COST Action IS1405 BIRTH
Building Intrapartum Research Through Health

STSM Report

Home births, gender, and the state

Comparing knowledge, power, and practices in Portugal and Israel

COST STSM Reference Number: COST-STSM-IS1405-38329

09-27 November 2017

Visitor: Mário Santos, MSc, Centre for Research and Studies in Sociology (CIES-IUL) at the University Institute of Lisbon (ISCTE-IUL), Lisbon, Portugal

Host: Sara Cohen Shabot, PhD, Women's and Gender Studies Graduate Program at the University of Haifa, Haifa, Israel

STSM - OVERVIEW

Title: Home births, gender, and the state - comparing knowledge, power, and practices in Portugal and Israel

Period: 09 and 27 of November 2017 (10 days were funded within the scope of this STSM)

Visitor: Mário Santos, MSc, Centre for Research and Studies in Sociology (CIES-IUL) at the University Institute of Lisbon (ISCTE-IUL), Lisbon, Portugal

Host: Sara Cohen Shabot, PhD, Women's and Gender Studies Graduate Program at the University of Haifa, Haifa, Israel

ABSTRACT

STSMs are a valuable tool for the exchange of scientific knowledge and skills. The aim of this STSM was to explore the social dynamics around home births in Israel and Portugal, in a comparative perspective. Professional dynamics, gender issues, and the role of the State are in the core of this comparative analysis. I am currently developing research on the professional dynamics of home birth professionals in Portugal as part of my PhD project. As such, this STSM was an opportunity to further explore home births in a different context – Israel. While in Israel, I lived for 3 days with a home birth midwife, I interviewed 2 home birth midwives, I participated in an interdisciplinary workshop for childbirth researchers, I was the keynote speaker in a seminar childbirth and feminist theory at the University of Haifa, and I met several times with Sara Cohen Shabot to discuss, among others, an article in production on gender and home births. In Israel, home births more institutionalised than in Portugal: there is a dedicated guideline issued by the government; and licenced home birth midwives are affiliated with an association that can work as a community of practice, at the same time as it mediates the communication between these midwives and other health professionals, and the state. The comparison between these two countries allowed me to expand my knowledge on the differences in the social and the legal status of home births internationally; but it also helped me to ask different questions regarding the Portuguese context – the one I am already familiar with – somehow renewing my sociological imagination. In this report, I describe the activities carried out, and discuss the results produced within this short research project.

KEYWORDS Home birth, STSM, Israel, Portugal

INTRODUCTION

Contemporary home births are rare events, and nevertheless they raise several social, legal and professional issues, as they usually do not fit with the socially established norm. Despite the global phenomenon of the hospitalisation of childbirth, led by the sanitarian concerns and the establishment of obstetrics as a medical specialty, particularly in the first half of the 20th century, many families opted and still opt to experience birth at home (Carneiro, 2008; Santos, 2017; Vallgårda, 2012). There are many motivations for this option, from a previous traumatic

experience at the hospital, to a desire for a more intimate environment, or a wish for securing the right to self-determination (Murray-Davis et al., 2012; Santos & Augusto, 2016). One can define home birth merely by reference of the space in which it happens, but the subjectivity and fluidity of meanings and practices in and around home births make this a very poor definition. And space, itself, can have different, complex meanings in home births, beyond being the mere place of birth (Burns, 2015).

Perhaps for being rare events happening in the private setting, little is known about home births when comparing with the knowledge produced on hospital births. There is a growing body of literature on the experience of childbirth at home, but many other social aspects remain little explored, particularly wider social dynamics, such as the professional dynamics – the issue of professionalisation, inter-professional conflicts, practices, routines and top-down or self-imposed rules.

My research project in Portugal aims at analysing 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; and to describe and characterise the strategies of power-knowledge of these different social actors. This project was used as a platform for the design of this STSM, where I aimed to explore the social dynamics around home births in Israel and Portugal, in a comparative perspective. Professional dynamics, gender issues, and the role of the State are in the core of this comparative analysis. Who is working in home births, and why? How do professionals combine home and hospital practices, and how do they network? Are home births a stage where particular gender dynamics are performed? With my stay in Israel, I planned to get to know the experience of different home birth midwives and, through it, acknowledge some of these dynamics.

My main theoretical framework is from the sociology of health and the sociology of childbirth. However, being hosted by the Women and Gender Studies Graduate Program at the University of Haifa was a strategic option, as gender issues and feminist theory offer a robust body of knowledge for discussing some of the aspects emerging from my research: ancient home births happened at home among women, and men had little participation in this event; midwifery historical was – and remains being – generally a female profession; and men only formally entered the field of childbirth with the advent of obstetrics (Carneiro, 2008; Donnison, 1977). Plus, contemporary home births are frequently associated with discourses on recovering childbirth as a feminine event and on giving birth back to women, and can thus be framed as a feminist claim; and, today, home births – as other places of birth – are generally no longer viewed as strictly feminine events, as men are socially expected to be involved and to participate, redefining gender roles in the private and the public sphere. Sara Cohen Shabot is an expert in philosophy and gender studies. The debate on the intersection around childbirth and gender has little development in Portugal (Santos, 2014); as such, being in Israel offered a valuable opportunity to discuss these issues with her and with other experts in this field.

METHODS

The STSM started long before the day of arrival. After being accepted, planning the operationalisation of this small research and networking project was challenging. Although Israel is a COST member state (with the status of cooperating state), the political and cultural issues, and the language made planning to be more demanding than expected. To some extent, it required acquiring basic knowledge about the history of the country, its political changes, its relations with other states, and its position in international charters and agreements; about the cultures, the religions, and the people, as well as its regional differences. Sara Cohen Shabot was indeed a precious help also in this early stage of planning this STSM, providing information, clarifying loose ideas, and breaking some myths.

After I arrived in Israel, approaching the field was performed using mainly qualitative strategies – ethnography and interviews. Regarding what was initially planned, there were less meetings and more time dedicated to data production than expected. This STSM had the duration of 10 days, although non-consecutive, from the 9th to the 27th of November:

9 Travel from Portugal to Israel.

9-12 Stay in Alon Shvut, a settlement in the West Bank, with Judy Slome Cohain, a home birth midwife trained in the USA, waiting for an Israeli formal midwifery licence.

13 Stay in Jerusalem. Interviewing Tammy Doron, a licenced home birth midwife.

19-22 Stay in Haifa.

Meeting and being mentored by Sara Cohen Shabot, to discuss and review an early version on my article on gender and home births.

Participating in an interdisciplinary workshop for childbirth researchers organised by Keshet Korem and Sara Cohen Shabot, where I gave a talk titled “Making the most out of the unexpected: Productive collaboration and non-linearity in my research on home births”.

Participating in the Gender studies seminar on “The Feminist Discussion on Motherhood: Philosophical, Psychological and Cultural Aspects”, organised by Sara Cohen Shabot and Chani Israeli, where I gave a lecture on “Doing gender through home births? Women and men crossing roles, norms and practices”.

Meeting Sivan Lienhart, a PhD candidate with a project on the bioethical aspects of home births, at the Faculty of Medicine of the University of Tel Aviv.

Interviewing Mihal Bonstein, a home birth midwife, chair of IMAHI – the home midwifery association of Israel.

27 Travel from Israel to Portugal.

RESULTS

Home births in Israel are in a further state of institutionalisation, compared to Portugal: there is a dedicated guideline issued by the government; and licenced home birth midwives are affiliated with IMAHI[1], the association of home midwifery in Israel.

In late 1980's and 1990's, home birth midwifery was still very much invisible and regarded as illegitimate. IMAHI was founded in 2001 by a small group of registered home midwives, before there was a formal and visible recognition of this branch of midwifery practice. Few midwives were available to practice at home, but the number raised after the establishment of the association, and today there are 24 associated midwives. The association publicly represents this professional group, mediating the communication between home midwives and other health professionals, and the state. It also works as a community of practice, promoting the definition of bottom-up, local consensus for home birth practices, and facilitating the communication and the pooling of experience between midwives. However, most of its members have above 50 years old, and few new midwives are working to become home birth professionals, leaving the future of IMAHI and the future of home births in Israel uncertain.

In 2008, seven years after the foundation of IMAHI, there was a governmental recognition of home birth as a legitimate option for women in Israel – despite still recognising institutional births as safer – and an administration circular[2], generally known as "the guideline", was published by the Ministry of Health. The guideline addresses specifications and conditions to carry out a home birth; exclusion criteria for homebirth; rules for treatment, registration and reporting; and rules for home-to-hospital transfers. It further presents a model of a written agreement between women and home birth professionals, a template for professionals to fill in with clinical information for each birth, a table for the assessment of the newborn, and a form for hospital transfers.

To grasp more details about home birth practices, I met several midwives, and interviewed three who can be regarded as representing distinct ideal types, as they offered different and complementary views on the overall situation of the organisation of home birth care. I do not offer her much detail about each interview individually, in order not to compromise confidentiality. Verbatim transcriptions in this report are both from interviews and from informal conversations with many other midwives, and were kept anonymous.

To meet Judy Slome Cohain, I opted for an ethnographic approach, and I spent three days with her and her family in their home, in an Israeli settlement in the West Bank. Settlements like this are generally considered illegal by the international community under the international law, a position which is disputed by Israel. There are 3180 people living in Alon Shvut[3]. To me, as a foreign visitor, it was impressive to see the walls surrounding the settlement, the guarded gate, and the contrast between the landscape inside and outside the walls. Being with Judy Slome Cohain helped me to grasp an insider's view on settlers and settlements, as well as to

[1] http://www.imahi.co.il/
[2] The guideline is available in Hebrew here: https://www.health.gov.il/hozer/mr17_2012.pdf and partially available in English here http://www.kolzchut.org.il/en/Home_Birth and here http://jerusalemdoula.com/ministry-of-health-on-home-birth/
[3] http://www.cbs.gov.il/ishuvim/reshimalefishem.pdf

produce and collect information about her professional trajectory as a midwife, and about midwifery practice at home in Israel. As someone pointed out to me, if midwifery practice at home is still described by many as marginal, Judy's practice would be in its outskirts – she is waiting for an Israeli formal midwifery licence and, for such, she is not part of the IMAHI, the Israeli association of home midwifery. Judy Slome Cohain was trained in the USA, and her certification was not yet recognised by the Israeli health authorities. When she arrived in Israel, she worked in an innovative project of respectful, humanised, women-centred care in a health institution, together with other foreign midwives, but the project eventually closed. She then started to offer support to families planning a home birth. From her discourse, she seems to have a very pragmatic approach to childbirth – she attends women who come to her, and she works with the knowledge and the tools she has available, assessing each situation and intervening when needed, aiming at the best possible outcome. It is worth saying her practice is scowled by many Israeli midwives and other health professionals. She was the first midwife to be rejected from entering IMAHI, although nowadays she is not the only one practicing without being part of the association. She was recently called for a meeting by the health authorities following complaints of alleged malpractice[4]. Still, today, she is a very active, resilient, and militant midwife, dedicated to research and publication, and to assisting women who ask for her assistance. Her position and her practice somehow make her loop between visibility and invisibility, recognition and criticism.

Tammy Doron is a midwife from Tsur Hadassah, not far from Jerusalem, where I met her. She was an educator for children with special needs, but later, decided she wanted to become a midwife. She trained in Israel, first as a nurse, and then as a midwife as, like in Portugal, it is compulsory to have a nursing background to be a midwife. She was over 40 years when she graduated. During her midwifery training, she already felt something was not right in the model of care she was being introduced to. But After being present at a home birth for the first time, she became very critical to the dominant ways of teaching and practicing midwifery. While she reported seeing many things she did not agree with, she acknowledges how it helped maturing her own position. Her midwifery practice at the hospital, offering emotional support, hugging women when she felt like it, contrasted with her colleagues' practice, which led to latent disagreement and conflict. Meanwhile, she followed midwives in their home birth practice and ended up finding a midwife who, contrary to most home birth midwives in Israel, was searching for a partner to set up a team. She now works in team with this same midwife, providing both antenatal care and intrapartum care for women who opt for a home birth.

Mihal Bonstein is the chair of IMAHI. I interviewed her after my lecture on gender and home birth, at the University of Haifa. She is one of the pioneers in home birth care in the country. She recalls how she has been attracted by nature and natural childbirth long before she became a midwife. It was after her first birth, at home, with a midwife, in the USA, that she decided she would like to offer this kind of care to other women. Later, already in Israel, she graduated nursing and midwifery, and had her 2nd child, also at home. Home births were always her target, as midwife. She knew they could be safe, but they could also be potentially dangerous, depending on many external and internal factors. She recalls how, early in her career, in one of her first home births as a midwife, she decided to recommend the family

[4] This meeting was audio-recorded and is available here: https://youtu.be/vew9Epm_6Bc

against having the baby there. The house had very poor accesses and a transfer would be problematic. Setting up the association meant having decisions like this one more institutionalised, and being more visible. Her practice also had a strong influence in her own health, and she now, not far from retiring, books less women per month than before, and invests part of her time teaching.

Beyond fieldwork, most part of this STSM I stayed in Haifa, where Sara Cohen Shabot shared her office with me. As an expert in Gender Studies, Sara's inputs on a draft version of an article I am writing, regarding gender issues in home birth professional dynamics, were of great value. She is now one of the co-authors of this article.

Additionally, I had an opportunity to meet Sivan Liehhart. Within the scope of the workplan of working-group 4 of this COST Action, I am coordinating a project aiming to map the organisation of out-of-hospital birth care in COST member states. Keshet Korem connected me to Sivan Lienhart some months ago, she became member of this project's research team and has contribute extensively to the development and the revision of the data collection tool. As such, meeting Sivan Lienhart offered a good opportunity to strengthen existing networks. She opened my lecture on "Gender and Home Births" with an introduction to the social and regulatory situation of home births in Israel which was very informative and useful, both for me and for the audience.

DISCUSSION

Exploring Israeli home birth care through this STSM, and comparing Israel and Portugal allowed me to expand my knowledge on the differences in the social and the legal status of home births internationally; but it also helped me to ask different questions particularly regarding the Portuguese context – the one I am already familiar with – somehow stirring my ability to inquire this social setting, refreshing my sociological imagination.

The main issues raised throughout this project were: formal hindrances to home birth caregiving; the others – non-licenced midwives and doulas.

Formal hindrances to home birth caregiving

The formal establishment of home birth care in Israel, through IMAHI and the guideline, brought visibility to midwifery and to home births, and it formalised the professional relation between home and hospital professionals, particularly in the event of a transfer. In Portugal, home birth care remains far from being formalised, and there have been some loose movements demanding home births to be recognised and clearly framed within professional recommendations and the law. Yet, Israel offers a good example of how being more formal can also bring new hindrances to quality care in home births. One midwife shared how, in her view, "visibility brings instability and makes it difficult for us to sleep at night".

Regulations, such as the guideline, may be written top-down by policy-makers who share the mainstream patriarchal views on childbirth, with little or no bottom-up participation of home birth professionals and women. Although it is a comprehensive document and it is regarded by many as a major step forward, the guideline is still criticised by home birth professionals (Meroz & Gesser-Edelsburg, 2015), by IMAHI and by other organisations for being too restrictive, for over-limiting what could be under the scope of normal birth care, for not being women-centred, and for discouraging home births. This guideline has no parallel in other fields of healthcare, with this level of detailing the competences and responsibilities of different professionals, in a way that it makes is similar to military chains of command (Brusa & Barilan, 2018). "It is a cage and a protection at the same time", as a midwife mentioned to me. Even after being revised, in 2012, it still could not meet the consensual agreement of all of those who are implicated, nor those who were involved (Blumenfeld, 2012). To give some examples: gestational diabetes must be ruled out, making the test compulsory for women who plan a home birth; plus, most midwives only accept starting antenatal care after having the result from the test, missing the first months of pregnancy. Another example: professionals must carry drugs, namely uterotonics, adrenalin, and vitamin K; however, midwives are not allowed to purchase these drugs from any local or hospital pharmacy. As another midwife mentioned, "they don't want to say it's legitimate, so they play these games". Also, a hospital transfer is compulsory after 12 hours of any type of membrane rupture, or in case of an arrest of dilation in the first stage of labour for over two hours, with the presence of regular contractions – these timings are argued to be too narrow, because "a clock and a good birth don't work well together", as a midwife said in this respect. These are some of the examples raised to claim how the state is limiting women's rights when restraining the professional autonomy of home birth professionals. In the words of another midwife, "we seem to be the vehicle to apply the rules and the policies into the women's bodies, into the labour context".

On the other hand, some interpret these rigid rulings as a limitation of women's rights, and as an invitation to unassisted home births and to un-licenced practices (Meroz & Gesser-Edelsburg, 2015). Is it clearly stated in the guideline that it is to be applied to the professional practice, not to home birth; any family is free to have a home birth outside the scope of the guideline, as long as they are not offered professional assistance. One midwife described a recent case in which a woman wanted a home birth despite having a previous caesarean section, and because she could not find a midwife who assisted her, she decided for a freebirth. Acknowledging the risks of an unassisted vaginal home birth after a caesarean and the woman's refusal to going to the hospital, two midwives decided they would stay with them at home. They were later charged for illegal activities but, according to this midwife, the court noted how "they performed very excellent practices, but still they were acting in an illegitimate way".

Others argue the guideline is among other policies for the government to discredit home births (Blumenfeld, 2012), because there are financial incentives undermining what could be an impartial support from the state. Hospitals are financed directly a flat-rate for each institutional birth, with or without interventions. Hospital professionals, particularly those in managing positions and in close connection with the Ministry of Health, are accused of lobbying against home births so that normal births from low-risk pregnancies take place in the

hospital, to lower health costs and to ensure this source of funding. It was described to me as "a pervasive funding strategy", in the sense that while there is this apparent interest in simple and normal births, there is also a great fear of litigation in case of a bad outcome, fuelling interventions and particularly caesarean sections. Still, in 2015 Israel reports a caesarean section rate of 16.2%, one of lowest in the OECD, while Portugal reported a rate of 32.3% (OECD, 2017).

Liability is a delicate issue also regarding home births. With strong evidence supporting both its safety (Birthplace in England Collaborative Group, 2011; Olsen & Clausen, 2012) and its dangers (Snowden et al., 2015), home births professionals in Israel, in Portugal, and in many other contexts seem to be walking the wire – the simplest mistake can have tremendous personal and social consequences. The acceptability of these practices seems to be permanently at risk. Home birth midwives in Israel could access a liability insurance until 2005, when two midwives were sued after attending two births, in a short period of time, which had bad outcomes. The insurance company retreated and, since then, no other insurance company offered liability protection for home birth professionals. This had wider consequences, as now many midwives, and younger midwives in particular, consider home births to be the unprotected branch of midwifery. This is pointed out as one of the reasons why so few midwives are applying to practice at home. According to some midwives, having more associated home birth midwives could enable a new liability insurance, and that could attract more young midwives. But without more midwives, there is no insurance, and without the insurance there are not many new midwives. It seems a cycle difficult to overcome.

Recently, another case led to prosecution. Allegedly, a very experienced midwife attending a home birth decided to transfer a labouring woman with full dilation, the waters broke at the hospital and there was thick meconium, and the baby was later diagnosed with cerebral palsy. Both the midwife and the hospital were sued, and this generated a wave of panic among home birth professionals.

Notwithstanding, some midwives acknowledge that having a recommended or compulsory insurance might also be a hindrance to home birth care, as it can be expensive enough to jeopardise independent midwifery practice, like it is happening in the UK and in other European countries (Cohain, 2007). Moreover, it can make it easier for women to sue midwives, when they know the insurance company will cover for the expenses, and not the midwife directly. Some families may also decide to put a case against the midwife even if they were satisfied with her professional performance. But "sometimes they need all the money they can get to support the needs of an impaired child, and taking legal action becomes one of the strategies", as one midwife shared.

The others – non-licenced midwives and doulas

Another consequence of formally establish home birth care in Israel, besides having top-down regulations defining good/legal practices, was having a formal distinction between eligible and non-eligible home birth professionals. The guideline defines two types of professionals who can attend home births: a midwife registered in the association of midwives in Israel with a

minimum of three years of experience in an official Israeli delivery room, and after attending at least ten homebirths supervised by an experienced homebirth midwife; and a doctor specialized in neonatal and women's health, with a certification of specialization and an Israeli license, who practices or practiced obstetrics in an official delivery room in Israel for at least three years. Nevertheless, there are several professionals who are left out of these definitions, but attend home births.

Many licenced midwives acknowledge the practice of non-licenced midwives, but formally there is a search for highlighting their differences. One midwife shared that "we invite them to go to our events and seminars, but we try to keep a distinction from them". Being un-licenced is understood by some as being free from the impositions of the guideline, and thus there are some accusations of un-licenced midwives attending home births of women with high-risk pregnancies, giving "home birth a very bad name"; of adopting an allegedly inadequate active management of labour and birth, even in non-problematic situations, illustrating this with the protocol for active management of the third stage of labour proposed by Judy Slome Cohain (Cohain, 2016); for not doing adequate and timely transfers; or for "doing dangerous things at home", in general. One of the midwives I met questioned: "but what is a home birth after all?" While the formalization allowed a definition and a regulation of home births, even if a disputed one, these un-licenced practices seem to defy the – rather fragile – existing consensus and the established order.

Doulas seem to occupy a distinct position in Israel, compared to Portugal. The level of professionalisation and their competences vary from country to country. In this STSM, I could not gather enough data on Israeli doulas, their organisation and their practices, that allows me to propose an in-depth analysis of their position in home birth care and their relationship with home birth midwives. However, there were some testimonies of how some doulas are allegedly threatening the public perception on home births, practicing outside of what is understood to be their scope of practice, namely carrying Pitocin, performing vaginal exams, or even independently assisting home births. Yet, some midwives agree this may be useful for someone who is present at home with a woman in labour before the arrival of a midwife, in order to be ready to administrate Pitocin in case of an emergent haemorrhage, or to perform a vaginal exam to know when to call the midwife. Still, the dominant position regarding this issue, in Israel and in Portugal, seems to be striving for midwives to have strategies for professional closure (Freidson, 1984) through the definition of exclusive knowledge and practices, particularly in home births.

The relation between midwives and doulas is, of course, subjective. There is the perception, like I found in Portugal, that "a midwife can be a doula, but a doula cannot be a midwife – midwifery contains both". There are home birth midwives who have refused working with doulas, despite being pressured by the families to accept it. Other midwives recognise benefits of having a doula, particularly when the midwife is working alone and not in a team. When alone, some midwives strong recommend the family to having a doula, but when working in teams, other midwives recognise the presence of the doula as redundant. Similarly to Portugal, there are latent conflicts between different home birth professionals, and the uncertainty associated with the informality of doula practices seems to sometime clash with

the somewhat unstable profession of midwifery, which today keeps redefining itself and striving to be an autonomous and recognised profession.

REFERENCES

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. http://doi.org/10.1136/bmj.d7400

Blumenfeld, R. (2012). New home birth rules okayed by obstetrics board despite criticism. *Haaretz.com*. Tel Aviv. Retrieved from https://www.haaretz.com/israel-news/new-home-birth-rules-okayed-by-obstetrics-board-despite-criticism-1.430712

Brusa, M., & Barilan, Y. M. (2018). Childbirth in Israel: home birth and newborn screening. In H. Boas, Y. Hashiloni-Dolev, N. Davidovitch, D. Filc, & S. J. Lavi (Eds.), *Bioethics and biopolitics in Israel: socio-legal, political and empirical analysis* (pp. 180–201). Cambridge: Cambridge University Press. http://doi.org/10.1017/9781316671986

Burns, E. (2015). More Than Four Walls: The Meaning of Home in Home Birth Experiences. *Social Inclusion*, *3*(2), 6. http://doi.org/10.17645/si.v3i2.203

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

Cohain, J. S. (2007). Mandatory malpractice insurance Increases CS rate & profitability of litigation, decreases planned homebirths. *Midwifery Today with International Midwife*, (84), 16–17. Retrieved from http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med5&NEWS=N&AN=18214260

Cohain, J. S. (2016). Back to Basics to Eliminate Postpartum Hemorrhage at Vaginal Birth. *Birth*, *43*(1), 93–93. http://doi.org/10.1111/birt.12209

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

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

Meroz, M. (Rosie), & Gesser-Edelsburg, A. (2015). Institutional and Cultural Perspectives on Home Birth in Israel. *Journal of Perinatal Education*, *24*(1), 25–36 12p. http://doi.org/10.1891/1058-1243.24.1.25

Murray-Davis, B., McNiven, P., McDonald, H., Malott, A., Elarar, L., & Hutton, E. (2012). Why home birth? A qualitative study exploring women's decision making about place of birth in two Canadian provinces. *Midwifery*, *28*, 576–581. http://doi.org/10.1016/j.midw.2012.01.013

OECD. (2017). *Health at a glance 2017: OECD indicators*. Paris: OECD Publishing. http://doi.org/10.1787/health_glance-2017-en

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

Santos, M. (2014). Para uma sociologia da maternidade - Um retrato temático da investigação sociológica portuguesa. *CIES E-Working Papers*, (194/2014). Retrieved from http://cies.iscte.pt/np4/?newsId=453&fileName=CIES_WP194_Santos.pdf

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

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. http://doi.org/10.7458/SPP2016825922

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. http://doi.org/10.1056/NEJMsa1501738

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*(2), 173–196. http://doi.org/10.1017/S0025727300060993