**EUT** EDIZIONI UNIVERSITÀ DI TRIESTE
POLIARCHIE/POLYARCHIES, vol. 6, 1/2023
ISSN 2611-2914 (online)
ISSN 2611-4216 (print)
(98-128)
https://www.openstarts.units.it/handle/10077/20566
DOI: 10.13137/2611-2914/35192

# *Home birth in Italy. The role of freelance midwives and parents in collective action and social change*

# Il parto in casa in Italia. Il ruolo delle ostetriche libere professioniste e dei genitori nell'azione collettiva e nel cambiamento sociale

*Daniela Bandelli*

## Abstract

*During the Sars-Cov-2 pandemic, more couples in Italy considered giving birth at home with the assistance of private midwives, by questioning the social norm of a hospital birth. This article discusses the findings produced through a qualitative study that has reached 16 home birth experts and 22 women who gave birth at home between 2020 and 2022. It emerges that the midwives' dedication to their profession is embedded in their awareness of being contributors to social change (in terms of the demedicalisation of birth and women's empowerment) initiated in the 1970s by older generations of midwives and birth activists. Parents tend to make sense of their home birth as a matter of individual choice and wish that this choice could be soon or later normalized. However, midwives and parents rarely engage with policy makers and tend to be content to express their values in their professional practice and birth/parenting choices.*

Durante la pandemia da Sars-Cov-2, un numero crescente di coppie si sono avvicinate alle ostetriche domiciliari e hanno considerato la possibilità di partorire a casa propria assistite da ostetriche private, mettendo in discussione la norma sociale del parto ospedaliero. Questo articolo discute i risultati di una ricerca qualitativa che ha raggiunto 16 esperte del parto domiciliare e 22 donne che hanno partorito a casa tra il 2020 e il 2022. Emerge che la dedizione professionale delle ostetriche è supportata dalla consapevolezza di contribuire al cambiamento sociale (in termini di demedicalizzazione del parto ed emancipazione femminile) avviato negli anni Settanta da precedenti generazioni di ostetriche e attivisti. I genitori tendono a interpretare la loro esperienza di parto in casa come una scelta personale e auspicano che essa perda la sua accezione "alternativa" e sia accettata socialmente. Tuttavia, è emerso che solo raramente ostetriche e genitori dialogano con i decisori politici, mentre tendono ad accontentarsi di esprimere i propri valori nella pratica professionale da una parte e nelle scelte di parto e genitoriali dall'altra.

## Keywords

*Childbirth, Pandemic, Lifestyle social movements, Individual choice*
Nascita, pandemia, movimenti sociali e stili di vita, scelta individuale

## Introduction

When faced with the contagion containment measures applied by hospitals in various Western countries, including Italy, during the Sars-Cov-2 coronavirus pandemic, the interest of women and their partners in giving birth in their own homes with the assistance of private midwives increased (Davis-Floyd and Gutschow 2021; Drandić et al. 2022; Sestito 2022; Quattrocchi 2022; Rocca-Ihenacho and Alonso 2020). The ban on access to partners, doulas and relatives before, during and after childbirth was a major factor for their choice (Benaglia and Canzini 2021; Grotti and Quagliariello 2020; Human Rights in Childbirth 2020). This phenomenon is part of a previous trend observed in Europe from 2015 to 2019 of a slight but continuous increase in home births (Galková et al. 2019). It still remains a largely minority choice in industrialised countries (1-3%) compared to the social norm that birth (as well as death) takes place in medicalised spaces separated from family life (Katz Rothman 2021).[1] While in some countries,[2] the possibility of giving birth at home and in midwife-led facilities is supported through the integration of domiciliary and hospital-based maternal and child health services, along with economic support to families through public funds or compulsory insurance, in Italy there is a separation of hospital and out-of-hospital births. Furthermore, the possibility of giving birth at home in Italy is not generally publicised by birth pathways, with it being restricted to the private sector (with some territorial exceptions)[3] and only in some regions are the costs incurred by the families partially reimbursed (Quattrocchi 2018).

The connotation that home birth has in many countries including Italy is mostly that of a risky and irresponsible choice. This representation is not supported by scientific evidence. On the contrary, several studies (Campiotti et al. 2017; Christiaens and Bracke 2009; Houd 2022; Olsen and Clausen 2012; Zielinski et al. 2015) show that childbirth under physiological conditions, when assisted by midwives (midwifery model) in the woman's home or in non-medicalised out-of-hospital settings, such as midwife-led birth centres *(casa maternità)*, results in fewer interventions and complications, generates a sense of empowerment, and promotes a good breastfeeding re-

[1] The Netherlands is an exception (16% of births occur at home) since it has maintained policies throughout the 20th century that discourage the use of hospitals for physiological pregnancies (De Vries 2005).

[2] For example, Canada (Biggs 1983; Mac Donald 2001 2004), New Zealand (Surtees 2003), Australia (Coddington et al. 2017), Great Britain (Rocca-Ihenacho and Alonso 2020), Denmark (Jensen et al. 2017) and the Netherlands (De Vries 2005).

[3] In Italy, there is partial reimbursement for home births in Piedmont, Emilia Romagna, Marche, the provinces of Bolzano and Trento, and Lazio. Free public assistance is limited to the municipalities of Turin, Reggio Emilia, Modena and Parma.

lationship. Furthermore, there is no correlation between the number of home births and increased neonatal mortality (Galková et al. 2019; Scarf et al. 2018). Prejudice against home birth persists (Coxon et al. 2013), even though a good fifty years have passed since a women's movement began in North America, Australia, New Zeland and Europe to claim a woman's ability to give birth independently and safely with the accompaniment of other experienced women, as well as to emphasise that the choice of place and mode of birth is in effect a reproductive right (Daniels 2022).

This article intends to discuss whether the current renewed interest in the social practice of home birth in Italy signals the existence and/or revitalisation of a social movement and what kind of movement it is. The question, on the nature of a "world" that revolves around home birth, has already been discussed in part in the past by American and Canadian authors, with it usually being posed in these terms: does a social movement for the recognition of home birth still exist even though since the 1990s midwives have undertaken a process of professionalism, leaving behind an initial phase of political commitment to the claiming of women's rights? Furthermore, in current international literature, women who choose to be assisted by midwives at home are generally considered actors of the movement both in the pioneering phase of the 1970s, in which the language of the "women's rights claim" prevailed, and after the professionalism turn in the 1990s, in which they came to be qualified as clients; in this latter view, the movement is qualified as a consumer movement. Does this interpretation fit the current Italian reality? Do these two categories of subjects, midwives and families, recognise themselves in a collective identity and take part in actions to achieve a common goal? An attempt will be made to answer these questions in light of the first results emerging from a qualitative study conducted by the author in 2022.

The discussion will begin with some methodological clarifications and continue by outlining the main features of the home birth movement. It will review a number of texts which discuss how the North American movement can be defined as such even though it has gone through a process of professionalism and that families are an active part of it as consumers. This will be followed by a discussion of the Italian case. After outlining the history of the movement, the data collected will be presented: the nature of the actions of midwives and families, the frame of meaning within which the relations established between these subjects take place, and the influence of the pandemic on the phenomenon will also be highlighted. In the conclusions, it will be argued that the Italian movement for home birth has never been institutionalised but has been able to create spaces in which through the exercising of a personal choice and a professional practice, both rooted in the correspondence with one's own values with respect to health and birth, the original objective of giving women alternative choices to the hospital is achieved and at the same time contributes to an envisioned gradual social change.

## Methodology

The choice of starting from the North American literature and then analysing the Italian case is motivated by the fact that in current Italian literature no trace has been found of the questions that drive this essay. Even if there are some sociological studies on the evolution of the figure of midwives and on the medicalisation of childbirth (e.g. De Sanctis 2020; Perrotta 2009; Sbisà 1992; Spina 2009), there is a gap in Italian literature on the systematic analysis of these social movements and their influence on the politics of childbirth. If for North America, there are ad-hoc studies available that outline the evolution and composition of the movements, as well as discuss their impact on policies (among them: Cramer 2021; Craven 2010; Daviss 2006; Hoffman 2016; Declerq 2012; Katz Rothman 2016), for Italy, this information has to be extrapolated from publications dedicated to the competition of different models and cultures of childbirth, along with the evolution of the midwifery profession. In other words, Italian literature deals with the topic of natural childbirth (and marginally with home birth) mainly as a social and cultural practice but does not focus on it as a topic of collective action as it does in international literature (Wrede 2001). However, it is not excluded that the question of the nature of the movement has not been addressed by scholars from other European countries in languages other than English.

In an attempt to begin to bridge this gap, with the intention of reading home birth in Italy through social movement theory, without any ambition to innovate the theory itself, this paper proposes a reconstruction of the Italian case based on the current scientific literature, on the so-called grey literature produced by associations promoting home birth (conference proceedings, sector magazines, websites), as well as on first-hand data produced through semi-structured interviews conducted between May and December 2022 with the following subjects: 22 women (12 of whom were interviewed together with their partners) who chose to give birth at home or in "*casa maternità*" between 2020 and 2022 with midwives working in 8 Italian regions;[4] 16 birth professionals (with or without the title of midwife) who assist with home births or support the practice through cultural and educational activities.[5] The families were selected through the facilitation of midwives who sent their clients a short invitation message and through the dissemination of the same invitation by the researcher in WhatsApp

[4] Friuli-Venezia Giulia, Veneto, Lombardia, Emilia-Romagna, Campania, Basilicata, Abruzzo and Calabria.

[5] From here on, this category of subjects will be called private midwives or simply midwives when there is no need to specify. This study has involved only those private midwives who practice home birth; those who engage only in pre and post birth domiciliary care are not considered in this study being part of the home birth movement.

and Telegram groups. The age of the women is between 27 and 39 years at the date of the interview, their educational level varies from middle school to doctorate, with most of them being university graduates. Eight of them have only one child, and only two of the 14 multiparous women have no experience of hospital births.

Finally, two vocabulary clarifications should be made before starting. The first is to identify and define the movement under analysis in the broader panorama of movements calling for less medicalised childbirth. In current literature, "childbirth movements" are qualified by various adjectives including "alternative", "respectful" and "natural". Furthermore, the movement against obstetrical violence has also become relevant in the last decade. These are all contiguous movements that cannot, however, be regarded as synonymous, but rather define movements with partly coinciding and partly different, and sometimes conflicting, visions and goals (Craven 2010). It might be helpful to think of the home birth movement as one that makes a more specific and radical demand than the others. While the other movements aim to improve the conditions of women's childbirth, irrespective of location, and have had some degree of success in changing hospital practices (Katz Rothman 1982; 2016), the movement studied here works to remove childbirth from the medical-hospital monopoly to realise women's right to choose where they give birth to their children.

The second clarification that must be made regards the word "midwife" which literally means among women and has no medical etymology (Perrotta 2009). In Italy, it used to be translated with *levatrice* and *mammana* (Lanzardo 1985) in a time when childbirth assistants worked outside of the hospital and built their knowledge in an informal way (Spina 2009). However, this term refers to a now extinct figure and today the most common word is "*ostetrica*", who has medical training in nursing and childbirth but is neither a doctor obstetrician nor an *ob-gyn*. "*Ostetrica*" in Italy is used both to qualify those midwives who work in a hospital and embrace the biomedical model (med-wives or mini-doctors in international literature such as Davis-Floyd 2007 and Peterson 2017), as well as those who assist at home (only during labour or also in the expulsive phase) applying the "midwifery" or "holistic model" (Davis-Floyd 2001).[6]

[6] In the study presented here, only private midwives working at home in labour, delivery and puerperium care were involved. A number of birth attendants (including doulas) were also involved, who do not have the qualification of midwife and play a role in assisting the former and providing emotional support to women.

## An international look at the home birth movement: claims and evolution

The home birth movement was founded in the 1970s in the United States to counter the mass hospitalisation of childbirth by reclaiming women's authoritative knowledge on procreation (Davis-Floyd and Sargent 1996; Ford 2020). The aim was to gain recognition for the role of the midwife, discredited as a-scientific, backward and inadequate to manage the birth event, and to instil in women the lost awareness that they had the skills necessary to carry out childbirth at their own pace and movement. By reclaiming the home as a place of safety and female empowerment, the movement attempted to unhinge the aura of morality attributed to the medical control of childbirth, as it was deemed necessary to protect the foetus from the danger inherent in the female body (Turner 2002). Conversely, the movement drew attention to the dangers inherent in the hygienic conditions of hospitals and the consequences of interference in the spontaneous processes of childbirth and breastfeeding (Fage Butler 2017; Illich 1995).

The context in which these claims originated was that of feminist mobilisations and self-consciousness groups in which people practised self-visits to gain awareness of their reproductive apparatus (Martin 1978; Katz Rothman 1982). However, women who belonged to religious communities also participated and were guided by the principle of the sanctity of the foetus and the sacred role of women in motherhood (Cramer 2021; Klassen 2001). Today, parents who choose home birth generally belong to the middle class, have an above-average level of education (Galera-Barbero and Aguilera-Manrique 2022; Jackson et al. 2020; Viisainen 2000) and cross-party political preferences (Craven 2010; Declercq 2012). Some of these families pursue nature-inspired lifestyles, cultivate psychophysical well-being through holistic medicine; some choose home-schooling for their children, and generally follow intensive mothering and gentle parenting styles (Daviss 2006; Fedele 2016).[7]

In Europe, at the same time as the emergence of the US movement, Fréderick Leboyer, head of the obstetrics clinic at the University of Paris, and Michel Odent, head of the gynaecology department at the Pithivier clinic, were proposing natural childbirth in their facilities and stated in their publications that the way in which birth takes place affects the child's psychological and physical well-being in the long term and that medicalised birth imprints society's violent values on human beings. Hence the

[7] It is interesting to note that in Canada, after the regulation that also provided for subsidised forms of home delivery, the audience opened up to families with more ordinary and less health-conscious lifestyles, so much so that from being a niche phenomenon, home births are sometimes perceived as an 'a la mode' phenomenon (MacDonald 2001; 2004).

belief of home birth advocates that changing the way we come into the world constitutes an act of social transformation (Cheyney 2011). In the 1970s and 1980s in several European countries,[8] as well as in Australia and New Zeland (Pollock 2011), women began to organise themselves into groups to assist each other, refusing to undergo hospitalisation. They studied physiology and rediscovered knowledge of a midwifery art that had been devalued for centuries in comparison to surgical and medical techniques. Over time, these groups formalised themselves, founded associations, and addressed regional and national policy makers, putting forward two complementary demands: to guarantee every woman a real freedom of choice on where and how to give birth, along with the recognition of the midwife as an expert figure and point of reference from conception to the first years of a child's life.

The "new midwifery" (Katz Rothman 1982) founded by the movement does not propose a dichotomy between natural and artificial childbirth (Mac Donald 2004) but rather an integration of biomedical technique, used sparingly, only when necessary, with the traditional knowledge of various cultures (Cheyney 2011), preserving the non-interventionist approach centred on the woman's ability to make decisions responsibly and in line with her values. The new midwife does not claim to be the reference figure in all pregnancies, but only in the physiological ones (which constitute 80% of the total) and to maintain them through prevention based on the continuity of personalised care throughout the nine months in which a profound knowledge and trust is established between the family and the midwives (Department of Health 1993). This model, after the second half of the 1980s, under the impetus of the World Health Organisation (WHO 1985 a, b) gained progressive legitimacy, the midwife was recognised as a competent profession in the management of physiological pregnancies and her bodies acquired a key role in defining training courses and best practices. However, only in some countries[9] did this recognition translate over the following decades into the employment of midwives in out-of-hospital and domiciliary births, and true autonomy is still generally experienced only by private midwives as well as those working in public midwife-led birth centres (where they exist as for example in the UK) (Vermeulen et al. 2019).

The Italian context reflects this division: since 1994, the midwife is to all intents and purposes a professional figure responsible for assisting women during pregnancy, childbirth and the puerperium, as well as for providing care to the newborn. Access to the profession is gained through a three-year university course that is usually offered

[8] These include Great Britain (Kitzinger 1995), Norway (De Vries et al. 2001), Germany (Bruehl 2001), Italy (Schmid 1992) and Spain (Quattrocchi 2018).

[9] See note 2.

by Departments of Medicine, with a qualifying examination, and then with registration to the Order. At the end of university training, which is often based on the hospital model where the midwife is subordinate to the gynaecologist, every graduate is free to choose whether to seek employment in the public or private system, in hospitals, consultancies, clinics, or to go freelance.

In the United States, legal recognition of figures authorised to assist women in childbirth in out-of-hospital settings was slow in coming and continued to be a claim of the home birth movement until after the 2000s (Cramer 2021).[10] Since the 1990s, the movement in North America has repositioned itself from a movement in defence of women's reproductive rights to a consumer movement interested in expanding available birthing options and indirectly contributing to public health goals. At this stage, a capitalist lexicon, considered more effective in dialogue with legislators than that of the citizenry, was strategically adopted (Craven 2010), and midwives began to counter the stereotype of "*fricchettoni*" (hippies) that hung over them and their clientele (Cramer 2021).

## A social movement, between profession and consumer choices

The professionalism process has triggered profound reflections on the transformation of the relationship between midwives and women as well as on the meanings attributed to home birth (O'Boyle 2013): is it still a claim, a political act, an alliance between women? Or is it rather a relationship between providers and users of a professional service? The sociologist Daviss (2006), as well as a militant midwife in the movement, dedicates an essay to this question in which she reviews the main social theories on the profession (taxonomic, neo-Weberian and neo-Marxist) and on social movements (structuralist, resource mobilisations, political opportunities and collective identities), and then verifies how these theories can read the work of midwives in favour of alternative and integrative practices to biomedical intervention. Daviss' intention is to break the dichotomy between professionalism and social movement: she argues that the daily commitment to provide quality services for a good birth and to increase one's credibility is in itself a form of activism that requires a vocation, not only professional but a "calling" for a lifelong commitment to social change. Daviss emphasises how,

[10] In 2006, Certified-professional midwives were only licensed in 22 states; in 2019, they remained illegal in only eight states (Cramer 2021). In contrast, midwives with nursing training accredited by the American College of Nurse Midwives are authorised to practise only in hospitals, usually under the supervision of the obstetrician-gynaecologist, and only in very few states are they also authorised to assist at home.

even if American and Canadian midwives have promoted the development of ethical codes and training courses, the production of scientific data and the construction of a public image of credibility, they have not, however, gone through the process of professionalism that generally culminates in the establishment of an exclusive club with rigid criteria for access and a claim to a monopoly on knowledge and standardised practices, as well as control of other professions. In other words, the process of empowerment of "alternative" midwives has not involved the acquisition of power, entry into State bodies and public agencies, let alone the legitimisation of their knowledge in the dominant culture.

Daviss reads the participation of families in the cause as a trait of inclusiveness typical of the so-called "new social movements", i.e., communities organised around specific identities that propose to produce social changes on a vast scale, producing an impact also at an institutional level, through cultural battles to modify the dominant visions on a given subject with new values (Melucci 1985; Touraine 1995). Parents' participation in the movement is realised both through the "consumption" of the service, which fuels the collective process of conscious-raising, and in the organisation of actual associations such as the National Association of Parents and Professionals for Safe Alternatives in Childbirth (NAPSAC) (Daviss 2006). The role of families in the United States was also decisive in organising conventions, such as the Midwives and Mothers in Action (MAMA) in 2009 and the Big Push in 2008, to convince policy makers to allow non-nursing midwives to assist women in childbirth in non-hospital settings (Craven 2010).[11]

The American sociologist and militant Katz Rothman does not question the appropriateness of the category of social movement to frame the collective action of midwives, families and in general what she calls "birthies", people who seek the meaning of birth annihilated by the medical and mechanical view of the body (Katz Rothman 2016). Family participation plays such a prominent role in Katz Rothman's reading, with the framing she proposes being that of a consumer movement, similar – but with far more limited visibility and results – to the hospice movement and the healthy food movement. Katz Rothman recognises the public dimension of the individual's choice of birthing at home. Even if these consumer choices are primarily about seeking an experience of authenticity and can be interpreted as a 'lifestyle' issue, they represent a form of activism even for people who do not feel politically active, since these choices have an impact on collective values.

[11] The mothers together with the midwives also initiated direct lobbying actions by, for example, writing letters to policy makers and organising workshops for emergency procedures in rural communities.

Mac Donald (2001) also agrees with including mothers in the movement on the basis of her studies of the Canadian context: the women interviewed feel they are part of the battle for the recognition of midwifery, especially as members of the Ontario Midwifery Consumers Network. However, after regulation in 1994, they tend to describe themselves as average women interested in making the best choice for themselves, not as activists. Cramer (2021) and Craven (2010) also report that mothers tend not to describe themselves as activists or grassroots organisers, despite taking part in public initiatives in defence of the midwives' cause. Families who have experienced home birth lend themselves to becoming informal spokespersons for their midwives, usually for a limited period coinciding with pregnancy and their children's early years, periods of life that are ill-suited to activism.

Finally, the Hungarian context also supports the hypothesis of considering families as activists. In defence of the doctor, midwife and activist Agnes Agreb, accused of negligence in the death of a child, local groups formed by midwives and families succeeded both in mobilising international networks and in bringing mothers, fathers and children to the streets to protest, and managed to position the issue of home birth within the framework of Human Rights (Peterson 2017).

To what extent is the picture described in the international literature applicable to the Italian context, that of a movement formed by midwives and families who, through their profession and their choice, but also through communication actions and political interlocution, contribute to the common goal of giving home birth social legitimacy and legality? Are the categories of 'new social movement' and "consumer movement" proposed by Daviss and Rothman respectively, exhaustive of the current Italian reality? The following paragraphs will attempt to answer these questions through observations gathered in the field.

## The Italian Case

### *The origins, the evolution of the movement and its results*

The home birth movement in Italy was founded at the end of the 1970s within a national framework marked by the broad debate on the social dimension of illness, prevention and the public function of medicine, which led to the reform of the National Health System in 1978 (Giorgi and Pavan 2019). The hospitalisation process that had begun at the end of the 19th century reached a mass level in Italy in this period. There were hardly any empirical midwives (informally known as *mammane)* on the territory, and the *ostetrica condotta* or *levatrice* (a sort of certified midwife established in the 1930s, who used to be the main community reference point for all maternity-related

aspects), operated in the 1970s mostly in hospitals in a subordinate position to the gynaecologist (Lanzardo 1987; Perrotta 2009; Spina 2009).

According to the reconstruction of one of the founders of the movement, Verena Schmid (1997), in the pages of the magazine *D&D*, a strong impulse to the Italian movement came from the translation of Raven Lan's *Birth Book*. Through this book, Italian women came to know of the experiences of some American women who in those years gave birth at home with the assistance of female friends. In those years, some women, who would become protagonists of the nascent movement together with the aforementioned Schmid, encouraged by the French experiences of Leboyer and Odent, followed the intuition that it was necessary to form groups in which women could help each other to prepare to give birth free of hospital rituals. Starting with the foundation in 1979 of the first group of midwives for home birth in Florence, similar groups sprang up all over Italy in connection with each other and, with the need to strengthen their expertise on the physiology of childbirth, they found the collaboration of the physician Lorenzo Braibanti. In 1981, the Italian midwives who wanted to assist at home came together in a co-ordination, initially led by Schmid and later by Marta Campiotti, where they shared the knowledge gained from their experience at the side of women in labour and analysed the scientific literature, which led to the definition of good practices and guidelines. In 1991, the co-ordination was formalised into the National Cultural Association of Midwives in Homebirth and Birth Centres, which today unites approximately 180 midwives and some twenty midwife-led birth centres (since 2003 the Association has been called *Nascere in casa*).[12] In the same years, the *Scuola Elementale di Arte Ostetrica* (SEAO) was founded, which still today offers specialisation courses and training days, publishes the magazine *Archimetra*[13] and raises awareness of the importance of women's health and birth. In the second half of the 1980s, Piera Maghella, a perinatal educator who in London together with Sheila Kitzinger and Janet Balaskas organised meetings to promote the centrality of women and their right to choose where, with whom and how to give birth, they formed the *International Active Birth Movement*, a spontaneous association initially hosted by the feminist association *Casa delle Donne di Bologna*. This network led to the founding of MIPA (*Movimento Internazionale Parto Attivo*), today a training school based first in Modena and then in Serle (Brescia).[14]

[12] www.nascereacasa.it

[13] *Archimetra* succeeded the magazine *D&D* published for 30 years by SEAO.

[14] A crucial moment in the public presentation of the movement was the 1985 conference "The Cultures of Childbirth", organised by the Province of Milan, in collaboration with the Department of Sociology of the University of Milan and the Griff, Research Group on the Family and the Condition of Women (Oakley 1985).

The 1990s were marked by a strong commitment to institutional interlocution. The alliance of several political representatives, both in Parliament and in the Regions, made it possible to give impetus to a number of proposals and bills on home birth and *case maternità* (e.g., De Simone 1192/2001 and Amati 260/2008), as well as local experimentation projects with a number of local health authorities, including hospital birth centres in Florence, Genoa, Turin and Rome, encouraged by a resolution passed by Tiziana Valpiana, MP. Despite this commitment, to date in Italy there are no comprehensive public policies supporting the real possibility for women to choose to give birth in their home or midwife-led birth centres, with it depending mostly on the presence of private midwives in the area as well as on the possibility of families to bear the expense. Only in Reggio-Emilia and Turin is a domiciliary midwifery service directly provided by the public system. Other local authorities, including the Regions of Emilia-Romagna and Marche, the Autonomous Provinces of Trento and Bolzano (laws of 1998), Piemonte (law of 2002), and Lazio (laws of 2011 and 2014) provide partial reimbursement of the expenses incurred. Other regions (Lombardy with its 1987 law, Abruzzo 1990, Liguria 1995, Valle D'Aosta 1998, Marche 1998, Toscana 1999, Sicilia2003) have over time passed laws in which the issue of home birth is mentioned or dealt with in more detail, but without providing for any real integration or support.

While requests for home birth and midwife-led birth centres remained largely unheeded, in the 1990s many hospitals began to accept some of the measures to humanise birth, proposed not only by the movement but also recommended by the WHO (De Sanctis et al. 2020; Schmid 1992). It became less frequent to prevent women from moving and eating during labour, fathers were welcomed into the delivery rooms, albeit as spectators, some facilities arranged for rooming-in and time for skin-to-skin contact with the newborn, and women began to make their wishes heard by including their own Birth Plan in their medical records. However, this flurry of sensitivity has not succeeded in changing the structure of the relationships between the various figures and the woman's approach to control (Schmid 1992), nor in undermining the hegemony of the biomedical model, which has progressively been strengthened through continuous innovations in practices and techniques to accelerate or monitor childbirth (Pizzini 2001). To date, Italy remains one of the countries with the highest medicalisation rate of pregnancies in Europe: only 9.4% of women comply with the only three ultrasound scans recommended by the WHO, 38% of deliveries take place by caesarean section, while the lithotomy position, induction with oxytocin and episiotomy are still routine practices (De Sanctis et al. 2020; Donati et al. 2005; Quattrocchi 2014). Nearly 80% of pregnant women are attended by a gynaecologist (Quattrocchi 2014), 88.2% of deliveries take place in public and equivalent care facilities, and less than 1% of mothers choose to give birth at home or in "*casa maternità*", (CEDAP 2021). Being over 35 years

old, highly educated, multiparous, and living in a small town in central and northern Italy are factors that increase the likelihood of a woman choosing to give birth outside the hospital (Campiotti et al. 2018)

At a conference held in Ischia in April 2000, the Italian movement together with several European exponents drew up rules for the opening of midwife-led birth centres, renewing the invitation to legislators and the public health system to support them, while warning against possible distortions of the project due to the infiltration of patriarchal or technocratic thinking (Schmid and Contin 2001). This concern is still widespread among freelance midwives but coexists with continuous attempts at a dialogue and collaboration with territorial health structures. Despite this basic scepticism, the movement has continued to demand, citing field studies and WHO guidelines with an evidence-based approach that sets it apart, that health authorities recognise the effectiveness of home-based midwifery care and the satisfaction of women who give birth in this way, with home birth therefore being integrated into or affiliated to the public health systems so that it becomes one of several forms of care that all families can concretely choose.

The first decade of the new millennium was a period of increased interest in the press and at the same time a time of generational renewal, with new young midwives arriving in the national co-ordination eager to learn from the founders and bring a different approach to communication (Campiotti 2016). Despite a general lack of interest on the part of the State, thanks to the formation of working groups and associations of private midwives, who sometimes experiment with opening private midwife-led birth centres, home births have survived and become consolidated as a social phenomenon, albeit a minority one and with the connotations of otherness compared to the norm of hospital births.

### *The results of the study: freelancing, individual choice and contribution to social change*

Interviews carried out with private midwives show that the passionate provision of quality care to women monopolises their time, leaving little room to devote themselves to anything else. Private midwives, often associated in teams of 4-5, offer visits during pregnancy and puerperium, on-call from 37-38 weeks, assistance during labour and delivery, and transfer to hospital when needed or desired. Continuity of care involves repeated discussions with colleagues, either through ordinary meetings or extraordinary meetings when a problem arises during a pregnancy or a request deviates from the ordinary ones. In addition, they are engaged in providing pre- and post-natal courses, which are also open to couples oriented towards giving birth in hospital.

Lastly, there is the continuing education component and the weaving of collaborative relationships with various health professionals (paediatricians, gynaecologists, osteopaths, nutritionists, psychologists, masseurs, yoga teachers, etc.) to offer them a solution for almost every need. Another routine activity is the cultivation of good relations with hospital doctors and midwives, which are essential to better manage situations in which a woman needs to be transferred during labour or after childbirth, as well as to offer domiciliary screening services (e.g., for streptococcus and metabolic diseases of the child) without having to go to a hospital facility before and after childbirth. These agreements, in the absence of regional laws, are often verbal and subject to renegotiation when departmental management changes. In addition, the personalisation of care involves a great deal of dedication: not only must the biological and clinical data of each woman be understood and analysed, but also their biographies, the stories that have marked their perceptions of motherhood, psychological characteristics, desires, and so on. Assisting home births as a private midwife entails complete responsibility and the relationship with the woman is always ongoing throughout the pregnancy.

> *"There are cases that don't let you sleep at night. It's not like at the hospital where I was covering the shift and I was providing service within a hierarchy. Here I am immersed 360° and I can't not to be there" (interview 1)*

It is important to highlight how the performance of all these professional activities is set within the frame of a commitment to social change. There is a widespread awareness of contributing, birth after birth, to nurture that slow cultural change towards a greater acceptance and knowledge of home birth, triggered by the senior midwives who founded the movement and continued, albeit with ups and downs between greater popularity and ebbs, to the present day. The intention of these midwives, or at least their hope, is to contribute to the unhinging of the prejudice of imprudence or extreme courage that still weighs on women who approach this birth option, inhibiting their freedom of choice. The transformation of home birth from a deviant practice to a normal expression of a choice among several available possibilities can be identified as an ideal goal to which midwives want to contribute with their professional commitment.

> *"The goal is that our children, born at home, will one day be able to say it openly because in the meantime we will have worked to make this mode of birth known and make it normal" (interview 2)*

The dedication to care and the corollary activities described so far leave little room for activism, in the sense of organising street events, collecting signatures, petitions and

political pressure for the improvement of laws and greater integration of domiciliary services into the public health system. On this aspect, a change of pace emerges with respect to the militant vocation that characterised the pioneers.

> *"There has been a generational change, and we younger ones focus more on strengthening the scientific and professional aspect, and less on the political aspect" (interview 3).*

This is not to say that in recent years there have been no attempts at interlocution for policy change, but they are to be read as isolated and marginal initiatives in relation to the "core mission" of the movement.

It is also worth noting how among the midwives interviewed there is a certain extraneousness with respect to the campaigns promoted by other civil society groups (obstetrical violence, gender violence, termination of pregnancy, access to assisted procreation techniques, patients' rights, alternative medicine movement, etc.). At most, there are personal relationships with associations and activist groups, but these do not evolve into partnerships, alliances or formal support. This is always motivated by a lack of time, by not being invited or asked as well as by an implicit decision to maintain neutral positions on divisive issues to be able to concentrate on assisting women regardless of ideological beliefs.[15]

The lack of dialogue with national and local government bodies is also partly due to a widespread mistrust in the ability of the public health system to understand and apply the female paradigm of childbirth without distorting it with measures designed based on protocol culture:

> *"making laws is dangerous because they provide the space in which to insert patriarchal rules, i.e., based on the control of the woman who is made to obey" (interview 4)*

An expression of this side-effect is, for example, that in some regional laws the reimbursement of expenses for home birth is tied to the performance and results of certain clinical tests. In other words, reimbursement only takes place if the physiological conditions of the pregnancy are verified. The tests are carried out by applying parameters decided according to the medical model, which tends to trigger the protocol of a pregnancy at risk even under conditions that in the midwifery model are considered simply elements to be kept under control.

[15] Departing from this division, there is the *casa maternità* based in Caserta, in Southern Italy, which is openly committed to combating violence against women and is a reference point for reproductive health for a feminist organisation.

On the other hand, in the face of this widespread mistrust, there is a shared recognition of the importance of the integration of public hospital and private home-based services, along with the involvement of private midwives in the formulation of birth pathways. In Emilia Romagna, where this occurs and is provided for by a law that has now been in force for fifteen years, there is a more serene and satisfied attitude towards collaboration with the regional government bodies and medical authorities.

From what has emerged, we can conclude that private midwives engaged in home birth in Italy can be reflected in the description given by Daviss (2006) insofar as this profession entails a strong vocation and a lifelong commitment to social activism. However, activism should be understood as nothing more than constant dedication to daily practice consistent with the intention of contributing to social change. We could say that the activism of Italian midwives is a form of epistemic politics (Morgan 1998): through the daily practice of midwifery, they question the biomedical paradigm of pregnancy and birth, while spreading knowledge about the midwifery model. In a space of legality, which they do not need to defend at the moment, these midwives exercise a profession which for them also represents a dedication with an immediate social impact, insofar as it enables some women to exercise a choice, and with a long-term impact in terms of the greater social legitimisation of that choice.

> *"Every time a woman chooses how and where to give birth, whereas before she met me, she would have instead taken the closest and easiest option without questioning the choice, a small political act takes place. It is political because it moves a need not perceived before that will become an explicit need and that will move change" (interview 5)*

As for families giving birth at home and in *casa maternità*, do we have reason to consider them, as current international literature suggests, as both consumers of a service as well as part of a new social movement? First of all, it should be noted that during this study, the term "consumers" was never come across. It can be suggested that the collective identity of the families who turn to domiciliary midwifery care is not defined by their activity of consuming a paid service, although it cannot be denied that for all intents and purposes the reason why relationships are established between couples and midwives is precisely a choice of "critical consumption" (Katz Rothman 2016): this choice sometimes springs from a sense of injustice in their own experience (Pelizzoni 2014), such as a bad childbirth experience in the first or third person; at other times, it stems from not wanting to live through a hospital experience in which they fear feeling uncomfortable or unsuited to their own feelings. However, it should be pointed out that this choice reflects individual values and does not translate into collective mobilisation (Micheletti 2003). Neither does the word "activists" seem suitable to qualify the

collective identity of the families interviewed, either if relying on their self-perception, or if adopting a theoretical perspective of contentious politics and therefore looking for the presence of these subjects in street demonstrations, conventions or political pressure initiatives.

> *"Italian mothers do not chain themselves to defend their midwives as happens in other countries" (interview 6)*

> *"If it does not start from women, it is useless for us to put pressure on the institutions. If anything, politics moves if a need is expressed and as long as women do not demand …. nothing will change" (interview 7)*

Despite this general tendency, the following mobilisation attempts were encountered. During the pandemic, two couples wrote to the President of the Veneto Region to urge for the provision of reimbursement for the cost of home birth. They also produced a video and opened a website to create mobilisation around their missive. In Lombardy, a couple of new mothers have written a popular initiative law (even if they still have not had the opportunity to collect the signatures necessary for its presentation). Once again, the request is for a reimbursement. A few years earlier, a group of midwives had attempted the same objective, but without any success. Less recent actions include the following: the protests of women to save *Acqua Luce*, the only public birthing centre in Lazio, which operated intermittently until 2017; the pressure actions of caesareanised women who in Puglia united in 2012 in the non-profit organisation *Rinascere al Naturale* and presented a petition for the regulatory recognition of out-of-hospital childbirth; a similar effort of awareness-raising and political pressure is also being carried out by a group of civil society associations in Calabria to see the light of the proposed regional law presented in 2017 (Mirabello and Guccione 240/10), which provides for both the reimbursement and direct payment.

The realisation of a real freedom to choose whether to give birth at home or in a non-medicalised facility such as a *casa maternità*, regardless of their economic and social status, seems to be a common wish. However, there is also a widespread opinion that the cost is not an insurmountable obstacle for those who are really determined to make this choice, but it has a deterrent function for the undecided. It is common practice to save up even before getting pregnant, to have collections among friends and relatives and to launch crowdfunding. Moreover, private midwives are generally open to generous extensions. More than affordability, the real possibility of exercising the right to decide where to give birth is weighed down by the little or no information that women receive from private gynaecologists and public reproductive health cen-

tres (*consultori*) about the possibility and safety of giving birth at home: most women learn about this option through chance encounters, personal relationships and readings, some before pregnancy but others only after they become pregnant. This lack of communication is perceived as a greater injustice than the economic disadvantage, since it prevents most women from knowing what their rights are and from asking themselves what is best for them and the birth.

> *"I think it is the lack of information that has deprived women of the opportunity to know that they can give birth themselves; they have entered the tunnel of the hospital because everyone does it there and it seems irresponsible to do otherwise. If you are not in a certain circle of people and if someone doesn't take you there, you don't even know that midwives exist outside the hospital. I hope that one day women will be free to choose: if they feel comfortable in their environment, they should be able to do so freely. I hope it can become an informed choice on a large scale and that it no longer burdens the family budget" (interview 8)*

The pandemic has acted in the described context by deteriorating the perception of safety in hospitals and prompting more women to seek alternatives to the norm (Sestito 2022). However, it is a common opinion among the midwives interviewed that the compulsion to give birth without a partner or midwife of choice, or the fear of contagion or of being taken away from the baby, were not by themselves sufficient factors for the many women who approached them over the last three years to actually decide to go through with it. More women have been exposed to this birthing option, with the stories of home births having broken through the wall of silence. However, the collected interviews reveal that the birthing conditions imposed by hospitals were at most an incentive or a "trigger" for choosing to give birth at home in people who already had some interest in this world, or in people who had only just become acquainted with it during pregnancy but already beforehand had a critical attitude towards medicalisation and were cautious about the use of drugs. Moreover, the social perception of hospitals as places of contagion meant that couples inclined to give birth at home were supported in their choice, or at least not judged as foolish, by relatives and friends. For many couples, giving birth at home marked the beginning or furthering of a path of knowledge of gentle parenting, in which from the very moment of birth they learn to approach their children with respect for their times, needs and inclinations. The exercise of this choice also represents for many a gateway (via WhatsApp and Telegram groups, online and face-to-face courses, and direct contact with other parents who have given birth with the same midwives) to knowledge on the independent and drug-free management of minor health problems of adults and children, educational experiences, references to professionals and childcare services, along with information on recreational events and courses. Sometimes these paths give rise to

friendships or become bridges to other communities such as home-schooling and outdoor kindergartens.

The mothers and fathers who have chosen a home birth in these years do not feel part of a social movement or a cause and frame the meaning of their action in the discourse of freedom and plurality of choice, suitable for their own person and their own visions of life, not for all women.

> *"I feel that I am consistent with the lifestyle I have chosen and want to be an inspiration to others. However, the place of birth is something that everyone chooses in a very personal way. We gave birth at home but I don't criticise those who go to hospital, in fact if they are not aware they are better off going to hospital. I don't think change comes with battles but with continuous drops brought by every single person who maintains a daily consistency. I see social movements as movements of squares and protest, and Covid has shown us that we no longer need that mode. Consistency of lifestyle choices, consistency with myself, is much more important" (interview 9)*

For the interviewed families, their own childbirth is not a political act (as it is for the midwives whose profession contributes to the broader cause of demedicalisation and to the claim of social recognition of their knowledge): there is at most an awareness on being increasingly numerous and somewhat less stigmatised, especially thanks to the changes in the collective perception of hospitals during the pandemic. These families seem to participate not so much in collective actions but rather in social networks, the constitution of which is facilitated by the midwives, in a more structured way when there is a *casa maternità* that acts as a physical meeting and sharing place. In some cases, these networks manage to interweave sufficiently to be considered communities, geographically delimited by the radius of action of the same group of midwives, whose members share first and foremost a common choice of childbirth but also similar approaches to health and parenting.

## Concluding remarks on the nature of the movement

It has been seen how in the current international literature on home birth, families, midwives and other birth professionals are considered part of a social movement. It has also been seen that the application of the category of movement to these "worlds" has been problematised in light of the professionalism process of midwives and their discursive repositioning from women's rights to that of consumer choices. In these concluding reflections, it was intended to contribute to the aforementioned problematisation, reading the observations that emerged from the study of the Italian context

in light of social movement theory. It should first be pointed out that the definitions of social movement are varied and over time have been reshaped to include forms of collective mobilisation with a low degree of organisation, long periods of inactivity and low visibility, little interest in addressing the State, and intent on producing cultural changes rather than changes in policies. Nevertheless, Snow and colleagues (Snow et al 2004: 6) make it clear that most definitions are based on three or more of the following axes: "collective or joint action; change-oriented goals or claims; some extra- or non-institutional collective action; some degree of organization; and some degree of temporal continuity". The proposed definition is therefore as follows: "collectivities acting with some degree of organization and continuity outside of institutional or organizational channels for the purpose of challenging or defending extant authority, whether it is institutionally or culturally based, in the group, organization, society, culture, or world order of which they are a part" (Snow et al 2004: 11).

This study has found how there are organisations that have been engaged in the training and dissemination of the midwifery model for decades (SEAO and MIPA for example), while the midwives united in the Association *Nascere in Casa* mostly focus on the provision of services, always accompanied by a profound dedication and awareness of the social significance of their action. At the same time, it emerged that couples give birth at home for personal reasons and without wishing to commit to a political act or civil disobedience. They do not consider their own choice more just than others and they do not wish to be labelled in a social category defined either by their choice of birth or by any kind of ideology. It was also observed that the reimbursement of expenses, the demolition of prejudice and the normalisation of home birth are recurrent themes among the women interviewed and their partners. However, it should be emphasised that these themes are mostly formulated in terms of expectations from the future, so it would be specious to see in them a real common objective capable of generating any collective action. It also emerged that, except in a few rare cases, women are not engaged in public protest actions and do not form themselves into associations, as is the case in other countries. Finally, only sporadically do midwives and families initiate an interlocution with legislators to generate policy change.

It could therefore be concluded that in the informal networks of midwives and parents, even if linked by common perspectives on the naturalness and medicalisation of birth, the axis of collective action, understood as "any goal-directed activity engaged in jointly by two or more individuals, for the pursuit of a common objective through joint action" (Snow et al 2004: 6), is hardly visible at this historical stage. Specifically, a clear and declared common goal is missing. It could not be concluded from this study that midwives and parents work jointly, except in a few sporadic initiatives, to achieve a social impact such as universal access to the choice of place of birth. It is more accurate to

state that they are content to contribute to a slow cultural change through the exercising of a profession on the one hand, and through the exercising of choice on the other.

In a diachronic perspective, it might be useful to read home birth in Italy as a social movement that experienced a phase of effervescence (Alberoni 1997) between the 1970-80s which, however, was never followed by a phase of institutionalisation. This is evident from the fact that today this practice falls in a large part of the national territory in the private sector and that the associations supporting home birth are not the usual interlocutors of the national and regional medical authorities and political decision-makers. After the effervescence, the home birth movement embarked on a different kind of process, that of commercialisation (De Nardis 2006). This has led to the following results: the self-organisation for the provision of an absent service, and its diffusion throughout Italy, albeit in a patchy manner; the widening of the birthing options that women can choose, making the right not to use hospital care a little more concrete, although the exercising of this right remains tied to economic availability and the family's degree of knowledge; the consolidation of a professional sub-community or epistemic community with common views on birth, as opposed to the formal midwifery register; the formation of networks of families who have given birth with the same midwives and who share their knowledge and experience. A kind of "comfort zone" seems to have been established in which midwives who wish to do so can engage in freelance work, train to assist at home, find a supportive professional community at a national level, organise themselves into territorial teams in associative form, find professionals to collaborate with the public health system and, from time to time, attempt to promote changes in social policies. The professional activity of private midwives has the twofold function of filling the limited demand for domiciliary services, given the low number of women who are aware of and consider the possibility of giving birth on their own in a non-medicalised place, and at the same time contributing daily to public awareness, which will inevitably lead to the enlargement of the aforementioned niche.

In this "comfort-zone", it was possible for a sub-culture to form (Yinger 1960), with a set of values about pregnancy, birth and parenthood, that are different from and opposed to those of the dominant birth culture in Italy, being cultivated by a group of people who choose not to conform and wish for a gradual expansion and acceptance of their vision in society. Participants in a sub-culture generally have no intentions of subversion or conflict with other groups or representatives of the dominant culture, at least as long as they are left free to choose and live according to their own values. *Case maternità* are important physical locations in the production of this sub-culture. They act as facilitators of relationships and networks of families in which experiences, information and advice on parenting are shared, along with the psycho-physical well-being of women and children. However, unlike other sub- or counter-cultures such as

veganism (Righetti 2018), that of home birth has not been integrated into the social body and is not conveyed into the mainstream. This allows it for the time being to resist the processes of incorporation, co-option and commodification.

In light of the absence of a clear and declared mobilisation objective as well as a strategy for achieving it, reading the aforementioned networks as a social movement is problematic (Diani 2003). More precisely, the families who choose it should not be included in the home birth movement, since they do not act in an organised and continuous manner and do not do so with the aim of questioning medical authority over childbirth. The concept of Lifestyle Social Movement (LS) (Haenfler et al. 2012) could come to the aid of interpreting the role of families: LS is a concept coined to interpret those "awkward movements" that are not recognised as social movements, neither according to the perspective of contentious politics, in that the action of the individual is not instrumental to change and there is little disinterest in interlocution with the State, nor can they be understood by the broad category of "new social movements", in that the latter presuppose an organisational set-up. Finally, they do not fall under political consumerism either because the practices of individuals are not the subject of campaigns. Individuals taking part in an LS contribute to social change through individual actions that build a sense of self-consistency. They are not united by a collective identity and are at most part of an "imagined community" made up of other individuals who have made the same choice and who do not necessarily frequent each other. Nevertheless, this sociological category does not fully fit the observed reality either, since the concept of lifestyle assumes a certain continuity of action, whereas birth is an extraordinary event in relation to everyday life. The choice to give birth at home is not a political act repeated on a daily basis. It does not imply a coherent lifestyle extended over time after childbirth and is not even motivated by a sense of identity and belonging to a community (e.g., you do not choose to give birth at home, neither the first nor the second time, because you are a "home birther"). The choice of these women is expressed from a certain individual awareness of the naturalness of birth as well as a critical attitude towards the medicalisation of life. New parents often access networks and communities in which the experience of giving birth at home does not constitute a collective identity but at most a more known and accepted experience than outside these networks.

On the other hand, the definition of social movement fits better with midwives, who act within an organised and continuous form, primarily to provide care for women, while maintaining a profound awareness of the impact of their daily practice on the construction of a better society. Among the members of the private midwives community, there is an evident sense of belonging to a collective identity (Daher 2013) and adherence to a common goal that guides their practice. With the assets of a transversal

relationship base, an awareness of their role in producing cultural change, as well as a history of political interlocution and activism, the midwifery movement has the potential to revitalise its collective action dimension, giving visibility to their mission and defining a strategy that includes a call to arms of their "clients". It seems that the Covid-19 pandemic did not revitalise collective action directed at the recognition of home birth but rather gave more visibility to the practice and accelerated the ongoing process of conscious raising for a few years. In this period, private midwives have only increased their social activism to the extent that requests for information and assistance have increased. On the other hand, regarding the direct influence on policy formulation, despite the fact that the Italian Government is interested in strengthening domiciliary services and community medicine (Vallerani 2022) with the intention of improving the health system's response to future crises, no signs of involvement of midwives, who are experts in home birth were found during this study. For the time being, the pandemic experience does not seem to represent an opportunity for mobilisation. However, this movement could come to the fore again if the restrictive regulations of the existing spaces of professional freedom and choice are feared.

*[Submitted 19 January 2023 – accepted 7 June 2023]*

## Bibliography

Alberoni, F.
1997 *Movimento e istituzione. Teoria generale*, Bologna, Il Mulino.

Benaglia, B. and D. Canzini

2021 'They would have stopped births, if they only could have: short-and long-term impacts of the COVID-19 pandemic. A case study from Bologna, Italy', in R. Davis-Floyd and K.I. Gutschow (eds.), *The global impact of COVID-19 on maternity care practices and childbearing experiences,* Lausanne, Frontiers, pp. 173-181.

Biggs, L.
1983 'The case of the missing midwives: a history of midwifery in Ontario from 1795-1900', *Ontario History,* 75, pp. 21-35.

Bonfanti, S.
2012 'Farsi madri. L'accompagnamento alla nascita in una prospettiva interculturale', *Quaderni di donne & ricerca*, 27, CIRSDE.

Bruehl, M.
2001 'La rete europea per l'incremento delle case maternità', in V. Schmid and A. Contin (eds.), *La casa maternità. Un esempio concreto di midwifery care in Italia e in Europa.* Atti del convegno, Ischia 14-16 aprile. Bologna, Editeam, pp. 106-109.

Campiotti, M.
2016 Primo intervento al convegno nazionale organizzato da Ostetriche Parto a Domicilio e Casa Maternità il 29 Ottobre 2016. Available at https://www.youtube.com/watch?v=DDjeu2UoTrI (accessed 25 January 2023)

Campiotti, M., R. Campi, M. Zanetti, P. Olivieri, A. Faggianelli and M. Bonati
2018 'Nascite a basso rischio programmate fuori dall'ospedale in Italia', *Ricerca e Pratica,* 34 (2), pp. 58-66.

Cheyney, M.
2011 'Reinscribing the birthing body: homebirth as ritual performance', *Medical Anthropology Quarterly*, 25 (4), pp. 519-42.

Christiaens, W. and P. Bracke
2009 'Place of birth and satisfaction with childbirth in Belgium and the Netherlands', *Midwifery,* 25(2), pp. 11-9.

Coddington, R., C. Catling and C.S.E. Homer
2017 'From hospital to home: Australian midwives' experiences of transitioning into publicly-funded homebirth programs', *Women and Birth,* 30 (1), pp. 70-76.

Cramer, R.A.
2021 *Birthing a movement. Midwives, law, and the politics of reproductive care,* Stanford, Stanford Universtiy Press.

Craven, C.
2010 *Pushing for midwives: homebirth mothers and the reproductive rights movement,* Philadelphia, Temple University Press.

Coxon, K., J. Sandall, J. and N.J. Fulop
2014 'To what extent are women free to choose where to give birth? How discourses of risk, blame and responsibility influence birth place decisions', *Health, Risk & Society,* 16(1), pp. 51-67, DOI: 10.1080/13698575.2013.859231

Daher, L. M.
2013 'Che cosa è l'identità collettiva? Denotazioni empiriche e/o ipotesi di ipostatizzazione del concetto', *Società Mutamento Politica*, *4* (8), pp. 125-139.

Daniels, O.C.
2022 'Reconciling reproductive rights: Eugenic abortion and home birth disputes at the European Court of Human Rights', *Duke Law Journal,* 71 (7), pp. 1605-1646.

Davis-Floyd, R.
1992 *Birth as an American rite of passage*, Berkeley, UCP.

Davis-Floyd, R.
2001 'The technocratic, humanistic, and holistic paradigms of childbirth', *International Journal of. Gynaecology and Obstetrics*, 75 Suppl 1, pp. 5-23.

Davis-Floyd, R. E. and K.I. Gutschow (eds.)
2021 *The global impact of COVID-19 on maternity care practices and childbearing experiences,* Lausanne, Frontiers.

Daviss, B. A.
2006 'From calling to career: keeping the social movement in the professional project', in R. Davis-Floyd and C. B. Johnson (eds.), *Mainstreaming midwives. The politics of change,* New York, Taylor & Francis, pp. 413-446.

De Vries, R.
2005 *Pleasing birth: midwives and maternity care in the Netherlands*, Amsterdam, Amsterdam University Press.

De Vries, R., H.B. Salvesen, T.A. Wiegers and S. Williams
2001 'What (and why) do women want? The desires of women and the design of maternity care'. In R. DeVries, S. Wrede, E. van Teijlingen and C. Benoit (eds.), *Birth by design. Pregnancy, maternity care, and midwifery in North America and Europe*, New York, Routledge.

Davis-Floyd, R.
2007 'Daughter of time: the postmodern midwife (part 1)', *Revista da Escola de Enfermagem*, 41(4), pp. 705-710.

Davis-Floyd, R. and C. Sargent
1996 The social production of Authoritative Knowledge in pregnancy and childbirth, *Medical Anthropology Quarterly*, 10 (2), pp. 111-120

De Nardis, F.
2006 *Introduzione alla sociologia dei movimenti,* Roma, Editori Riuniti.

Declercq, E.
2012 'The politics of home birth in the United States', *Birth*, 39 (4), pp. 281-285.

De Sanctis, D., S. Fariello and I. Strazzeri
2020 *Sociologia della maternità*, Milano, Mimesis.

Department of Health (UK)
1993 *Report of the expert maternity group: changing childbirth (Cumberlege Report),* London, HMSO.

Diani, M.
2003 'Networks and social movements: a research programme', in M. Diani and D. McAdam (eds.), *Social movements and networks: relational approaches to collective action. Comparative Politics*, Oxford, Oxford Academic, pp. 299-319.

Donati, S., M. Grandolfo and A. Giusti
2005 'Epidemiologia del fenomeno in Italia', *Tendenze nuove,* 1, pp. 87-94.

Drandić, D., K. Hartmann, C. Barata and R. Torguet
2022 'Parent organizations' experiences of the pandemic response in maternity care in thirteen European countries', *European Journal of Midwifery*, 6, pp. 1-10.

Fage-Butler, A.M.
2017 'Risk resistance: constructing home birth as morally responsible on an online discussion group', *Health, Risk & Society*, 19(3-4), pp. 130-144.

Fedele, A.
2016 'Holistic mothers' or 'bad mothers'? Challenging biomedical models of the body in Portugal', *Religion & Gender* 6(1), pp. 95-111.

Ford, A.
2020 'Birthing from within: nature, technology, and self-making in Silicon Valley childbearing, *Cultural Anthropology*, 35 (4), pp. 602-630.

Galera-Barbero, T.M. and G. Aguilera-Manrique
2022 'Women's reasons and motivations around planning a home birth with a qualified midwife in Spain', *Journal of Advanced Nursing*, 78(8), pp. 2608-2621.

Galková, G., P. Böhm, Z. Hon, T. Heřman, R. Doubrava and L. Navrátil
2022 'Comparison of frequency of home births in the Member States of the EU between 2015 and 2019', *Global Pediatric Health,* 9, pp.1-18.

Grotti, V. and C. Quagliariello
2020 'Partorire da sole', *In Genere.* Available at: www.ingenere.it/articoli/ partorire-da-sole (accessed 25 January 2023)

Giorgi, I. and C. Pavan
2019 'Le lotte per la salute in Italia e le premesse della riforma sanitaria. Partiti, sindacati, movimenti, percorsi biografici (1958-1978)', *Studi Storici,* 60 (2), pp.417-455.

Jackson, M.K., V. Schmied and H.G. Dahlen
2020 'Birthing outside the system: the motivation behind the choice to freebirth or have a homebirth with risk factors in Australia', *BMC Pregnancy Childbirth,* 20, pp. 254- 267.

Jensen S., L.B. Colmorn, A.M. Schroll and L. Krebs
2017 'Quality assessment of home births in Denmark', *Danish Medical Journal,* 64 (5), pp. 53-67.

Haenfler, R., B. Johnson and E. Jones
2012 'Lifestyle Movements: exploring the intersection of lifestyle and social movements', *Social Movement Studies*, 11 (1), pp. 1-20.

Hoffman, B.
2016 'Birth activism, law, and the organization of independent midwifery in Oregon', *Oregon Historical Quartely,* 117 (2), pp. 198-231.

Houd, S., H.C.F. Sørensen, J.A. Clausen and R.D. Maimburg
2022 'Giving birth in rural Arctic *Greenland.* Results from an Eastern Greenlandic birth cohort, *International Journal of Circumpolar Health*, 81 (1), pp. 1-10.

Human Rights in Childbirth
2020 *Rights violations in pregnancy, birth and postpartum during the COVID-19 pandemic*, New York, Human Rights in Childbirth.

Katz Rothman, B.
1982 *In labor. Women and power in the birthplace,* New York, W.W. Norton & Company.
2016 *A bun in the oven. How the food and birth movements resist industrialization*, New York: NY University Press.

2021 *The Biomedical Empire: Lessons Learned from the COVID-19 Pandemic,* Stanford, Stanford Universiy Press.

Kitzinger, S.
1995 *Homebirth and other alternatives to hospital*, London, Dorling Kindersley.

Klassen, P.A.
2001 *Blessed events. Religion and home birth in America,* Priceton, Priceton University Press.

Illich, I.
1995 *Limits to medicine: medical nemesis and the expropriation of health*, London, Marion Boyars.

Lanzardo L.
1985 *Il mestiere prezioso. Racconti di ostetriche*, Firenze, Forma.

Leboyer, F.
1974. *Pour une naissance sans violence*, Paris, SEUIL

Mac Donald, M.
2001 'Postmodern negotiations with medical technology: the role of midwifery clients in the New Midwifery in Canada', *Medical Anthropology, Cross-Cultural Studies in Health and Illness*, 20 (2), pp. 245-276.

2004 'Tradition as a political symbol in the New Midwifery in Canada', in I. L. Bourgeault, C. Benoit and R. Davis-Floyd (eds.), *Reconceiving midwifery*. Montreal, McGill-Queen's University Press, pp. 58-78.

Martin, E.
1978 *The woman in the body. A cultural analysis of reproduction*, Boston, Beacon Press

Micheletti, M.
2003 *Political virtue and shopping individuals. Consumerism and collective action*, London, Palgrave.

Melucci, A.
1985 'The symbolic challenge of contemporary movements', S*ocial Research* 52(4), pp. 789–816.

Morgan, K. P.
1998 'Contested bodies, contested knowledges: women, health, and the politics of medicalization', in Sherwin, S. (ed.), *The politics of women's health: exploring agency and autonomy*, Philadelphia, Temple University Press, pp. 83-121.

Oakley, A. (ed.)
1985 *Culture del parto*, Feltrinelli, Milano.

O' Boyle, C.
2013 'Just waiting to be hauled over the coals': home birth midwifery in Ireland', *Midwifery.* 29(8), pp. 988-95.

Odent, M.
1975 *Bien naître*, Paris, SEUIL.

Olsen, O. and J.A. Clausen
2012 'Planned hospital birth versus planned home birth', Cochrane Database Systematic Review, 9 (9).

Pelizzoni, L.
2014 'Territorio e movimenti sociali. Continuità, innovazione o integrazione?' *Poliarchie,* 2, pp 6-33.

Perrotta, D.
2009 'Il parto conteso. L'ostetrica tra discorso medico e discorso umanizzante', *Etnografia e ricerca qualitativa,* 3, pp. 383-412.

Peterson, N.
2017 *De facto feminism: an analysis of the respectful childbirth movement in Hungary*, Master's thesis, Central European University.

Pizzini, F.
2001 'La costruzione sociale della gravidanza e del parto', in M. Bucchi and F. Noresini (eds.), *Sociologia della salute,* Roma, Carocci, pp. 241-263.

Pollock, K.

2011 'Pregnancy, birth and baby care - Childbirth, 1950s to 1980s', *Te Ara - the Encyclopedia of New Zealand*, http://www.TeAra.govt.nz/en/pregnancy-birth-and-baby-care/page-4 (accessed 29 June 2023)

Quattrocchi, P.
2014 'Homebirth and the National Health Service in Italy. A qualitative study in the Emilia-Romagna Region', *Revue Canadienne de la recherche et de la pratique sage-femme,* 13(3), pp. 32-39.

2018 *Oltre i luoghi comuni. Partorire e nascere a domicilio e in case maternità,* Firenze, EditPRess.

2022 'Policies and practices on out-of-hospital birth: a review of qualitative studies in the time of Coronavirus', *Current Sexual Health Reports,* 9, pp. 1-13.

Righetti, N.
2018 'Il veganismo tra mainstream e controcultura', *Micro & Macro Marketing,* 1, pp. 109-128.

Rocca-Ihenacho, L. and C. Alonso
2020 'Where do women birth during a pandemic? Changing perspectives on Safe Motherhood during the COVID-19 pandemic', *Journal of Global Health Science*, 2(1), pp. 1-9.

Scarf, V.L., C. Rossiter, S. Vedam, H.G. Dahlen, D. Ellwood, D. Forster, M.J. Foureur, H. McLachlan, J. Oats, D. Sibbritt, C. Thornton and C.S.E. Homer

2018, 'Maternal and perinatal outcomes by planned place of birth among women with low-risk pregnancies in high-income countries: A systematic review and meta-analysis', *Midwifery*, 62, pp. 240-255.

Schmid, V.
1992 'Figura e compiti dell'ostetrica. Problemi aperti e possibilità di evoluzione', in M. Sbisà (ed.), *Come sapere il parto: storia, scenari, linguaggi*, Torino, Rosenberg & Sellier, pp. 117-135.

1997 'Riprendiamoci il parto! Le radici culturali del parto extraospedaliero', *D&D,* 16, pp. 13-18.

2019 *Il parto in casa e in casa maternità. Criteri di sicurezza e di qualità,* Milano, Terra Nuova.

Schmid, V. and A. Contin
2001 *La casa maternità. Un esempio concreto di midwifery care in Italia e in Europa,* Atti del convegno, Ischia 14-16 aprile, Bologna, Editeam.

Sestito, R.
2022 'Covid-19: restare a casa o andare in ospedale per partorire? Intervista con Gabriella Pacini', in L. Gentile, C. Quagliariello and R. Sestito, R. (eds.), *Coronial. Antropologia della riproduzione e delle sessualità al tempo del Covid-19,* Milano, Franco Angeli, pp. 183-190.

Snow, D., S.A. Soule and H. Kriesi
2004 'Mapping the terrain', in D. Snow, S.A. Soule, and H. Kriesi (eds.), *The Blackwell companion to social movements,* Malden, Blackwell, pp. 3-16

Spina, E.
2009 *Ostetriche e midwives. Spazi di autonomia e identità corporativa,* Milano, Franco Angeli.

Surtees, R.J.
2003 *Midwifery as feminist praxis in Aotearoa/New Zealand*, PhD thesis, University of Canterbury.

Touraine, A.
1992 'Beyond social movements?', *Theory, Culture and Society,* 9(1), pp. 125–145.

Turner, P. K.
2002 'Is childbirth with midwives natural? The gaze of the feminine and the pull of the masculine', *Qualitative Inquiry*, *8*(5), pp. 652–659.

Vallerani, S.
2022 'Riflessioni sociologiche su un rapporto in bilico. Salute e Pnrr tra pulsioni conservatrici e istanze trasformative', *Autonomie locali e servizi sociali*, 2, pp. 255-272.

Vermeulen, J., A. Luyben, R. O'Connell, P. Gillen, R. Escuriet and V. Fleming
2019 'Failure or progress? The current state of the professionalisation of midwifery in Europe', *European Journal of Midwifery*, 3 (22), pp.1-9.

Viisainen, K.
2000 'The moral dangers of home birth: parents' perceptions of risks in home birth in Finland', *Sociology of Health & Illness*, *6*(1), pp. 792–814.

Yinger, J.M.
1960 'Contraculture and Subculture', *American Sociological Review*, 25(5), pp. 625-635.

WHO
1985a 'Appropriate technology for birth', *Lancet* 24 (2), pp. 436-437.

1985b *Having a baby in Europe,* Copenaghen, WHO.

Wrede, S.
2001 'Introduction', in R. DeVries, S. Wrede, E. van Teijlingen, and C. Benoit (eds.), *Birth by design. Pregnancy, maternity care, and midwifery in North America and Europe*, New York, Routledge.

Zielinski, R, K. Ackerson and L. Kane Low
2015 'Planned home birth: benefits, risks, and opportunities', *International Journal of Women's Health,* 8 (7), pp. 361-77.

## About the Author

Daniela Bandelli, Ph.D. at the University of Queensland, is currently a Lecturer of sociology at the LUMSA University in Rome. As a Marie-Sklodowska Curie Fellow and visiting scholar at the University of Texas, she conducted the project "Women's movements and gestational surrogacy" (WoMoGeS), with field-work in Mexico, Italy and United States. Her research interests span across assisted reproduction, domestic violence, and social movements. She is author of two monographs: *Sociological Debates on Gestational Surrogacy: Between Legitimation and International Abolition* (Springer, 2021) and *Femicide, Gender and Violence: Discourses and Counter-discourse in Italy* (Palgrave, 2017).

Daniela Bandelli

Department of Human Sciences, LUMSA University, Piazza delle Vaschette, 10, 00193 Rome.

e-mail: d.bandelli@lumsa.it