Abstract

Background: The option of a planned home birth defies medical and social normativity across countries. In Denmark, despite the dramatic decline in the home birth rates between 1960 and 1980, the right to choose the place of birth was preserved. Little has been produced documenting this process.

Aim: To present and discuss Susanne Houd's reflection on the history and social dynamics of home birth in Denmark, based in an in-depth interview.

Methods: This paper is part of wider Short Term Scientific Mission (STSM), in which this interview was framed as oral history. The whole interview transcript is presented, keeping the highest level of detail.

Findings: In Susanne Houd's testimony, four factors were highlighted as contributing to the decline in the rate of home births from the 1960's to the 1970's: new maternity hospitals; the development of obstetrics as a research-based discipline; the compliance of midwives; and a shift in women's preference, favouring hospital birth. The development of the Danish home birth models was described by Susanne Houd in regard to the processes associated with the medicalisation of childbirth, the role of consumers, and the changing professional dynamics of midwifery.

Conclusion: An untold history of home birth in Denmark was documented in this testimony. The Danish childbirth hospitalisation process was presented as the result of a complex interaction of factors. Susanne Houd's reflections reveal how the concerted action of consumers and midwives, framed as a system-challenging praxis, was the cornerstone for the sustainability of home birth models in Denmark.

Keywords

Home childbirth; Midwifery; Denmark; Social change; Medicalisation; History of childbirth.

1. Introduction

Summary of Relevance	
Problem or Issue	*Little is known about the remarkably uninterrupted history of the Danish home birth public system, and the social dynamics generated as a reaction to institutional and political changes.*
What is Already Known	*The social and legal status of home birth varies globally. The social construction of risk and the hegemony of the medical model has contributed for the marginalisation of this option.*
What this Paper Adds	*This paper discloses part of the history of the Danish home birth system. Through this narrative, consumer movements and maverick midwives emerge as the key actors for change.*

Within the diversity of maternity care and maternity experiences, the option of a planned home birth is a particular case that defies medical and social normativity across countries.[1–5] The social and legal status of home births varies, from crime to a publicly funded option. Recent literature reinforces the safety of home births and the multidimensional impacts of having limited choices in childbirth for women and families.[6–8] Nevertheless, the social construction of risk in childbirth,[9] and the hegemonic emergence of the medical model of maternity care, [3,10] especially throughout the 20th century, contributed to the fact that, in most developed countries, home birth rates declined. The hospital, with its technocratic model, [11] was institutionalised as the normal place to give birth, and there are now countries with few or no policies addressing and supporting home births.

Looking at contexts where women and families are freer to choose the circumstances of their childbirth experiences might inspire and stimulate the framing of new models of care elsewhere, in line with the recent international recommendations for mother-baby friendly birthing facilities. [12] Concerted multi-level actions can, in fact, trigger changes in maternity care. Regarding the place of birth, in Iceland, following the rising rates of home births, it has been shown how the option of a home birth is now being portrayed as a safe choice by the media; [13] and the recent release of the evidence-based national guidelines from the National Institute for Health and Care Excellence, in the United Kingdom, [14] reaffirmed the need to

support a universal access to out-of-the-hospital childbirth care in the country. These examples illustrate how contemporary research, professional practices, and social movements are being translated into new policies and practices.

Denmark, however, has an uninterrupted history of supporting women's rights in childbirth. Nowadays, women are legally entitled of having public midwifery care at home. [15] National guidelines for the practice of midwifery are widely accepted and protect midwives from litigation when conflicts arise, [16] and midwives have the right to independently request uterotonics at a pharmacy to use in their out-of-hospital practice in case of a post-partum haemorrhage, [17] which, in most countries, is reserved to physicians. Within the Nordic countries, Denmark is where women can find stronger support to their right to choose the place of birth, followed close by Iceland. [18] Roughly three-fifths of all Nordic home births happen in Denmark, and the number of midwives attending births at home is much higher than in any of the other surrounding countries. [16] The rates of home births are now 2.2% in Iceland, 1 to 2% in Denmark, 1.5/1000 in Norway, and 0.7/1000 in Sweden. [16]

It is not clear why neighbour countries with significant similarities at the social, economic, and historical levels present these important differences regarding their organisational conditions for home births. [18,19] In fact, they seem to share a common past regarding the place of birth: by the end of the 19th century, almost all births in the Nordic countries happened at home; by 1950 the decline of the rate of home births was evident; and by the end of the 20th century home births were already rare events. [18,19] Still, Denmark was one of the last Nordic countries to institutionalise hospital birth as the norm. [19] Paradoxically, one of the most remarkable difference regarding this institutionalisation process is found between Denmark and Sweden, countries which are particularly similar in most aspects of their history, economy and social development. A comparative study on the changes of place of birth in these countries from the late 19th century to 1970 shows that a steeper decline in the rate of home births initiated in Sweden around the 1920s and 1930s, while in Denmark this only happened in the 1960s. [19] In both countries the contributing factors seem to have been the emergence of a hospital-centred health system, the establishment of obstetrics,

and the dissemination of a discourse on risk and pathology in childbirth, but it is not clear why the differences between countries took place. Vallgårda presents a tentative conclusion - Sweden went through slightly faster and more radical social and economic changes, which might have set the stage to the emergence of a new model of childbirth, where the hospital was the representation of the modern, hygienic, scientific, and technological way to give birth. Home births represented a rural and traditional past, while the hospital gave way for a new consensual birth ritual among women, families, politicians, and health professionals. [19] However, while planned home births almost disappeared from Sweden, they kept a low but relevant rate in Denmark until today.

The available data and the comparison with the contemporary organisation of home birth care in neighbour countries contribute to the hypothesis that the history of home births in Denmark has been linear, with a continued and consensual support of the women's right to choose the place of birth. Yet, little has been produced documenting the singular development of the Danish home birth models, particularly in the period from 1960 to 1980, when the decline of the home birth rates was more evident. The Danish system seems to have changed and evolved in the face of challenges. In 1968, 39% of all births still happened at home, but in 1973 the rate was already around 1%. [20] Following this decline, the number of county midwives, who provided community-based childbirth care, decreased, and they were formally abolished in 1973. [19] It is not clear which decline led to the other, but this abolishment definitely compromised the universal access to quality midwifery care at home. [19]

Personal testimonies of privileged informants constitute valuable sources of information and grant the access to this recent period of history. Acknowledging the subjectivity of this approach, framed within a qualitative research project, this paper presents a privileged informant's testimony as the ground for a discussion on the social transformations associated with the descending rate of home births in Denmark. It explores the experience of the well-known Danish midwife Susanne Houd, who was not only a witness of this process, but was also part of it. The aim of this paper is to present and discuss

Susanne Houd's reflection on the history and social dynamics of home births in Denmark, based in an in-depth interview.

Susanne Houd has broad experience in midwifery practice, research, and training, both in developed and developing regions - in Scandinavia and Greenland, Eritrea, Canada (Ontario and Nunavik), and New-Zealand. She directed midwifery courses in several countries, and was consultant for the World Health Organisation (WHO) Regional Office for Europe. Susanne was trained and started working as a midwife in Denmark when the decline of the home birth rate was more evident. She was one of the midwives who fought for the continuity of midwifery care at home in the country. The inspiring testimony captured in this in-depth interview with Susanne Houd reminds us of the potential for social change lying within each social actor, and reveals how midwives are in a privileged position to enable situations in which women can feel empowered to exercise choice and self-determination.

2. Methods

This paper is part of the wider project of a Short Term Scientific Mission (STSM) held in Denmark in February 2014 with the purpose of exploring the Danish contemporary home birth care, its organisation and background, in a comparative perspective. An interdisciplinary framework, intersecting sociological and health sciences perspectives, was the basis for this STSM. The core dimensions to explore were the roles and views of different social actors - midwives, researchers, and women and families - as well as the coexistence of different models of home birth care. The methodological design encompassed short ethnographic explorations of the field, and interviews to key informants. This STSM was crucial for the design of an ongoing doctoral research on the organisation and further social dynamics of the home birth care network within a country with no professional guidelines or formal system in this matter, and no public support for women planning to give birth at home.

Susanne Houd was interviewed in English, in Copenhagen. While the other interviews were focused on the contemporary organisation of home birth care, her interview allowed

filling in some of the gaps in the history of home births in Denmark. Framed as oral history, the meaningful testimony produced in this interview brought to light the links between the memory of her individual and subjective experience, and the organisational and structural phenomena. [21,22] The recorded interview was transcribed, analysed, and edited - mainly cleaned from breaks and repetitions - in order to sharpen its focus without introducing new words or new meanings. [21] The edited version of the transcript was given back to Susanne Houd in order to check for its accuracy, [21] and publication was agreed.

The interview is presented in the *question & answer* format, keeping the highest level of detail, clarifying which subjects were mentioned spontaneously and which were not, and reproducing the interactional dimension – an essential element in oral history. [21] However, subheadings were introduced to allow better readability. Susanne Houd's testimony, in her own words, is a valuable resource for understanding and discussing the development of the contemporary home birth care in Denmark. The main limitation associated with this method is its individual focus, even acknowledging that individual experiences may not represent individualistic approaches. [22] Nevertheless, it is important not to overemphasise the potential contribution of one single interview. The analysis and discussion presented in this paper are grounded in Susanne Houd's experience and testimony, and cannot be read regardless of this. The risk of excessive individualism is particularly present when researching social movements and collective experiences. [22,23] As such, by making this entire transcript public as oral history, it becomes also available to other researchers for verification, criticism, or development in other research projects. [21]

3. Interviewing Susanne Houd

Q: First, I would like you to share your vision on the establishment of the Danish home birth system as it exists today.

A: I became a midwife in 1967. In those days there were 38% of home births in Denmark. But in 1972, there was less than 1%. What happened in those 5 years? There were several factors. First of all, in the 1960s and the beginning of the ‘70s, there was suddenly a lot of public money, and some of it was used to build large hospitals. Previously, you had to have a reason to go to hospital to give birth, there had to be a reason, some pathology, in order to go to the hospital. Then, suddenly there was room for women to go to the hospital even if they were expecting normal birth. So that was one thing: there was money to build big maternity wards where there was room for ordinary women as well. That was one reason.

At the same time, there were a lot of medical specialities that were used up, so to speak. And doctors were looking for a new field of research. Obstetrics was a virgin field of research. There was not that much research done. But in order to do research, you need to have your research specimens collected, the women, and obstetricians needed to have the women seated not in their little homes and all over the place, but in their hospitals. So that was the second factor. The doctors really wanted to look at obstetrics as a new research field.

The third factor was that a lot of the Danish midwives had maybe three of four hundred births per year. One midwife, three and four hundred births. That meant that they were working, and working, and working. And many preferred to have those births in one place, so they could go from one woman to the next woman. They were not opposed to the move from home to hospital. They thought it was very practical, as they could have three births in eight hours, and they could earn a lot of money from it.

The fourth factor was that actually some women really thought it would be fantastic to give birth in a hospital, because it has not been available before, and they thought the treatment could be really good in a hospital. So there were four important factors - the place, as there was room for them; the research factor; the midwives who wanted births to go into the hospital; and then the women. It was not one single thing. It was a whole bunch of things that happened.

3.1. The independent midwives

Before ‘72, midwives could either be publicly employed by their county or they could be private practicing midwives. But in ‘72 there was an arrangement made with the Government in order to publicly employ all midwives, all of them, ending the private practice of midwifery. In the midst of all this, home births were almost forgotten. However, there was a very strong consumer group advocating for home births. It was a small group, with Loa Kampbjorn, who wrote the book *Moder jord, mor og hjemmefødsler* [“Mother-Earth, mother and home birth”, published in 1976]. They fought for the possibility of a having the right of a free home birth stated in the law, so all women could give birth wherever they wanted - at home or in a hospital. The problem was very few midwives, at that point, were prepared to attend home births. Midwives had a stable salary and days off, and otherwise they would be working all the time. All of a sudden they felt - in the beginning, at least - this was real progress. And only little by little they discovered what they had lost. They did not know the women they were helping; neither had they the continuity of care. Eventually when they met a woman they had helped before in the hospital, they had to leave at four o’clock because their duty was over. Little after little, midwives, the old midwives, understood what they had lost - the knowledge and the connection to women. But the new midwives, they did not know what they had lost, because they had never experienced it.

I was part of this process. In the beginning I thought it was fine, because when you have small kids you like to know when you are off work. Anyway, in the years from 1972 and up to maybe 1984-85, there was a lot of new technology that came into new maternity hospitals - electronic fetal monitor, ultrasound - all this happened at the same time. So people were more focused on this new technology than on the kind of human care they got in the hospital. It was terrible what happened in those years. Births got more and more technological and women did not have much say. Another consumer movement called *Forældre og fødsel* - which means “parents and childbirth” - emerged as a protest organisation for all the terrible things that were happening in the hospital.

Anyway, I think in ‘84-85, one woman called Susanne Bromann - another Susanne - started a home birth practice and later a birth clinic. In 1986 I started to work with her for a couple of years, where we attended only home births - at private basis, as people paid us. I did not continue my collaboration with her because of a few things we did not agree on, so our ways sort of separated in, I think, the end of ‘87. But I was concerned with the situation of home births. I had been attracted to home births and I knew their quality. Nevertheless I could see, in those years, home births were almost being looked upon as a very dangerous thing, something you should not do. Doctors were opposed to it, and the young midwives did not regard it as a possibility for practice.

In the beginning of February ’88, together with a colleague of mine - another Susanne - Susanne Winding, we started the *Frie Jordemødre*, meaning “the independent midwives”. We had our little shop, as we called it, in Østerbro, Copenhagen, and already in the first year we had around fifty home births. People were paying us, although they could instead have a home birth within the system - yet only with the midwife on duty that day, who might be someone who had no experience as a home birth midwife, or who might even be opposed to it. So it was really a period when home births were almost being extinct, it was almost disappearing. Susanne and I really did not know, but we needed to do something about it before home births were forgotten, altogether. After almost two years being on call all the time, the two of us, we decided to include a young midwife, who was just out of school. We kept on having around fifty homebirths per year in our practice, with a transfer rate of about 12%. 65% of the women were having their first baby, so our transfer rate was not much. I was involved in it until ’92.

3.2. Being mavericks

Q: Looking at the contemporary organisation of home births, we see it varies across Denmark. Why do you think this happened?

A: Yes, in ’92 I wasn’t involved because I went to Canada. But at the same time, it must have been in ’91, there was a midwife, one of my friends, who started to work as a home birth midwife in the Sjælland region. The hospital where she was working closed and she refused to go to a large hospital. Her name was Hanne Lunøe and for years and years she worked by herself, assisting home births in that area. She was clever. There was also a very open-minded county representatives - even though parents were paying her, they got reimbursed from the county. It became a service this county could provide, in order to have free home birth. Hanne was really the person who started what is now the Vest Sjælland home birth practice. As you can see, Susanne Bromann started in ’84, we continued with the liberated midwives, and Hanne Lunøe was also inspired to start in ’91. It was a small little thread that was going on, and then in the ‘90s there was a renewed attention on the value of home births. There were more and more places where women wanted to give birth at home. The more hospitals that closed and the further distances they were to the hospitals, the more women sort of found home birth was a possibility.

Also many midwives were having their babies at home, with a midwife they knew. Very few of them would go to the hospital to give birth, with a woman who they probably did not know. Midwives, they knew; and the young midwives knew what a good way to have a baby was. The thread of home births never broke. There was a small trend in ’67, very much held by the consumers that fought for the home births to be within the law as a possibility for the women - and it is very important that it is within the law. Women were never criminalised, mostly due to these movements in ’72 and ’73. I think it was thanks to those consumers we still today have such an awareness of home births. It is a combination of the consumers and the midwives, but it was always the consumers who took the first few steps. There has to be a very strong consumer movement and you also have to have a few mavericks that can really start, like Hanne Lunøe, like us, like Susanne Bromann, strongly believing that home births are a solution. In the liberated midwives, it was very tough to go to the hospital. In the case we had to transfer a woman, we always had to make sure she have had an appointment at the hospital, she had papers and blood tests there, and so forth. So, we did

not have to fight throughout the pregnancy. We did not want to fight across the woman when she was in labour. We had to have all the formal issues so the woman would not be a victim in this. The fight had to be between the obstetricians and us, between midwives and obstetricians, not across labouring women.

Q: What barriers have you found and which were more difficult to cross, in these years when home birth gained this legitimacy in Denmark?

A: Well, it was legitimate, that was the point. It was not a criminal act. Here women have the right to give birth at home. They do not have the right in other countries. [*] Here, with the law in your hand, you have the right for a home birth. And that makes a big difference. But of course there were barriers. In a system in which there is an alternative to the system, the alternative becomes a threat, even being a very small alternative. I did some work for the WHO in the '80s, exactly on this issue. I have been traveling across Europe to search for alternatives, and we edited a book called "Having a baby in Europe" [published in 1985 by WHO]. The main conclusion was almost everywhere there was an alternative. The thing is, even if there are only ten women a year having a baby at home, it still is an alternative. There is somewhere else women can go to. It becomes a threat to the system, and that is very interesting. How could they be threatened by ten women choosing an alternative, when maybe there are 100,000 women going into the system? Suddenly those working in the system realised women could go other ways and have their babies in other places - women did not have to depend on them. It is very threatening.

One of the chief obstetricians in Copenhagen said, in a public meeting, he really wanted to take away my licence, so I could not work anymore as a midwife. And he was

[*] Apart from Denmark, women also have the right to publicly-funded home births in other settings, e. g. in the Netherlands, in the United Kingdom, in Iceland, in the capital region of Stockholm in Sweden, and in some regions of Italy (Torino, Reggio Emilia, Modena, and Parma). Moreover, women have the right to be partially reimbursed for their expenses with midwifery care at home births in Norway, and in the Italian regions of Piemonte, Emilia Romagna, Marche, and the provinces of Bolzano e Trento. The preconditions for home birth (if any) and the access to a professional who can provide this service vary across settings.

really trying to work on that. This meant, in every birth we went to, we had this thing hanging over our heads. We needed to be very straight with what we did. We did not move outside what we considered to be good midwifery, and the parents had to agree to go to a hospital if we said so. We had to do all this in order to keep ourselves within our limits. I have been working in Canada also, as part of the recognition of midwifery, and this was one of the problems - some of the midwives went far over what is good midwifery when following the will of parents who refused a hospital transfer. In the end midwives would be the ones punished if something had gone wrong. There are things you should not do as a midwife, at home.

Q: Do you feel, from your experience, midwives who assist home births are different from other midwives?

A: As a midwife, I think it is a matter of feeling comfortable and feeling safe, and feeling that you can work as a midwife in the best possible way. Some midwives might need the security of the hospital and some midwives need the security of the home. I feel constrained in the hospital. For the last ten years I have been working in Greenland and now I am going there two weeks again, and I did not feel constrained there because we do not have fetal monitor, we do not have a lot of technology there. I am working as a real midwife, I would say, where I am working together with the women and so on. But that is my feeling. That is how I feel safe and feel confident. I think some of the young midwives have the same feeling. I have just been working with a young midwife in Greenland and she loved being there without the constraints of technology, and the rooms, and the computer stuff you have to write all the time. Other midwives might feel this is where they have been trained so it is where they feel safe.

It has also to do with the experience you have. I was the director of the midwifery education at the Metropol University College in Copenhagen for five years and I really felt all the new students should have an experience of at least one or two home births in their first

year, so they knew what it was like. Some midwives have never been to a home birth. They do not know what they are saying no to, or they do not know what they are longing for. They have to have the experience.

Q: If you could change the home birth system here or abroad, what would you change?

A: There are a lot of good things happening. More home birth practices and so on. I think this line should be not changed, but supported more. It is really sad to see young midwives being overwhelmed by the hospital and the technology. If I could change something, I would wish that it is not the rules and the accreditation system that is ruling how birth is going to be, but more what is needed for that woman.

For instance, one of my colleagues is working now in one of the major hospitals in the Copenhagen region - it is like a factory. Still those midwives do a lot of good thing within those tight frames. But then I cannot be too critical, because at the same time there is a readiness to start “know your midwife” initiatives, and home birth schemes, and so on. More support to those schemes would be a really nice thing. I do not want to say the situation in Denmark is totally terrible, because actually we have been, to a certain degree, quite well. I wish more women and more families could shout out, and this would work for home births as well as for more humanised assistance in the hospital.

Q: What do you think could trigger a change in other health systems?

A: The consumers need to get together and get visible. That is really the number one thing. It is fine if there is a little midwife here and other little midwife there doing a fantastic work, but if they do not work closely together with the consumers, it is too much. I also worked in New Zealand for some years and the system was terrible, back in the ‘70s. Now they are one of the best midwifery systems in the World. Why? Because consumers and midwives worked together. It was almost going down the drain in the ‘80s, but then they turned out ok. It was

the same in Canada. You have to get those consumers out of the bushes, really. And they have to work, they have to confront the politicians, they have to write things, they have to write in the papers, they have to send pictures, they have to do all these kinds of things. Use Facebook, whatever. That is the only way to do it.

4. Discussion

The history of home birth in Denmark was, indeed, not linear. Susanne Houd's testimony highlighted a complex interaction of factors contributing to the decline of the rates of home birth, and to the development of the contemporary Danish home birth system. These factors pose a tentative hypothesis to justify the differences between Denmark and the neighbouring countries in respect to the existing support, and public funding of home births. Three main dimensions can be identified as emerging from Susanne Houd's discourse specifically regarding the Danish setting: (1) the processes associated with the medicalisation of childbirth; (2) the role of consumers; and (3) the changing professional dynamics of midwifery.

As in other countries, the shift in the place of birth, through which hospital births were institutionalised as the norm, have been mainly framed within the wider process of the medicalisation of childbirth, i.e. the expansion of the pathology-centred practice of medicine to physiological labour and birth, [10] and the shift to a technocratic paradigm in maternity care. [11] Susanne Houd further suggests that the profusion of hospitals and the development of obstetrics were crucial contributions to the decline of the rate of home births, but this does not seem to be enough to explain the differences with other countries, namely Sweden. [19] Nevertheless, Susanne Houds identifies several social actors contributing to the medicalisation of childbirth - midwives, women, families, as well as obstetricians - mitigating the focus on the role of medical doctors presented in some critical perspectives that ignore the key participation of consumers, other health professionals, and the state in the medicalisation process. Notwithstanding the major role of obstetricians in normalising

hospital birth, women and families also played a relevant part in this process when demanding the legitimation of having physiological events treated as medical conditions, [24] and this also seems to have been the case in the Danish setting. Specifically concerning the views of midwives and medical doctors regarding home births, these elements in Susanne Houd's testimony contradict the polarised position often found in the literature regarding other contexts. [10,25,26] Actually, it seems that some Danish midwives were in favour of the childbirth hospitalisation process, due to the convenience of having time off work, compared to the unregulated work time of home birth midwives. [27] When comparing the technocratic/medical model with the holistic/midwifery model of care, it is thus necessary to acknowledge the multiple, possible combinations of models if applied either to professionals, to their values and ideologies, or to their practices. [28] Practices can be better analysed when positioned in a continuum between the medical and the midwifery practice, rather than in either one side or the opposite. [28] Moreover, home births do not always happen under the holistic/midwifery model, nor does the hospital implies the medical model of care. Local professional cultures, together with the physicality of the place of birth in itself, have the potential to highly influence the professional practice of midwives. [29]

Directly linked to the medicalisation processes and the social actors involved, there is a set of events and movements mentioned by Susanne Houd as "alternatives" that might help explaining the singularities of the Danish home birth models of today. These movements were more than alternatives or minority movements; they feature system-challenging *praxes*, threatening the hegemony of the technocratic/medical model of care by creating new public narratives on childbirth, building networks for advocating women's rights, and making available a contrasting alternative that more women could adhere to. [3] Both consumers and midwives are described by Susanne Houd as having played a crucial part in challenging the emerging technocratic paradigm. The consumer movements demanded midwifery care in planned home births and put the choice of the place of birth on the public agenda. The maverick midwives created alternative models of home birth, providing new opportunities for women to exercise their choices and self-determination within the formal limitations imposed

by the maternity care system. It seems plausible to consider that the concerted actions of consumers and midwives described in this interview, and the particular social and political impacts these actions had in the Danish setting, significantly contributed to the renovation of home birth care in Denmark and to the development of different publicly-funded home birth models in the country. Like in many other settings, such as Australia, [30] and the United Kingdom, [31] consumer involvement was a vital element in the process of improving maternity care.

Finally, there are valuable elements throughout Susanne Houd's testimony than contribute to the idea of midwifery as facing changing professional dynamics, alongside the decline in the rates of home births. The abolishment of the county midwives, and the transfer of all midwives to the medicalising and bureaucratic setting of the hospital is presented as a landmark for the profession of midwifery. She specifically refers to the influence of technology in midwifery practice after the imposition of a technocratic paradigm in childbirth at the hospital. For Susanne Houd, the opportunity for being a "real midwife", relying on the experience of working together with the women, rather than on medical knowledge and technology, seemed to be incompatible with the hospital setting. Plus, midwives as consumers are said to have mainly preferred to experience home births with a midwife, which might have contributed to the construction and reinforcement of their own embodied knowledge and professional narratives about the optimal conditions to give birth. The midwifery values and practices described illustrate the balancing between achieving higher degrees of differentiation through scientific knowledge and technology, or through professional experience, intuition, and learning from the embodied knowledge of women. In line with what Benoit discussed, [32] formal midwifery training focusing on the use of technology and on the hospital practice is said here to have contributed to the professionalisation of midwifery mostly as a science, and not that much as an art.

5. Conclusion

An untold history of home birth in Denmark was documented in this testimony. The differences between Denmark and their neighbouring countries regarding the decline of the rate of home births remains mainly unexplained. However, the Danish childbirth hospitalisation process is presented here as the result of a complex interaction of factors, promoted not only by medical doctors, but also by midwives and consumers. These elements mitigate the common reference to a conflict between midwives and obstetricians underlying home births.

There are different social dynamics promoting and sustaining home birth practice, globally. The development and sustainability of the Danish home birth models could be explained, at least partially, by the emergence of home birth as a system-challenging praxis, in response to the medicalisation of childbirth. Susanne Houd's testimony reveals how the concerted action of consumers and midwives was the cornerstone for the sustainability of home birth models and the improvement of maternity care in Denmark.

Focusing on one interview, further research is needed for a comprehensive analysis of the singular social dynamics behind the development of the Danish publicly-funded home birth models. Applying a different analytical framework to this interview might allow developing different arguments, and drawing innovative conclusions. More than documenting an historical moment, this paper poses an invitation to the reflection upon different social settings and particular local dynamics that can drive change in childbirth.

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