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Institutionalisation and professional dynamics in home births: insights from a STSM comparing Israel and Portugal

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Abstract

The aim of this paper is to explore some of the professional dynamics around home births in Israel and Portugal, in a comparative analysis. Institutionalisation of home births is recognised for its advantages, including making home births safer. In Israel, home births are more institutionalised than in Portugal: there is a dedicated guideline issued by the government; and licensed 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 between these midwives and the state. However, Israel also serves as an example of how institutionalisation may also lead to intra and inter-professional conflict and further limitation of the autonomous practice of midwives. The involvement of key stakeholders in the process of institutionalisation, including users, on the definition and review of regulations and guidelines seems vital for an adequate integration of home births in the wider health system.

Keywords: home birth, regulation, 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. The extent to which home births are integrated in the general health system seems to influence their safety, as settings with higher levels of institutionalisation of home births also present lower risks and better outcomes (Olsen & Clausen, 2012; Snowden et al., 2015).

My ongoing research project in Portugal is an ethnographic study, aiming 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 a short term scientific mission (STSM),[1] where I aimed to

[1] STSMs are tools for the exchange of scientific knowledge developed within COST Actions. More information can be found here: http://www.cost.eu/COST_Actions/networking (accessed 12 April

explore the level of institutionalisation of home births in Israel and Portugal, in a comparative perspective. Professional dynamics and the role of the state was at 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? With my stay in Israel, hosted by the Women and Gender Studies Graduate Program of the University of Haifa, I planned to explore the experience of different home birth midwives and activists, so I could, through it, analyse 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 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). The debate on the intersection around childbirth and gender has little development in Portugal (Santos, 2014); as such, being in Israel also offered a valuable opportunity to discuss these issues with several experts in this field.

Methods

The main research project in Portugal is a multi-sited ethnography (Hannerz, 2003; Marcus, 1995) in and around home births, including the direct observation of situations related to pregnancy, birth, postpartum, and the interviews to home birth professionals. The production of data happened mainly during the years of 2015 and 2017, and this data is now being organised and analysed.

The STSM took place in Israel, from 9th to the 27st of November 2017. But it 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 more demanding than

2018). This paper is a reviewed and developed version of the STSM report previously presented to the COST Action IS1405.

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 within international charters and agreements; about the cultures, the religions, and the people, as well as its regional differences. Previous informal contacts with local informants and the STSM host, 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. There were less meetings and more time dedicated to data production than expected. Fieldwork included ethnography in an Israeli settlement in the West Bank with an unlicensed home birth midwife, and interviews to Israeli licensed midwives in Jerusalem and Haifa. The STSM was also an opportunity to share and discuss research findings with other academics from the Women and Gender Studies Graduate Program, which allowed a validation and further development of this analysis.

Results

In Portugal, home births are not illegal, but they are not clearly regulated either. There is only one formal document with recommendations for parents who wish to plan a home birth, from the Order of Nurses, but it is rather limited and some of the statements made are missing an appropriate reference to evidence or to published discussions on this matter. Practices and the organisation of care varies between professionals, given the lack of a comprehensive guideline or of a tacit consensus between home birth midwives. The definition of what is one's independent scope of practice at home may differ from one midwife to another, and most midwives work mainly individually. Families having a home birth often hire a doula, but it is clearly established that doulas are not health professionals and are not eligible as birth attendants. In some doula groups, there is a sort of code of conduct defining as unacceptable a doula being at a home birth without the presence of a qualified health professional. Unlicensed home birth midwifery is rather infrequent, and most midwives who regularly attend home births are registered in the Order of Nurses.

Home births in Israel are in a further state of institutionalisation, compared to Portugal: there is a dedicated guideline issued by the government; and licensed home

birth midwives are affiliated with IMAHI,[2] 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 birth 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 birth midwives and other health professionals, and between these midwives 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 hospital births as safer – and an administration circular, generally known as 'the guideline',[3] 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 in this STSM, 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 – one in the West Bank, one in Jerusalem, and one in Haifa. 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

[2] http://www.imahi.co.il/ (accessed 18 November 2017).
[3] 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/ (all accessed 27 November 2017).

interviews and from informal conversations with many other midwives, and were kept anonymous.

In the West Bank, I opted for an ethnographic approach, and I spent three days in Alon Shvut, an Israeli settlement. 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.[4] 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 some of the locals helped me grasping an insider view on settlers and settlements, as well as to produce and collect information about the professional trajectory of the midwife I followed, and about her practice at home. As someone pointed out to me, if midwifery practice at home is still described by many as marginal, this midwife'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. She was trained in the United States of America (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 offering 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 whenever she understands is 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 outside of the association. She was recently called for a meeting by the health authorities following complaints of alleged malpractice.[5] 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.

[4] http://www.cbs.gov.il/ishuvim/reshimalefishem.pdf (accessed 2 December 2017).
[5] This meeting was audio-recorded and is available here: https://youtu.be/vew9Epm_6Bc (accessed 12 December 2017).

The second midwife was from Tsur Hadassah, not far from Jerusalem, where I met her. She was an educator for children with special needs, but later decided to become a midwife. She trained in Israel, first as a nurse, and then as a midwife – like in Portugal, a nursing degree is a prerequisite for the midwifery training. During her midwifery training, she already felt something was not right in the model of care she was being introduced to. After being present at a home birth for the first time, she became very critical to the dominant ways of teaching and practicing midwifery. She was over 40 years when she graduated, which allowed her to be even more critical to the midwifery program and to the contrasts between what was being thought in school and what she saw in clinical practice. 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 and physical support, with direct body contact, 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 full time as a home birth midwife, in a team of two with that same midwife, providing both antenatal, intrapartum, and postpartum care for women who opt for a home birth.

The third midwife was interviewed in Haifa. She is one of the pioneers in home birth care in the country, and one of the founders of IMAHI. 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 in nursing and midwifery, and had her second child, also at home. Home births were always her target, as a midwife. She knew home births could be safe, but they could also be potentially dangerous, depending on several factors, such as the training and skills of the birth attendant, the quality of antenatal care and risk assessment, the conditions of the home birth setting, the local and system-related constrains to a home-to-hospital transfer, etc. She recalls how, early in her career as a midwife, she decided to recommend the family against having a home birth. The house had very poor accesses, emergency transport would have been extremely difficult, and a transfer would have taken too long and would have been too problematic. Setting up the association meant having decisions like this one less dependent on individual criteria, more institutionalised, and more visible. Nowadays, not far from retirement,

she acknowledges how her midwifery practice was demanding and had a strong influence in her own health. She now books less women per month than before, and invests part of her time teaching.

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 are further discussed below, namely the formal hindrances to home birth caregiving; the intra and inter-professional dynamics; and the others – non-licensed 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 in the law. Yet, higher degrees of institutionalisation may constrain the independent practice of home birth midwives. Israel offers a good example of how being more formal can 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', also recognising how it may protect midwives from liability, but it also exposes their work to the evaluation and criticism from other professional groups.

Regulations, such as the guideline in Israel, 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 as service users. Although it is a comprehensive document and it is regarded by many as a major step

forward, the Israeli 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 makes it 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 of all of those who were involved (Blumenfeld, 2012). To name some of the most frequently mention critiques: gestational diabetes must be ruled out, making the test compulsory for women who plan a home birth, limiting the scope of informed consent. Plus, most midwives only accept starting antenatal care after having the result from the test, missing the first months of pregnancy. Another frequent critique is regarding the material required. 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, trapping midwives in a bureaucratic void. As another midwife mentioned, 'they don't want to say it's legitimate, so they play these games'. A third common critique is regarding transfers. Hospital transfers are 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 the midwifery independent scope of practice 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-licensed 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 her 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 that 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, which are usually less expensive, take place in the hospital, 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. In Portugal, insurances are said to cover the practice of midwives at home, and it is not formally established that a specific insurance is compulsory or highly recommended for independent practice. In Israel, the guideline made the insurance compulsory, and recently it was revised, only recommending it. Home birth midwives could access a liability insurance up until 2005, when two midwives were sued after attending two home births which had bad outcomes. The insurance company retreated and, since then, no other insurance company offered liability protection for home birth professionals. 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. This had wider consequences, as now many midwives, and younger midwives in particular, consider home births to be the unprotected branch of midwifery. It is pointed out as one of the reasons why so few midwives are applying to practice at home. According to some, 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.

Notwithstanding, some midwives acknowledge that having a recommended or compulsory insurance might also be a hindrance to high quality 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. One midwife shared how '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', which may also further compromise the already fragile social image of home birth.

Intra and inter-professional dynamics

Despite being generally uncommon, negative outcomes in home births may have wider social impacts, challenging the legitimacy of home births or triggering discussions on the current intra-professional dynamics – differently from the eventual wider social impacts (if any) that a bad outcome in a hospital birth would have.

Working individually or in teams has been one of the most visible change in these dynamics. Both in Portugal and in Israel, independent home birth midwives have been working mainly individually. The most obvious explanation would be the economic reasons behind this decision, as working in teams demands a significant increase in the amount payed out-of-pocket by the families, and implies less income for midwives for the same work, which may compromise independent practice in itself. As one midwife noted, when midwives work in a team 'they may charge more, but they don't charge double'. But another likely hypothesis is that home birth midwives, by

rejecting the hospital model of practice, frequently described as oppressive and under a permanent control and scrutiny from others, opt for a model of practice where they can be as autonomous as possible. And in many cases, this means working alone, instead of in a team.

However, in both countries, in the last few years there has been a tendency towards the constitution of permanent or one-off teams of two midwives in each home birth, to secure an effective response in case of an emergency and/or to insure additional protection in case of litigation. Yet, one of the midwives interviewed in Israel, who worked in a permanent team, acknowledged that it also has challenges. To some extent, it conditions their autonomy in their practice and decision making, and it implies an agreement on procedures, registration documents, payments, and on the general organisation of care, which may not be completely straightforward to accomplish. Despite not being the more effective solution, making an occasional team of two independent midwives in each home birth was regarded as a mid-range solution, allowing these midwives to avoid the constrains eventually found in a permanent team, while partially securing a more effective response in case of a complication.

Inter-professional dynamics are also crucial to the overall organisation of home birth care, and to the risk of negative outcomes. This may be one of the most critical aspects of the institutionalisation of home births, given the potentially ill effects of having a poor liaison between home and hospital professionals. In Portugal, women giving birth at home may not trust in hospital professionals and may fear censure and disrespectful care (Santos & Augusto, 2016), and transfers may be delayed. Meroz and Gesser-Edelsburg (2015) give a further account on how, in Israel, there seems to be a clear dissonance between the perceptions of home birth professionals and hospital professionals regarding childbirth, in general, thus explaining the difficulties in establishing effective communication and estrategic partnerships between home and hospital professionals. Yet, one of the interviewed midwives stated that, despite the hostility she generaly met when she arrived at the hospital after transfering a labouring women, she personaly opted to always follow each women in a hospital transfer, during transport and until she is admitted to the hospital. This was not formally stated in the guideline, but she recognised it as a good practice. Even so, both in Portugal and in Israel, not all women and not all midwives agreed that having a midwive with them in a hospital transfer was the best option, particularly in uncomplicated tranfers for minor reasons. This would label them as coming from a home birth, which could have an

influence in how care would be delivered. Thus, in both countries, and despite being at different stages of institutionalisation of home births, it is not infrequent that either the woman or the midwife decide that it is better for the woman to go to the hospital without a health professional.

The others – non-licensed 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. In Portugal, the registration in the Order of Nurses as a nurse-midwife or a midwife is enough for being able to attend home births. In Israel, 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 licensed midwives acknowledge the practice of non-licensed 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-licensed is understood by some as being free from the impositions of the guideline, and thus there are some accusations of un-licensed midwives attending home births of women with high-risk pregnancies, giving 'home birth a very bad name'; adopting an allegedly inadequate active management of labour and birth, even in non-problematic situations; not doing adequate and timely transfers; or 'doing dangerous things at home', in general. One of the midwives I met questioned: 'but what is a home birth after all?' On the one hand, having a definition and a regulation of home births, even if a disputed one, secures this higher degree of institutionalisation. But on the other, it also tends to simultaneously marginalise, condemn, and make visible non-licensed practices, regardless of their clinical legitimacy, given the fact that defy the – rather fragile – existing consensus and the established order.

Doulas also 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, which would allow 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 being informally taught to independently assisting home births. While this is broadly condemned by most home birth midwives, some confided 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. In Israel, 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 individually instead of in a team. When alone, some midwives strongly recommend the family to hiring a doula, but when working in teams, other midwives recognise the presence of the doula as redundant. Like in Portugal, in Israel there are latent conflicts between some of the home birth professionals, and the uncertainty associated with the informality of doula practices seems to, sometimes, clash with the somewhat unstable profession of midwifery, which today keeps redefining itself and striving to be an autonomous and recognised profession.

Conclusion

This exploratory, comparative analysis of home birth care in two different countries, despite being limited by a very narrow time-frame in the field, brings some relevant insights to the discussion of the position of home births in society. While higher

degrees of institutionalisation of home births are widely regarded as examples by home birth advocates, in Israel we find an example of how the process of integrating home births in the health system matter.

In Israel, home births are more institutionalised than in Portugal: there is a dedicated guideline issued by the government; and licensed 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 between these midwives and the state. However, there is also more complex intra and inter-professional conflict arising from the regulation and formalization of home birth midwifery, and further limitations to the autonomous practice of home birth midwives.

The involvement of key stakeholders in the process of institutionalisation, including users, on the definition and regular review of regulations and guidelines which can serve as models of good practice, seems vital for an adequate integration of home births in the wider health system.

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