://doi.org/10.1016/j.srhc.2017.06.003

Rothman, B. K. (1982). *In labour: women and power in the birth place*. London: Junction Books.

Santos, M. (2012). *Nascer em casa: a desinstitucionalização reflexiva do parto no contexto português* (Marter's thesis, ISCTE-IUL, Portugal). Retrieved from http://repositorio-iul.iscte.pt/handle/10071/4684

Segal, S. (2007). The masculinization project of hospital birth practices and Hollywood comedies. *ESharp*, (9), 1–18. Retrieved from https://www.gla.ac.uk/media/media_41220_en.pdf

Sjöblom, I., Lundgren, I., Idvall, E., & Lindgren, H. (2015). Being a homebirth midwife in the Nordic countries – a phenomenological study. *Sexual & Reproductive Healthcare*, *6*(3), 126–131. https://doi.org/10.1016/j.srhc.2015.02.004

West, C., & Zimmerman, D. H. (1987). Doing gender. *Gender & Society*, *1*(2), 125–151. Retrieved from http://links.jstor.org/sici?sici=0891-2432%28198706%291%3A2%3C125%3ADG%3E2.0.CO%3B2-W

Wodak, R. (1997). Introduction: Some important issues in the research of gender and discourse. In R. Wodak (Ed.), *Gender and Discourse* (pp. 1–20). London: Sage.

5. A CRITICAL ANALYSIS OF THE ORGANISATION OF HOME BIRTH CARE IN PORTUGAL: REGULATIONS, LIMITATIONS, AND RECOMMENDATIONS FOR CHANGE

In Portugal, the hospital is the only publicly funded, legally defined, and adequately regulated place of birth. Home births are only available as a privately funded and loosely regulated option, and little is known about how in fact it is offered and practiced. In this essay[13], we aim to map and critically analyse the organisation of home birth care, in Portugal. We look at the macro, meso, and micro level of this organisation, discussing the available regulations and the room for further regulation, and examining the different modalities of caregiving and their limitations. Based on this analysis, we propose a set of recommendations which can be used as a ground for social and political discussion, and for triggering national-level policy change.

5.1. INTRODUCTION

There are striking differences in Europe regarding the availability, the accessibility, and the formal status of different places of birth – obstetric-led hospital, midwifery-led unit, or home. In Denmark, Iceland, the United Kingdom, the Netherlands, and in few other parts of Europe, women are offered the possibility of having a publicly funded, midwife-attended home birth. In other countries or regions, there are total or partial reimbursement schemes for women who decide to have a home birth. However, in most European countries – namely Portugal – the hospital is the only publicly funded, legally defined, and adequately regulated place of birth. In most countries, home births are only available as a privately funded and loosely regulated option. In some countries, particularly in Eastern Europe, attending out-of-hospital

[13] This essay benefited from the contributions of Amélia Augusto and Jette Aaroe Clausen, and an edited version was submitted for publication in the form of an article in the journal *Social Science and Medicine*.

births may be considered illegal, and women who plan a home birth may have to decide between an unassisted home birth, associated with increased risks (Feeley & Thomson, 2016; Loughney, Collis, & Dastgir, 2006; McLelland, McKenna, Morgans, & Smith, 2018), or a safer, yet illegal midwife-attended birth at home.

A complete mapping of the European social and legal scenario regarding these different places of birth remains to be done. The available statistical data reveals the rareness of out-of-hospital birth across Europe: in 2010[14], most countries had home birth rates of less than 1% (Euro-Peristat, 2013). Few countries showed higher rates, namely the Netherlands, the United Kingdom, Denmark, Iceland, and Austria; yet home was always the least frequent place of birth. These data must be read and analysed beyond numeral differences. Statistical data, even if drawn from official records, are not immune to criticism. Most likely, the majority of the country-level official statistics does not differentiate between planned and accidental home birth, or between planned hospital birth and those who were planned to happen at home but were later transferred. There is little systematised and differentiated data regarding the type of professional attendance in these reported home births in Europe. Serious concerns should be raised regarding the reliability of these data, overall, given the likelihood of under or misreporting.

Moreover, these differences between European countries represent more than regional patterns in the option of place of birth. They also reflect the unequal access to quality maternity care across Europe. The circumscription of home birth care to the private sector found in most countries raises relevant access inequalities, as not all families would be able to afford the out-of-pocket costs; and the widespread absence of consensus, specific regulation, or guidelines prevents the adequate assessment of the quality of care in home births (Santos, 2018a).

It also remains unclear whether or not women in Europe have the right to opt for a home birth. European countries do share a common legal framework drawn from the European Convention on Human Rights (Council of Europe, 2010) and, in this regard, the case of Ternovszky v. Hungary was a landmark. In this case, the European Court of Human

[14] The most recent data is from 2010. The Euro-Peristat Project issued a new report with data from 2015 (Euro-Peristat, 2018), but place of birth was not part of the published analysis.

Rights recognised that, under article 8 of this convention, “the circumstances of giving birth incontestably form part of one's private life”, and that domestic “legislation which arguably dissuades such professionals who might otherwise be willing from providing the requisite assistance [in a home birth] constitutes an interference with the exercise of the right to respect for private life by prospective mothers”; but it also stated that “the right to choice in matters of child delivery includes the legal certainty that the choice is lawful and not subject to sanctions, directly or indirectly” (European Court of Human Rights, 2011, pp. 7–8). Hence, women have the right to decide where to give birth, as long as this option is legally defined. This is an important remark, as this ruling should not be interpreted as a recognition of a universal right, in Europe, to choose a planned and assisted home birth (Leeuwen, 2015). In fact, in the following cases of Dubská and Krejzová v. the Czech Republic, the Court considered the Czech law, which forbids the delivery of health care at birth outside a medical institution, did not collide with article 8 of the Convention (European Court of Human Rights, 2014). There was an interference with these women’s right to private life, but this interference was considered to be rightful, as it was in accordance with the domestic law. Women may have the right to give birth at home, but not necessarily to a planned, professionally supported – and thus potentially safer – home birth. Women’s rights thus vary across Europe, according to the frequently biased and ill-supported legal framework of maternity care of the country they live in.

Not only place of birth, but the organisation of care, in general, varies considerably across Europe, making visible how little evidence-based recommendations have been translated into European maternity care (Euro-Peristat, 2013). Unsurprisingly, given this wide variation in the organisation of childbirth care between countries, several cross-border movements of women and midwives have been reported, when women face hindrances to what they believe is adequate quality maternity care, and when midwives are discouraged from delivering midwifery care at home (Pařízková & Clausen, 2018). Europe’s low rates of neonatal, infant, and maternal mortality may stand as a good example, globally (Euro-Peristat, 2018); yet, the persisting use of intrapartum clinical interventions without clear indication frequently undermines women’s agency and self-determination, with a potential

negative impact in their childbirth experience and their health (World Health Organization, 2018).

The pathogenic approach to childbirth currently existing in most societies has roots in the trend of childbirth hospitalisation that took place throughout the twentieth century. Accounts on the early history of obstetrics commonly address the high rates of maternal and perinatal death as the main trigger for the medicalisation and hospitalisation of the physiological processes surrounding labour and birth when, in fact, today's lower rates of perinatal mortality have been the result of a set of factors which generally improved the health and quality of care for women and babies (Cahill, 2001; Santos, 2012). Indeed, mortality rates dropped together with the hospitalisation process, but a closer look reveals how it was not the place of birth but the quality of the staff that mattered the most when comparing standards of maternity care (Loudon, 1992), and the same can surely be observed today (Davis & Homer, 2016). In the early periods of the hospitalisation process in Europe, it was not uncommon to find higher mortality rates associated with hospital births, when compared to home births (Loudon, 1992).

Unlike other cases in the history of medicine, in maternity care it was not the existence of a more effective technology that outdated or extinguish the use of the other. Community midwives were set aside without any evidence that the assistance provided by hospital obstetricians was more effective, or more advanced, or safest (Rothman, 1982). Yet, the growing authority and public legitimacy of medicine offered a privileged position to obstetricians. Medicine progressively replaced other institutions in the social definition of morality (Lupton, 1994), and thus the hospital came to be represented not only as the safest place, but as the right place to give birth. The dominance of the hospital staff over the physiological processes of labour and birth became naturalised, even when configuring experiences that could otherwise be perceived as violent by birthing women (Sadler et al., 2016).

5.1.1. PLACE OF BIRTH IN PORTUGAL

Compared to other countries, Portugal had a late childbirth hospitalisation movement. In 1960, approximately 80% of all births still happened at home, but in 1985, home births were already rare (Santos, 2018a). In the early 20th century, when the first maternity wards were created in the three main Portuguese cities, the hospital was not consensually considered the most adequate place to give birth, even among medical doctors. As in other European countries, the perinatal health outcomes early associated with hospital births were generally poorer than those associated with home births; thus, many doctors advocated for improving the quality of childbirth care at home, instead of promoting the hospital (Baptista, 2016). By then, while some home births had the professional assistance of a midwife or a doctor, many were informally attended by lay midwives or by older and experienced female relatives or neighbours (Carneiro, 2008). In fact, the high rates of home births were also sustained by a prevalent moral belief – subscribed and promoted by the state – that (birthing) women should stay at home with their family (Baptista, 2016; Carneiro, 2008). Approximately until the mid-20th century, most pregnant women had little or no antenatal care, and hospital wards for maternity care were mostly dedicated to the care of unprivileged women from urban areas (Carneiro, 2008).

Particularly from the 1950's onward, the criticism over the poor organisation of maternity care in the country grew, fuelled by the persisting high rates of infant and maternal mortality. Obstetricians and nurse-midwives, both with a hospital-based training and experience, had achieved important improvements in the development and establishment of their professions, but attended only a minority of all births. It seems fair to estimate that, by then, the majority of women still gave birth with no professional assistance, even in major urban centres (Carneiro, 2008). This ultimately led to reframing the organisation of maternity care, slowly making antenatal and intrapartum care available for all women, placing childbirth, even if unproblematic, under the control of medicine, and inscribing the hospital as the safest place to give birth. The rapid decrease of infant mortality rates following the mainstreaming of childbirth hospitalisation legitimised and reinforced the general acceptance of the hospital management of childbirth, and definitely outcasted home births and home

birth carers. The hospital represented the modern solution, the future; while home birth symbolically represented the memory of an underdeveloped past (Fedele & Guignard, 2018; Santos, 2017; Vallgårda, 2012).

It seems important to highlight that, as in other countries, many factors beyond the hospitalisation may have contributed to improving perinatal outcomes: the end of the Portuguese dictatorship in 1974 made way for higher literacy levels, better health services, better and universal access to antenatal care, to water, to electricity, and to information, which have certainly influenced the overall decrease in maternal and infant mortality rates. Yet, the recent memory of this association between the improvement in perinatal outcomes and the increasing rate of hospital births contributed to the fact that the rhetoric of "the hospital as the unquestionably safest place to give birth" is still well present today in Portuguese maternity care (Santos, 2018a). Contemporary planned home births in Portugal are a very distinct phenomenon from the mid-20th century home births, in terms of the sociodemographic characteristics of parents (Pintassilgo & Carvalho, 2017), their motivations and their use of technologies (Santos & Augusto, 2016) and in terms of the knowledge and training of the professionals involved (cf. chapter 3), yet this option is still condemned by many today under the belief that it will bring back the rural, poor, underdeveloped, and unwanted past, strongly increasing maternal and perinatal mortality, and undoing the progresses made in terms of maternal and child care (Rocha, 2016; Santos, 2014b).

Internationally, there are settings where contemporary home births are as safe or safer that hospital births, as England or the Netherlands (Birthplace in England Collaborative Group, 2011; De Jonge et al., 2015; De Jonge et al., 2013) and others where they represent an increased risk, as the United States of America. Snowden et al. (2015, p. 2652), whose research on planned out-of-hospital birth in the United States found lower risks of perinatal death and other adverse neonatal outcomes with planned in-hospital births, note how:

> [t]he extent to which midwifery is integrated into a health care system probably explains some of the differences in practice and outcomes reported in U.S. and European studies. For example, the Dutch home-birth system (in which home birth is common and adverse outcomes are rare) includes formal collaborative agreements between out-of-hospital and in-

hospital providers, clear and mutually agreed-upon stratification of risk, and protocols for the transfer of care.

There is, however, no evidence to support any claims on the safety of home vs hospital births in Portugal and, as such, there is no scientific reason to limit women's choice of place of birth. As in other countries in Europe, the statistical data obtained from official sources does not distinguishes between planned or unplanned home or hospital births, and there are additional issues related with mis and underreporting, making any population-based study on these matters challenging, if not impossible. Also, the modes of organisation applied to contemporary home birth care are generally invisible to the general population, to the regulatory bodies, and to the government, limiting the scope of any public debate on these matters, which is frequently anchored in prejudice and personal opinions, rather than in science (Santos, 2014b).

In this article, we aim to map and critically analyse the organisation of home birth care, in Portugal. We look at the macro, meso, and micro level of this organisation, discussing the available regulations and the room for further regulation, and examining the different modalities of caregiving and their limitations. Based on this analysis, we propose a set of recommendations which can be used as a ground for social and political discussion, and for triggering national-level policy change.

5.2. METHODS

This article reports findings drawn from a wider research project focused on the intra and interprofessional dynamics among Portuguese home births practitioners – mostly midwives and doulas, on their relationship with women and families, and on the overall landscape of home birth assistance in Portugal. Looking at such a moving and disperse object, filled with invisibilities and informality, demanded a creative approach and a high level of personal engagement. Ethnography was elected as the most adequate strategy for producing meaningful data. A preceding study on Portuguese women's experience with home birth,

based on in-dept interviews (Santos, 2012), helped gaining familiarity with the field and laid the first stones for the following project. Still, entering the field and performing an ethnography in such specific settings required time, particularly in the first stages. Initially, fieldwork was carried mainly in formal and structured contexts, and complemented with 20 semi-structured interviews to home birth practitioners. Only at an advanced stage accessing intimate settings – such as midwifery consultations, doula sessions, and births at home – became more common.

For the purpose of this study, we adopted a wide-encompassing concept of home birth, acknowledging that, as a social phenomenon, it is more than the moment when a baby is born at home. Home births extend to several contexts surrounding the moment of birth, such as, more strictly, the antenatal care with a midwife and the doula sessions, but also, more broadly, group meetings or scientific events on home or natural childbirth, doula courses, informal training sessions in obstetric emergencies for midwives, activities organised by activist groups, information disseminated by the media, and online interactions on this topic. Instead of relying on a lengthy stay in a circumscribed setting, this multi-sited ethnography was the result of a permanent navigation in and between different settings, searching for the specific features of each context, while reflecting on the commonalities and the links between each social actor (Hannerz, 2003; Marcus, 1995).

Data production was carried by M. S. between October 2015 and December 2018. Interviews were conducted to 13 home birth midwives, 1 birth photographer, and 6 doulas, 3 of which regularly organised doula courses. These interviews had an average length of 96 minutes, were recorded, and verbatim transcribed. Fieldwork included a total of two 120-hour doula courses, 27 midwifery consultations, 15 doula sessions, and 8 home births, apart from numerous informal encounters in different contexts. Fieldnotes and verbatim transcripts were analysed assisted by the software MaxQDA, version 12, using an inductive, thematic analysis framework. Several themes emerged, and those related with organisational aspects of home birth care were drawn to the following discussion. All quotations, originally in Portuguese, were translated to English by the authors.

This project was further complemented with two short-term scientific missions, in which the Portuguese organisational features of home births were compared with those in

Denmark, in 2014 (reported in Santos, 2018a), and in Israel, in 2017 (reported in Santos, 2018b). The findings from these comparative analyses are not directly brought to the present discussion, yet they made visible some aspects of the organisation of home birth care in Portugal that would otherwise be unnoticed, had we limited our approach to the national context throughout the project.

5.3. FINDINGS AND DISCUSSION

5.3.1. FORMAL ASPECTS OF HOME BIRTH CARE

Having or attending a home birth in Portugal is legal, or at least is not clearly illegal. There is no legislation that specifically addresses the option or the practice of home birth care. Law 15/2014 generically defines that "each health services user has the right to choose the services and the care providers, within the available resources"[15], but so far this has had little or no practical translation to home birth care. Home birth is an option only available if privately funded, paid out-of-pocket by families. Some families with a private health insurance that covers "nursing care at home" have successfully claimed a partial reimbursement of their expenses, but there are no insurances clearly covering home birth care. Having home births as part of the National Health Service seems too far in the horizon, yet. With the Circular 7495/2006, the then Minister of Health determined "the enshrinement of the right of each woman to freely choose the place where she wishes to give birth to her children with conditions of better quality for mother and child"[16]. However, it is not clear if home birth could be considered under a strict interpretation of this Circular. It was published as part of the widely contested 2006-2007 national initiative for the centralisation of maternity

[15] Law nr. 15/2014 consolidates the legislation in respect to the rights and duties of health services users. Available at: https://data.dre.pt/eli/lei/15/2014/03/21/p/dre/pt/html

[16] Order nr. 7495/2006 defines the reorganisation of the national network of hospitals with labour and delivery wards, centralising the public provision of childbirth care in maternity units with larger volumes of deliveries. Available at: https://dre.pt/application/conteudo/958060

care, which encompassed the closing of public maternity units with less than 1500 births per year to safeguard adequate levels of professional experience and expertise, but inevitably reinforcing regional disparities (Matos, 2010). The text of this Circular highlights the progresses made in the improvement of perinatal outcomes through hospital care and, as such, it conveys the notion of the hospital as the only legitimate place of birth. This right for women to choose the place where they give birth can be read here as their right to choose *in which hospital* to give birth, although this is never clearly stated.

This legal void is not casual. The existing hospital-centred Portuguese network of maternity care clearly stems from a conservative ideology of pregnancy as eminently pathological, rooted in the rhetoric of the hospital as warrant of safe and high-quality maternity care. Yet, even more progressive legislative initiatives – namely, the recently published Law 110/2019[17] – do not mention the option for a planned home birth. In this law, despite the fact that some of its proponents acknowledge the relevance of stating the right of women to choose a home birth, this was left out of the proposal fearing that it could ignite too many disagreements and jeopardise the law's approval in the parliament (Member of the Portuguese Parliament, personal communication, December, 2018). Portuguese policy-makers seem underprepared for discussing the issue of home birth.

A similar situation is found at the meso level, in terms of professional regulation and guidance. There are no formal guidelines addressing home birth practice, neither issued by Portuguese health authorities, nor by professional regulatory organisations. In March 2012, following an interdisciplinary initiative aiming at defining a national consensus on "the right to a normal birth", both professional regulatory organisations – the Order of Nurses[18] and the Order of Doctors – engaged in a public debate on the legitimacy of home births and the professional authority over physiological labour and birth. The College of Gynaecology and

[17] *Lei 110/2019*, DR I série N.º 172/XIII/4 (pp. 94-101). This law defines a new provision for the legal protection of families in preconception, assisted reproductive technologies, pregnancy, childbirth, and postpartum. Available at https://data.dre.pt/eli/lei/110/2019/09/09/p/dre

[18] In Portugal, the professions of nurse, midwife, and nurse-midwife are regulated by the Order of Nurses. Nurse-midwives more commonly identify as specialised nurses in maternal health and obstetrics, and not that much as midwives (*parteira/o*, in Portuguese). This probably has roots in the need of distinguishing certified and formally trained nurse-midwives from lay midwives, when formal training for midwives became available (on this subject, see chapter 2).

Obstetrics, the College of Paediatrics, and the College of Neonatology of the Order of Doctors released one statement each, declaring they did not recognise the competence of nurse-midwives as autonomous practitioners in antenatal and intrapartum care, even in low-risk pregnancies (Ordem dos Médicos, 2012). The Order of Nurses replied, denying any campaign for home births from their behalf, and clarifying that nurses and midwives do not practice under medical supervision since 1996; that nurse-midwives are the best qualified professionals for attending normal birth; and that women in Portugal can chose the place of birth for their children, including at home (Ordem dos Enfermeiros, 2012b). We had no access to early versions of the consensus document on "the right to normal births", but the final version was published in May 2012 without any reference to home births (Leite, 2012).

Even after this debate, no concrete guidelines were issued, nor was there any initiative from the General Inspection of Health Activities to survey the practice of home births practitioners, as suggested by the Order of Doctors. However, the Order of Nurses issued a 2-page document with a set of recommendations for families planning a home birth, but with no reference to any evidence that could support these recommendations (Ordem dos Enfermeiros, 2012a, p. 2, our emphasis):

> The college of the Nursing Specialty in Maternal Health and Obstetrics of the Order of Nurses recommends that […] the pregnant couples who definitely wish for a home birth *should prepare it in a safe and responsible way*, guaranteeing that:
>
> 1) The health status of mother/baby follow *all basic security criteria* – healthy pregnancy with 37 to 42 weeks, spontaneous onset of labour, and maternal/foetal wellbeing on the onset of labour.
> 2) They choose the *adequate* health professional. […]
> 3) The chosen health professionals support their intervention in a philosophy of care that respects the physiological process of birth and that, regarding labour at home, they follow the *criteria for transferring* to the closest hospital, and the College thus recommends that:
>
> - The health professional does not work alone, we advise having other health professional present. […]

This document points to the families' responsibility – rather than to the professionals – in ensuring they have the adequate set of human and physical resources when planning a home birth. It is not clear if families are able to assess the pregnant woman's health status, or to guarantee that the professionals they hire follow the criteria for transferring. It is even less clear if such role should be expected from the families. Plus, none of the criteria mentioned is clearly stated, nor is there any reference to which these criteria should be. Being the Order of Nurses the professional regulatory body for nurses and midwives, it seems fair to expect a greater level of involvement in the definition of these criteria, and a commitment to the assessment of the quality of care delivered by these professionals. Yet, this document seems more part of a reaction to the debate with the Order of Doctors than a pondered, robust contribution for improving this field of practice. Home births, as a contemporary social phenomenon, remained largely undebated in this process. And with the absence of specific professional guidance, the liberal practice of those who attend home births stayed mostly invisible, underdiscussed, and poorly assessed.

In fact, in Portugal, the practices of different health professionals in home births vary greatly, e.g. in terms of the minimum number of antenatal and postpartum appointments, the clinical records, the material used, or the interventions carried at home, etc. Actually, in many other scenarios of health care, even those where clinical guidelines are available, the practice of different professionals may also vary immensely. Nevertheless, ideally, this variation should be predominantly a result of the professional's respect for the changing needs and preferences of health services' users (Krumholz, 2013), and not a sign of the prevalence of non-evidence-based practices, which abound in maternity care worldwide (S. Miller et al., 2016; Sadler et al., 2016). Setting standards for high-quality decisions and developing strategies to assess the quality of decisions seems to be key for improving care and for moving towards a user-centred framework (Krumholz, 2013). Home births, however, being mostly invisible and underdiscussed, escape this exercise of a serious, unbiased, evidence-based assessment.

But if there is unpreparedness and inertia among policymakers and professional regulatory bodies to discuss and develop further guidance for the practice of home birth care, among home birth practitioners there are concerns regarding the likely negative impacts of

such initiatives. When interviewing home birth practitioners and discussing the possibility of developing specific regulation and guidelines for home birth practice, some believed there was no need to further regulate the practice of midwives at home, as the available regulation is broad but sensitive enough to encompass all work settings of nurse-midwives:

> From my point of view, there is a lot of confusion regarding the [need for further] regulation. Because our profession is regulated. What do people want to regulate? For example, the transfer criteria? It could be good or bad. […] So, it depends of what we are talking about when we discuss regulation. If [it would say that] home birth has to have always a nurse-midwife or a doctor, it says that already, because those are the ones who can attend births. What more would we regulate? (Tânia, midwife)

In other settings, having a specific regulation for home births has been recognised as a hindrance to women's rights in childbirth. In Israel, the need of developing a guideline for home birth practice was fostered by the professional representative of home birth professionals and the guideline was designed with the participation of some of its members; still, it is now acknowledged that it narrowed the autonomous scope of practice of home birth professionals and overly limited the eligibility for women to have a home birth (Santos, 2018b). Likewise, many of the Portuguese professionals interviewed shared the same concerns. There was a common fear that further regulation or guidance could be developed based on prejudice instead of reason and scientific evidence:

> Regulation, yes, of course, as long as they do it properly. All right, I think it's great. But I have some fear of what can be expected in terms of regulation with the context we have. People don't even know what a home birth is, so how will we regulate home birth? (Cristiana, doula)

> Having protocols and having everything very explicit is great, but it could perhaps limit us too much. It had to be really well done, we couldn't leave this at the discretion of the Order of Doctors, for example. I think it would have to be something really well done, but that could in a way safeguard ourselves. It is really good to have protocols that can offer us some guidance,

> but it is also true that if things don't go according to the protocol we could be blamed or something. (Núria, midwife)

> The issue with regulation is a two-edged sword, right? I see countries where from the moment when they regulated, home births were over. We must be careful with what we wish for. (Olga, midwife)

This same fear of liability has inhibited practitioners in other countries in Europe to enable the choice of a planned, midwife-attended home birth to women. Following the case of Ternovszky v. Hungary at the European Court of Human Rights, a new system of licences for home birth midwives was implemented in Hungary but, in fact, it took almost one year until the first licence was issued, given the fear of litigation and biased judgement (Fábián, 2013; Santos, 2014a).

In fact, it is debatable if the possible/potential limitations imposed by a guideline or by specific regulation are more serious than this risk of misjudgement in the case of litigation. In the absence of specific standards for assessing and judging home birth practices, the standards used will inevitably be those of the hospital. In 2016, a Portuguese nurse-midwife was sentenced to two years and four months imprisonment for her malpractice in home births, which included the death of a newborn in 2012. This was a controversial process, dividing opinions even among those who actively advocated for the right to give birth at home. Without questioning the rightfulness of this sentence, we argue that a similar case of negligence could have been carried differently if the malpractice had taken place at the hospital. This case was clearly surrounded by the pervasive prejudice towards home birth families and professionals. According to the media, the judge declared on trial that "it is a dangerous trend to compare the humanisation of birth to a home birth; it is primitive" and "it endangers the right to life" (Simões, 2016).

There are also issues of uneven professional powers between obstetricians and nurse-midwives that must be considered. It is fair to presume that any court ruling and any policy-making today will likely be biased by the hegemonic position of obstetrics in Portuguese maternity care (Pintassilgo & Carvalho, 2017) and the devaluing and

unappreciation of the specific knowledge held by home birth practitioners concerning the models, the practices, and the evidence behind childbirth at home (Cheyney, 2008; Davis-Floyd & Davis, 1996). It thus seems critical that future efforts for developing guidelines and regulation on home births involve the direct and effective participation of users, home birth practitioners, and academics.

5.3.2. ORGANISATION OF HOME BIRTH CARE

In Portugal, the organisation of home birth care is diverse and has been changing during the past few years. The number of professionals regularly attending home births has been rising, as well as the number of those who publicly disclose their identity as home birth practitioners (e.g. on the internet)[19]. However, it was not possible to accurately define the number of active professionals in the country: some websites list between 11 and 15 professionals; yet there are lists passed from hand to hand (mostly by doulas) with more names; and there are other professionals that only get known by word of mouth. The majority combines their independent practice at home with a more secure job at a hospital labour ward, a health centre, or a private clinic. Most are nurse-midwives, few are direct-entry midwives who graduated abroad, and there is a small number of doctors who also attend home births occasionally, alone or teamed up with a midwife.

There are regional disparities, as the distribution of care is dependant of the geographical coverage of privately practicing professionals. Most professionals are located in the western coast of the country, and in the larger metropolitan areas, such as Lisbon and Porto. There are professionals in other areas, but together they do not cover the entire national territory. Yet, many of these professionals have wide geographical coverage, and some are willing to travel 200km or 2 hours to attend a home birth. In exceptional cases, some professionals accepted caring for families who live 3 hours way, offering both antenatal

[19] The development of the professional identity of home birth midwives, their growing willingness to publicly disclose their identity and the social factors behind it were further analysed in chapter 3.

and intrapartum care. Other professionals define smaller areas, circumscribed to the region where they live.

When this research project began, in 2012, most home birth midwives worked alone, eventually backed up by a second midwife who could replace them, for example, in case they had two women in labour at the same time. In 2018, most midwives already worked in pairs or expressed their intention to do so. Several factors contributed to this change. Despite not standing as a guideline, the information for women and couples issued by the Order of Nurses, recommending families to hire two nurse-midwives instead of just one (Ordem dos Enfermeiros, 2012a), was taken by some practitioners as a professional recommendation. But the media attention that surrounded home births along with the process of the nurse-midwife later sentenced to two years and four months imprisonment for malpractice also contributed to increase the fear of liability among home birth practitioners. Stressing that "two heads are better than one", teaming up with a colleague was also a strategy to deal with uncertainty:

> [I] have been searching for this partner, because for me it makes sense to work in pairs at home, for every reason, either because it is important to have someone there who knows what to do to support you if there are complications; because if you are alone you have to make choices and everything is slower… Anyway. Also, legally, if there is something... If someone sues you and calls you into question, [it is better if] you have someone with you who confirms, or not, what you are saying. (Isa, midwife)

Finding a partner is not straightforward, particularly for those who practiced alone for several years and only later tried building a team. Most independent nurse-midwives had a very personal definition of their practice, built in reaction to mainstream hospital care, as outsiders. In many cases, this was a lonely journey. As such, going beyond occasional partnerships and establishing a permanent team was not a merely pragmatic move. Geographical proximity, for example, was not of key importance. Instead, interpersonal coherence, shared beliefs, and practicing under the same model and philosophy were the primary requisites for collaboration:

> I was always alone, working alone and then… […] for example, [midwife] invited me to work with her. I don't know, I worked with her once, but… I don't know. I would like to work with someone. At this stage, that flows, where things flow. And I still don't feel that it's the time to work with [midwife]. I once worked with her, but I don't feel, I didn't feel it flowing. I don't want to work like that, see, I prefer to work alone. (Júlia, midwife)

The same rationale applies to any networking initiatives between home birth midwives. They recognised the benefits of having a wider group or a community of practice, where home birth midwives could share resources and reflect upon specific clinical cases. But some of the attempts to create a network have either failed or waned with time due to the lack of consensus:

> [Y]ears ago there was an attempt to create a working-group of midwives, for home birth, but then there clearly wasn't a common goal. [Midwife] wanted to do a school for midwives, the rest wanted to make an association, and we ended up having several meetings but each one then ended up going on with their life. (Júlia, midwife)

With the precarious position of home birth midwifery, given the prejudice they face and the lack of specific professional guidance, having a community of practice could positively impact on the quality of care and on their own wellbeing (McCourt, Rayment, Rance, & Sandall, 2012). One midwife describes her experience with a then recently created group:

> Right now, we have a group of midwives from several parts of the country and we try to do a bit of that [sharing]. Really informally, but "there is this situation, what do you think?" and everyone sends what they have, the research they have, the evidence they have, the experiences they have and, well, this exchange is interesting and we are trying to, in this group, to have a bit of… let's see if we can make some protocols. (Paula, midwife)

Although discrete, these signs of further institutionalisation – formal documents issued by professional regulatory bodies, the establishment of teams, and the tentative creation of communities of practice – reflect a shift in the organisational paradigm of home birth in Portugal in the past few years. Yet, considering the Portuguese scenario described in the previous section, an initiative to further integrate home births in the National Health Service in Portugal still seems too far in the distance.

Integrating home birth care into the Portuguese health care system is likely to contribute to its safety (Campbell, Carson, Azzam, & Hutton, 2019; Olsen & Clausen, 2012, Quattrocchi, 2014; Snowden et al., 2015), as it improves the quality of communications between home and hospital practitioners, it promotes timely emergency transport, it increases the continuity of care, and it reduces access inequalities caused by financial constraints. Instead of questioning the safety of home births, efforts should be made to question how to integrate home births in order to make them safer. A recent guideline from the Society of Obstetricians and Gynaecologists of Canada (Campbell et al., 2019, p. 225) stresses that:

> [T]he data indicate that individuals at low risk for poor perinatal outcomes who plan homebirth with a regulated provider in an integrated health care system may have improved obstetric outcomes without increased neonatal morbidity or mortality. […] In Canada, homebirth with a registered midwife or an appropriately trained physician is a reasonable choice for those who are evaluated to be at lower risk of obstetric or neonatal complications.

Despite recognising many of the potential advantages of having publicly-funded home births, many home birth practitioners are themselves sceptical about the unintended consequences of integrating home birth care in the National Health Service, both for women and for nurse-midwives. Firstly, such an organisation of home birth care raises broader issues that have to do with the fragile position of nursing in health care (Carpenter, 1993; Hugman, 1991; Lopes, 2001) which, in Portugal, is inextricable linked to midwifery. Some of the home birth nurse-midwives interviewed accounted for the added level of responsibility and the higher risk of liability in home births, which would be difficult to accept given the precarious position and the low wage of nurse-midwives in publicly-funded hospitals:

> [In a privately-funded home birth] the value may be high for those who pay, but for those who deliver the service, with all that it involves, it isn't. In the National Health Service, what happens is that we, nurse-midwives, are still poorly paid. Me, for example, with 20 years' experience, I have the same salary as a generalist nurse who starts working today. And now, asking me to attend at home with this salary […], the base monthly salary is so low that I wouldn't do it. I was never in this for money, but there are limits. We are really poorly paid. (Tânia, midwife)

Indeed, transitioning to publicly-funded home births is likely to have a negative financial impact for privately practising midwives, at the same time as it may not fully cover the same area nor provide the same services; yet, there is no reason why both public and private practices cannot coexist (Catling-Paull, Foureur, & Homer, 2012), analogously to what happens in institutional birth care and in other areas of healthcare.

Other interviewees stressed the general unpreparedness of most Portuguese nurse-midwives to attend and promote physiological labour and birth at home:

> Everyone talks about regulation, but what's the use of having a regulation if people don't have the skills? Imagine that we would now have the health minister [saying]: "ah, let's cut the costs in here" and they start placing all nurse[-midwives] on home births. My God! Panic! Scary. Scary. What's the regulation for if we don't have the basis? (Cristiana, doula)

In fact, one of the most common features among Portuguese home birth nurse-midwives is the recognition of how ill-prepared to attend physiological and home births they are after completing the officially-required midwifery training (as developed in chapter 3). All of the nurse-midwives interviewed complemented their training with some sort of course, many of them abroad, before they felt they could regularly and autonomously attend home births. Likewise, in the United Kingdom, where the National Health Service has to provide home birth care to those who request it, some midwives lacked confidence to offer home birth care, and some women reported being indirectly discouraged to plan a home birth by

their own midwife (McCourt et al., 2012). In Denmark, in regions where publicly-funded home birth care if offered by hospital-based midwives, the rates of home births tend to be lower and the rates of hospital transfers tend to be higher, compared with the region of Sjælland where midwives are fully dedicated to home birth (Santos, 2018a). Looking at other settings, we find anecdotal evidence [20] that, despite the opportunity of having publicly-funded midwifery care at home, some women continued to prefer paying out-of-pocket to independent midwives, given their motivations, their preparedness to attend physiological labour and birth, their models of care, and their inclusion criteria. In these cases, women and families seemed to acknowledge and value the differences between the practices of independent home birth midwives and hospital-based midwives.

On the other hand, there are also circumstances where this integration in the health system was positive. In Australia, despite the initial apprehension of some midwives in delivering publicly-funded home birth care, particularly those who had never been exposed to home births, they later recognised feeling reassured and transformed through their practice at home, "seeing birth in a new light" (Coddington et al., 2017, p. 73). In the public hospitals of four of the five regions in Denmark (Lindgren, Kjaergaard, Olafsdottir, & Blix, 2014) and in the Emilia Romagna region in Italy (Quattrocchi, 2014), having at least one midwife per shift in the labour ward who is designated to attend any eventual home birth in the area has also been the basis for a successful scheme, with clear advantages compared with solely having private home birth care. The equipment and medication are taken from the hospital, simplifying the management of midwives' independent practice. Also, these midwives experienced a continuous exposure to both low and high-risk pregnancies, and had better communication channels with the hospital team, which may be viewed as positive.

[20] In some of the Italian regions where publicly-funded schemes were sustained or developed, the inclusion criteria were criticised for being too narrow, leaving too many otherwise eligible women out (A. M. Rossetti, personal communication, May, 2017; E. Skoko, personal communication, September, 2016). In Denmark, Susanne Houd reported how she established a very successful private midwifery practice in Copenhagen, in 1988, despite the possibility of having midwifery care free of charge through the public health system. She highlights that, when opting for the public system, women knew they could get someone with no experience of home birth or even someone who is opposed to it, so they preferred an experienced yet private midwife (Santos, 2017).

5.3.3. EXPERIENCING UNCERTAINTY

When home births are unregulated and circumscribed to the private sector, instead of integrated in the broader health system, this leaves room for ambiguity. If this may foster an unconstrained and thus potentially more complete exercise of midwives' formally defined autonomous scope of practice (Santos, 2018b), there are also grey areas and uncertainties that hinder optimal home birth care and that would be difficult to resolve unless home births are, in fact, further integrated in the health system and/or regulated. Of these, some impact directly on the experience of home birth practitioners, indirectly affecting women and families; others affect women's childbirth experience more directly.

The issue with the acquisition of equipment and pharmacotherapy by independent health professionals is one of the most relevant. Although clinical consumable items, medication, and oxygen are not routinely used in home births, it is rather consensual that professionals should have it, in case of need. Yet, gaining access to them may be challenging. Being part of a group or having a community of practice was pointed out by some of the midwives interviewed as a facilitator, given that, in some cases, these items are only available to independent practitioners when bought in bulk. But purchasing medication poses additional difficulties. Unlike Portugal, it is part of the midwives' independent scope of practice in Denmark to obtain, from a pharmacy, an injectable local anaesthetic to administer if suturing is needed, a uterotonic to stimulate the contraction of the uterus if there are signs of postpartum haemorrhage, and vitamin K to the prevention of the haemorrhagic disease of the newborn – not having this material would be considered malpractice (Santos, 2018a). In Portugal, the Order of Nurses recognises the right of nurses (and, consequently, nurse-midwives) to autonomously prescribe and administer medication in case of an emergency (Ordem dos Enfermeiros, 2009). However, independent health professionals – e.g. nurses, midwives, but also medical doctors and dentists – are not allowed the direct procurement of medication for human use, in accordance with the Decree-Law 176/2006 (Ministério da Saúde, 2006). As such, home birth professionals can administer medication, should have it in case of an emergency, but are not entitled to buy it. This Decree-Law allows exceptions for

cases where there are well-founded public health reasons or to allow the normal exercise of a given activity, but the criteria for the evaluation of permit requests, if any, are not publicly available. To our knowledge, no request was made with the purpose of supplying home birth practice. Among the midwives interviewed, there was no knowledge or experience regarding this legal exception or its applicability to independent health professionals attending home births.

Additionally, there are different views in regard to what should be considered essential equipment and medication for home birth care. Different professionals compile different sets of material to take with them to a home birth, according with their training, their skills, and their experience. Without a formal definition of what is adequate, any outside and potentially misinformed judgment would only arbitrarily assess the appropriateness of a given set of material. Portuguese press articles on home births have described a Pinard foetal stethoscope as a very rudimentary kind of horn[21], although this is common clinical devise; and not having an oximeter at a home birth has been asserted as malpractice, despite the lack of guidelines on this matter. Without clear guidance, a faulty practice seems to lie essentially in the eyes of the beholder.

The limits of health professionals' action at home is not clear either. The broad nature of the Portuguese regulation on the midwives' autonomous scope of practice (Ordem dos Enfermeiros, 2019) makes it difficult for midwives to translate it into particular contexts of individual practice and to define what is legitimate for each context, and what is not. At home, if labour and birth progress within what is physiologically expected, there is a large consensus over the – supportive, yet mostly passive – role of midwives. However, when dealing with a variation within normalcy or with something deviating from what is considered normal, it becomes less clear what the limits of midwifery practice at home should be:

> [Midwife] reported her experience with being at a home birth and occasionally having to intervene: "In a way I feel I am doing something wrong. There is a bit of this idea that the

[21] Both articles are from the same journalist and may be accessed online: https://observador.pt/especiais/olivia-lider-ritual-e-parteira-perdeu-a-licenca-nos-estados-unidos-mas-faz-partos-ao-domicilio-em-portugal/ and https://observador.pt/especiais/morte-e-prisao-a-moda-perigosa-dos-partos-em-casa/

> midwife is there to empower the woman, but she is also there to intervene when it's needed, to shout if the woman is getting in that cycle of panic. […] What is my role? To empower, but also to intervene if necessary. People get stuck in that idea that they are there not to intervene, and sometimes it's necessary. If a birth is going well, there is nothing we need to do, and we take pictures and thank for letting us be there. But when it's not, you need to take action and do something, and overcome that feeling that this means failing in the physiological approach to childbirth". (Fieldnotes, May, 2017)

This midwife described how, in her own practice, she recognised the need to go beyond the romanticised view of home births as necessarily natural and physiological, and how this had practical implications: in the first years of her home birth practice, the threshold for transferring to a hospital was much lower that it was now, given that she now accepts a certain level of intervention at home, when necessary, before transferring. Defining this threshold, thus, depends on each professional's personal experiences and, as such, it is a dynamic process, it changes with time, it varies from professional to professional, and it may be situational.

Among the professionals who participated in this research, there are some differences regarding the definition of when to intervene at home and when to transfer. These differences somehow divide these professionals. As mentioned earlier, communication and collaboration between home birth practitioners are more common when there are shared values, and this clearly includes a shared opinion on the limits of home birth practice:

> [E]ven inside this group [on home birth midwifery] that was just created, there are different philosophies. There are different approaches. And this has to do with the development and the culture of each person. I believe that, somehow, the fact that these midwives are not included in a group has to do with… this empathy, this kind of practice that we are not much in favour of. […] Now, what I occasionally observe is that the people in this group look for this more holistic perspective and the least interventive. And some of the people that are not in this group are really interventionist. In home births. (Isa, midwife)

This personal nature of the definition of a threshold between intervening or transferring also impacts on the professionals' experience when working in teams and may influence the relationship established between women and professionals, when there is a lack of consensus. Acknowledging their susceptible position, some home birth professionals clarify their limits of practice to women early on the beginning of prenatal care, defining unarguable motives for transferring:

> [In an informal obstetric emergency teamwork training session] While they trained the techniques and the procedures, I asked them what would happen if, upon the retention of a placental cotyledon, a couple wouldn't want to be transferred. [Midwife] said that she knows a colleague that once did a cotyledon removal at home. In their case, she says they wouldn't do it. And that it is not negotiable. There is a limit to negotiation that they establish right in the first antenatal consultation. I said that, in principle, there is a trust relationship [between them and the woman] beyond the contractual and professional relationship, and that the woman will probably want to go [if the midwives said so]. But they insisted that it was not negotiable. (Fieldnotes, October, 2016)

On the one hand, this seems a legitimate clarification, so families would clearly know what to expect from a given professional. On the other hand, this restrains the woman's right to consent and/or refusal. This dilemma between applying good standards of care and respecting women's rights has been reported in other countries, as a strategy to when home birth midwives were facing greater risk of liability (Santos, 2017). In this regard, the Danish law specifically protects home birth midwives from litigation when a woman's will and consent diverges from the midwives' recommendation. If the midwife proves they provided all the necessary information regarding the increased risks of staying at home, but the woman refuses to be referred, the midwife should continue caring for that women at home. Women cannot be transferred to the hospital against their will (Sundhedsstyrelsen, 2013). For the Portuguese setting, this is an important, however, abstract reflection. Given the fact that families tend to establish trust-based relationships with their home birth practitioners (Santos

& Augusto, 2016), none of our interviewees reported a situation of actual conflict between the professional advice of a transfer and the woman's consent. In such situations, women usually agree with the professional's opinion and consent being referred to the hospital.

There are other factors adding complexity to the process of deciding whether to intervene or to transfer. One of the most significant is women and home birth practitioners' negative experience with the reactions of the hospital staff in a referral. Due to the fear of reprisals when arriving at the hospital, families or home birth professionals may unintentionally delay the transfer:

> [W]hen I need to transfer, sometimes, unintentionally, I delay the transfer a bit. I notice that sometimes I see myself delaying the transfer because I understand what that means in terms of what is going to happen next. Because they [the family] will get to the hospital, the odds of being mistreated are very high, just because they chose to have a home birth. And this is something that weights. And as much as we want to be objective and scientific, with all the birth hormones and with all the involvement you end up having, this may add some risk. […] Because sometimes I think "wait a minute, [herself], let's stop. Are you waiting because it is indeed safe, or are you waiting because you know what is on the other side?" (Olga, midwife)

The relative invisibility of planned home births, both in the health professionals' curricula and at a broader social level, seems to feed the fear and the overall unpreparedness of the hospital staff to deal with this phenomenon. It is not uncommon to find negative experiences of encounters between home birth families or professionals and the hospital staff. One senior midwife recounted her experience:

> [E]very transfer is horrible. They treat you like shit. And, likewise, the women you transfer. They like to punish you because you're outside the system. With what right? […] [*Have you ever had a good experience transferring?*] No, never. (Elisabete, midwife)

In Portugal, transfers from a planned home birth to the hospital can have great impact in the way birth is inscribed into women's biography, and may be experienced as a failure or

as traumatic (Fedele, 2018). In fact, not having an efficient referral system is commonly pointed as the most important problem in Portuguese home births:

> [I]t's the difficult part of attending a home birth, in Portugal. It's not the emergency network, as people say, having an ambulance at your door, it's not what this is about. It's about being able to contact the hospital saying that we are going there with a woman with this and this, and someone being able to hear us and activating the emergency plan that needs to be activated. Or getting to the hospital and being able to pass on the information in a short time. If the other [professional] is concerned with judging us, they are wasting time, and that endangers the situations. It's not a matter of having an ambulance at our door because, in the Portuguese territory, we already have a well efficient emergency network, compared to other European countries. (Tânia, midwife)

Although there is no registry of hospital transfers in Portugal, our data suggests that the majority would be non-urgent and performed in a private care, similarly to what has been discussed by Blix et al. (2016). These are also the cases more prone to ambiguity. The level of uncertainty associated with the hospital is one of the main reasons behind the option of a home birth (Santos & Augusto, 2016). Instead of a coherent philosophy and a concerted approach across different professionals, women's hospital experience is often contingent on individual "windows of care" (White & Queirós, 2018, p. 661). In most transfers, this also adds new variables to the process of decision-making, when facing the need to transfer:

> Two hours have passed since the baby was born, [we are waiting for the placenta delivery,] and they decide to recommend transferring. There is some discussion about which hospital to transfer to: [hospital A] is farthest, but it is probably more humanised; [hospital B] is more uncertain and depending on the team on duty. I suggest [hospital C, the closest to our location] but they say that obviously not. They reflect about proximity (thinking about the relatives that would like to visit them at the hospital afterwards) and the trust in the [hospital] teams. Because [hospital A] is the one that gathers a lower degree of uncertainty, it's the one they choose. (Fieldnotes, January, 2016)

The lack of systematic data on home to hospital transfers in Portugal – and in many other European countries – stand as a source of uncertainty in itself. Official birth registries identify actual place of birth but not the planned place of birth, contributing to the statistical invisibility of the experience with home-to-hospital transfers, hindering the development of research on these matters (Campbell et al., 2019; Hutton et al., 2019; Snowden et al., 2015).

Furthermore, many families face additional challenges with birth registration at civil registration offices. There are different interpretations of the law regarding the documents and information required for registering the baby when birth happens outside a health facility. Hence, while some families experience a straightforward process, others are asked to present a medical declaration issued by a doctor from the hospital or the health centre, or a copy of the midwife's licence, or to bring at least two civil witnesses to officially figure in the registration act. Another study reporting women's experience with home births found that, due to these bureaucratic barriers, some births might have be registered as having happened in "other" location, the third available category besides home or the hospital, raising additional matters of concern regarding the reliability of official home birth registries (Santos, 2012). Any research aiming at a detailed and rigorous statistical analysis of home births in Portugal should rely on primary data, and not on the available official birth registries.

These different levels of uncertainty that permeate the experience of home birth families and professionals illustrate well their unequal, unsupported, shaky, and fragile position in the broader scenario of maternity care. On the other hand, they open way to the debate and the reflection on what could be done to improve maternity care for all, in the wake of other initiatives from leading countries in matters of perinatal health.

5.4. CONCLUSIONS AND RECOMMENDATIONS FOR CHANGE

Home births are not inherently dangerous, but they are not inherently safe either. The same can be said regarding hospital births. As earlier demonstrated by Loudon (1992), it is not so much the place but the quality of the staff and the circumstances in which care is provided

that have greater influence on the overall quality and safety of home or hospital childbirth care. Being a minority choice, there are certain conditions that can make home birth a safer choice for women and families. Despite the lack of evidence for the Portuguese context, studies on other contexts do point to the level of integration of home births in the broader maternity care system as a key element. On the other hand, they show how countries where home births are marginalised have poorer outcomes (Snowden et al., 2015).

Across high-income countries, producing reliable data on the quality of maternity care – including women's assessment of the quality of care they received – and translating this evidence into public policies should be one of the main drivers of improving maternity care, moving to a women-centred paradigm and an evidence-based care (Shaw et al., 2016). In regard to Portuguese maternity care, and home birth in particular, our research points to the need to further integrate home births in the health system, to assure the systematic evaluation of the quality of care, and to involve users and home birth professionals in all stages of policy making and implementation. Creating further legal or regulatory limitations to home birth practice will not eliminate home births, as seen in European countries where home birth practice is illegal. Yet, forbidding or further marginalising home births definitely increase its risks, and that should not be the aim of any public policy.

The distinct facets of Portuguese home births here presented and analysed are, in fact, interconnected by a loop-feedback system. The hegemonic discourse of home births as inherently dangerous and socially backwards contributes to the clinical, scientific, and political resistance to analyse this phenomenon; which in turn obstructs regulatory bodies and health authorities to issue evidence-based guidelines. Without clear criteria for assessing their practice, many professionals fear the risks of litigation or the prejudice from peers and colleagues. This hinders interprofessional communication and inhibits the sustainable establishment of communities of practice through which they could share specific knowledge and concerns, working towards harmonisation of procedures and care excellency. Instead, home birth care is kept in the margins of maternity care, and this reinforces the general unfamiliarity among several layers of society regarding the professionals, the users, the practices, and the evidence behind home births. With a nearly invisible public presence, the care paradigms developed in home births are left out of the discussion on the overall

childbirth care, impeding any move towards the integration of home births in the National Health Service. Ultimately this feeds back the hegemonic discourse of home birth as marginal and unarguably dangerous, and hospital birth as necessarily safe.

Improving maternity care for those who plan a home birth thus requires interrupting this loop-feedback system in one or more of its interconnections, through concerted and participated policy-making. Based on our findings and on the international evidence summoned to our analysis, change at the policy level should encompass but not be limited to:

1. Unifying official national-level data collection on childbirth and perinatal health outcomes, and including the distinction between planned and actual place of birth;
2. Creating a consensus document for guidance of home birth practice – including guidance for the practice of hospital staff in case of a transfer – based on the available scientific evidence, with an effective participation of users, home birth practitioners, and all relevant stakeholders;
3. Clarifying the law regarding the right to informed consent and informed refusal, protecting all health professionals from litigation when they prove to have respected women's consent (and users' consent, in general), particularly when there are unconventional yet rightful choices that go against the health professional's recommendations;
4. Enabling an easier access to the direct acquisition of medication for home birth midwives and obstetricians, in accordance with the minimum standards defined in 2);
5. Standardising the procedures and clarifying the requisites for the civil registration of out-of-hospital births by the Institute of Registration and Notary Affairs (*Instituto dos Registos e Notariado*);
6. Setting a publicly-funded home birth pilot project in one of the main urban areas, in close connection with a public hospital, with a training-action-evaluation

programme coordinated by a multidisciplinary team (including users and academics); which could be replicated to other sites, after due assessment.

Although these recommendations are country-specific, they can also be used to trigger further discussion on the regulation and organisation of home birth care in other countries, particularly European countries with a health care service that roughly shows similarities with the Portuguese National Health Service.

Notwithstanding the country-specific or regional level research of the legal, organisational, and social dimensions of home births, and out-of-hospital childbirth care more broadly, a comprehensive picture of Europe is not yet available. We expect this research and the analytical framework we provide can serve as a ground for comparative studies at the European level and beyond. These studies could expose successful models, similarities between countries, and further inequalities experienced by women, families and practitioners. Altogether, this could serve as a European roadmap of best practices in minority choices in maternity care.

5.5. REFERENCES

Baptista, V. (2016). Os partos e as maternidades em Portugal (1889-1943) – Os casos nas cidades de Lisboa, Porto e Coimbra. *Revista de Historia Regional*, *21*(2), 364–388. https://doi.org/10.5212/Rev.Hist.Reg.v.21i2.0003

Birthplace in England Collaborative Group. (2011). Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study. *BMJ*, *343*, d7400. https://doi.org/10.1136/bmj.d7400

Blix, E., Kumle, M. H., Ingversen, K., Huitfeldt, A. S., Hegaard, H. K., Ólafsdóttir, Ó. Á., … Lindgren, H. (2016). Transfers to hospital in planned home birth in four Nordic countries – A prospective cohort study. *Acta Obstetricia et Gynecologica Scandinavica*, *95*, 420–428. https://doi.org/10.1111/aogs.12858

Cahill, H. A. (2001). Male appropriation and medicalization of childbirth: An historical analysis. *Journal of Advanced Nursing*, *33*(3), 334–342. https://doi.org/10.1046/j.1365-2648.2001.01669.x

Campbell, K., Carson, G., Azzam, H., & Hutton, E. (2019). No. 372-Statement on Planned Homebirth. *Journal of Obstetrics and Gynaecology Canada*, *41*(2), 223–227. https://doi.org/10.1016/j.jogc.2018.08.008

Carneiro, M. (2008). *Ajudar a nascer: parteiras, saberes obstétricos e modelos de formação: séculos*

XV-XX. Porto: UP.

Carpenter, M. (1993). The subordination of nurses in health care: towards a social divisions approach. In E. Riska & K. Wegar (Eds.), *Gender, Work and Medicine: Women and the medical division of labour*. London: Sage.

Catling-Paull, C., Foureur, M. J., & Homer, C. S. E. (2012). Publicly-funded homebirth models in Australia. *Women and Birth*, *25*(4), 152–158. https://doi.org/10.1016/j.wombi.2011.10.003

Cheyney, M. J. (2008). Homebirth as systems-challenging praxis: knowledge, power, and intimacy in the birthplace. *Qualitative Health Research*, *18*(2), 254–267. https://doi.org/10.1177/1049732307312393

Coddington, R., Catling, C., & Homer, C. S. E. (2017). From hospital to home: Australian midwives' experiences of transitioning into publicly-funded homebirth programs. *Women and Birth*, *30*(1), 70–76. https://doi.org/10.1016/j.wombi.2016.08.001

Council of Europe. (2010). *European Convention on Human Rights as amended by Protocols nos. 11 and 14*. Retrieved from http://www.echr.coe.int/Documents/Convention_ENG.pdf

Davis-Floyd, R., & Davis, E. (1996). Intuition as authoritative knowledge in midwifery and homebirth. *Medical Anthropology Quarterly*, *10*(2), 237–269. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/8744086

Davis, D. L., & Homer, C. S. E. (2016). Birthplace as the midwife's work place: How does place of birth impact on midwives? *Women and Birth*, *0*(0), 343–119. https://doi.org/10.1016/j.wombi.2016.02.004

De Jonge, A., Geerts, C. C., Van Der Goes, B. Y., Mol, B. W., Buitendijk, S. E., & Nijhuis, J. G. (2015). Perinatal mortality and morbidity up to 28 days after birth among 743 070 low-risk planned home and hospital births: A cohort study based on three merged national perinatal databases. *BJOG: An International Journal of Obstetrics and Gynaecology*, *122*(5), 720–728. https://doi.org/10.1111/1471-0528.13084

De Jonge, A., Mesman, J. A. J. M., Manniën, J., Zwart, J. J., Van Dillen, J., & Van Roosmalen, J. (2013). Severe adverse maternal outcomes among low risk women with planned home versus hospital births in the Netherlands: nationwide cohort study. *BMJ*, *3263*(June), 1–10. https://doi.org/10.1136/bmj.f3263

Euro-Peristat. (2013). *European Perinatal Health Report - Health and Care of Pregnant Women and Babies in Europe in 2010*. Retrieved from http://www.europeristat.com

Euro-Peristat. (2018). *European Perinatal Health Report. Core indicators of the health and care of pregnant women and babies in Europe in 2015*. Retrieved from www.europeristat.com

European Court of Human Rights. (2011). *Case of Ternovszky v. Hungary (Application no. 67545/09)*. Retrieved from http://hudoc.echr.coe.int/sites/fra/pages/search.aspx?i=001-102254#%7B%22itemid%22:[%22001-102254%22]%7D

European Court of Human Rights. (2014). *Case of Dubská and Krejzová v. the Czech Republic (Applications nos. 28859/11 and 28473/12)*. Retrieved from http://hudoc.echr.coe.int/eng?i=001-148632

Fábián, K. (2013). Overcoming Disempowerment: the Homebirth Movement in Hungary. In K. Jacobsson & S. Saxonberg (Eds.), *Beyond NGO-ization: The Development of Social Movements in Central and Eastern Europe* (pp. 71–95). Burlington: Ashgate.

Fedele, A. (2018). When homebirth "goes wrong": holistic mothers who end up giving birth in a

Portuguese hospital. *Etnográfica*, *22*(3), 691–714. https://doi.org/10.4000/etnografica.6099

Fedele, A., & Guignard, F. P. (2018). Pushing from the Margins: "Natural childbirth" in holistic spiritualities and natural parenting in France and Portugal. In M. Delaporte & M. Martin (Eds.), *Sacred Inception: Reclaiming the Spirituality of Birth in the Modern World* (pp. 131–149). Lanham: Lexington Books.

Feeley, C., & Thomson, G. (2016). Why do some women choose to freebirth in the UK. *BMC Pregnancy and Childbirth*, 1–12. https://doi.org/10.1186/s12884-016-0847-6

Hannerz, U. (2003). Being there... and there... and there!: Reflections on Multi-Site Ethnography. *Ethnography*, *4*, 201–216. https://doi.org/10.1177/14661381030042003

Hugman, R. (1991). *Power in caring professions*. Houndmills: Macmillan Press.

Hutton, E. K., Reitsma, A., Simioni, J., Brunton, G., & Kaufman, K. (2019). Perinatal or neonatal mortality among women who intend at the onset of labour to give birth at home compared to women of low obstetrical risk who intend to give birth in hospital: A systematic review and meta-analyses. *EClinicalMedicine*. https://doi.org/10.1016/j.eclinm.2019.07.005

Krumholz, H. M. (2013). Variations in health care, patient preferences, and high-quality decision making – Editorial. *JAMA*, *310*(2), 151–152. https://doi.org/10.1001/jama.2013.7835

Leeuwen, F. Van. (2015). Milestone or stillbirth ? An analysis of the first judgment of the European Court of Human Rights on home birth. In M. van den Brink, S. Burri, & J. Goldschmidt (Eds.), *Equality and human rights: nothing but trouble?* (pp. 197–210). Utrecht: Netherlands Institute of Human Rights (SIM) & Utrecht University.

Leite, L. (Ed.). (2012). *Pelo direito ao parto normal - uma visão partilhada*. Lisboa: Ordem dos Enfermeiros.

Lindgren, H., Kjaergaard, H., Olafsdottir, O. A., & Blix, E. (2014). Praxis and guidelines for planned homebirths in the Nordic countries – An overview. *Sexual and Reproductive Healthcare*, *5*(1), 3–8. https://doi.org/10.1016/j.srhc.2013.12.002

Lopes, N. M. (2001). *Recomposição profissional da enfermagem*. Coimbra: Quarteto Editora.

Loudon, I. (1992). *Death in Childbirth: An international study of maternal care and maternal mortality 1800-1950*. Oxford: Oxford University Press.

Loughney, A., Collis, R., & Dastgir, S. (2006). Birth before arrival at delivery suite: Associations and consequences. *British Journal of Midwifery*, *14*(4), 204–208. https://doi.org/10.12968/bjom.2006.14.4.20786

Lupton, D. (1994). *Medicine as Culture. Illness, Disease and the Body in Western Societies.* London: Sage.

Marcus, G. E. (1995). Ethnography In/Of the World System: The Emergence of Multi-Sited Ethnography. *Annual Review of Anthropology*, *24*, 95–117. https://doi.org/10.1146/annurev.anthro.24.1.95

Matos, A. R. (2010). "De longe se faz «parto»!" - Os movimentos de protesto sobre o encerramento de maternidades em Portugal enquanto modalidade legítima de participação cidadã nas decisões políticas. In *O Cabo dos Trabalhos*.

McCourt, C., Rayment, J., Rance, S., & Sandall, J. (2012). Organisational strategies and midwives' readiness to provide care for out of hospital births: An analysis from the Birthplace organisational case studies. *Midwifery*, *28*(5), 636–645. https://doi.org/10.1016/j.midw.2012.07.004

McLelland, G., McKenna, L., Morgans, A., & Smith, K. (2018). Epidemiology of unplanned out-of-

hospital births attended by paramedics. *BMC Pregnancy and Childbirth*, *18*(1), 15. https://doi.org/10.1186/s12884-017-1638-4

Miller, S., Abalos, E., Chamillard, M., Ciapponi, A., Colaci, D., Comandé, D., … Althabe, F. (2016). Beyond too little, too late and too much, too soon: a pathway towards evidence-based, respectful maternity care worldwide. *The Lancet*, *6736*(16), 1–17. https://doi.org/10.1016/S0140-6736(16)31472-6

Ministério da Saúde. *Decreto-Lei n.º 176/2006*. (2006).

Ordem dos Enfermeiros. (2009). *Parecer CJ 118/2009*. Retrieved from https://www.ordemenfermeiros.pt/arquivo/documentos/CJ_Documentos/Parecer118_2009_resp_administracao_farmacos.pdf

Ordem dos Enfermeiros. (2012a). *Informação / recomendações à grávida / casal quando desejam um parto no domicílio*.
Retrieved from
http://www.ordemenfermeiros.pt/comunicacao/Documents/2012/Recomendacao_MCEESMO_localparto_Mar2012_VF.pdf

Ordem dos Enfermeiros. (2012b). Partos em casa motivam campanha de desinformação sobre competências dos enfermeiros especialistas. Retrieved September 15, 2016, from Press release website: https://www.ordemenfermeiros.pt/sala-de-imprensa/comunicados/conteudos/partos-em-casa-motivam-campanha-de-desinformação-sobre-competências-dos-enfermeiros-especialistas/

Ordem dos Enfermeiros. *Regulamento n.º 391/2019 - Regulamento das competências específicas do enfermeiro especialista de saúde materna e obstétrica*. (2019).

Ordem dos Médicos. (2012). Partos no domicílio. *Revista Da Ordem Dos Médicos*, 20–23.

Pařízková, A., & Clausen, J. A. (2018). Women on the move: A search for preferred birth services. *Women and Birth*. https://doi.org/10.1016/j.wombi.2018.10.003

Pintassilgo, S., & Carvalho, H. (2017). Trends and consequences of the technocratic paradigm of childbirth in Portugal: A population-based analysis of birth conditions and social characteristics of parents. *Sexual & Reproductive Healthcare*, *13*, 58–67. https://doi.org/10.1016/j.srhc.2017.06.003

Quattrocchi, P. (2014). Homebirth and the NHS in Italy. *Canadian Journal of Midwifery Research and Practice*, *13*(3), 32–39.

Rocha, S. B. da. (2016). Partos no domicílio - contributo do enfermeiro especialista em saúde materna e obstetrícia. *Sinais Vitais*, (121), 15–25. Retrieved from http://www.sinaisvitais.pt/index.php/revista-sinais-vitais-publicacoes-78/revistas-2015/735-sinais-vitais-121

Rothman, B. K. (1982). *In labour: women and power in the birth place*. London: Junction Books.

Sadler, M., Santos, M. JDS. J., Ruiz-Berdún, D., Rojas, G. L., Skoko, E., Gillen, P., & Clausen, J. A. (2016). Moving beyond disrespect and abuse: addressing the structural dimensions of obstetric violence. *Reproductive Health Matters*, *24*(47), 47–55. https://doi.org/10.1016/j.rhm.2016.04.002

Santos, M. (2012). *Nascer em casa: a desinstitucionalização reflexiva do parto no contexto português* (Master's thesis, ISCTE-IUL, Portugal). Retrieved from http://repositorio-iul.iscte.pt/handle/10071/4684

Santos, M. (2014a). Private and Public Home Births - Comparing access , options and inequalities in Portugal and Denmark. In B. Padilla, S. H. Plaza, E. Rodrigues, & A. Ortiz (Eds.), *Saúde e Cidadania: Equidade nos cuidados de saúde materno–infantil em tempos de crise* (pp. 99–113).

Retrieved from http://repositorium.sdum.uminho.pt/bitstream/1822/32484/1/Saude e Cidadania.pdf

Santos, M. (2014b). Trajetórias de desintitucionalização do parto. A rejeição da hegemonia biomédica na opção pelo parto em casa. *VII Congresso Português de Sociologia*. Retrieved from http://www.aps.pt/viii_congresso/VIII_ACTAS/VIII_COM0021.pdf

Santos, M. (2017). Where the thread of home births never broke - An interview with Susanne Houd. *Women and Birth*, *30*, 159–165. https://doi.org/10.1016/j.wombi.2016.09.008

Santos, M. (2018a). Can the unequal access to home birth be framed as a source of inequalities? A comparison between Portugal and Denmark. *Portuguese Journal of Social Science*, *17*(3), 335–347. https://doi.org/10.1386/pjss.17.3.335_1

Santos, M. (2018b). Institutionalisation and professional dynamics in home births: insights from a STSM comparing Israel and Portugal. In *CIES e-Working Papers*. Retrieved from http://cies.iscte-iul.pt/np4/1853.html

Santos, M., & Augusto, A. (2016). "Se estava tudo bem, porque é que eu havia de ir a uma obstetra?" - Identidade, risco e consumo de tecnologia médica no parto domiciliar em Portugal. *Sociologia, Problemas e Práticas*, (82), 49–67. https://doi.org/10.7458/SPP2016825922

Shaw, D., Guise, J. M., Shah, N., Gemzell-Danielsson, K., Joseph, K. S., Levy, B., … Main, E. K. (2016). Drivers of maternity care in high-income countries: can health systems support woman-centred care? *The Lancet*, *388*(10057), 2282–2295. https://doi.org/10.1016/S0140-6736(16)31527-6

Simões, S. (2016, July 12). Condenação. A "moda perigosa" dos partos em casa. *Observador*. Retrieved from https://observador.pt/especiais/morte-e-prisao-a-moda-perigosa-dos-partos-em-casa/

Snowden, J. M., Tilden, E. L., Snyder, J., Quigley, B., Caughey, A. B., & Cheng, Y. W. (2015). Planned Out-of-Hospital Birth and Birth Outcomes. *New England Journal of Medicine*, *373*(27), 2642–2653. https://doi.org/10.1056/NEJMsa1501738

Sundhedsstyrelsen. (2013). *Anbefalinger for svangreomsorgen [National guidelines for maternity care]* (2. udgave). Retrieved from https://sundhedsstyrelsen.dk/da/udgivelser/2015/anbefalinger-for-svangreomsorgen

Vallgårda, S. (2012). Hospitalization of deliveries: The change of place of birth in Denmark and Sweden from the late nineteenth century to 1970. *Medical History*, *40*(02), 173–196. https://doi.org/10.1017/S0025727300060993

White, J., & Queirós, F. (2018). Reconcilable differences? Portuguese obstetricians' and midwives' contrasting perspectives on childbirth, and women's birthing experiences. *Etnográfica*, *22*(3), 643–668. https://doi.org/10.4000/etnografica.6041

World Health Organization. (2018). *Intrapartum care for a positive childbirth experience*. Retrieved from http://www.who.int/reproductivehealth/publications/intrapartum-care-guidelines/en/

6. GENERAL REFERENCE LIST

Ahl, M., & Lundgren, I. (2018). Working with home birth – Swedish midwives' experiences. *Sexual and Reproductive Healthcare*, *18*(August), 24–29. https://doi.org/10.1016/j.srhc.2018.08.006

Akrich, M., Leane, M., Roberts, C., & Arriscado Nunes, J. (2014). Practising childbirth activism: A politics of evidence. *BioSocieties*, *9*(2), 129–152. https://doi.org/10.1057/biosoc.2014.5

Amit, V. (2000). Introduction - Constructing the field. In V. Amit (Ed.), *Constructing the Field. Etnographic Fieldwork in the Contemporary World*. London: Routledge.

Annandale, E., & Clark, J. (1996). What is gender? Feminist theory and the sociology of human reproduction. *Sociology of Health & Illness*, *18*(1), 17–44. https://doi.org/10.1111/1467-9566.ep10934409

APDMGP. (2019). *Submission of Associação Portuguesa pelos Direitos da Mulher na Gravidez e Parto (APDMGP) to the United Nations Special Rapporteur on violence against women*. Retrieved from United Nations Office of the High Commissioner on Human Rights website: https://www.ohchr.org/EN/Issues/Women/SRWomen/Pages/Mistreatment.aspx

Augusto, A. (2004). *Infertilidade e reprodução medicamente assistida em Portugal: dos problemas privados aos assuntos públicos* (Unpublished doctoral dissertation, Universidade da Beira Interior, Portugal).

Augusto, A. (2013). Género e Saúde. In F. Alves (Ed.), *Saúde, Medicina e Sociedade: uma visão sociológica* (pp. 29–34). Lisboa: Pactor.

Aune, I., Hoston, M. A., Kolshus, N. J., & Larsen, C. E. G. (2017). Nature works best when allowed to run its course. The experience of midwives promoting normal births in a home birth setting. *Midwifery*, *50*, 21–26. https://doi.org/10.1016/j.midw.2017.03.020

Ayres-De-Campos, D., Cruz, J., Medeiros-Borges, C., Costa-Santos, C., & Vicente, L. (2015). Lowered national cesarean section rates after a concerted action. *Acta Obstetricia et Gynecologica Scandinavica*, *94*(4), 391–398. https://doi.org/10.1111/aogs.12582

Badinter, E. (2011). *The conflict: How modern moderhood undermines the status of women*. New York: Metropolitan Books.

Baptista, V. (2016). Os partos e as maternidades em Portugal (1889-1943) – Os casos nas cidades de Lisboa, Porto e Coimbra. *Revista de Historia Regional*, *21*(2), 364–388. https://doi.org/10.5212/Rev.Hist.Reg.v.21i2.0003

Barreto, R. (2007). A ciência do parto nos manuais portugueses de obstetricia. *Gênero*, *7*(2). https://doi.org/10.22409/rg.v7i2.152

Barreto, R. (2011). A «ciência do parto» e a atuação de Joaquim da Rocha Mazarém (século XIX). In C. Bastos & R. Barreto (Eds.), *A circulação do conhecimento: Medicina, Redes e Impérios* (pp. 51–80). Lisboa: ICS.

Beckett, K. (2005). Choosing cesarean: Feminism and the politics of childbirth in the United States. *Feminist Theory*, *6*(3), 251–275. https://doi.org/10.1177/1464700105057363

Benoit, C. (1989). The professional socialisation of midwives: balancing art and science. *Sociology of Health & Illness*, *11*(2), 160–180. https://doi.org/10.1111/1467-9566.ep10844338

Birthplace in England Collaborative Group. (2011). Perinatal and maternal outcomes by planned place

of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study. *BMJ*, *343*, d7400. https://doi.org/10.1136/bmj.d7400

Blix, E., Kumle, M. H., Ingversen, K., Huitfeldt, A. S., Hegaard, H. K., Ólafsdóttir, Ó. Á., … Lindgren, H. (2016). Transfers to hospital in planned home birth in four Nordic countries – A prospective cohort study. *Acta Obstetricia et Gynecologica Scandinavica*, *95*, 420–428. https://doi.org/10.1111/aogs.12858

Borrelli, S. E. (2014). What is a good midwife? Insights from the literature. *Midwifery*, *30*(1), 3–10. https://doi.org/10.1016/j.midw.2013.06.019

Bourdieu, P. (1998). *La domination masculine*. Paris: Éditions du Seuil.

Braga, T. (1867). *Romanceiro Geral*. Coimbra: Imprensa da Universidade.

Bryman, A. (2012). *Social research methods* (4th Ed.). New York: Oxford University Press.

Burns, E. (2015). "Thanks, but no thanks": Ethnographic Fieldwork and the Experience of Rejection from a New Religious Movement. *Fieldwork in Religion*, *10*(2), 190–208. https://doi.org/10.1558/firn.v10i2.27236

Butler, J. (1990). *Gender Trouble: Feminism and the Subversion of Identity*. New York and London: Routledge.

Byrne, D., & Callaghan, G. (2013). *Complexity Theory: The State of the Art*. Taylor & Francis.

Cahill, H. A. (2001). Male appropriation and medicalization of childbirth: An historical analysis. *Journal of Advanced Nursing*, *33*(3), 334–342. https://doi.org/10.1046/j.1365-2648.2001.01669.x

Campbell, K., Carson, G., Azzam, H., & Hutton, E. (2019). No. 372-Statement on Planned Homebirth. *Journal of Obstetrics and Gynaecology Canada*, *41*(2), 223–227. https://doi.org/10.1016/j.jogc.2018.08.008

Carapinheiro, G. (1993). *Saberes e poderes no hospital - Uma sociologia dos serviços hospitalares*. Porto: Edições Afrontamento.

Carapinheiro, G. (2006). A saúde enquanto matéria política. In G. Carapinheiro (Ed.), *Sociologia da saúde: Estudos e perspectivas* (pp. 137–164). Coimbra: Pé de Página.

Carneiro, M. (2008). *Ajudar a nascer: parteiras, saberes obstétricos e modelos de formação: séculos XV-XX*. Porto: UP.

Carpenter, M. (1993). The subordination of nurses in health care: towards a social divisions approach. In E. Riska & K. Wegar (Eds.), *Gender, Work and Medicine: Women and the medical division of labour*. London: Sage.

Carter, S. K. (2009). Gender performances during labor and birth in the midwives model of care. *Gender Issues*, *26*(3–4), 205–223. https://doi.org/10.1007/s12147-009-9084-x

Catling-Paull, C., Foureur, M. J., & Homer, C. S. E. (2012). Publicly-funded homebirth models in Australia. *Women and Birth*, *25*(4), 152–158. https://doi.org/10.1016/j.wombi.2011.10.003

Chadwick, R. (2017). Embodied methodologies: challenges, reflections and strategies. *Qualitative Research*, *17*(1), 54–74. https://doi.org/10.1177/1468794116656035

Challinor, E. P. (2018). Exploring the power of the written word: on hospital birth and the production of birth narratives. *Etnográfica*, *22*(3), 669–690. https://doi.org/10.4000/etnografica.6077

Cheyney, M. J. (2008). Homebirth as systems-challenging praxis: knowledge, power, and intimacy in the birthplace. *Qualitative Health Research*, *18*(2), 254–267. https://doi.org/10.1177/1049732307312393

Clausen, J. A. (2010). *How does materiality shape childbirth? An explorative journey into evidence ,*

childbirth practices and Science and Technology Studies (Doctoral dissertation, Aarhus University, Denmark). Retrieved from http://sts.imv.au.dk/jette-phd-defence

Clausen, J. A., & Santos, M. J. (2017). Capturing the complexity of practice as an insider: in-labour ethnography. In S. Church, L. Frith, M.-C. Balaam, M. Berg, V. Smith, C. van der Walt, … E. van Teijlingen (Eds.), *New thinking on improving maternity care - international perspectives* (pp. 73–89). London: Pinter and Martin.

Coddington, R., Catling, C., & Homer, C. S. E. (2017). From hospital to home: Australian midwives' experiences of transitioning into publicly-funded homebirth programs. *Women and Birth*, *30*(1), 70–76. https://doi.org/10.1016/j.wombi.2016.08.001

Cohen Shabot, S. (2016). Making Loud Bodies "Feminine": A Feminist-Phenomenological Analysis of Obstetric Violence. *Human Studies*, *39*, 231–247. https://doi.org/10.1007/s10746-015-9369-x

Collière, M.-F. (1982). *Promouvoir la vie*. Paris: InterEditions/Masson.

Connell, R. W. (1987). *Gender and Power: Society, the Person, and Sexual Politics.* Oxford: Polity Press.

Correia, T. (2012). *Medicina - O agir numa saúde em mudança*. Lisboa: Mundos Sociais.

Costa, A. F. da. (1987). A pesquisa de terreno em Sociologia. In A. Santos Silva & J. Madureira Pinto (Eds.), *Metodologia das Ciências Sociais* (pp. 129–148). Porto: Afrontamento.

Council of Europe. (2010). *European Convention on Human Rights as amended by Protocols nos. 11 and 14*. Retrieved from http://www.echr.coe.int/Documents/Convention_ENG.pdf

Crozier, M., & Friedberg, E. (1977). *L'acteur et le système*. Paris: Éditions du Seuil.

D'Oliveira, A. F. P. L., Diniz, S. G., & Schraiber, L. B. (2002). Violence against women in health-care institutions: an emerging problem. *Lancet*, *359*(9318), 1681–1685. https://doi.org/10.1016/S0140-6736(02)08592-6

da Silva Carvalho, A. (1931). *Subsidios para a historia das parteiras portuguesas*. Lisboa: Tip. Labor.

Dahlen, H. (2019). Is it Time to Ask Whether Facility Based Birth is Safe for Low Risk Women and Their Babies? *EClinicalMedicine*, (xxxx), 1–2. https://doi.org/10.1016/j.eclinm.2019.08.003

Dahlen, H., Jackson, M., & Stevens, J. (2011). Homebirth, freebirth and doulas: Casualty and consequences of a broken maternity system. *Women and Birth*, *24*(1), 47–50. https://doi.org/10.1016/j.wombi.2010.11.002

Daniels, N. M., & Chadwick, R. J. (2017). Doing homebirth like a man? Constructions of masculinity in South African men's narratives of homebirth. *Journal of Gender Studies*, *27*(6), 1–15. https://doi.org/10.1080/09589236.2017.1301811

Dantas, J. (1915). *Ao ouvido de Mme. X*. Porto: Livraria Chardron.

Davis-Floyd, R, & Davis, E. (1996). Intuition as authoritative knowledge in midwifery and homebirth. *Medical Anthropology Quarterly*, *10*(2), 237–269. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/8744086

Davis, D. L., & Homer, C. S. E. (2016). Birthplace as the midwife's work place: How does place of birth impact on midwives? *Women and Birth*, *29*(5), 343–119. https://doi.org/10.1016/j.wombi.2016.02.004

De Jonge, A., Geerts, C. C., Van Der Goes, B. Y., Mol, B. W., Buitendijk, S. E., & Nijhuis, J. G. (2015). Perinatal mortality and morbidity up to 28 days after birth among 743 070 low-risk planned home and hospital births: A cohort study based on three merged national perinatal databases. *BJOG: An International Journal of Obstetrics and Gynaecology*, *122*(5), 720–728.

https://doi.org/10.1111/1471-0528.13084

De Jonge, A., Mesman, J. A. J. M., Manniën, J., Zwart, J. J., Van Dillen, J., & Van Roosmalen, J. (2013). Severe adverse maternal outcomes among low risk women with planned home versus hospital births in the Netherlands: nationwide cohort study. *BMJ*, *3263*(June), 1–10. https://doi.org/10.1136/bmj.f3263

DeFrancisco, V. (1997). Gender, power and practice: or putting your money (and your research) where your mouth is. In R. Wodak (Ed.), *Gender and Discourse* (pp. 37–56). London: Sage.

Desmond, M. (2014). Relational ethnography. *Theory and Society*, *43*(5), 547–579. https://doi.org/10.1007/s11186-014-9232-5

Desmond, M. (2016). *Evicted – Poverty and profit in the American city*. New York: Crown.

DeVries, R. (1993). A cross-national view of the status of midwives. In E. Riska & K. Wegar (Eds.), *Gender, Work and Medicine: Women and the medical division of labour* (pp. 131–146). London: Sage.

Diniz, S. G., Salgado, H. D. O., Andrezzo, H. F. de A., Carvalho, P. G. C. de, Carvalho, P. C. A., Aguiar, C. de A., & Niy, D. Y. (2015). Abuse and disrespect in childbirth care as a public health issue in Brazil: Origins, definitions, impacts on maternal health, and proposals for its prevention. *Journal of Human Growth and Development*, *25*(3), 377–384. https://doi.org/http://dx.doi.org/10.7322/jhgd.106080

Donnison, J. (1977). *Midwives and medical men. A history of inter-professional rivalries and women's rights*. London: Heinemman.

Downe, S. (2010). Beyond evidence-based medicine: complexity and stories of maternity care. *Journal of Evaluation in Clinical Practice*, *16*(1), 232–237. https://doi.org/10.1111/j.1365-2753.2009.01357.x

Durham, D. (2011). Disgust and the anthropological imagination. *Ethnos*, *76*(2), 131–156. https://doi.org/10.1080/00141844.2010.547941

Euro-Peristat. (2013). *European Perinatal Health Report - Health and Care of Pregnant Women and Babies in Europe in 2010*. Retrieved from http://www.europeristat.com

Euro-Peristat. (2018). *European Perinatal Health Report. Core indicators of the health and care of pregnant women and babies in Europe in 2015*. Retrieved from www.europeristat.com

European Court of Human Rights. (2011). *Case of Ternovszky v. Hungary (Application no. 67545/09)*. Retrieved from http://hudoc.echr.coe.int/sites/fra/pages/search.aspx?i=001-102254#%7B%22itemid%22:[%22001-102254%22]%7D

European Court of Human Rights. (2014). *Case of Dubská and Krejzová v. the Czech Republic (Applications nos. 28859/11 and 28473/12)*. Retrieved from http://hudoc.echr.coe.int/eng?i=001-148632

Everson, C., & Cheyney, M. (2015). Between Two Worlds: Doula Care, Liminality, and the Power of Mandorla Spaces. In A. N. Castañeda & J. J. Searcy (Eds.), *Doulas and intimate labour: boundaries, bodies, and birth* (pp. 203–225). Bradford: Demeter Press.

Fábián, K. (2013). Overcoming Disempowerment: the Homebirth Movement in Hungary. In K. Jacobsson & S. Saxonberg (Eds.), *Beyond NGO-ization: The Development of Social Movements in Central and Eastern Europe* (pp. 71–95). Burlington: Ashgate.

Favret-Saada, J. (1980). *Deadly Words – Witchcraft in the Bocage*. Cambridge: Cambridge University

Press.
Fedele, A. (2013). *Looking for Mary Magdalene: Alternative Pilgrimage and Ritual Creativity at Catholic Shrines in France*. New York: Oxford University Press.
Fedele, A. (2016). 'Holistic Mothers' or 'Bad Mothers'? Challenging Biomedical Models of the Body in Portugal. *Religion and Gender*, *6*(1), 95–111. https://doi.org/10.18352/rg.10128
Fedele, A. (2018). When homebirth "goes wrong": holistic mothers who end up giving birth in a Portuguese hospital. *Etnográfica*, *22*(3), 691–714. https://doi.org/10.4000/etnografica.6099
Fedele, A., & Guignard, F. P. (2018). Pushing from the Margins: "Natural childbirth" in holistic spiritualities and natural parenting in France and Portugal. In M. Delaporte & M. Martin (Eds.), *Sacred Inception: Reclaiming the Spirituality of Birth in the Modern World* (pp. 131–149). Lanham: Lexington Books.
Feeley, C., & Thomson, G. (2016). Why do some women choose to freebirth in the UK. *BMC Pregnancy and Childbirth*, 1–12. https://doi.org/10.1186/s12884-016-0847-6
Foley, L., & Faircloth, C. a. (2003). Medicine as discursive resource: legitimation in the work narratives of midwives. *Sociology of Health & Illness*, *25*(2), 165–184. https://doi.org/10.1111/1467-9566.00330
Foucault, M. (1975). *Surveiller et punir : naissance de la prison*. Paris: Gallimard.
Foucault, M. (1989). *The Birth of the Clinic*. London: Routledge.
Fox, B., & Worts, D. (1999). Revisiting the critique of medicalized childbirth: A Contribution to the Sociology of Birth. *Gender & Society*, *13*(3), 326–346. https://doi.org/10.1177/089124399013003004
Freidson, E. (1984). *La profession médicale*. Paris: Payot.
Garnel, M. R. (2013). Da Régia Escola de Cirurgia à Faculdade de Medicina de Lisboa - O ensino médico: 1825-1950. In S. C. Matos & J. Ramos do Ó (Eds.), *A Universidade de Lisboa, séculos XIX-XX*: *Vol. II* (pp. 538–650). Lisboa: Tinta da China.
Gérvas, J., Ferna, M. P., & Starfield, B. H. (1994). Primary Care, Financing and Gatekeeping in Western Europe. *Family Practice*, *11*(3), 307–317. https://doi.org/10.1093/fampra/11.3.307
Gomes, G. (1955). As parteiras na Literatura e na Arte. *Revista de Enfermagem*, (6–7).
Hannerz, U. (2003). Being there... and there... and there!: Reflections on Multi-Site Ethnography. *Ethnography*, *4*, 201–216. https://doi.org/10.1177/14661381030042003
Heat, I. (2013). Complexity, uncertainty and mess as the links between Science and the Humanities in Health care. In J. P. Sturmberg & C. Martin (Eds.), *Handbook of Systems and Complexity in Health*. Springer.
Hochschild, A. (2012). *The outsourced self: Intimate life in market times*. New York: Metropolitan Books.
Hugman, R. (1991). *Power in caring professions*. Houndmills: Macmillan Press.
Hunter, C. A., & Hurst, A. (2016). *Understanding doulas and childbirth - Women, love and advocacy*. New York: Palgrave Macmillan.
Hutton, E. K., Reitsma, A., Simioni, J., Brunton, G., & Kaufman, K. (2019). Perinatal or neonatal mortality among women who intend at the onset of labour to give birth at home compared to women of low obstetrical risk who intend to give birth in hospital: A systematic review and meta-analyses. *EClinicalMedicine*. https://doi.org/10.1016/j.eclinm.2019.07.005
Hyde, A., & Roche-Reid, B. (2004). Midwifery practice and the crisis of modernity: implications for the

role of the midwife. *Social Science & Medicine*, *58*(12), 2613–2623. https://doi.org/10.1016/j.socscimed.2003.09.014

Iversen, M. L., Midtgaard, J., Ekelin, M., & Hegaard, H. K. (2017). Danish women's experiences of the rebozo technique during labour: A qualitative explorative study. *Sexual and Reproductive Healthcare*, *11*, 79–85. https://doi.org/10.1016/j.srhc.2016.10.005

Joaquim, T. (1983). *Dar à luz: Ensaio sobre as práticas e as crenças da gravidez, parto e pós-parto em Portugal*. Lisboa: D. Quixote.

Johnson, C. (2016). *Maternal Transition: A North-South Politics of Pregnancy and Childbirth*. New York: Routledge.

Jordan, B. (1997). Authoritative knowledge and its construction. In R. Davis-Floyd & C. F. Sargent (Eds.), *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives* (pp. 55–79). Berkeley and Los Angeles: University of California Press.

Kozinets, R. V. (2010). *Netnography: Doing ethnographic research online*. London: Sage.

Krumholz, H. M. (2013). Variations in health care, patient preferences, and high-quality decision making – Editorial. *JAMA*, *310*(2), 151–152. https://doi.org/10.1001/jama.2013.7835

Leeuwen, F. Van. (2015). Milestone or stillbirth ? An analysis of the first judgment of the European Court of Human Rights on home birth. In M. van den Brink, S. Burri, & J. Goldschmidt (Eds.), *Equality and human rights: nothing but trouble?* (pp. 197–210). Utrecht: Netherlands Institute of Human Rights (SIM) & Utrecht University.

Leite, L. (Ed.). (2012). *Pelo direito ao parto normal – uma visão partilhada*. Lisboa: Ordem dos Enfermeiros.

Lindgren, H., Kjaergaard, H., Olafsdottir, O. A., & Blix, E. (2014). Praxis and guidelines for planned homebirths in the Nordic countries – An overview. *Sexual and Reproductive Healthcare*, *5*(1), 3–8. https://doi.org/10.1016/j.srhc.2013.12.002

Lobato, G. (1890). *Lisboa em Camisa*. Lisboa: Empreza Litteraria de Lisboa.

Lopes, N. M. (2001). *Recomposição profissional da enfermagem*. Coimbra: Quarteto Editora.

Loudon, I. (1992). *Death in Childbirth: An international study of maternal care and maternal mortality 1800-1950*. Oxford: Oxford University Press.

Loughney, A., Collis, R., & Dastgir, S. (2006). Birth before arrival at delivery suite: Associations and consequences. *British Journal of Midwifery*, *14*(4), 204–208. https://doi.org/10.12968/bjom.2006.14.4.20786

Lupton, D. (1994). *Medicine as Culture. Illness, Disease and the Body in Western Societies.* London: Sage.

Lusztig, I. (2013). *The motherhood archives*. Retrieved from http://motherhoodarchives.net/

Macintyre, S. (1980). The Sociology of Reproduction. *Sociology of Health and Illness*, *2*(2), 215–222. https://doi.org/10.1111/1467-9566.ep10487797

Mansfield, B. (2008). The social nature of natural childbirth. *Social Science and Medicine*, *66*(5), 1084–1094. https://doi.org/10.1016/j.socscimed.2007.11.025

Marcus, G. E. (1995). Ethnography in/of the World system: the emergence of multi-sited ethnography. *Annual Review of Anthropology*, *24*, 95–117. https://doi.org/10.1146/annurev.anthro.24.1.95

Martin, E. (1992). *The woman in the body: a cultural analysis of reproduction*. Boston: Beacon Press.

Martin, K. A. (2003). Giving Birth Like A Girl. *Gender & Society*, *17*(1), 54–72. https://doi.org/10.1177/0891243202238978

Martínez-Mollá, T. M. (2015). *Etnografía sobre la decisión del parto en el domicilio* (Doctoral dissertation, University of Alicante, Spain). Retrieved from https://rua.ua.es/dspace/bitstream/10045/46250/1/tesis_martinez_molla.pdf

Matos, A. R. (2010). "De longe se faz «parto»!" - Os movimentos de protesto sobre o encerramento de maternidades em Portugal enquanto modalidade legítima de participação cidadã nas decisões políticas. In *O Cabo dos Trabalhos*.

MaxQDA. (2017). *software for qualitative data analysis*. Retrieved from http://www.maxqda.com/

Mazarem, J. da R. (1823). *Compendio de obstetricia*. Lisboa: A Nova Impressão da Viuva Neves e Filhos.

Mazarem, J. da R. (1838). *Recopilação da arte dos partos ou Quadro elementar obstetricio para instrucção das Aspirantes, que frequentão o Curso de Partos*. Lisboa: J. M. R. e Castro.

McCourt, C., Rayment, J., Rance, S., & Sandall, J. (2012). Organisational strategies and midwives' readiness to provide care for out of hospital births: An analysis from the Birthplace organisational case studies. *Midwifery*, *28*(5), 636–645. https://doi.org/10.1016/j.midw.2012.07.004

McLelland, G., McKenna, L., Morgans, A., & Smith, K. (2018). Epidemiology of unplanned out-of-hospital births attended by paramedics. *BMC Pregnancy and Childbirth*, *18*(1), 15. https://doi.org/10.1186/s12884-017-1638-4

Melo, F. M. de. (1665). *Obras metricas*. Leon: Horacio Boessat y George Remeus.

Miller, A. C. (2009). "Midwife to Myself": Birth Narratives among Women Choosing Unassisted Homebirth. *Sociological Inquiry*, *79*(1), 51–74. https://doi.org/10.1111/j.1475-682X.2008.00272.x

Miller, S., Abalos, E., Chamillard, M., Ciapponi, A., Colaci, D., Comandé, D., … Althabe, F. (2016). Beyond too little, too late and too much, too soon: a pathway towards evidence-based, respectful maternity care worldwide. *The Lancet*, *6736*(16), 1–17. https://doi.org/10.1016/S0140-6736(16)31472-6

Ministério da Saúde. *Decreto-Lei n.º 176/2006*. (2006).

Newnham, E. (2014). Birth control: Power/knowledge in the politics of birth. *Health Sociology Review*, *23*(3), 254–268. https://doi.org/10.1080/14461242.2014.11081978

Newnham, E., McKellar, L., & Pincombe, J. (2018). *Towards the humanization of birth: A study of epidural analgesia & hospital birth culture*. https://doi.org/10.1007/978-3-319-69962-2

Norman, B. M., & Rothman, B. K. (2007). The new arrival: labor doulas and the fragmentation of midwifery and caregiving. In W. Simonds, B. K. Rothman, & B. M. Norman (Eds.), *Laboring On: Birth in Transition in the United States* (pp. 251–282). New York: Routledge.

Oakley, A. (1980). *Women confined - Towards a sociology of childbirth*. Oxford: Martin Robertson.

Oakley, A. (2016). The sociology of childbirth: an autobiographical journey through four decades of research. *Sociology of Health & Illness*, *38*(5), 689–705. https://doi.org/10.1111/1467-9566.12400

OBoyle, C. (2009). *An Ethnography of Independent Midwifery in Ireland* (Doctoral dissertation, University of Dublin, Ireland). Retrieved from http://hdl.handle.net/2262/70390

Olsen, O., & Clausen, J. (2012). Planned hospital birth versus planned home birth. *Cochrane Database of Systematic Reviews*, *2012*(9). Retrieved from http://almenpraksis.ku.dk/nyheder/oleolsen/Hjemmef_dsel.pdf

Ordem dos Enfermeiros. (2009). *Parecer CJ 118/2009*. Retrieved from https://www.ordemenfermeiros.pt/arquivo/documentos/CJ_Documentos/Parecer118_2009_resp_administracao_farmacos.pdf

Ordem dos Enfermeiros. (2012a). *Informação / recomendações à grávida / casal quando desejam um parto no domicílio*. Retrieved from http://www.ordemenfermeiros.pt/comunicacao/Documents/2012/Recomendacao_MCEESMO_localparto_Mar2012_VF.pdf

Ordem dos Enfermeiros. (2012b). Partos em casa motivam campanha de desinformação sobre competências dos enfermeiros especialistas. Retrieved September 15, 2016, from Press release website: https://www.ordemenfermeiros.pt/sala-de-imprensa/comunicados/conteudos/partos-em-casa-motivam-campanha-de-desinformação-sobre-competências-dos-enfermeiros-especialistas/

Ordem dos Enfermeiros. *Regulamento n.º 391/2019 - Regulamento das competências específicas do enfermeiro especialista de saúde materna e obstétrica*. (2019).

Ordem dos Médicos. (2012). Partos no domicílio. *Revista Da Ordem Dos Médicos*, 20–23.

Pařízková, A., & Clausen, J. A. (2018). Women on the move: A search for preferred birth services. *Women and Birth*. https://doi.org/10.1016/j.wombi.2018.10.003

Pintassilgo, S. (2014). *O Risco e as Condições Sociais e Assistenciais da Maternidade em Portugal* (Doctoral dissertation, ISCTE-IUL, Portugal). Retrieved from http://hdl.handle.net/10071/7898

Pintassilgo, S., & Carvalho, H. (2017). Trends and consequences of the technocratic paradigm of childbirth in Portugal: A population-based analysis of birth conditions and social characteristics of parents. *Sexual & Reproductive Healthcare*, *13*, 58–67. https://doi.org/10.1016/j.srhc.2017.06.003

Pombo, D. (2010). *Modelos terapêuticos em movimento no Portugal do século XIX: actores, discursos e controvérsias* (Master's thesis, ISCTE-IUL, Portugal). Retrieved from http://hdl.handle.net/10071/3836

Pruvost, G. (2016). Qui accouche qui? Etude de 134 récits d'accouchement à domicile. *Genre, Sexualité & Societé*, (16). https://doi.org/10.4000/gss.3849

Quattrocchi, P. (2014). Homebirth and the NHS in Italy. *Canadian Journal of Midwifery Research and Practice*, Vol. 13, pp. 32–39.

Queirós, E. de. (1875). *O Crime do Padre Amaro*. Porto: Livraria Chardron.

Queirós, E. de. (1878). *O Primo Basílio*. Porto: Livraria Chardron.

Riessman, C. (1992). Women and medicalization: a new perspective. In G. Kirkup & S. Keller (Eds.), *Inventing women* (pp. 123–144). Cambridge: Polity Press.

Rocha, S. B. da. (2016). Partos no domicílio - contributo do enfermeiro especialista em saúde materna e obstetrícia. *Sinais Vitais*, (121), 15–25. Retrieved from http://www.sinaisvitais.pt/index.php/revista-sinais-vitais-publicacoes-78/revistas-2015/735-sinais-vitais-121

Rothman, B. K. (1982). *In labour: women and power in the birth place*. London: Junction Books.

Rothman, B. K. (2007). Introduction. In W. Simonds, B. K. Rothman, & B. M. Norman (Eds.), *Laboring On: Birth in Transition in the United States* (pp. XI–XXII). New York: Routledge.

Rothman, B. K. (2016). *A bun in the oven: how food and birth movements resist industrialization*. New York: NYU Press.

Sadler, M., Santos, M. J. D. S., Ruiz-Berdún, D., Rojas, G. L., Skoko, E., Gillen, P., & Clausen, J. A. (2016). Moving beyond disrespect and abuse: addressing the structural dimensions of obstetric violence. *Reproductive Health Matters*, *24*(47), 47–55. https://doi.org/10.1016/j.rhm.2016.04.002

Santos, M. (2012). *Nascer em casa: a desinstitucionalização reflexiva do parto no contexto português* (Master's thesis, ISCTE-IUL, Portugal). Retrieved from http://repositorio-

iul.iscte.pt/handle/10071/4684

Santos, M. (2014a). Private and Public Home Births - Comparing access, options and inequalities in Portugal and Denmark. In B. Padilla, S. H. Plaza, E. Rodrigues, & A. Ortiz (Eds.), *Saúde e Cidadania: Equidade nos cuidados de saúde materno–infantil em tempos de crise* (pp. 99–113). Retrieved from http://repositorium.sdum.uminho.pt/bitstream/1822/32484/1/Saude e Cidadania.pdf

Santos, M. (2014b). Trajetórias de desintitucionalização do parto. A rejeição da hegemonia biomédica na opção pelo parto em casa. *VII Congresso Português de Sociologia*. Retrieved from http://www.aps.pt/viii_congresso/VIII_ACTAS/VIII_COM0021.pdf

Santos, M. (2017). Where the thread of home births never broke - An interview with Susanne Houd. *Women and Birth*, *30*, 159–165. https://doi.org/10.1016/j.wombi.2016.09.008

Santos, M. (2018a). Can the unequal access to home birth be framed as a source of inequalities? A comparison between Portugal and Denmark. *Portuguese Journal of Social Science*, *17*(3), 335–347. https://doi.org/10.1386/pjss.17.3.335_1

Santos, M. (2018b). Institutionalisation and professional dynamics in home births: insights from a STSM comparing Israel and Portugal. In *CIES e-Working Papers*. Retrieved from http://cies.iscte-iul.pt/np4/1853.html

Santos, M., & Augusto, A. (2016). "Se estava tudo bem, porque é que eu havia de ir a uma obstetra?" - Identidade, risco e consumo de tecnologia médica no parto domiciliar em Portugal. *Sociologia, Problemas e Práticas*, (82), 49–67. https://doi.org/10.7458/SPP2016825922

Segal, S. (2007). The masculinization project of hospital birth practices and Hollywood comedies. *ESharp*, (9), 1–18. Retrieved from https://www.gla.ac.uk/media/media_41220_en.pdf

Serra, H. (2008). *Médicos e poder - Transplantação hepática e tecnocracias*. Lisboa: Almedina.

Serra, H. (2010). Medical technocracies in liver transplantation: Drawing boundaries in medical practices. *Health*, *14*(2), 162–177. https://doi.org/10.1177/1363459309353297

Shaw, D., Guise, J. M., Shah, N., Gemzell-Danielsson, K., Joseph, K. S., Levy, B., … Main, E. K. (2016). Drivers of maternity care in high-income countries: can health systems support woman-centred care? *The Lancet*, *388*(10057), 2282–2295. https://doi.org/10.1016/S0140-6736(16)31527-6

Simões, S. (2016, July 12). Condenação. A "moda perigosa" dos partos em casa. *Observador*. Retrieved from https://observador.pt/especiais/morte-e-prisao-a-moda-perigosa-dos-partos-em-casa/

Sjöblom, I., Lundgren, I., Idvall, E., & Lindgren, H. (2015). Being a homebirth midwife in the Nordic countries – a phenomenological study. *Sexual & Reproductive Healthcare*, *6*(3), 126–131. https://doi.org/10.1016/j.srhc.2015.02.004

Snowden, J. M., Tilden, E. L., Snyder, J., Quigley, B., Caughey, A. B., & Cheng, Y. W. (2015). Planned Out-of-Hospital Birth and Birth Outcomes. *New England Journal of Medicine*, *373*(27), 2642–2653. https://doi.org/10.1056/NEJMsa1501738

Sousa Santos, B. de (2014). *Epistemologies of the South: justice against epistemicide*. New York: Routledge.

Sundhedsstyrelsen. (2013). *Anbefalinger for svangreomsorgen [National guidelines for maternity care]* (2. udgave). Retrieved from https://sundhedsstyrelsen.dk/da/udgivelser/2015/anbefalinger-for-svangreomsorgen

Teijlingen, E. van. (2005). A critical analysis of the medical model as used in the study of pregnancy

and childbirth. *Sociological Research Online*, *10*(2). https://doi.org/10.5153/sro.1034

Tereso, A. (2005). *Coagir ou emancipar*. Lisboa: Formasau.

Thomas, G. M. (2017). Doing gender in a hospital setting: Reflections of a male researcher. *Sociological Research Online*, *22*(2), 1–14. https://doi.org/10.5153/sro.4307

Topçu, S. (2019). Caesarean or vaginarean epidemics? Techno-birth, risk and obstetric practice in Turkey. *Health, Risk & Society*, *21*(00), 1–23. https://doi.org/10.1080/13698575.2019.1641588

Torres, J. M. C. (2015). Families, Markets, and Medicalization: The Role of Paid Support for Childbirth and Breastfeeding. *Qualitative Health Research*, *25*(7), 899–911. https://doi.org/10.1177/1049732314553991

Treichler, P. A. (1990). Feminism, Medicine and the Meaning of Childbirth. In M. Jacobus, E. F. Keller, & S. Shuttleworth (Eds.), *Body/politics: Women and the Discourses of Science* (pp. 113–138). New York: Routledge.

Vallgårda, S. (2012). Hospitalization of deliveries: The change of place of birth in Denmark and Sweden from the late nineteenth century to 1970. *Medical History*, *40*(02), 173–196. https://doi.org/10.1017/S0025727300060993

Van Der Geest, S., & Finkler, K. (2004). Hospital ethnography: Introduction. *Social Science and Medicine*, *59*(10 SPEC. ISS.), 1995–2001. https://doi.org/10.1016/j.socscimed.2004.03.004

Vicente, G. (1562). *Obras completas* (Ed. fac si). Lisboa: Biblioteca Nacional.

Viisainen, K. (2000). The moral dangers of home birth: parents' perceptions of risks in home birth in Finland. *Sociology of Health and Illness*, *22*(6), 792–814. https://doi.org/10.1111/1467-9566.00231

Weber, M. (1978). *Economy and society: an outline of interpretive sociology* (G. Roth & C. Wittich, Eds.). Berkeley: University of California Press.

Weitz, R., & Sullivan, D. (1985). Licensed lay midwifery and the medical model of childbirth. *Sociology of Health & Illness*, *7*(1), 36–54. https://doi.org/10.1111/1467-9566.ep10831346

West, C., & Zimmerman, D. H. (1987). Doing gender. *Gender & Society*, *1*(2), 125–151. Retrieved from http://links.jstor.org/sici?sici=0891-2432%28198706%291%3A2%3C125%3ADG%3E2.0.CO%3B2-W

White, J., & Queirós, F. (2018). Reconcilable differences? Portuguese obstetricians' and midwives' contrasting perspectives on childbirth, and women's birthing experiences. *Etnográfica*, *22*(3), 643–668. https://doi.org/10.4000/etnografica.6041

Wind, G. (2008). Negotiated interactive observation: Doing fieldwork in hospital settings. *Anthropology & Medicine*, *15*(2), 79–89. https://doi.org/10.1080/13648470802127098

Winkler, I. (2017). Doing Autoethnography: Facing Challenges, Taking Choices, Accepting Responsibilities. *Qualitative Inquiry*, 107780041772895. https://doi.org/10.1177/1077800417728956

Wodak, R. (1997). Introduction: Some important issues in the research of gender and discourse. In R. Wodak (Ed.), *Gender and Discourse* (pp. 1–20). London: Sage.

World Health Organization. (2014). *The prevention and elimination of disrespect and abuse during facility-based childbirth: WHO statement*. https://doi.org/WHO/RHR/14.23

World Health Organization. (2018). *Intrapartum care for a positive childbirth experience*. Retrieved from http://www.who.int/reproductivehealth/publications/intrapartum-care-guidelines/en/

Annex

Interview guide

Interviews to home birth professional actors (doulas, midwives, etc.)

[Current] Aims of the PhD project:

- To analyse home birth as the front-stage of professional interactions, in order to identify which actors, professional and non-professional, are part of the set of resources mobilised during pregnancy and birth
- To observe the features and dynamics of the informal networks of support and assistance
- To describe and characterise the strategies of power-knowledge of these different social actors.

Main objectives of the interviews:

- To map the existing network of professional actors involved in home births
- To explore how personal biographies are shaped and are shaping the professional trajectories
- To explore views on the regulation and inclusion of home births in the broader health system
- To build ways of entering the field

1. **Can you share how you got into home births?**
    a. What drove you to develop your activities in home births?
    b. What made you chose/change paradigm?

2. **How different is assisting home births from assisting hospital births?**
    a. Can you give some concrete examples?
    b. Are there two different professional identities?
    c. Have you experiences moments of conflict between these two practices?

3. **How would you describe the existing network of home birth assistance?**
    a. How does a woman or a family gets in touch with you and gets to know you? The last time, how was it? Is this the usual way?
    b. How many professionals do you know? Do you have an idea of how many assist home births in Portugal today?
    c. Do you work isolated or in group? Thinking about the idea of a network, who is part of your network? With whom do you have a more close contact?

4. **How could home births be part of the official health system?**
    a. What happens, for example, when you transfer a woman to the hospital? Have you ever been in a home birth where there was a transfer or where you now think that transferring would have been the most adequate?
    b. Integrating home births into the NHS would, probably, require some regulation. How do you think this regulation could be done?
    c. What could trigger this regulation? And who could or should be behind this process? Or who is in better conditions for this?

5. **Would you consider having me with you in some moments so I could learn more about the organisation of home births?**
    a. There are certain aspects of the reality of home births that cannot be captured in interviews, and can only be captured observing while it takes place. I am specifically talking about the prenatal meetings, the home visits (including childbirth), and the meetings after birth. With the due consent of women, and with you consent, would you consider having me following you in some of these encounters?