Birth in Power[1]

Case study of homebirth in France and its link to sustainability

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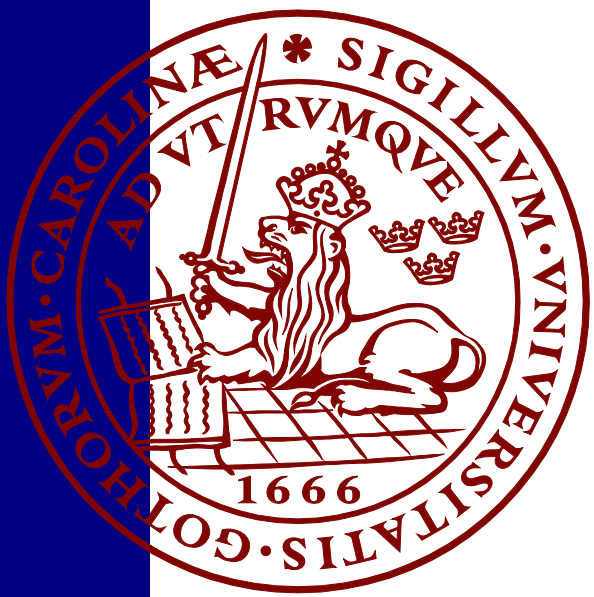

LUCSUS
Lund University Centre for Sustainability Studies

LUND UNIVERSITY

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Submitted May 10, 2022

Supervisor: Sara Gabrielsson, LUCSUS, Lund University

[1] Phrasing borrowed from Jonea, a freebirth activist on Instagram, account @wild.pregnancy_free.birth, with her approval.

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Abstract

If homebirth can offer better outcomes than hospital-birth why do so few French women make this choice? The literature review on birth in France shows an increasing critique of overmedicalization. Through an Ecofeminist approach, conducting a qualitative questionnaire and interviews I found women choosing homebirth seek intimacy, respect and to avoid fear-based protocols and hospitals' violence. Women who experienced homebirth tend to embrace 'nature' and their animality, not seeing it as oppressing but empowering. Homebirth and my respondents lie within Ecofeminism and its notion of reclaiming. Reclaiming one's body, one's sovereignty, one's animality.

Homebirth can be seen as both a consequence and source of questioning Western modern ways resulting in a turn to more sustainable practices, relevant to sustainability science. Interviewees linked homebirth to sustainability, believing that changing how babies are born is one step towards changing the world by caring for more empathetic humans who will care for the Earth.

Keywords: Homebirth, Ecofeminism, Empowerment, Nature, Animality, Sustainability

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[2] All the names have been changed for anonymity but they will recognise themselves.

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Abbreviations

AAD	Accouchement Assisté à Domicile (homebirth with a midwife)
AG	Accompagnement Global (holistic care)
ANA	Accouchement Non Assisté (homebirth without a midwife)
APAAD	Association Professionnelle de l'Accouchement Accompagné à Domicile (Professional Association of homebirth assisted by a midwife)
CDAAD	Collectif de Défense de l'Accouchement A Domicile (Advocacy collective for homebirth)
CIANE	Collectif InterAssociatif autour de la NaissancE (Interassociative collective around birth)
CNGOF	Collège National des Gynécologues et Obstétriciens Français (National College of French Gynecologists and Obstetricians)
CNSF	Collège National des Sage-Femmes Françaises (National College of French Midwives)
CODSF	Collège de l'Ordre Départemental des Sage-Femme (Regional College of Midwives)
CR	Critical Realism
DREES	Direction de la Recherche, des Etudes, de l'Evaluation et des Statistiques
FFRSP	Fédération Française des Réseaux de Santé en Périnatalité (French Federation of Perinatal Health Networks)
HAS	Haute Autorité de Santé (High Health Autority)
MdN	Maison de Naissance (Birth center)
OT	Own Translation
OV	Obstetrical Violence
PMS	Pre-Menstrual Syndrome
PPD	Post-Partum Depression
PT	Plateau Technique
UNSSF	Union Nationale et Syndicale des Sage-Femmes Françaises (National Union of French Midwives)

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Figure 1. Homebirth picture by @vanessamendezphotography[3] (2019, October 31)

We can see the fairy lights, the mantra cards, the emotions on the mother's face, supported by her partner.

1. Introduction

"The witch-hunt is back, last week a colleague received a complaint after a completely physiological birth for endangering the life of others[4]. Complaint justified by 'what ifs'."[5]

The complaint was filled by a gynaecologist, not the parents. Mother and baby are fine after a birth without complications. It is quite telling of how birth is commonly viewed through the prism of risks. What is a risk? Who decides what is a risk? Risks to whom?

In 2021, 738 000 babies were born in France, compared to 832 799 in 2010 (INSEE, 2022). About 0,3% of women in France give birth at home with a midwife (AAD, assisted homebirths), however it is

[3] https://www.instagram.com/p/B4SITBLgwZP/

[4] According to Article 223-1 of the Penal Code "The fact of directly exposing others to an immediate risk of death or injury likely to result in permanent mutilation or disability by the deliberate violation of a particular duty of care or safety imposed by law."

[5] Obrecht, F.[@floriane_sf_aad] (2022, April 25) https://www.instagram.com/floriane_sf_aad/?hl=fr

difficult to know how many have given birth at home on their own (ANA, non-assisted homebirth) (Letesse, 2021). There are only 88 midwives who assist homebirth in France, unable to satisfy all requests (APAAD, 2021).

The APAAD (Professional Association of homebirth assisted by a midwife) requested a poll in January 2021 which showed that 17% of the respondents would 'absolutely' want a homebirth if it was possible and 19% answered 'rather yes' (Ifop, 2021). APAAD's report of the year 2019(2020) analyses the files of 65 midwives: 1298 women were accompanied. They had no deaths and lower rates of both medical acts and maternal morbidity[6] compared with hospitals and Maisons de Naissance (MdN) (Annex A) (APAAD, 2020; Saget-Orliac, 2019; Sestito, 2017). Their 2020 report shows 115% increase in requests although a lot of them were denied due to the small number of homebirth midwives (APAAD, 2021).

If homebirth does not show more risk, or even less, than hospital-birth, why do so few women make this choice? Past studies, like Pruvost (2016), present positive outcomes of homebirth.

In the Netherlands, 16,3% of births happen at home, their neonatal mortality rate is within Europe's average (around 0.3%) (Galková, 2022). France has the 4th higher neonatal mortality rate in Europe, 0,42% (ibid). 28% of births worldwide are homebirths, the highest rate being in Chad (78%) (Hernández-Vásquez et al, 2021). The richest countries have lower rates of homebirth and the poorest countries have the higher rates, rural areas were also more represented (ibid). Hernandez-Vasquez et al's study (2021) shows that women who have a homebirth worldwide are usually less educated when it is the opposite in France (Saget-Orliac, 2020).

The debate on obstetrical violence in France has emerged in the 2010s and even more so since 2017 encouraged by Feminists actions and the MeToo movement that helped women come forward about the violence they had been facing (Azcué & Tain, 2021).

Birth is a central topic within Ecofeminism (Hache, 2016). Reproduction matters are at the core of ecological questions (Mies, Shiva, 1993). How we give birth is linked to well-being, physical and mental health (Rowlands, Redshaw, 2012), therefore fundamental to communities' well-being and sustainability (Sung, Phillips, 2018). If there are some studies on behavioural change and sustainability after a child's arrival (Schäfer et al, 2012) it seems there is no research on sustainability and birth.

Departing from the notions within ecofeminism of the link between nature, women, motherhood and oppression (Merchant, 2021) and reclaiming (Hache, 2016), I am looking at how French women

[6] Maternal morbidity such as taring of the perineum or Postpartum haemorrhage (when or after the placenta is born).

articulate their experiences and possible links to societal movements and debates regarding the sustainability of current birth practices for women, their children and to broader sustainability issues.

My research questions are:

What are the concept and practices of homebirth among French women?

a. What meaning do women give to homebirth?
b. Why may some women consider and choose to do a homebirth?
c. How do women perceive sustainability within homebirth?

My study follows the current argument in social sciences in a critique of over-medicalisation and the need to attract attention to women's wishes by making available alternative options that respect women, babies, families and the physiology of birth, such as homebirth.

Following the introduction, I present a literature review focusing on birth and homebirth in Western and French contexts (2). I then introduce Ecofeminism as my theoretical approach and key notions like Reclaiming (3). Then follows my research design, methods (4). Afterwards I present my findings and discuss them examining the reasons for choosing homebirth and homebirth experiences (5). Finally, I conclude my thesis and offer entryways for further research (6).

2. Literature Review

By looking at the history of birth and birth work, it is a history of appropriation by men and the state of a field that was exclusively handled by women (Pruvost, 2016; Ehrenreich, Deirdre, 2015; Morel, 2018). Women have been robbed of their knowledge and power, traditional and empirical expertise have been denigrated and replaced by scientific and certified medical knowledge (Abbott, 1986).

Since the 1990s birth has been apprehended in terms of risks: low, medium, high, which will determine in what type of maternity wards the woman will be directed to (type 1, 2 or 3, see Case description) (Carricaburu, 2007). The notion of risk and what should be considered one is itself a subject for debating, showing two approaches: one justifying hyper-medicalisation and one leaning towards de-medicalisation (ibid). The divide is present between obstetricians and midwives (ibid). The definition of risk by obstetricians is seen by Carricaburu (2007) as a way of maintaining their hegemony on birth as they do not accept the midwives appropriating more ground particularly thanks to the MdN (see Case description) and Type-1 maternity wards (ibid). American studies show that feelings of not being listened to, lack of information and support or over-medicalisation have been linked to Post-Traumatic Stress Disorder (PTSD) (Denis and Callahan, 2009) and "negative physical and psychosocial consequences for families" (Dessureault, 2015). Midwife-led care results in less medical interventions and higher satisfaction (Shandall et al, 2016).

Physiological birth (Odent, 1976) and a fortiori homebirth are the exception, the norm has become the technocracy with the birthing person surrounded by strangers, machines and injected with artificial hormones (Pruvost, 2016; Morel, 2018). Pruvost (2016) writes "The use of local analgesics played a decisive role in the transformation of the parturient into a 'patient'. The obstetrician can deliver the baby with the minimal help of the woman who can now attend her own birthgiving as a spectator" (p4, Own Translation, OT). Homebirth can be seen as a "systems-challenging praxis"(Cheyney, 2008; Singer, 1995). Although it cannot be generalized to the whole population, studies on hospitals (Dutriaux et al, 2008) and alternative places of birth (Plateau Technique, MdN and homebirth) show the wish of women and parents to have access to less medicalized options, to know and trust the caregiver who will be present for them, to have more autonomy and freedom etc; however these options are not available for all nor fully supported by the medical institutions or the main discourse (Vitrai, 2018; Thomas, 2017; Jamet, 2020).

In France there is a strong opposition to homebirth, by the medical professionals who see it as reckless and by feminists who see it as retrograde (Thomas, 2015; Sestito, 2017). From the last decades of Feminism, we have inherited a "flight from nature", the will to get rid of potential remains of essentialism and to lessen the "significance of materiality" (Alaimo, 2008, p237). Yet, some scholars think Feminism would benefit from rethinking the complexity of "nature" and biology and use it to our advantage and counter how biology has been used to oppress minorities (indigenous people, racialized people, women…) and the non-human world (Alaimo, 2008, p240). Birke (1999, p48) specifically advocates for “renam[ing] nature through complexity and transformation”. Our biology is not immutable, it is a constant interaction with its environment and can be studied in terms of biology, but also in terms of culture, discourse (Alaimo, 2008, p238). Alaimo proposes "trans-corporeality, the time-space where human corporeality, in all its material fleshiness, is inseparable from 'nature' or 'environment’” (2008, p238). This materialist feminism can be linked to Ecofeminism and its approach to reclaim one's biology (Hache, 2016) (see theoretical framework).

There is no debate in social sciences regarding birth: researchers all seem to critique medical's technocratic approach (Sestito, 2017; Thomas, 2016; Pruvost, 2016). There is some research on birth and nature (Burke & Seltz, 2018) but not about the contemporary nor French context. If research can be found on how becoming parents can influence consumption behaviours to be more sustainable (Schäfer et al, 2012), it seems there has been no research in sustainability science on (home)birth.

3. Theoretical framework

In this thesis I use Ecofeminism and its different dimensions, in particular the notion of Reclaiming, to comprehend how my respondents understand and experience homebirth, its meanings, its role.

The modern tradition of philosophy of Enlightenment and positivism (Callinicos, 2007), is articulated around dichotomies and dualisms: culture is superior to nature, the mind is superior to the body, men are superior to women (Merchant, 2021; Glazebrook, 2021). Becoming human would mean rejecting nature and any form of animality (Taylor, 2017). The 17th century marks a shift from the medieval beliefs and ideas (Bordo, 1987). Bordo writes this period is a "flight from the feminine, from the memory of union with the maternal world, and a rejection of all the values associated with it" replaced by an obsession for "detachment and objectivity" (1987, p9),) nature is then seen as passive, mechanical, at humans' mercy (ibid). Merchant (2021) also explains how Nature was seen as a nurturing mother until the scientific revolution of the 17th century.

Feminism has long been about the rejection of motherhood (Thomas, 2015), of the association to nature, of all that was considered 'feminine' (Bahaffou in Bienaimé, 2019). As Hache (2016) writes, it is the privileged perspective of white western feminists, to consider low wage labour as necessarily more empowering than motherhood, having in most cases not experienced it to the extent that racialized women have. It forgets that racialized and poor women had been working way before White and privileged women did and it was not empowering (hooks, 1982). If mainstream Feminism did not seize 'motherhood' until recently, Ecofeminism had (Hache, 2016).

Ecofeminism does not have one definition, it is a pluralist movement. Yet, key themes commonly shared can be identified. Ecofeminists see patriarchy, capitalism and white supremacy as one system of oppression (Burgart-Goutal, 2020; Mies and Shiva, 1993). This system oppresses both Nature and women in similar ways, both undergo the predation of colonial, white, capitalist male domination (Merchant, 2021; d'Eaubonne, 2020). Merchant (2021) makes a parallel between sexual assaults that women face and mining, seeing it as a rape of the Earth and exploitation of its 'womb'. Ecofeminism is inherently intersectional, decolonial and radical (Bhaffou and Gorecki, 2020).

Ecofeminism is a grassroots political movement rooted in activism: anti-nuclear like the Women's Pentagon Action in the 80s (King, 1989), against deforestation (Shiva, 1986) etc. These women had to rise against very concrete and imminent threats to their lives, their children's lives, the health, subsistence and well-being of their community and of the Earth itself (Hache, 2016). Since these actions the notion of empowerment has been present within Ecofeminism (ibid). Empowerment is

understood as power from within, self-confidence, the ability to face oppression and a creative power (Calvès, 2009). Ecofeminists created new ways of activism; they brought joy to activism, singing, knitting, they brought emotions (King, 1989; Macy, 1995).

Ecofeminism is about reclaiming (Hache, 2016). Reclaiming what has been denigrated, reclaiming what has been suppressed, reclaiming agency and power (ibid). Among what has been denigrated are 'feminine' skills and practices: knitting, embroidery, knowledge of medicinal plants etc (ibid). It is not going backwards, it is reparation, creation and moving forward (ibid). Women have also been reclaiming their biology: getting rid of the stigma around menstruations, female sexuality, finding pride in their reproductive and nurturing powers (ibid). They do not see these as a fixated fate but as a way to "get out of the nature/culture dualism demanding us to choose between a body without mind and a mind without body"(Hache, 2016, p25, OT).

One of the main critiques of Ecofeminism is essentialism (Hache, 2016). There would be a respectable Ecofeminism, non-essentialist, and a non-respectable one, essentialist (ibid). Hache (2016) refutes this critique: Ecofeminism acknowledges the spectrum of gender identities and does not force anyone to use their uterus to procreate. Ecofeminism aims at reclaiming what has been denigrated and so was motherhood (ibid).

Reclaiming is also reclaiming one's agency (Hache, 2016). Agency is understood as power of action within social structures and institutions and a constant adjustment between experiences of the past, critiques of the present and hopes for the future (Emirbayer & Mische, 1998). Agency is also situational and has to be assessed in each given situation acknowledging the power dynamics at play (Smette et al, 2009).

Ecofeminism was never meant to be an intellectual discipline and trying to make it fit into one academic box is counterproductive and a form of knowledge imperialism (Cook, 1998).

It has been criticizing the modern episteme (Hache, 2016):

> *The result is hybrid texts, of various styles and natures, overlapping several disciplines, mixing theory, poetry, therapy, history, fiction, politics, etc. This experimental and creative dimension of the ecofeminist corpus, too often ignored -because it is strange, non-academic-, seems to me fundamental, on the contrary. The very women who have invented new political forms that make room for the body, imagination, aesthetics, emotions and even magic, breaking with the traditional codes of demonstrations, have also paid particular attention to the form given to their statements in order to express them in terms different from those favoured by the culture of distancing that they criticize. (Hache, 2016, p16, OT)*

Following this legacy, Bahaffou and Gorecki (2020, p11) write: "we refuse to separate our writing, our research, our actions, our emotions and our lives"(OT).

Ecofeminism allows us to revise history in order to write 'herstory' (Burgart Goutal, 2020). A good example is the Witch-hunt that occurred during the Renaissance which, until recently, was not studied through the prism of gender (Whitney, 1995; Federici, 2004). These events are very important within Ecofeminism, representing key themes of the movement (Hache, 2016):

> *[The Witch-hunt] eradicates the link to the earth, the link that villagers celebrated through rituals the cycle of the seasons. It is also a confiscation of knowledge: by qualifying popular knowledge as superstitious and obscurantist, or even diabolical, the figure of the healer integrated into the community is replaced by that of the doctor who dispenses his science from above. The patient, deprived of his confidence in his own culture and his own strength, is henceforth kept in the consciousness of his impotence and his fundamental unworthiness. […] The domination of the body and of nature, are glorified. (Chollet, n.d., OT)*

This quote can be applied to birth, pregnant women have been 'patientalized' and "deprived of [their] confidence" making them in need of 'someone who knows', someone with scientific knowledge, a medical professional (Pruvost, 2016). Burgart Goutal (2021) sees the Witch-hunt as a popular, traditional epistemicide. The Witch-hunt is also considered a Midwife-hunt (Ehrenreich, English, 2015).

For Hache (in Bienaimé, 2019) motherhood, natality are central notions within Ecofeminism. With the Witch-hunt, the Midwives-hunt, the State appropriated women's wombs, women's autonomy, it took control of the reproduction power of a whole nation (ibid). Without reproduction of the labour force, by birthing new humans and caring for those already working, Capitalism would not stand (ibid). The exploitation of motherhood is extended to other animals, the egg and dairy industries are examples (Bahaffou in Bienaimé, 2019). The reproduction of these animals is forced and the physiological consequences such as lactation are commodified and these species' babies used as a new reproductive force or flesh to be consumed (ibid).

'Obstetrical violence' (OV) is a concept, part of 'violence against women' and has to be apprehended through the notion of gender (Lévesque et al, 2018). It encompasses both physical and psychological violence such as: absence of free and informed consent, unnecessary medical acts, iatrogenic acts[7],

[7] Iatrogenic is said "of a disease or problem caused by medical treatment or by a doctor" (Cambridge, n.d.) In the case of birth some medical acts, like injection of artificial oxytocin that provokes stronger contractions and can lead to foetal distress (Tolofari, Shepherd, 2021).

denied agency, discriminations (gender, race, social class etc) (ibid). OV affects women's "physical, sexual, moral and psychological integrity" which can lead to PTSD (ibid, p228, OT).

4. Methodology

4.1. Ontological and epistemological stance

My ontological approach is Critical Realism (CR). CR means that there is a reality 'out there' and a reality that is observable which is always socially constructed thus "Our knowledge of the world is fallible and theory-laden" (Sayer, 1992, p. 5 in Easton, 2010). Both my respondents and I are producing a social understanding of homebirth (Bryman, 2012) which is coherent with the use of qualitative methods and specifically interviews.

I follow Ecofeminist theories and epistemologies questioning the common Western, masculine way of doing science (Hache, 2016) and feminist standpoint theory (Haraway, 1988; Harding, 1992). I refuse to take part in the Western scientific tradition that despises different kinds of knowledge and knowledge production and transmission (ibid). I value empirical and vernacular knowledge and did not view my respondents as laywomen and I as an expert; we only have different, but also similar, fields of expertise. I consider my research a coproduction with all my respondents and interviewees.

4.2. Research Design

This research is an exemplifying case study (Bryman, 2012) of French women who have considered, are considering or have experienced homebirth. A case study is the intensive examination of a particular group or situation, my sample is my unit of analysis (ibid). I have used qualitative methods and my approach is inductive (ibid).

4.2.1. Case description

In mainland France there were 461 maternity wards in 2019,1359 in 1975 and 717 in 2000 (DREES, 2021). There are three main categories of maternity wards (Annex B):

- Type 1: obstetric service (43 %)
- Type 2 a,b: obstetric and neonatal services (a, 28%) and a neonatal intensive care unit (b, 17%)
- Type 3: obstetric, neonatal and neonatal resuscitation services (12%)

Type 3 structures tend to be bigger (81% register more than 3500 births per year, all public), Type 1 are smaller (all maternity wards registering less than 500 births per year are Type 1), most private clinics are Type 1 and 2a (ENP, 2017).

There are different kinds of places where women can give birth: hospitals, private clinics, 'plateaux techniques' (PT) and 'maisons de naissances'(MdN) existing on trial since 2016. Both hospitals and clinics are medicalized with standardized protocols (ENP, 2017). PT are rooms in the hospital that self-employed midwives can rent to assist the birth of their own patients; these births are less medicalized and more physiological (Vitrai, 2018). MdN are managed by midwives, they offer a 'cosier' atmosphere to women with some medical material, considered a compromise between hospital birth and homebirth, reserved for low risks pregnancies (Government, n.d.).

In the latest national report, we see that 76,6% of women gave birth in a public hospital, 23,4% in a private clinic, as these equal 100% they do not count MdN nor homebirths (ENP, 2017). I was not able to find specific numbers for PT and MdN, however, the births in PT must be counted within the 76,6% in public hospitals. 12% of the facilities have a signed convention to allow self-employed midwives in a PT (Annex C) (ENP, 2017); the number of births in MdN is low given there are only 9 MdN in France.

In France midwifery studies last four years, combining theory and practical learning (Ordre des Sage-femmes a, n.d.). The 'philosophy' transmitted around birth seems to be more about risk than in other European countries (Blanchard, 2016). Women also seem to have less autonomy and to be more dependent on their medical-care providers (ibid). There has been a technicization of the training and the expected practices of midwives, some of whom think it is detrimental to the essence of their profession (Puill, 2011).

There are not enough midwives in France, according to Caroline Combot, secretary-general of the National midwifery union (UNSSF), on average there is a lack of 42 midwives per maternity wards (Descamps, 2021). Midwives were on strike ten times in 2021 and so far three times in 2022 (UNSSF, n.d.). They demand an increase in salary, in staffing, changes in the decrees on their profession from 1998 and to be considered as a medical profession given their responsibilities etc. Understaffing leads to mistreatments (Thomas, 2016). In November 2021 Anna Roy, a hospital midwife, launched the hashtag #jesuismaltraitante (I am mistreating) and #1femme1sagefemme (1 woman 1 midwife), despite herself, due to her working conditions, she found herself mistreating her patients (Roy, 2020). It led to an online movement where other medical professionals, especially midwives, have come forward to denounce their working conditions and their own behaviour; this movement has been picked up by some media (Europe 1, 2020).

French law is not fully explicit regarding homebirth. The code of public health stipulates that midwives are allowed to assist births, that patients have the right to choose their medical care provider and the place to receive care (Ordre des Sage-femmes b, n.d.). The APAAD reminds that no law article imposes

giving birth in a hospital (or a specific place in general) nor explicitly forbids assisted homebirth (n.d.). However the law of 2002 March 4th on patients' rights and the quality of the health system (Art. L. 1142-2 in Légifrance, n.d.) stipulates that all practicing medical professional must be insured or should suffer disciplinary sanction. In France, no insurer is willing to cover for midwives assisting homebirth- or asking for about 22.000€ which equals a midwife's yearly salary which is impossible to pay- making them illegal, although there is a tolerance as assisting homebirth itself is not explicitly forbidden (APAAD, n.d.).

4.3. Research Methods

4.3.1. Data collection, sampling

Questionnaire

I used the questionnaire as a source of exploratory qualitative data, to have an overview of perceptions and practices of homebirth on a bigger sample than interviews (Bryman, 2012). I have used generic purposive sampling (ibid): I identified four targeted groups a priori, guided by my research questions, assuming their answers would be different depending on their situation. I shared my survey on my own Facebook account and on a Facebook group about homebirth. I have asked women or groups of women handling Instagram accounts on birth and homebirth to share it. It was shared from February 28th and closed on March 4th.

The targeted groups were:

- **Group 1:** Women considering a homebirth for their first child who had not yet given birth at the time of the survey, to know about their assumptions about homebirth,
- **Group 2**: Women who were considering a homebirth for their first baby but had given birth elsewhere (for whatever reason), I assumed they wanted a physiological birth and were confronted to the hospital (good or bad experiences),
- **Group 3:** Women considering home birth after having already given birth elsewhere, to know how their experience of birth influences their choice of a future homebirth,
- **Group 4:** Women who have had at least one homebirth, to know if their expectations were confirmed or infirmed by their experience(s).

Most of my questions were open ended (Appendix D). It was the only way to have access to these people's perceptions and experiences, as closely as possible. I wanted to influence their answers as

little as possible, not impose themes or pre-made answers on them and let them choose their own words.

The aim of my survey was to understand:

- Why they are considering/have considered homebirth,
- Why they have had one (or more) homebirth(s),
- How they would describe their homebirth experience(s).

Interviews

The purpose of the interviews was to deepen my understanding of the survey answers. I reached my interviewees through the survey. They had the possibility to leave their email address if they were interested in participating in an interview. 163 women requested more information. I sent them an information email explaining the interview process, anonymity, audio recording (Annex E). As I was not able to conduct interviews with all of them due to lack of time and resources, I selected them following three main criteria. They had to fit into at least one of my six categories (mentioned below), be available during a specific timeframe and reply. For some categories I had too many candidates so I chose the ones whose email sounded the most enthusiastic and those who explicitly said how much they wanted to share their story. I used different categories than for the questionnaire because I did not know who would answer the questionnaire but chose my interviewees. I then made more specific categories to access specific experiences.

The midwives interviewed did not answer the questionnaire. I contacted APAAD's Facebook group, Sandrine answered me and after our interview she sent my email to their contact list (Annex F).

I have conducted a total of 11 interviews distributed in the seven categories as follow (Interview guides in Annex G):

1. women who have had a bad experience with medical/hospital birth and now only considers a homebirth (with or without medical professional), to understand what is a bad experience for them and how it influences their future decision.
2. women who have had a homebirth, to discuss the experience of homebirth.
3. women who have had at least 2 homebirths, to see the evolution between the different homebirths experiences and how they differed.

4. women who have had at least one medical/hospital birth and at least one homebirth, to allow comparison between hospital birth and homebirth by women who have experienced both at least once.
5. midwives specialized in homebirths, to gain professional informed perspectives, they were able to deepen my knowledge of their education and practices and they also gave me their observations about the women they assist.
6. doulas who have supported homebirths, to access their professional non-medical perspective.
7. I later added women who had a good hospital birth experience and now want a homebirth.

I chose narrative interviews, rather unstructured for different reasons (Bertaux, 2010, Bryman, 2012). Firstly, this is quite an intimate topic, some talked about previous traumatic experiences and I wanted to give them the time and space to elaborate (or not) as they wished. From previous informal observations on Instagram I saw that these women who speak up about respected physiological birth and homebirth specifically are 'craving' to be heard and legitimated in their experience. By giving them the freedom to elaborate their answer from broad questions, I gave them the opportunity to choose what to talk about, what to mention, what is of relevance. I wanted to show them that I value their expertise as such and blur the boundaries between scientific and laywoman knowledge (Pruvost, 2016). My first questions were very open and they could answer with how many or how few details they wanted (which I emphasized even more for those who had had previous negative or traumatic experiences). I would then pick up on some words or ideas to have further explanations and better understand what they meant.

Interviews helped to have a better understanding of women's perceptions of homebirth, why women choose homebirth over other options, if and how this experience has changed them, how they felt during their homebirth and afterwards. Did they feel empowered? Did they feel a 'link to nature', a 'sense of animality'? Without defining the terms, I asked my interviewees to define 'nature' and 'animality' themselves.

4.4. Data Analysis

4.4.1. Questionnaire

Term Frequency counts and Content analysis

I purposely asked for open-ended responses in the questionnaire so that the respondents would have the freedom to elaborate and use their own words (Bertaux, 2010). I first screened all the answers and identified recurrent words/phrases from the responses and categorized them into 10 themes that I named using their own words or phrases that would summarize the different answers. Each theme was associated to a colour (see the recurrent words of each theme in Annex H) (Bryman, 2012). I highlighted the words in the responses that fell into these themes. I proceeded to a frequency count to objectify my observations (Bryman, 2012). I decided to keep the same 10 categories for the different questions (why home birth, perceptions of home birth, experience of home birth) mainly because these categories recur in all types of questions. The same categories also recur in the 4 groups of women as separated in the questionnaire although their occurrence differ. For the questions about their birth experiences that were not at home I used some of the same categories but also new ones as other themes appeared or the former ones needed sub-divisions.

As for the counting, I counted once the presence (single or multiple) of a theme in the same answer. That is, if several keywords of the same theme appeared in the same response, I counted it only once. Thus, the frequency corresponds to the number of responses where a theme is present in relation to the total number of respondents in the group.

Thus, fitting in the themes was the inclusionary criteria. Some words appear in different themes because depending on the context in which they were used, they had different meanings. Some words or phrases were excluded as they did not fit into any of the categories and did not add value to create a new category or because their meaning was not clear enough.

4.4.2. Interviews

I applied thematic analysis (Bryman, 2012). After transcribing the interviews, I read them through and noticed the same themes identified by analysing the questionnaire and highlighted them. Unlike the survey, it was not a matter of frequency of the themes but of meaning, how the interviewees were linking (or not) different ideas. I did not ask questions about all the themes, only explicitly on Empowerment, Nature and Animality. The other themes were spontaneously covered by the interviewees as they were telling me about their birth experiences. The interviews gave more details

and understanding of the survey's answers and have been used to illustrate arguments in the discussion.

4.5. Scope and Limitations

My questionnaire only focuses on women positive towards homebirth, not representing all the opinions regarding the issue. My research is a case study focusing on a particular group and their personal perceptions and experiences. Opposite opinions are implicitly present in their answers like in the criticism they have received.

This research has been a learning process. Retrospectively my interview design could have had more or better questions although I have gathered relevant data. I might have missed important papers on the topic, exhaustive literature review being impossible. With more time I could have exploited my data in more depths. My data being in French, some meaning was inevitably lost in translation.

Covid and my mental health have been limitations. The pandemic prevented face to face interviews; however, online interviews allowed me to find interviewees regardless of their location. I was not able to meet in person with my supervisor and this has had a considerable impact regarding our communication and understanding. On top of that, I have had depression, starting before the thesis-semester. It has made it very difficult for me to focus and have a consistent studying schedule. I believe menstrual cycle is, to a certain extent, a limitation. My Pre-Menstrual Syndrome (PMS) increases my depressive symptoms. PMS and period combined equal a full week of various symptoms negatively altering my ability to work. On the thesis timeframe, it is about a month of decreased efficiency.

4.6. Positionality

I am a White, cisgender lesbian woman. I come from a middle-class family with a strong cultural capital. I am well aware these factors place me in a privileged position although also subject to oppressions. I have never been pregnant nor given birth, however I am looking forward to becoming a mother.

Since 2017 I have been passionate about perinatal topics and more specifically pregnancy and birth, calling myself a 'birth junkie'. I have integrated the 'birth community' on Instagram where I have learned a lot and got to know some women with whom I text occasionally or often. I had already

informally observed some patterns that I have now studied in depth in this thesis. I am convinced of the benefits of homebirth for all the parties involved and will choose it for myself when the time comes. If this makes me biased in a way, it would have been the same if I had been sceptical, as there is no neutrality nor objectivity (Haraway, 1988; Harding, 1992). I believe my position on the matter was very positive for my interviews. Half of them explicitly told me how they enjoyed being able to talk about their experience without being considered 'crazy', to someone who understands. They are all as passionate as I am. Because I have been within the community for so long, I have the same vocabulary as them, I know who or what they are talking about when they mention some known midwives, doctors, childbirth preparation methods or when they tell me about their birth, I understand the different phases, their names, their effects on their body and psychology. My knowledge allowed them to trust me and to elaborate on their stories and feelings without the fear of being judged or ridiculed. I have never considered the fact of never being pregnant or having given birth yet a problem. Firstly, because giving birth does not necessarily mean having all the knowledge on birth physiology. Secondly, most midwives when they start working are not mothers themselves as they are very young. The women interviewed were all very enthusiastic to pass on their knowledge to me, encouraging me for my future homebirth(s).

4.7. Ethical considerations

Regarding the interviews, verbal consent to record the audio was given at the beginning of each interview (Bryman, 2012). I am using fake names to keep my interviewees anonymous.

My respondents could have been psychologically impacted as we talked about personal, intimate, potentially traumatic events (Bryman, 2012; Butler, 2002).

I am well educated on obstetrical violence and their consequences both physical and psychological[8]. I have explained before the interviews what would be talked about and reminded these women that they were required not to answer any question they felt uncomfortable with, that it was an open and safe space where all emotions were welcome. I intended to be very attentive and tuned in to their reactions. However, there was no issue with the respondents during the interviews. I was in contact with all of them afterwards to check they were allowing me to use quotes and they all agreed and have insisted on how much they had appreciated taking part in my research.

[8] I wrote a paper in my Bachelor about Obstetrical violence in France, I had interviewed liberal (former hospital) midwives.

5. Findings and Discussion

5.1. Description of the respondents

The survey was answered by 304 persons. 97,7% of them are cisgender women, 86,4% are White. The main age group represented is 29-33 years old, the average age of the respondents is 31,2 years old. 81,7% have at least one child, 51,3% of them are in the upper professional categorization, 44% work in care (Annexe I, J). They are on average in higher professional categories than the national average (Annex K) (INSEE, 2022).

I conducted 11 interviews, eight mothers and three homebirth midwives (Table 1), all cisgender heterosexual women.

Table 1. Recap chart of the interviewees' characteristics

	Names[9]	Duration of interview	Year of Birth	Activity	Category [10]/Group [11]	Births
1	**Elena**	40 min	1997	Nurse, doula	4/4	1 hospital birth 1 homebirth
2	**Manon**	2h15	1993	At home mom, doula	3, 4, 6/4	1 hospital birth 2 homebirths
3	**Maelis**	2h06	1991	Market gardener, doula	1, 6/3	Started homebirth and transfer
4	**Aurore**	1h46	1989	Hairdresser	4/4	1 hospital birth 1 homebirth
5	**Sophie**	1h01	1991	Manager animal shelter	3/ 4	2 homebirths

[9] The names have been changed for anonymity.
[10] Pertains to the categorisation of interviewees.
[11] Pertains to the categorisation of questionnaire respondents.

6	**Charlotte**	57min	1995	AESH, educator	4/4	1 hospital birth 1 homebirth
7	**Clara**	55min	1992	Childcare worker	1/3	1 hospital birth
8	**Mathilde**	1h04	1985	Project manager in a research lab	-/3	1 hospital birth
9	**Sandrine**	1h	1973	Homebirth Midwife since 2016	5/-	/
10	**Florence**	30min	1959	Homebirth Midwife since 2014	5/-	/
11	**Vanessa**	1h37	1992	Homebirth Midwife since 2016	5/-	/

5.2. Analysis and Discussion

5.2.1. Why homebirth?

Pull Factor: Comfort Intimacy

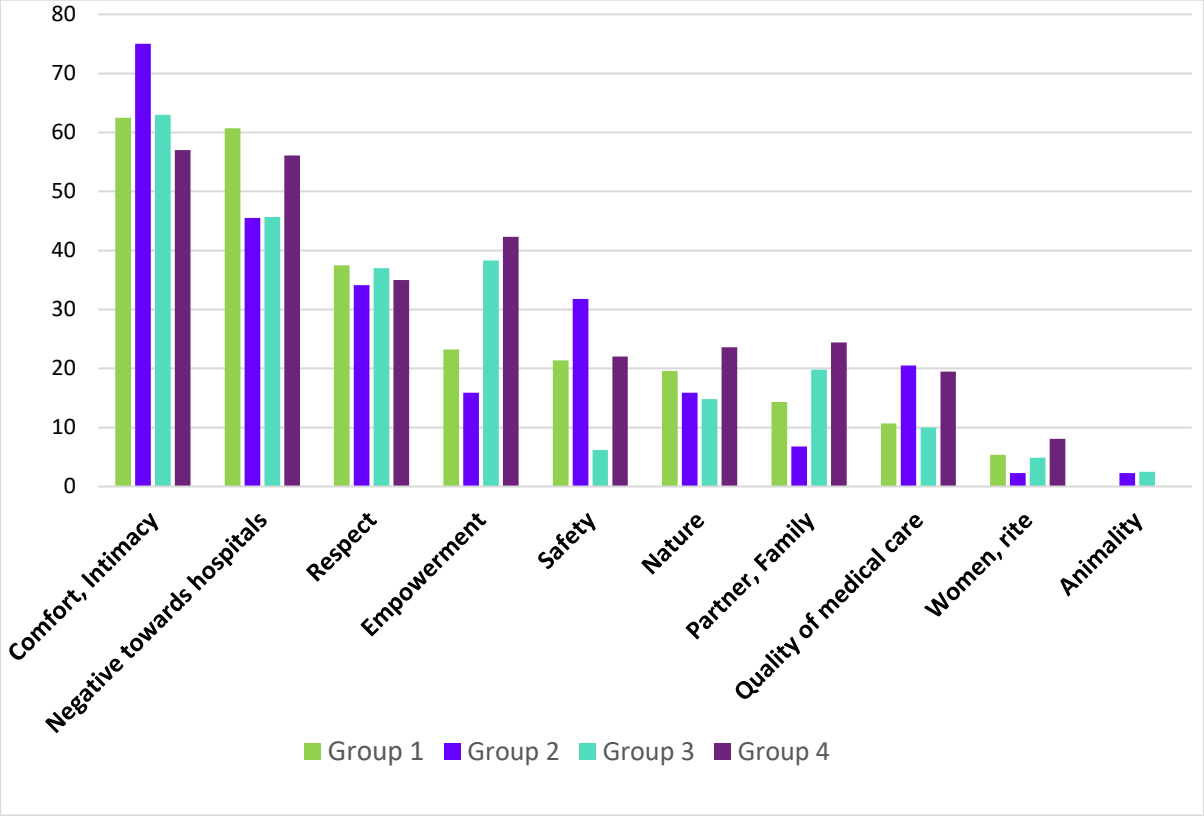

Figure 2. Frequency of the ten themes in the answers to the question "Why did you consider/choose homebirth? The frequencies are different across the groups but we can see trends. The most recurring themes are Comfort, intimacy and Negative towards hospitals for all groups. (Annex L).

The environment of birth is very important (Odent, 2021). Women who choose homebirth seek the comfort of their home (in 63,4% of the survey answers across the four groups, Table A), to have access to their own bed and bathroom. Being at home also makes it easier to fulfil the necessary conditions for a physiological birth, according to Odent (2021): warmth, darkness, quiet, intimacy, safety, not feeling observed, needs met (drinking, eating etc). My interviewees have told me how they prepared their birthing space: mantra cards to remind them of their strength or to breathe, fairy lights, playlists, a 'birth altar' (with candles, pictures, stones etc). Birth requires feeling safe (ibid), all my interviewees expressed they felt safe at home or even safer than in a hospital. Vanessa explains how birth is sexual, intimate and compares birth to orgasm. Orgasm can also happen during birth allowing the secretion of oxytocin which is responsible for contractions. She explains:

The environment too, it's very important to be in this bubble of love. I always use the example of the orgasm, you can't have an orgasm on the side of the road with bright lights when it's cold, well it's the same for giving birth. The fact of being at home, in an environment that we know, it's reassuring."

Vanessa, homebirth-midwife

For example, the word "bubble" was used by 36,4% of my interviewees and is the 11th most used word in the questionnaire (Table 2). Respondents of both the questionnaire and the interviews seem to share a vocabulary to describe birth and its process. All respondents were reached through social media on accounts about birth and homebirth. All the mothers interviewed explained how Instagram accounts and podcasts have been integral parts of their homebirth choice and preparation and more broadly an alternative source of information on motherhood (breastfeeding, co-sleeping, babywearing etc).

Table 2. Words that appeared at least 20 times in the questionnaire to the question "Why did you consider/choose homebirth?" (in numbers)

	TOTAL	GROUP 1 (56)	GROUP 2 (44)	GROUP 3 (81)	GROUP 4 (123)
RESPECT	70	11	10	16	33
NATURE/NATUREL/ NATURELLEMENT	59	11	6	14	28
SÉCURITÉ/SÉCURITAIRE	56	11	15	6	24
INTIMITÉ/INTIME	53	7	9	14	23
PHYSIOLOGIE	49	6	7	19	17
(SUR)MÉDICALISATION	44	15	7	1	21
COCON	38	5	8	12	13
CONFORT/CONFORTABLE	29	8	3	8	10
UNE SAGE-FEMME/ LA MÊME SAGE-FEMME	28	3	4	7	14
LIBRE/LIBERTÉ	27	3	2	5	17
BULLE	21	1	3	9	8
CONFIANCE	21	11	2	4	4

ACTRICE	20	2	1	6	11
PUISSANCE/PUISSANTE/ PUISSANT	20	3	1	7	9
PROTOCOLES	20	2	1	5	12

Comfort and intimacy being the first reason why they choose homebirth across the four groups suggests they assume or have experienced that it is not present in a hospital setting (Thomas, 2016).

Push Factor: Negative towards Hospitals

'Negative towards hospitals' is in 50,9% of the survey' answers across the four groups and reaches 60,7% in Group 1 who have never given birth, showing that many expect a negative experience in a hospital (Annex L). Experience seems to confirm these expectations as the other groups who have experienced birth and hospital birth place this theme in second, the smallest occurrence being 45,5%.

Their answers are either based on their own experiences or on what they have read or heard. In both the survey and the interviews examples include: obstetrical violence, infantilisation, threats, acts without their consent, denied needs and wishes, lack of information, racist, misogynist or fatphobic comments etc. Their answers illustrate forms of violence without ambiguity (Lévesque et al, 2018). Other acts or words can appear as violent even if there is no consensus around them, each woman's perceptions are valid and should not be disputed (category 'perçu comme violent' in Table 3).

Table 3. Group 3's answers to "Can you describe each of your birth experience(s)?" correlated with the place of birth (in %).

	Hospital (68)	**Clinic (34)**	**PT[12] (6)**	**MdN[13] (6)**
NON CONSENTEMENT	**3**	2,9	0	0
VIOLENCES	26,5	**44,1**	0	0
PERÇU COMME VIOLENCE	**50**	35,3	33,3	33,3

[12] PT: Plateau technique, 'physiological room' within a hospital.
[13] MdN: Maison de Naissance, considered a compromise between hospital birth and homebirth, reserved for low risks pregnancies.

MANQUE DE PHYSIOLOGIE	3	**23,5**	0	0
RESPECT	14,7	17,6	**50**	16,7
BONNE EXPÉRIENCE	23,5	20,6	**83,3**	66,7
EMPOWERMENT	3	5,9	**33,3**	**33,3**
NATURE	3	**11,8**	0	0
CONFORT, INTIMITÉ	3	0	**16,7**	0
ANIMALITÉ	0	**2,9**	0	0

Translation of the terms (in the same order): no consent, violence, perceived as violence by the respondents, lack of physiology, respect, good experience, empowerment, nature, comfort and intimacy, animality.

My data reveals that for 64,7%[14] of births from Group 3 that happened in hospitals women experienced violence. It affects 70,6%[15] of the births in clinics. In each case, less than 25% had a good experience. Knowing that 96% of births happen in hospitals and clinics (INSEE, 2017), it is likely numerous women enter motherhood negatively impacted physically, psychologically of both by their birth experience (Rowlands, Redshaw, 2012). Florence tells me sadly:

> *Maybe we save babies. [in hospitals] But with what kind of trauma on women, on babies? with emergency forceps, inductions[16] with babies that are extracted[17] when they weren't ready to be born.... all of that is serious trauma.*

This is unfortunately confirmed by Maelis, two years ago, she started a homebirth but was transferred to a hospital due to a medical error by her midwife:

> *I am flooded with waves of sorrow every day at 6:30 pm, time of birth. I cry for my body, I am unable to look at it. [...] I was diagnosed with PPD [postpartum depression], it has reoccurred every winter for the past 2 years. [...] We are afraid of how we are treated in the hospital, because we know.*

[14] Counted each 'Perceived as violence' and/or 'violence', once per answer
[15] Idem
[16] Induction is when labour is started artificially. If the baby is overdue or in case of pathology and when they suspect macrosomia (too big baby), usually using artificial oxytocin (other methods exist) (NHS, n.d.).
[17] She means either by caesarean or the use of forceps or vacuums to facilitate/accelerate the baby's expulsion.

Lahaye (2018), a feminist jurist, has written on how hospitals do not have enough midwives, so technology has to take over as well as a neoliberalist management of hospitals, as it is expected from the medical professionals to 'make money'. She condemns the 'Fordist standardization' of care of births which Manon expressed in the same terms:

> *You have to submit, it's industrial, it's Fordist, profitability, the least amount of time possible*
>
> Manon, 1 hospital-birth, 2 homebirths

My data and the literature (Azcué, Tain, 2021; Sestito, 2017) suggest that both mothers interested and educated about homebirth and homebirth midwives agree on the medical system's violence and are critical of it, seeing it as oppressive, as all my interviewees talked about it. For Sophie it was a matter of self-protection. Because she is an incest survivor, she could not envision her physical and psychological integrity being compromised and she knows this could not be guaranteed in a hospital. Sandrine, a homebirth midwife I interviewed explains how the standardized protocols lead to violence as demonstrated by Jacques (2019):

> *There is a whole protocol in the hospital that there isn't at home, so we can do according to each woman, to her rhythm, whereas in the hospital it is so much in a row that you have to do the same for everyone [...] to make everyone safe. But you're not safe when they do things to you that you didn't need.*

Some women realize later the violence they endured, when learning more about birth' physiology, reading other birth stories, learning how things 'could be' or even 'should be'.

> *I was happy [of her hospital birth], I had no idea of everything that had happened. When my daughter was 6 months old, I discovered podcasts and that what I experienced wasn't normal. They didn't listen to me. I was told they had read my project[18], so why did they bring me that table[19] or maybe they didn't tell me everything [...] I felt robbed from birth.*
>
> Clara, 1 hospital-birth

This implies that women are not educated on the birth process enough to know what to expect and be able to give free and informed consent (in compliance with Kouchner's law) and choose how to give birth (Thomas, 2016), as 91% of my interviewees expressed.

> *The basic courses [childbirth's preparation] teach you to submit to hospital protocols, they tell you how it's going to happen, without telling you that you're going to have a choice, and it's often under the prism of the epidural. There is not much freedom... the first intervention is to leave home. Now it seems absurd to me to leave your home, from a place where you are in intimacy, in your comfort to*

[18] Her birth plan, she did not want a medicalized birth.
[19] The midwife brought a table to put Clara on it, altering physiology.

go to a place with a lot of strangers, a lot of light. [...] The reality is that the hospital protocols sabotaged your birth, so it's a good thing they're here to fix their screw-ups! If I had realized this all at once after my first birth, I think I would have had a breakdown. I became aware of this over the years. I already felt raped at my first birth, but over the years I have realized the impact, the new knowledge I have gained. It is serious. If people live it well, it's only because they don't know.

Manon, 1 hospital-birth, 2 homebirths

Kouchner's law on patients' rights is 20 years old but seems not to be applied, especially regarding consent (Azcué & Tain, 2021). Aurore (1 hospital-birth, 1 homebirth) explains:

For my first birth, I didn't want an epidural, I was not given the choice, I was told "You will go up to the delivery room and we will inject the epidural". I didn't say no, but I don't know if I would have had the strength to argue my no. I didn't say no so I, I can make myself feel guilty.

Her feeling guilty recalls victim-blaming often found in cases of sexual assaults (Claire et al, 2019). The midwife who informed her of what was going to happen to her did not ask for consent. One can ask if the technology around birth is such a progress if it is at the expense of the care relationship and emotional support (Puill, 2011). The midwife's phrasing suggests medical professionals see the patients' bodies as being at their disposal and on which they can act as they wish, reminding of the treatment of Nature as innert (Merchant, 2021).

Ecofeminist writers identify and criticize the scission between the positivist, rational, scientific, western world and other ways of knowing, more organic, empirical (Merchant, 2021).

This scission is found among the actors around birth (Pruvost, 2016). Different actors have very different opinions (Davis-Floyd, 1994). Gynaecologists, hospitals and medical institutions in general (national orders of gynaecologists, CNGOF, and midwives, CNOSF) still hold the monopoly on risk definition, depriving women of their agency (Carricaburu, 2007). They embody the technico-medical care, the rational scientific world that requires proofs, numbers, standardized protocols, control (Davis-Floyd, 1994). On the other side, women, homebirth midwives and doulas[20] work to inform, educate, and support those who are interested in homebirth and want to live this experience. They show empirical knowledge, flexibility, confidence and trust in the birth process (ibid). They organize themselves, create associations, like the CDAAD (homebirth advocacy group), CIANE (inter-associative collective around the birth), or APAAD to make their voices heard and take part in decision making regarding perinatal protocols like at the FFRSP (French Federation of Perinatal Health Networks). They

[20] The word 'doula' comes from ancient Greek and means 'female slave', in service of the lady of the house they would also help during pregnancy and labor. Doulas advocate for birthing people to be supported and cared for throughout pregnancy, birth and postpartum in a non-medical way (Association Doulas de France, n.d.).

embody physiological care, opposed to the techno-medical one (ibid). As the former despises the latter (Sestito, 2017), women face a power imbalance, the expert/laywoman divide, which can be reinforced by other systemic oppressions like gender, race, social class, ability etc (ibid), hence the need to have an intersectional approach (Crenshaw, 1989; El Kotni, Quagliariello, 2022). My interviewees are aware of this divide and some have expressed it explicitly:

> *A woman going to the hospital, she thinks they [medical professionals] know and she doesn't, they will do what they have to do and she won't question if it is good or not.*
>
> Sandrine, homebirth-midwife

Women who historically became patients have been robbed of their confidence regarding their own bodies and sensations which force them to blindly trust their medical care providers, not being able to assess if the decisions made for them are helpful, useless or even harmful for themselves and/or their baby (Pruvost, 2016; Chollet, n.d.; Blanchard, 2016).

> *For them [medical professionals] the female body has its limits but no. […] It's difficult to be assertive with the professionals being 'we know because we are gynaecologists, midwives, we know'. No, they know protocols, they know pathologies but they know nothing about physiology!*
>
> Charlotte, 1 hospital-birth, 1 homebirth

Cheyney (2008) writes "As they come to value additional forms of authoritative knowledge that include embodied and intuitive ways of knowing, mothers displace physicians as the unequivocal or sole experts in the birthplace" (p265). As Charlotte explains, the divide is not only about the source of knowledge but also about its contents. All the homebirth midwives interviewed deplore the French midwife studies and their lack of contents about physiology as they focus primarily on pathology, even though obstetricians are the ones in charge of pathological pregnancies and births while midwives care for the physiological ones, it is coherent with Sestito's (2017) findings. They have also shared reflections on the role of the (homebirth) midwife and her 'true role' during the birth process:

> *I've learned to unlearn the myths they teach at school. If we stay in hospitals, we keep our ideas but if we truly observe what happens in nature, it actually goes very well, without interventions, hands-off, it's beautiful.*
>
> Vanessa, homebirth-midwife

> *We have to be very humble as a midwife and realize that if you observe women giving birth you are useless. My presence allowed them to feel safe, to let go, they used their archaic brain, didn't put intellect into it. Our job is not to deliver babies, it is to care for women the best way so they can access their power.*
>
> Sandrine, homebirth-midwife

I don't do anymore, I am… midwife, I hold the space. I have this anchored faith that women are able to give birth, no matter what happens they can count on me if they need me. If they don't, I will learn. I've learned with some women who asked me to stay behind the door. Ok! It was new!

Florence, homebirth-midwife

This vision of the role of the midwife (hands-off, observing not intervening etc) or of the medical care providers in general is an exception to the rule in the mainstream ideas around birth and among medical professionals working in more common settings like hospitals (Puill, 2011), it is very different. The language is also telling. Florence explains it well:

[when working in hospitals] I used to say 'I delivered 2 babies tonight' Now when I am back from a birth, I never say that. I say 'I have cared for a birth tonight'.

This discourse breaks away with the belief shared by many professionals and the population that childbirth is a dangerous pathological event requiring the presence of medical personnel (Pruvost, 2016; Jacques, 2017), or another person to 'deliver' the baby, as if the mother was not involved in the process, as demonstrated by an article in Le Parisien published April 21st 2022, titled: " Dylan, gendarme, gave birth to/delivered[21] a little boy on the A3". They imply that a woman needs to be in the presence of someone to give birth, even if that someone knows nothing about birth and its physiology.

When I asked Vanessa about her exclusionary criteria[22] for her homebirth patients, as there are no official guidelines and it is up to each midwife to include or exclude some situations or not (age of the mother, diabetes, term overrun, macrosomia[23] etc.) she explained, laughing:

I INDIVIDUALIZE, and that pisses off the gynos! Because they tell me: 'yes but we need numbers and protocols!' No, it is individualized depending on the woman, so yeah it bothers them a lot!

We see the divide again between the medical scientific rationale and a holistic approach (Davis-Floyd, 1994; Thomas, 2016; Merchant, 2021). Vanessa, and the other two midwives interviewed, individualize the care they offer (ibid). They understand the woman as a whole and decide using many factors, not only the presence of one potential risk factor (Thomas, 2016). All disagree with some 'risk factors' that hospitals ask them to exclude (e.g. term overdue, age, macrosomia).

[21] The French phrasing is ambiguous.
[22] Homebirth is for women with low risks pregnancies. Having some pathologies or characteristics (age, weight, diabetes etc) excludes them from homebirth.
[23] Baby estimated to be too big.

Because of Covid, women were forced to go through labour alone, without their partner, or wearing a mask which was linked to higher rates of anxiety and PTSD (Oddo-Sommerfeld et al, 2022). These have been reasons to choose homebirth in both the questionnaire and the interviews.

My data shows women want to be respected, as well as their baby and birth's physiology (Pruvost, 2016). They want their wishes and needs to be respected, like moving, drinking or eating (ibid). They also want to know their midwife, to trust her and for her to be available throughout their birthing ('quality of medical care') (ibid). Some interviewees mentioned the hashtag #1femme1sagefemme, one of the demands of hospital midwives during their strikes. They know through experience or other women's stories that often not all needs are respected in hospitals (ibid).

This questions the role of the hospital, in particular concerning patients with more specific needs. This place where one expects to feel safe becomes a hostile place where one is afraid and where one's rights are no longer respected (Pouchelle, 1998; Azcué & Tain, 2021).

5.2.2. Homebirth Experiences

Few women choose homebirth…

The women I have interviewed - and most likely the ones who answered my questionnaire – as they are considering, choosing or have made a marginal choice regarding their birth, had to question and 'deconstruct' a lot of norms, images and social expectations to allow themselves to behave differently (Pruvost, 2016; Thomas, 2016). Manon expresses how women are conditioned to believe their body is failing and they are unable to birth safely on their own or without medical help (Pruvost, 2016; Thomas, 2016):

> *We consider it [hospital-medicalized-birth] normal, it's the majority, we are conditioned like that, we don't see anything else. In baby boom[24], in movies, we always see a woman who is out of breath, who blows 'like a little dog', who screams, she always needs at the last minute that someone assists her or saves her from her own body, the baby is born in extremis, no but my god!*
>
> Manon, 1 hospital-birth, 2 homebirths

Both in the questionnaire and during interviews women reveal how birthing outside a medical structure is considered 'crazy' and 'reckless' (Thomas, 2015).

[24] French TV show, docu-reality, filming births in hospitals, broadcasted since 2011.

I am surrounded by friends who have children but I think that none of them really asked themselves the question of why and how to give birth in a hospital... I had this image in my head that it's completely crazy to want to give birth at home, that people are reckless…it's the image we have...

Mathilde, 1 hospital-birth

Medical professionals can be negatively judging and violent when women explain their choice to birth at home (Thomas, 2015; Pruvost, 2016) as experienced by Charlotte, the hospital made a report for endangering the life of others, as if to punish her for her deviance from the norm (ibid).

All this shows how choosing homebirth really is going against social norms.

Any step outside the norm is costly as one risks a backlash (Faludi, 1991; Becker, 1963). To avoid being brought back to the norm and to avoid being polluted by the fears of others, some did not mention their homebirth plan to anyone. When they did talk about it, they were not met with approval.

My father-in-law didn't understand at all and we almost got yelled at for giving birth at home. [...] It's a pleasure to talk about it and especially to meet people who understand us and who don't think we are crazy!

Aurore, 1 hospital-birth, 1 homebirth

None of my interviewees described themselves as Ecofeminists. However, many of their thoughts can be linked to Ecofeminism or at least some of its dimensions. Some mentioned Feminism, patriarchy (Walby, 1989) or male domination (Bourdieu, 1998). Mathilde, who wants a homebirth for her second child, sees a clear political dimension in her choice unlike Gouilhers-Hertig's findings (2014). It is for her an act of feminist activism about women's right to have ownership over their own body (Azcué & Tain, 2021). Mathilde wants to talk about her choice to friends, colleagues, families, to introduce people to the possibility of homebirth, so more people see it as a real option and not only something for 'crazy' people.

… yet homebirth shows better experiences.

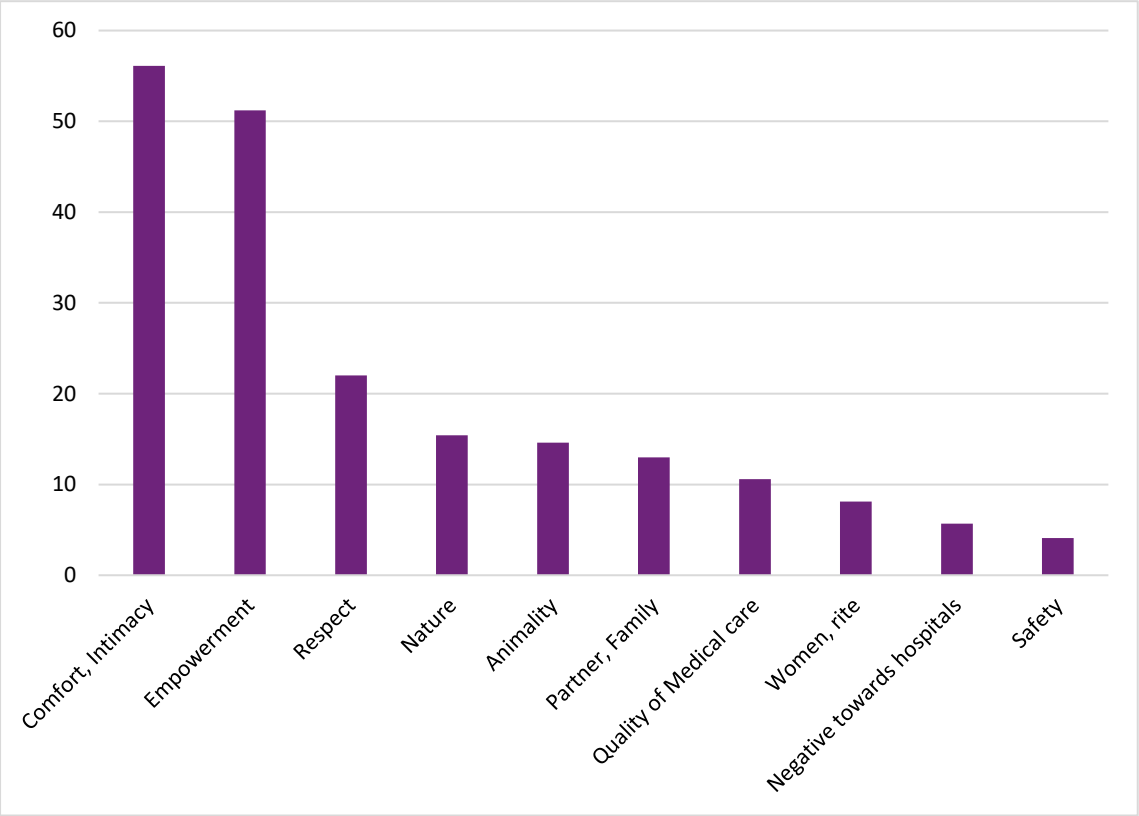

Figure 3. Frequency of the ten themes in the answers to the question "How would you describe your experience(s) of homebirth?" (Group 4)

In the questionnaire answers, 28 out of the 32 most used words to describe homebirth experience(s) are inherently positive, only one being 'negative' (Table 4). Figure 3 shows Comfort, Intimacy and Empowerment to be the most present themes, in respectively 56,1% and 51,2% of the answers (Annex M). Comfort was the main reason to choose homebirth (Annex L, Figure 2), it is confirmed by experience as Comfort is the most recurrent theme. Although there is a recruitment bias, Maelis who had a bad homebirth experience still advocates for it and became a doula to support women in this choice and experience.

Table 4. Words appearing at least 5 times in the answers to the questionnaire question "How would you describe your experience(s) of homebirth?" (Group 4)

Words	Numbers	Words	Numbers
Puissant, puissance, puissante	45	**Confiance**	8
Doux, douce, couceur	30	**Instinct, instinctif**	7
Intense, intensité	27	**Magnifique**	7
Rapide	26	**Simple**	7
Intime, intimité	22	**Douleur, douloureux**	7
Nature, naturelle, naturel, naturellement	21	**Forte, force**	6
Magique	21	**Mari**	6
Respect, respectée, respectueux	17	**Confort, confortable**	6
Sereine, sérénité	13	**Amour**	6
Incroyable	13	**Parfait, parfaite**	6
Animal, animalité	12	**Evident, évidence**	5
Merveilleux	12	**Empowerment, empouvoirement**	5
Beau	10	**Accompagnée, accompagnement**	5
Bonheur	9	**Extraordinaire**	5
Libre, liberté	8	**Facile**	5
Calme	8		

Translation of the words (in the same order): power/powerful, soft/gentle, intense, fast, intimate, nature, magical, respect, serene, unbelievable/amazing, animal, marvellous, beautiful, happiness, freedom, calm, confidence/trust, instinct, wonderful, simple, pain, strong, husband, comfort, love, perfect, obvious/self-evident, empowerment, cared for, extraordinary, easy.

Reclaim and empowerment

Is homebirth empowering and more than hospital births? In the questionnaire 'powerful' is the most used word to describe their homebirth experience (Table 4). The notion of empowerment is most present in the younger women (Annex N), probably because there is no proper translation of 'empowerment' in French and it appeared in the 2000s in France (Bacqué, M. & Biewener, 2013) In all my interviews appeared terms expressing the notion of empowerment, of self-confidence and creative power (Calvès, 2009). For those who had given birth in a hospital before, they all declared their feeling of empowerment was much more present during their homebirth.

> *Women who want to give birth at home they feel sovereign and they trust their instincts.*
>
> Sandrine homebirth-midwife

> *It gave me a lot of strength, there was something inside me that happened that day! [...] There is something to be done to give back to women, they have this strength within them but they don't know it. We are infantilized all the time.*
>
> Aurore, 1 hospital-birth, 1 homebirth

The gain in confidence happens at different levels. Sophie explains how her homebirths gave her self-confidence to care for her daughters. Birth does not only empower the mother,it can cross other spheres and empower the woman (Gouilhers-Hertig, 2014).

> *I want to give birth again, it's so beautiful, it's a shot of hormones completely addictive, and it's a confidence... there is a before and after. My childbirth at the hospital didn't transform me, my homebirths strengthened me in my identity as a woman, before I thought women were a sub-sex, that men were stronger, now it makes me laugh [...] I am not afraid, now even of my employers I am not afraid, I gave birth to my children at home, what can you do to me? There is a notorious, remarkable empowerment*
>
> Manon, 1 hospital-birth, 2 homebirths

Manon tells how homebirth helped her reclaim her power and agency (Pruvost, 2016) over male domination and to now feel like she can stand up for herself. Elena concludes with a similar idea:

> *We managed to make women believe that they were incapable, that it was not at all instinctive that even they were patients. It was a pathology.. Once you are in labor, people come, your vagina becomes a 'train-station-concourse'[25] , hands and fingers can be put in it.[…] We disconnect generations and generations of women who will say things like 'I don't know how to give birth, I'm lucky they told me how to do it' but nobody teaches you how to poop and it's exactly the same! your body is able to do it! [...] What I keep is this power taken back on a society.*
>
> Elena, 1 hospital-birth, 1 homebirth

She has reclaimed her sovereignty (Pruvost, 2016) and feels more able to face society's expectations and go against them. One of the main notions of Ecofeminism is Reclaiming, to find value and pride in knowledge, skills, activities that have been undervalued and denigrated (Hache, 2016) which Elena expresses:

> *We have been disconnected from our feelings, we have been disconnected from the power of the plants […] from all the natural medicines to which we used to have access to. [...]. And that's really the very power of…we have a lot to learn from nature. I think we have a lot to learn about our deep nature from where we come from, from our roots, from our ancestors and that we forget precisely all these values that were invented afterwards, all these notions of propriety, of politeness that are totally contrary to many things like the female cycle, the cycle of life.*
>
> Elena, 1 hospital-birth, 1 homebirth

Although she does not use the term, Elena is in line with Ecofeminism, the wish to reconnect and reclaim old knowledge and practices, reclaiming her agency (Hache, 2016). Reclaiming can be seen as reversing stigma (Goffman, 1963).

[25] French expression meaning that everyone can enter it, put their hands in it.

Nature and animality

Women and Nature have been associated, Nature was seen as a nurturing mother and women seen as beings of nature when men are beings of culture (Merchant, 2021).

Ecofeminism suggests a way to extricate ourselves from the nature/culture divide because rejecting nature is playing the game of patriarchal capitalism (Hache, 2016). Rejecting one's own 'nature', however we define it, can be experienced as oppressive when embracing our link to Nature can be empowering (ibid).

Nature and Animality are more present in the homebirth experiences than in the reasons to choose homebirth (Figure 2,3). All the women interviewed answered like it was self-evident.

> *Nature is the source of life, we[26] are completely dependent on it. […] The internal movement that the baby does at the beginning, to present the smallest part of their skull, when a seed germinates, its leaves are curved and the smallest part pushes the ground and then stands up straight. We are born like a seed.*
>
> Maelis, 1 transferred homebirth

Maelis sees connections among living beings of different species and humans as an integrated part of Nature, showing a form of system thinking (Meadows, 2008). Aurore also acknowledges this interdependence with the Earth:

> *Yes for me there's a link with childbirth, feeling this energy from the Earth, help us birthing our child. With our placenta we did the life-tree of our baby[27], it shows a tree, it's not a coincidence, there is this connection with nature, the Earth, it's obvious.*
>
> Aurore, mother of 2, 1 homebirth, 33 years old

Interviewees would often combine the two notions of nature and animality. If the question of animality is raised in Pruvost (2016), it is not explored. Interviewees used similar words to those showing in the questionnaire: mammals, instinct, instinctive, primal etc (Annex H.a).

> *Clearly there is something animal, primal, completely bestial. […] I was hoping to connect with a very animal part of myself and to be able to turn off my brain and experience everything that is natural in the functioning of the body and in the physiology of the body and I was very happy to experience it.*
>
> Sophie, 2 homebirths

[26] She means 'humans'.
[27] They did a placenta print, using ink on the placenta and putting paper on it to keep an image of the placenta and umbilical cord.

I think that when you enter this archaic, animal state, I think it is instinctive. Even someone who doesn't like nature, it calls to them, really.

Manon, 1 hospital-birth, 2 homebirths

All of them welcomed these feelings positively, even hoping for that state to occur as it is linked to physiological labor (Odent, 2021). However, two of the midwives said it is not as positive for some:

This mammalian side of our being, completely inhibited elsewhere. Childbirth is an act, there is an animal side, a woman on all fours, is it ok for these civilized women? Is shouting civilized? [...] it's part of my preparation, this animal part, to accept that.

Florence, homebirth-midwife

As Florence suggests, it might not be evident to accept this 'other side' of oneself, one that is less polished and less socially acceptable (Martin, 1998). Florence uses the word 'civilized', reminding of colonisation when colonists would 'civilize' the 'savage' people (Emerson, 1969), with this idea that the western, white, male, rational knowledge and practices are the only ones valuable, indigenous knowledge and practices being entirely discarded (Althaus, 2020; Glazebrook, 2021) which is also critiqued by Ecofeminism (Hache, 2016). Women being raised not to be too loud, not to scream etc, it could seem not proper for them to behave in a 'wilder' way (Martin, 1998) which Elena said:

I think that I had for a long time been disconnected precisely from this natural side. From this side, a little bit animal that we have in each of us because it's what is expected of us anyway. Nature would impose itself anyway. We restrain our nature way too much, to ultimately, to conform.

Elena, 1 hospital birth, 1 homebirth

Manon makes a clear division between what is 'social' and what is 'natural' and 'animal', the social norms and expectations sabotaging what has been designed by 'nature'.

You rob women of the true image of birth, that is social, and the more social i,t is the more it is sabotaged.

Manon, 1 hospital-birth, 2 homebirths

In a way, science proves her right. Michel Odent (2021), French gynaecologist, explains how our neocortex[28] can inhibit instincts and physiological actions, which is an exception within the mammal species. He tells that birthing women require neocortical inhibition in order for the full physiological process to happen, which helps relieving pain and avoiding lengthening labour. They should not feel observed or not be talked to as it reactivates the neocortex (ibid). For an easier birth, women need to free themselves from social constraints and rely solely on their archaic brain (ibid) which was also

[28] "The neocortex is part of the human brain's cerebral cortex where higher cognitive functioning is thought to originate from" (Bennet, 2019)

mentioned by my interviewees, many of them referenced Michel Odent. However, what Manon suggests is that the Human is out of Nature since when a Human intervenes, she says it is not natural anymore. We are back to the Nature/Culture divide (Merchant, 2021). Yet during the interview, Manon repeatedly criticized our industrial society where "everything is industrialized", wishing for a more natural way of life, to reconnect to the biological cycle etc. Is this divide unsurpassable?

Sustainability

Thomas (2015) concludes that women choosing homebirth do so by being well educated and as a form of reappropriation of their autonomy and not to "claim an environmentalist way of life at all costs, as the defenders of modernity like to make fun of." (p11, OT). My data agrees with women reclaiming birth as their own. However I do not oppose environmental pursuits and informed autonomy, nor do my respondents. Sestito's respondents (2017) connect homebirth and environmentalist activism. Some of my interviewees made a link between respected homebirth and sustainability of both human communities and the Earth system.

> *As Michel Odent says, 'to change the world you have to change the way babies are born', well, that's it. I see that babies born at home and at the hospital do not have the same behavior, not at all, […] for me it's obvious, I see it.*
>
> Vanessa, homebirth-midwife

> *At home you have more chance to experience things, hormonally, and to transmit them to your baby, making humans for the world of tomorrow, hyper connected, to respect everything of the nature. My son is the only one of his friends who doesn't pick flowers, because I'm in that respect, while the others 'ah it's pretty, I'll take it, I'll make it my own', no! it's something that lives! [...] the more we respect the natural functioning of birth, of how children come into the world, the more it's going to make human beings who are going to be able to care for it.*
>
> Maelis, 1 transferred homebirth

Vanessa is convinced of the impact of birth in the first few months of the baby and Maelis thinks the effects are even more lasting.

Birth can be considered the basis of everything. How can we raise empathetic caring humans if they are met with violence as early as on their birth-day? How can we expect them to be empathetic with all living beings and the Earth if they are met with no empathy?

These women who have chosen homebirth have questioned so many norms they end up tending towards more sustainable living. They did not all become vegan or zero waste but several told me about the way they changed their consumption habits, so as to be more careful about the products

they use (Schäfer et al, 2012). Some became feminists and politically committed (Lacoude, 2019). If women who choose homebirth lie within modernity (use of technologies, social media etc) (Pruvost, 2016) my interviewees questioned it. This choice can be seen as both a logical consequence and a source of questioning norms and common behaviours, the Western notion of modernity and our understanding of progress and what progress should be. Homebirth allowed these women to question and reclaim their link to nature, to their own animality, to embody them in their own terms.

6. Conclusion

This thesis has explored homebirth in France. The literature review looking at birth and homebirth in France and Western contexts showed two opposed approaches to apprehend birth (Davis-Floyd, 1994). The technico-medical care is the mainstream approach, risk-based, pathology-focused and the physiological care is alternative one, trusting the birth process. Homebirth lies within the physiological approach (ibid). Social sciences have researched birth and critiqued the paradigm of over-medicalization which is to the detriment of birthing people.

Through a qualitative questionnaire and interviews I have found that the meaning women give to homebirth vary, but two trends appear: seeing it as evident, 'natural' and seeing it as activism to promote women's rights and their ownership of their own body and reproductive life.

My data shows the reasons why women choose homebirth is a combination of push and pull factors. They are mainly seeking comfort, intimacy, trust in their care provider and to be respected in their wishes and needs. They are avoiding hospitals, the fear-based approach and standardized protocols to preserve their agency. Homebirth can be empowering and help women face everyday obstacles in motherhood and other spheres of their life. Women who have experienced homebirth tend to feel a close link to nature and embrace their animality, not seeing it as oppressing but empowering. Homebirth and what my respondents have expressed about it is in line with Ecofeminism theories and approach. The notion of reclaiming is very present. For some of them, homebirth has been part of a process of reappropriation of their reproductive power. They are also reclaiming knowledge and practices that existed in traditional midwifery before birth was appropriated by the medical institution and the state. Reclaiming one's body, one's pride, one's autonomy, one's sovereignty, one's animality.

Homebirth is a right but is threatened. History seems to repeat itself and homebirth midwives face a new 'Witch-hunt' as they are put in trials by the CNSSF, hospitals or even gynaecologists, disbarred and banned from practice. They are forced to organize and fight to keep homebirth available to those who want it.

Because homebirth can be seen as both a consequence and source of questioning Western modern ways and turn to more sustainable practices, it is relevant to sustainability science. Some of my interviewees have linked homebirth to broader sustainability issues, believing that changing the way babies are born is one step towards changing the world by caring for more empathetic humans who will then care for other living beings and the Earth.

At the beginning of my research, I have been contacted by CDAAD, they wanted my data to participate to the FFRSP[29] and have more insight on why women choose homebirth, emphasizing the need for more research on the topic.

This thesis suggests more research exploring how women (mothers, doulas, homebirth midwives) organise themselves to overcome the system's failures. On Instagram I see many accounts offering educational content, an alternative discourse to prepare women to face the medical institutions or help them to have the necessary information to get ready for an 'alternative' birth without an epidural or at home. They have created networks of mutual aid and sisterhood, making them all stronger.

[29] French Federation of Perinatal Health Networks

7. References

Abbottt, A. (1988). *The system of professions, an essay on the division of expert labor,* Chicago, Chicago University Press.

Alaimo, S. (2008) Trans-corporeal feminisms and the ethical space of nature. In *Material Feminisms*, Alaimo, S. and Hekman,S., Indiana University Press, 448p

Althaus, C. (2020) Different paradigms of evidence and knowledge: Recognising, honouring, and celebrating Indigenous ways of knowing and being. *Australian Journal of Public Administration*., Vol. 79 Issue 2, p187-207. 21p. 8 Diagrams, 2 Charts. DOI: 10.1111/1467-8500.12400.

APAAD (2020). Sécurité et qualité des accouchements assistés à domicile en France : Analyse des données de l'année 2019. [Safety and quality of assisted homebirths in France: analysis of 2019 data]

https://www.apaad.fr/wp-content/uploads/2020/11/RAPPORT-2020-CONSOLIDE.pdf

APAAD (2021). Accouchements accompagnés à domicile en 2020 en France :Evolution et clés pour la pratique. [Assisted homebirths in France in 2020: Evolution and keys for practice.] https://drive.google.com/file/d/1KD1K4dOzWBNXtNi32C0MnPXlml9NkaGY/view

Arnal, M. (2018). Les enjeux de l'accouchement médicalisé en France et au Québec. *Travail, genre et sociétés*, 39, 201-206. [The challenges of medicalized childbirth in France and Quebec] https://doi.org/10.3917/tgs.039.0201

Association Doulas de France. (n.d.) Une doula c'est quoi ? [what is a doula?] https://doulas.info/une-doula-cest-quoi/

Azcué, M. & Tain, L. (2021). L'émergence du concept de « violence obstétricale »: l'impact du mouvement féministe. *Santé Publique*, 33, 635 643. [The emergence of the concept of "obstetric violence": the impact of the feminist movement] https://doi.org/10.3917/spub.215.0635

Bacqué, M. & Biewener, C. (2013). L'empowerment, un nouveau vocabulaire pourparler de participation ?. *Idées économiques et sociales*, 173, 25-32. [Empowerment, a new vocabulary to talk about participation?] https://doi.org/10.3917/idee.173.0025

Becker, H. S. (1973). *Outsiders: Studies in the Sociology of Deviance*. Free Press. https://search.alexanderstreet.com/lti/view/work/bibliographic_entity%7Cbibliographic_details%7C4708467

Bennet, C. (2019, March 5). What is the Neocortex, *News Medical*
https://www.news-medical.net/health/What-is-the-Neocortex.aspx

Bienaimé, C. (Executive producer).(2019, November 6). Ecoféminisme, 1er volet : Défendre nos territoires(21). [Audio podcast episode]. In *Un podcast à soi*. Arte radio. [Ecofeminism, Part 1: defend our land]
https://www.arteradio.com/son/61662635/ecofeminisme_1er_volet_defendre_nos_territoires_21

Bienaimé, C. (Executive producer).(2019, December 4). Ecoféminisme, 2ème volet : Retrouver la terre(22). [Audio podcast episode]. In *Un podcast à soi*. Arte radio. [Ecofeminism, Part 2: Reconnect to the Earth]
https://www.arteradio.com/son/61662820/ecofeminisme_2eme_volet_retrouver_la_terre_22

Birke, Lynda. 1999. "Bodies and Biology." In Feminist Theory and the Body: Reader, ed. Janet Price and Margrit Shildrick, 42–49. New York: Routledge.

Blanchard L. (2016) Sages-femmes en Europe: vers une analyse comparative de la formation et des conditions d'exercice de la profession en Europe [Master's Thesis Midwifery, Université Pierre et Marie Curie] [Midwifery in Europe: towards a comparative analysis of training and practice conditions in Europe].

Bordo, S. (1987). *The Flight to Objectivity, Essays on Cartesianism and Culture*, 1987, State University of New York Press

Bourdieu, P. (1998). La domination masculine, Paris, Seuil, (Liber) [Male Domination]

Burgart Goutal, J. (2020) *Etre Ecofeministe: Théories et pratiques*. Editions L'échapée

[Being Ecofeminist: Theories and Practices/experiences]

Burgart Goutal, J. (2021, October 21) Écoféminisme : Quelles théories pour quelles pratiques ? [Conference within the Conference cycle Futur.E.s], hosted by Lauren Bastide in Le Carreau du temple. [Ecofeminism, what theories for what practices?]

Burke, F., & Seltz, J. (2018). Mothers' Nature: *Feminisms, Environmentalism, and Childbirth in the 1970s*. *Journal of Women's History 30*(2), 63-87. doi:10.1353/jowh.2018.0014.

Butler, I. (2002) A Code of Ethics for Social Work and Social Care Research, *The British Journal of Social Work*, Volume 32, Issue 2, Pages 239-248, https://doi.org/10.1093/bjsw/32.2.239

Callinicos, A. (2007). *Social theory : a historical introduction* (2. ed.). Polity Press.

Calvès, A-E. (2009). Empowerment : généalogie d'un concept clé du discours contemporain sur le développement. *Revue Tiers Monde* , (n° 200), p735-749. [Empowerment: genealogy of a key concept in contemporary development discourse]

Carricaburu, D. (2007). De l'incertitude de la naissance au risque obstétrical : les enjeux d'une définition. *Sociologie et sociétés*, 39(1), 123–144. []. From the uncertainty of birth to obstetrical risk: the challenges of a definition] https://doi.org/10.7202/016935ar

Cascales, B. & Négrié, L. (2018). L'accouchement, une question clivante pour les mouvements féministes ?. *Travail, genre et sociétés*, 39, 179-185. [Is childbirth a dividing issue for feminist movements?] https://doi.org/10.3917/tgs.039.0179

Cheyney M. (2008). Homebirth as systems-challenging praxis: knowledge, power, and intimacy in the birthplace. Qualitative Health Research;18(2):254-267.

Chollet, M. (n.d.) *Femmes, magie et politique*, de Starhawk « Quitter la terre ferme des certitudes ». [Women, magic and politics, by Starhawk "Leaving the firm ground of certainties] https://www.peripheries.net/article215.html

Cook, J. (1998). The Philosophical Colonization of Ecofeminism, Environmental Ethics, vol 20, 3, p227-246

Crenshaw, K. (1989). Demarginalizing the Intersection of Race and Sex: Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics. *University of Chicago Legal Forum, 1989,* 139-168.

Davis-Floyd, R. (1994) The Technocratic Body: American childbirth as cultural expression*, Social Science and Medecine*. Vol. 38, No. 8, pp. 1125-l 140,

Denis A, Callahan S.(2009). État de stress post-traumatique et accouchement classique : revue de littérature. *Journal de Thérapie Comportementale et Cognitive* ;19(4):116-9.[Post-traumatic stress disorder and conventional childbirth: a review of the literature.]

Descamps, M. (2021, December 25). Sages-femmes en grève : quelles sont leurs revendications ?, *Europe 1,* [Midwives on strike: what are their demands?] https://www.europe1.fr/societe/sages-femmes-en-colere-une-greve-pour-denoncer-le-manque-deffectifs-4084560

Dessureault, A. (2015). La médicalisation de l'accouchement : impacts possibles sur la santé mentale et physique des familles. *Devenir*, 27, 53-68.[ ). La médicalisation de l'accouchement : impacts possibles sur la santé mentale et physique des familles] https://doi.org/10.3917/dev.151.0053

DREES (2021). La naissance : les maternités [Birt: Maternity wards] https://drees.solidarites-sante.gouv.fr/sites/default/files/2021-07/Fiche%2023%20-%20La%20naissance%20-%20les%20maternit%C3%A9s.

Dutriaux N, Chevalier I, Muray JM, Dran C. (2008). Vécu et attentes des usagers d'une maternité francilienne. *La Revue Sage-Femme*. 7(4):177-86. [Experiences and expectations of users of a maternity hospital in the Paris region]

Ehrenreich, B., English, D. (2015). Sorcières, sages-femmes et infirmières, Paris, Cambourakis [Witches, midwives and nurses: a history of women healers]

El Kotni, M. E., & Quagliariello, C. (2022). L'injustice obstétricale: Une approche intersectionnelle des violences obstétricales. *Cahiers Du Genre*, *71*, 107–127. [Obstetric injustice: An intersectional approach to obstetric violence]. https://doi.org/10.3917/cdge.071.0107

Emerson, R. (1969). Colonialism. *Journal of Contemporary History*, *4*(1), 3-16.

Emirbayer, M., & Mische, A. (1998). What Is Agency? *American Journal of Sociology*, *103*(4), 962–1023. https://doi.org/10.1086/231294

Europe 1 (2020, November 17). #Jesuismaltraitante : l'appel d'Anna Roy, sage-femme, pour plus de moyens dans les hôpitaux, *Europe 1.* [#I am an abuser/I am mistreating: the call of Anna Roy, midwife, for more resources in hospitals] https://www.europe1.fr/societe/jesuismaltraitante-lappel-danna-roy-sage-femme-pour-plus-de-moyens-dans-les-hopitaux-4005999

Faludi, S. (1992). *Backlash : the undeclared war against women*. Vintage.

Federici, S. (2004). *Caliban and the witch : women, the body and primitive accumulation*. Autonomedia.

Galková, G., Böhm, P., Hon, Z., Heřman, T., Doubrava, R., & Navrátil, L. (2022). Comparison of Frequency of Home Births in the Member States of the EU Between 2015 and 2019. *Global Pediatric Health*. https://doi.org/10.1177/2333794X211070916

Glazebrook, T.(2021) What is Worth Knowing? Science, Knowledge, and Gendered and Indigenous Knowledge-Systems. *Axiomathes* **31,** 727–741. https://doi.org/10.1007/s10516-021-09597-w

Gouvernement. (n.d.). Les maisons de naissance [Birth centers] https://solidarites-sante.gouv.fr/systeme-de-sante-et-medico-social/structures-de-soins/article/les-maisons-de-naissance

Gouilhers-Hertig S., (2014), Vers une culture du risque personnalisée, *Publication de la Sorbonne*. [Towards a personalized risk culture] https://journals.openedition.org/socioanthropologie/1696#:~:text=63La%20culture%20du%20risque,hospitali%C3%A8re%20soit%20applicable%20%C3%A0%20toutes.

Gravelin, C.R., Biernat, M., Bucher,C.E. (2019) Blaming the Victim of Acquaintance Rape: Individual, Situational, and Sociocultural Factors . *Frontiers in Psychology*, 9 https://www.frontiersin.org/article/10.3389/fpsyg.2018.02422 DOI=10.3389/fpsyg.2018.02422

Harding, S. (1992). After the Neutrality Ideal: Science, Politics, and" Strong Objectivity". Social Research, 567-587.

Haraway, D. (1988). Situated knowledges: The science question in feminism and the privilege of partial perspective. Feminist studies, 14(3), 575-599

hooks, bell. (1982). *Ain't I a woman : black women and feminism*. Pluto press.

Ifop. (2021). Accouchement à domicile Rapport Janvier 2021 [Homebirth, 2021 January Report] https://drive.google.com/file/d/1JWsFTatGtMlbxD-gI8E7X2KVIl5oyPMN/view

INSEE (2017, August, 30). Les 784 000 naissances de 2016 ont eu lieu dans 2 800 communes [The 784,000 births in 2016 took place in 2,800 municipalities] https://www.insee.fr/fr/statistiques/3047024

INSEE (2022, January 18). Naissances et taux de natalité Données annuelles de 1982 à 2021 [Births and birth rates Annual data from 1982 to 2021] https://www.insee.fr/fr/statistiques/2381380 l

INSEE (2022, March 9). Catégorie socioprofessionnelle selon le sexe et l'âge https://www.insee.fr/fr/statistiques/2489546

INSERM and DREES. (2017)Enquête nationale périnatale Rapport 2016 Les naissances et les établissements Situation et évolution depuis 2010 [National Perinatal Survey 2016 Report Births and Facilities Situation and Changes since 2010]

https://enp.inserm.fr/wp-content/uploads/2020/05/ENP2016_Rapport.pdf

Jamet, B. (2020) Accoucher en maison de naissance : motivations des femmes et expérience de l'accompagnement global à la naissance. Médecine humaine et pathologie [Master's Thesis, Midwifery, Université Clermont-Auvergne]. [Giving birth in a birthing center: women's motivations and experience of comprehensive birth support. Human medicine and pathology]

Jacques, B. (2019) Des pratiques d'accouchement routinisées aux violences obstétricales. *2e congrès international du GIS Institut du genre « Genre et émancipation »*, Université d'Angers,Angers, France. [From routine childbirth practices to obstetric violence.] halshs-02295199⟩

Lacoude, F. (2019, December 10). Quand la maternité rend féministe, *Neon* [When motherhood makes you a feminist] https://www.neonmag.fr/quand-la-maternite-rend-feministe-542348.html

Légifrance (n.d.) LOI n° 2002-303 du 4 mars 2002 relative aux droits des malades et à la qualité du système de santé. [LAW n° 2002-303 of March 4, 2002 relating to the rights of patients and the quality of the health system]
https://www.legifrance.gouv.fr/jorf/id/JORFTEXT000000227015/

Letesse, V. (2021, May 19) Accouchement à domicile : "J'aurais préféré aller chez le vétérinaire plutôt qu'à l'hôpital". [Home birth: "I would have preferred to go to the vet's than to the hospital]
https://www.franceculture.fr/emissions/le-reportage-de-la-redaction/elles-seraient-de-plus-en-plus-nombreuses-a-accoucher-seules-chez-elles-et-sans-assistance

Lévesque, S., Bergeron, M., Fontaine, L. & Rousseau, C. (2018). La violence obstétricale dans les soins de santé : une analyse conceptuelle. *Recherches féministes*, *31*(1), 219–238. [Obstetric Violence in Health Care: A Conceptual Analysis] https://doi.org/10.7202/1050662ar

Martin, K. A. (1998). Becoming a Gendered Body: Practices of Preschools. *American Sociological Review*, *63*(4), 494–511. https://doi.org/10.2307/2657264

Meadows, D. (2008). *Thinking in Systems: A Primer*.White River Junction

Merchant, C. (2021)*The Death of Nature, Women, Ecology and the Scientific Revolution,* Editions Wildproject

Mies, M., & Shiva, V. (1993). *Ecofeminism*. Zed Books.

Morel, M. (2018). Naître à la maison d'hier à aujourd'hui. *Travail, genre et sociétés*, 39, 193-199. [Being born at home from the past to the present.] https://doi.org/10.3917/tgs.039.0193

NHS. (n.d.) Inducing labour.
https://www.nhs.uk/pregnancy/labour-and-birth/signs-of-labour/inducing-labour/

Odent, M. (2021, November 15). Naissance : du pessimisme à l'optimisme. [Online conference]. [Birth: from pessimism to optimism]
https://naitreenconscience.fr/les-conferences/

Oddo-Sommerfeld, S., Sommerlad, S., Pernidaki, V., Köhnlein, A., Wonner, N., Schermelleh-Engel, K., Louwen, F. (2022). Enhanced postnatal anxiety, traumatic stress symptoms, and lower well-being after giving birth alone due to The COVID-19 Pandemic, *European Journal of Obstetrics & Gynecology and Reproductive Biology,* Volume 270, Page e79, ISSN 0301 2115, https://doi.org/10.1016/j.ejogrb.2021.11.263.

Ordre des Sage-femmes a (n.d.) Formation initiale [initial training]
https://www.ordre-sages-femmes.fr/etre-sage-femme/formation/initiale/

Ordre des Sage-femmes b (n.d.) Code de déontologie des sages-femmes. [Code of Ethics for Midwives]
https://www.ordre-sages-femmes.fr/wp-content/uploads/2015/10/Code-de-d%c3%a9ontologie-des-sages-femmes-version-consolid%c3%a9e-au-19-juillet-2012.pdf

Pouchelle, M.-C. (1998). « Ici on ne fait pas de cadeau »: Partages du temps et don de soi à l'hôpital. *Ethnologie Française*, *28*(4), 540–550. ["Here we don't do gifts": Sharing time and giving of oneself/self-sacrifice in the hospital.] http://www.jstor.org/stable/40990041

Pruvost, G. (2011) Récit de vie, Sociologie, *Les 100 mots de la sociologie*, [Life story, Sociology] http://journals.openedition.org/sociologie/671

Pruvost G.(2016) Qui accouche qui ? Étude de 134 récits d'accouchement à domicile. *Genre, sexualité & société*, 16 [Who is delivering whom? A Study of 134 Stories of Home Births]

Puill C., (2011), Les sages-femmes face à la médicalisation de la naissance et de leur formation, mémoire de fin d'études de sage-femme, école de sage-femme de Rouen. [Master's Thesis, Midwifery school of Rouen]. [Midwives facing the medicalization of birth and their training]

Revenu, N. (2022, April 21) «Ça arrive une fois dans une vie» : Dylan, gendarme, a mis au monde un petit garçon sur l'A3, *Le Parisien***.** ["It happens once in a lifetime": Dylan, gendarme, gave birth to/delivered a little boy on the A3]
https://www.leparisien.fr/seine-saint-denis-93/ca-arrive-une-fois-dans-une-vie-dylan-gendarme-a-mis-au-monde-un-petit-garcon-sur-la3-21-04-2022-GZNWNHCIIBBVLPIFFWSEVIKXTI.php

Rowlands, I.J., Redshaw, M.(2012) Mode of birth and women's psychological and physical wellbeing in the postnatal period. *BMC Pregnancy Childbirth* **12,** 138. https://doi.org/10.1186/1471-2393-12-138

Roy, A. [_anna.roy_] (2020, November 11). #1femme1sagefemme #jesuismaltraitante [Instagram post]. [#1woman1midwife #I am mistreating/abusing] https://www.instagram.com/p/CHckbupFJE7/

Sandall J, Soltani H, Gates S, Shennan A, Devane D. (2016). Midwife-led continuity models versus other models of care for childbearing women. Cochrane Database of Systematic Reviews, Issue 4. Art. No.: CD004667. DOI: 10.1002/14651858.CD004667.pub5.

Saget Orliac, V.(2019) L'accouchement accompagné à domicile comparé au bas risque en milieu hospitalier : une étude exposé-non exposé historique multicentrique. Médecine humaine et pathologie. ffdumas-02893888f [Midwife Master's Thesis]. [Assisted homebirth compared with low-risk hospital delivery: a multicenter historical exposure-non-exposure study. Human Medicine and Pathology]

Schäfer, M., Jaeger-Erben, M. & Bamberg, S. Life Events as Windows of Opportunity for Changing Towards Sustainable Consumption Patterns?. *J Consum Policy* **35,** 65–84 (2012). https://doi-org.ludwig.lub.lu.se/10.1007/s10603-011-9181-6

Semali, L. M., & Kincheloe, J. L. (2002). *What is indigenous knowledge?: Voices from the academy*. Routledge.

Sestito, R. (2017) Faire naître à la maison en France , *Anthropologie & Santé*, 15, http://journals.openedition.org/ anthropologiesante/279. [To be born at home in France] https://doi.org/10.4000/anthropologiesante.2798.

Shiva, V., & Bandyopadhyay, J. (1986). The evolution, structure, and impact of the Chipko movement. *Mountain research and development*, 133-142.

Singer, M. (1995). Beyond the ivory tower: Critical praxis in medical anthropology. Medical Anthropology Quarterly, 9(1), 80-106

Smette, I., Stefansen, K., & Mossige, S. (2009). Responsible victims? Young people's understandings of agency and responsibility in sexual situations involving underage girls. *YOUNG*, *17*(4), 351–373.

Taylor, S. (2017). *Beasts of burden: Animal and disability liberation*. The New Press.

Sung, H., Phillips, R.G.(2018). Indicators and Community Well-Being: Exploring a Relational Framework. Int. Journal of Com. WB 1, 63–79. https://doi.org/10.1007/s42413-018-0006-0

Thomas C., (2015), Accoucher naturellement, un choix écolo ? , in *Emulation,* n°14 « Femmes et écologie », Presses universitaire de Louvain. [Natural childbirth, an eco-friendly choice?]

Thomas, C. (2016) Accoucher en France aujourd'hui. Les enjeux de la profession de sage-femme et la position des femmes face à la naissance médicalisée. Anthropologie sociale et ethnologie. [PhD thesis, Université de la Réunion]. [Giving birth in France today. The stakes of the midwifery profession and the position of women in the face of medicalized birth. Social anthropology and ethnology]

Thomas, C. (2017).L'accompagnement global par les sages-femmes , *Anthropologie & Santé*, 15 . [The global support/holistic care by the midwives] http://journals.openedition.org/anthropologiesante/2729; DOI : https://doi.org/10.4000/anthropologiesante.2729

Tolofari, M., Shepherd, L. (2021). Postpartum haemorrhage and synthetic oxytocin dilutions in labour, *British Journal of Midwifery*, Vol. 29, No. 10

UNSSF(n.d.) Communiqué
https://unssf.org/category/communique/

Vitrai, E. (2018) Accouchement en plateau technique lors de l'accompagnement global à la naissance : motivation et satisfaction des patientes : étude réalisée sur le territoire auvergnat auprès de 209 sage-femmes. Médecine humaine et pathologie. [Master's Thesis, Midwifery school Clermont-Ferrand]. [Delivery in a 'plateau technique' during holistic care for birth: motivation and satisfaction of patients: study carried out on the Auvergne territory with 209 midwives. Human medicine and pathology]

Walby, S. (1989). Theorising Patriarchy. *Sociology*. 23(2). 213-234

Whitney, E. (1995). The Witch "She"/The Historian "He": Gender and the Historiography of the European Witch-Hunts. *Journal of Women's History 7*(3), 77-101. doi:10.1353/jowh.2010.0511.

8. Annexes

Annex A – Table 1. Different characteristics and birth outcomes in relation to the place of birth, APAAD (2020, p26)

Figure 16 : Comparatif des principaux indicateurs entre les différents lieux de naissance en France				
	Naissances extrahospitalières		**Naissances Hospitalières**	
	APAAD 2019 : accouchements accompagnés à domicile	Maison De Naissance France	EPN 2016 : toutes femmes	AUDIPOG : femmes a bas risque exclusivement
Effectifs	1081	649	12270	6224
Morbidité maternelle				
État périnéal				
Intact	66%	48.7%	27.9%	31.5%
Déchirure simple (degré 1 et 2)	33.6%	47.7%	51.3%	36.7%
Déchirure complète	0.1%	0.7%		
Déchirure complète et compliquée	0%		0.8%	0.9%
Épisiotomie	0.3%	3.3%	20.1%	31.9%
Délivrance				
Administration prophylactique d'ocytocine	0.5%	31%	92.7%	47.3%
Complète	98.3%			
Incomplète	0.8%			
Artificielle	0.6%			10.4%
Hémorragie du post-partum				
HPP sévère > 1000ml	1%	1.4%	1.8%	3.1%
Mortalité maternelle	0%	0%	0.01% [43]	

[39] Nous précisons car un mouvement récent de femmes, se définissant comme des « sages-femmes traditionnelles » ou des « sages-femmes quantiques », est en développement sur le territoire afin d'accompagner les naissances à domicile. Notre rapport étudie exclusivement les accompagnements par des sages-femmes ayant un titre officiel reconnu par l'état et l'ordre des sages-femmes.

[40] Le rapport sur les maisons de naissance étudie la santé des mères et des enfants nés en 2018 au sein des 7 maisons de naissances expérimentales françaises

[41] La dernière Enquête Nationale Périnatale date de 2016. Elle concerne la santé des mères et des enfants, pour des naissances hospitalières, tous niveaux de risques confondus

[42] L'association AUDIPOG a pour but de promouvoir l'utilisation d'un "dossier périnatal commun" et l'informatisation des maternités. Grâce à la création d'un dossier informatisé commun elle dispose d'une large base de données. Elle nous a fourni en 2018 une base de données – la même que pour l'étude des maisons de naissance - pour les femmes à bas risque accouchant à l'hôpital. Cette base de données n'a pas été revue.

[43] Données issues de l'Enquête Nationale Confidentielle sur les Morts Maternelles 2017 car non disponible dans l'EPN

Annex B – Table 2. Different places of birth and distribution of births by place, ENP (2017, p110)

Tableau 31. Lieu d'accouchement
(France métropolitaine ; femmes majeures et naissances vivantes)

	2010		2016		
	%	p	n	%	IC à 95 %
Statut de la maternité [1]					
CHU / CHR	17,7	< 0,001	2 546	19,8	19,1 - 20,5
CH	46,4		6 353	49,4	48,5 - 50,2
ESPIC [2]	7,5		962	7,4	7,0 - 7,9
Privé à but lucratif	28,4		3 008	23,4	22,6 - 24,1
	(14 474)		(12 869)		
Niveau de spécialisation de la maternité [1]					
Type I	29,9	< 0,001	2 893	22,5	21,8 - 23,2
Type II A	27,0		3 759	29,2	28,4 - 30,0
Type II B	20,8		2 817	21,9	21,2 - 22,6
Type III	22,3		3 398	26,4	25,7 - 27,2
	(14 465)		(12 867)		
Taille de la maternité [1]					
< 300 acc/an	0,3	< 0,001	85	0,7	0,5 - 0,8
300 - 499	2,2		251	1,9	1,7 - 2,2
500 - 999	15,0		1 916	14,9	14,3 - 15,5
1 000 - 1 499	20,7		2 052	15,9	15,3 - 16,6
1 500 - 1 999	14,0		1 900	14,8	14,2 - 15,4
2 000 - 2 999	29,1		2 936	22,8	22,1 - 23,6
3 000 - 3 499	9,8		1 695	13,2	12,6 - 13,8
3 500 - 4 499	6,5		1 211	9,4	8,9 - 9,9
≥ 4 500	2,4		825	6,4	6,0 - 6,9
	(14 474)		(12 871)		
Temps de transport pour aller accoucher [1]					
< 30 min	76,9	NS	8 854	76,2	75,4 - 77,0
30 - 44 min	16,3		1 926	16,6	15,9 - 17,3
≥ 45 min	6,8		836	7,2	6,7 - 7,7
	(13 669)		(11 616)		

(1) Rapporté au nombre de femmes.

(2) Établissement de santé privé d'intérêt collectif.

Annex C – Table 3. Facilities of the different maternity units according to their size, ENP (2017, p203)

► **Tableau 107. Locaux du secteur naissance et aménagement selon la taille des maternités en 2016**

	Nombre d'accouchements par an						Total
	< 500	500 à 999	1000 à 1499	1500 à 1999	2000 à 3499	≥ 3500	
Nombre de salles de naissance dans la maternité							
minimum	1	2	2	3	4	7	1
médiane	2	2	3	4	5	7	3
maximum	5	5	8	11	11	13	13
estimation du nombre minimal réglementaire de salles*	1	1 à 2	2 à 3	3 à 4	4 à 7	7 à 9	
Part des maternités conformes à cette estimation	100%	100%	100%	100%	96%	100%	99%
répondants	*58*	*146*	*98*	*65*	*98*	*27*	*492*
Nombre de salles de pré-travail dans la maternité							
minimum	0	0	0	0	0	0	0
médiane	1	1	2	2	3	4	2
maximum	4	6	8	6	10	7	10
Estimation du nombre minimal réglementaire de salles*	1	1	1 à 2	2	2 à 4	4 à 6	
Part des maternités conformes à cette estimation**	81%	96%	89%	86%	86%	63%	88%
répondants	*58*	*146*	*98*	*64*	*98*	*27*	*491*
Le secteur naissance comprend un espace dédié pour réaliser des accouchements peu médicalisés (espace physiologique, salle nature…)* **							
oui	14%	40%	44%	55%	40%	48%	40%
répondants	*58*	*146*	*98*	*65*	*98*	*27*	*492*
Convention de l'établissement avec des sages-femmes libérales pour leur accès au plateau technique pour faire des accouchements							
oui	16%	18%	9%	5%	10%	4%	12%
répondants	*58*	*146*	*98*	*65*	*98*	*27*	*492*

*D'après l'arrêté du 25 avril 2000 relatif aux locaux de prétravail et de travail, aux dispositifs médicaux et aux examens pratiqués en néonatologie et en réanimation néonatale. Une marge de 15 % du nombre d'accouchements a été utilisée pour tenir compte des fluctuations du nombre d'accouchements selon les années.
**Les moins bons résultats des maternités concernant la conformité à la réglementation pour les salles de pré-travail par rapport aux salles de naissances sont en partie expliqués par l'absence de prise en compte de salles mixtes. Les salles mixtes, aménagées de façon à pouvoir accueillir des femmes à la fois pendant le pré-travail et pendant le travail, ont vraisemblablement été uniquement comptabilisées parmi les salles de naissances. Lorsqu'on inclut dans le calcul de la conformité à la réglementation du nombre de salles de pré-travail les salles de naissances excédentaires par rapport à l'estimation du nombre minimal réglementaire de salles de naissance, la part des maternités conformes à l'estimation du nombre minimal réglementaire de salles de pré-travail passe de 88 % à 97 %.
***Les chiffres présentés pour cet item ne sont pas comparables à ceux concernant la présence d'une salle physiologique en 2010, en raison d'une formulation différente en 2010 et en 2016.

Lecture : 14 % des maternités de moins de 500 accouchements déclarent avoir un espace dédié pour réaliser des accouchements peu médicalisés dans le secteur naissance.

Champ : France métropolitaine.

Source : Enquête nationale périnatale 2016, questionnaire établissements.

Annex D. Questionnaire

I am Garielle, a Master's student in Sustainability. I am writing my Master's Thesis on homebirth. I am trying to understand why some women consider/choose to give birth at home and what was the experience like. I am personally very passionate about the topic.

This survey is for people who have considered and/or have had one homebirth or more.

All the answers are anonymous and will be used in the purpose of my research only.

As this can feel like a very intimate topic or even be triggering, even if the questions are programmed to be 'mandatory' there is always the option to say that you do not want to answer the question. Take care.

It should take about 5 to 10 min to complete.

Thank you!

Part A – To lead to the different part

You:

- Are considering/planning a homebirth for your first birth (and have not given birth yet)
- Have considered a homebirth and gave birth elsewhere
- Have had a homebirth after having given birth elsewhere
- Have had at least one homebirth

Part B – You are considering/planning a homebirth for your first birth (and have not given birth yet)

1. Why did you choose homebirth?
   Up to 10 words/ phrases
2. What are your perceptions of homebirth?
   Up to 5 words/phrases
3. Do you have expectations for your homebirth?
   a. If yes, what expectations?
   Up to 5 words/phrases

Part C – You have considered a homebirth (for your 1st child) and gave birth elsewhere

1. Why did you consider having a homebirth?

   Up to 10 words/ phrases
2. Did you have expectations for your homebirth?
    a. If yes, what expectations?

   Up to 5 words/phrases
3. Where did you give birth?

   Hospital, clinique, plateau technique, maison de naissance, other
4. Can you describe your birth experience?

   Up to 5 words/phrases
5. Why didn't you give birth at home?

   Open question

Part D – You are considering/planning a homebirth after having given birth elsewhere

1. How many times did you give birth?

1-2-3-4-5-other

2. Where did you give birth?
    a. The 1st time?
    b. The second time?
    c. The third time?
    d. …

   Hospital, clinique, plateau technique, maison de naissance, other
3. Can you describe each of your birth experiences?
    a. The 1st time
    b. The 2nd time
    c. The 3rd time
    d. …

   Up to 5 words/phrases
4. Why are you considering to have a homebirth?

Up to 10 words/ phrases

5. Do you have expectations for your homebirth?
    a. If yes, what expectations?

Up to 5 words/phrases

Part E – You have had at least one homebirth

1. How many times did you give birth?

1-2-3-4-5-other

2. Where did you give birth?
    a. The 1st time?
    b. The second time?
    c. The third time?
    d. ……

Hospital, clinique, home, plateau technique, maison de naissance, other

3. Can you describe in a few words each of your birth experiences **not at home**?

Up to 5 words/phrases for each birth, please answer in the chronological order

4. Why did you choose homebirth?

    Up to 10 words/ phrases

5. What were your perceptions of homebirth before you gave birth at home yourself?

    Up to 5 words/phrases

6. How would you describe your experience(s) of **homebirth**? *if you have had more than one you can write for each birth, please answer in the chronological order.*

    Up to 10 words/ phrases

7. What are your perceptions of homebirth now that you have had one (or more) homebirth?

    Up to 5 words/phrases

8. If you were to give birth again, where would you prefer to give birth?

    Hospital, clinique, home, plateau technique, maison de naissance, other
    a. Why?...

Part F – For everyone

Some of these questions might seem unrelated to the topic, I am trying to see if there are corelations to be made or not.

1. Gender: …
2. Sexual Orientation:
   heterosexual, homosexual, bisexual, pansexual, asexual, other, don't want to answer
3. Year of birth:
4. CSP:…
5. Nationalité: …
6. Race/Ethnicity
7. Religion: *…, don't want to answer*

8. Would you be interested in participating to an online interview? If so, you can write your email and I will send you more information
9. If you have a comment or want to share something, please do!
   …

   Thank you for your participation!

Annex E. Information Email to potential interviewees *(original, English translation below)*

Bonjour,

Merci d'avoir répondu à mon questionnaire.

Je suis émue de lire vos réponses et vos encouragements. Je suis sincèrement reconnaissante que vous ayez partagé vos vécus avec moi. Au-delà de ma simple recherche, c'est pour moi aussi un élan de sororité, et plein d'ocytocine 😊

Si vous recevez ce mail c'est que vous souhaitiez recevoir plus d'information à propos des entretiens.

Vous avez été nombreuses à partager votre email (163 à ce jour), et je vous en remercie, cela m'a fait vraiment plaisir de voir votre enthousiasme. Malheureusement, comme je suis seule et que j'ai des deadlines assez proches je ne pourrai pas réaliser autant d'entretiens (même si j'adorerais !).

Si nous ne pouvons pas réaliser d'entretien ensemble mais que vous tenez vraiment à partager votre histoire, je verrai peut-être pour un format écrit, c'est logistiquement plus facile à organiser et ça me demande moins de temps de traitement (de retranscription notamment).

L'entretien se déroule en ligne, je vous enverrai un lien si vous décidez de participer.

J'aimerais qu'ils aient lieu entre le 7 et le 20 mars (inclus).

Pour les besoins de ma recherche je devrai enregistrer l'audio des entretiens. Ils ne seront pas partagés et si je me sers de citations dans le texte final, tout sera anonymisé.

Idéalement, j'aimerais réaliser des entretiens avec au moins :

1. Une femme qui a eu une mauvaise expérience pour une naissance à l'hôpital et qui maintenant n'envisage que l'enfantement à domicile (assisté ou non)
2. Une femme qui a vécu un enfantement à domicile (assisté ou non)
3. Une femme qui a vécu au moins deux enfantements à domicile (assistés ou non)
4. Une femme qui a vécu au moins une naissance à l'hôpital et au moins une à la maison (assisté ou non)
5. Une sage-femme qui accompagne des enfantements à domicile
6. Une doula qui a déjà accompagné des enfantements à domicile

L'entretien devrait durer environ 1h.

Je suis la méthode du 'récit de vie', j'ai donc des grands thèmes et vous demanderai d'élaborer, de vous raconter. J'ai aussi des questions plus précises pour aider ou guider si besoin.

Vous n'avez rien besoin de préparer.

Vous pouvez envisager cet entretien comme une conversation. (je n'ai pas fait cet 'exercice' depuis longtemps, il est probable que je sois aussi nerveuse que vous, voire plus!)

J'ai conscience qu'on risque de parler de sujets difficiles, voire de souvenirs douloureux. Comme pour le questionnaire, vous ne serez obligée de rien. Je vous le rappellerai le moment venu mais sachez que vous pouvez à tout moment demander à faire une pause, passer à une autre question ou arrêter l'entretien.

Si vous ne voulez pas ou ne pouvez pas participer je comprends, aucun problème, vous pouvez simplement ne pas répondre à ce mail.

Si vous souhaitez participer à un entretien, merci de répondre à ce mail en indiquant dans laquelle des 6 catégories mentionnées plus haut vous entrez.

(J’enverrai par la suite un doodle pour les disponibilités)

Que vous participiez ou non à un entretien, si vous souhaitez lire mon mémoire terminé (ça m'a déjà été demandé), vous pouvez me le faire savoir et si vous le préférez en anglais ou en français (je l'écris en anglais comme j'étudie à l'étranger mais pense le traduire), je ferai une liste de mails dédiée et tacherai de ne pas oublier en juin.

Dans tous les cas, n'hésitez pas à m'écrire si vous avez des questions ou en ressentez l'envie ou le besoin.

Encore merci pour l'intérêt que vous portez à ma recherche, à ce sujet, et d'avoir pris le temps de répondre au questionnaire et de lire ce mail beaucoup trop long !

Gabrielle

English translation:

Hello,

Thank you for answering my questionnaire.

I am moved to read your answers and your encouragement. I am sincerely grateful that you have shared your experiences with me. Beyond my research, it is also for me a surge of sisterhood, and full of oxytocin 😄

If you are receiving this email, it is because you wanted to receive more information about the interviews.

Many of you have shared your email (163 so far), and I thank you for that, it really made me happy to see your enthusiasm. Unfortunately, as I am alone and have deadlines that are quite close, I will not be able to do as many interviews (although I would love to!).

If we can't do an interview together but you really want to share your story, I might consider a written format, as it's logistically easier to organize and requires less processing time (especially transcribing).

The interview is online, I will send you a link if you decide to participate.

I would like them to take place between March 7th and 20th.

For the purposes of my research, I will need to record the audio of the interviews. They will not be shared and if I use quotes in the final text, everything will be anonymized.

Ideally, I would like to conduct interviews with at least:

1. A woman who had a bad experience with a hospital birth and is now considering home birth only (assisted or not)
2. A woman who has had a home birth (assisted or not)
3. A woman who has had two or more home births (assisted or unassisted)

4. A woman who has experienced at least one hospital birth and at least one home birth (assisted or not)
5. A midwife who has accompanied home births
6. A doula who has accompanied home births

The interview should last about 1 hour.

I follow the 'life story' method, so I have broad themes and will ask you to elaborate, to tell your story. I also have more specific questions to help or guide if needed.

You do not need to prepare anything.

You can think of this interview as a conversation. (I haven't done this 'exercise' for a long time, I will probably be as nervous as you, if not more!)

I realize that we may be talking about difficult subjects, even painful memories. As for the questionnaire, you will not be obliged to do anything. I will remind you when the time comes, but you can ask to take a break, move on to another question or stop the interview at any time.

If you don't want to or can't participate, I understand, no problem, you can simply not respond to this email.

If you want to participate in an interview, please reply to this email indicating which of the 6 categories mentioned above you fit into.

(I will send a doodle afterwards for availability)

Whether you participate in an interview or not, if you want to read my finished work (I've been asked before), you can let me know and if you prefer it in English or in French (I'm writing it in English as I'm studying abroad but I'm thinking of translating it), I'll make a dedicated email list and try not to forget in June.

In any case, don't hesitate to write to me if you have any questions or feel the need.

Thanks again for your interest in my research, in this subject, and for taking the time to answer the questionnaire and to read this much too long email!

Gabrielle

Annex F. Information email to homebirth midwives *(original, English translation below)*

Bonjour,

Je suis Gabrielle. Je suis en Master 2 en Environmental Studies and Sustainability Science, et je travaille sur mon mémoire que j'ai choisi de réaliser sur l'enfantement à la maison étant passionnée par la question depuis 4 ans.

J'ai réalisé un questionnaire destiné aux femmes ayant envisagé, envisageant ou déjà vécu un AAD ou un ANA.

Depuis je réalise aussi des entretiens avec des femmes au sujet de l'AAD/ANA.

Je viens de réaliser un entretien avec Stéphanie et j'aimerais en réaliser au moins un autre avec une sage-femme qui accompagne (ou a accompagné) des naissances à domicile.

Je réalise les entretiens en ligne, sur zoom.

Ils durent en moyenne 30min. Vous n'avez rien besoin de préparer. Vous pouvez l'envisager comme une conversation.

J'ai besoin d'enregistrer l'audio de l'entretien pour pouvoir ensuite l'analyser mais je suis la seule à y avoir accès. Tout sera anonymisé et si j'ai besoin de vous citer dans mon texte final vous aurez une sorte de pseudo.

Je m'intéresse au sens qui est donné à l'enfantement à la maison et à son vécu. Dans le cas des sage-femmes je m'intéresse également à votre parcours d'études, votre pratique, ce que vous avez pu observer 'sur le terrain' depuis que vous exercez.

J'aurais besoin qu'ils aient lieu la semaine prochaine (semaine du 28 mars-3 avril), je suis assez disponible donc je peux m'adapter à vos horaires.

Si vous souhaitez participer on pourra décider d'un rendez-vous et je vous enverrai un lien pour zoom.

Si vous avez des questions ou besoin de plus d'information n'hésitez pas à me contacter par mail ou téléphone : +33 6 13 64 16 42 (sms ou what's app ou signal, comme vous préférez).

Merci beaucoup,

Gabrielle

English translation

Hello,

I am Gabrielle. I am a Master 2 student in Environmental Studies and Sustainability Science, and I am working on my dissertation that I chose to do on homebirth as I have been passionate about it for 4 years.

I made a questionnaire for women who have considered, are considering, or have already experienced a AAD or ANA.

Since then, I have also been interviewing women about AAD/ANA.

I have just had an interview with Stephanie and would like to do at least one more interview with a midwife who cares (or has cared) for homebirths.

I do the interviews online, on zoom.

They last on average 30 minutes. You do not need to prepare anything. You can think of it as a conversation.

I need to record the audio of the interview so that I can analyze it later, but only I have access to it. Everything will be anonymized and if I need to quote you in my final text you will have some sort of pseudonym.

I am interested in the meaning given to childbirth at home and its experience. In the case of midwives, I am also interested in your educational background, your practice, what you have observed 'in the field' since you have been practicing.

I would need them to take place next week (week of March 28-April 3), I am fairly available so I can accommodate your schedule.

If you would like to participate, we can set up a time and I will send you a link to zoom in.

If you have any questions or need more information don't hesitate to contact me by email or phone: +33... (sms or what's app or signal, as you prefer).

Thank you very much,

Gabrielle

Annex G. Interview Guides

a. Category 1 – Bad hospital-birth experience

- Year of birth
- Profession/Activity

- Why considering homebirth?
- 1st experience
- How did you get to homebirth?
- Expectations
- Empowerment- did you feel empowered at your 1st birth? Would you say homebirth is empowering?
- Meaning- what meaning do you give to homebirth?
- Nature- Would you say there is a link between Nature and homebirth?
- Animality- Would you say there is something animal in birth and a fortiori homebirth?
- Instagram- Are you on Instagram? If yes, do you follow accounts about birth? If yes, would you say it participated to your preparation?

(Had no one fitting only the 2nd category)

b. Category 3 – A/ least 2 homebirths

- Year of birth
- Profession/Activity

- Perceptions of homebirth before and after
- Why homebirth?
- Homebirth experiences
- Preparation
- Safe- do you consider homebirth safe?
- Empowerment- Would you say homebirth is empowering?
- Nature- Would you say there is a link between Nature and birth and a fortiori homebirth?
- Animality- Would you say there is something animal in birth and a fortiori homebirth?

c. Category 4- at least one hospital-birth and one homebirth

- Year of birth
- Profession/ Activity

- Perceptions of homebirth before and after
- Why homebirth? (Would touch upon the previous hospital experience)
- Experiences
- Preparation – what did you do to prepare your homebirth?

- Empowerment- did you feel empowered at your hospital birth? Did you feel empowered at your homebirth?
- Nature- Would you say there is a link between Nature and birth and a fortiori homebirth?
- Animality- Would you say there is something animal in birth and a fortiori homebirth?
- Safety- Do you consider homebirth safe?
- Instagram- Are you on Instagram? If yes, do you follow accounts about birth? If yes, would you say it participated to your preparation?

d. Category 5 – Homebirth midwife

- Year of birth
- Year of graduation

- Midwifery studies – what approach of birth was taught? Did you talk about homebirth? If yes, in what terms?
- How did you get to homebirth?
- Profiles of women you care for
- Meaning- what meaning would you give to homebirth?
- How is it different from being a hospital midwife?
- Empowerment- Would you say homebirth is empowering?
- Nature- Would you say there is a link between Nature and birth and a fortiori homebirth?
- Animal- Would you say there is something animal in birth and a fortiori homebirth?
- Stand on unassisted homebirths

e. Category 6 – Doula

- Year of birth
- How did you get to doula?
- Doula training
- Caring for women and families

f. Category 7 – Good hospital experience

- Year of birth
- Profession/Activity
- 1st experience
- How did you get to homebirth?
- Expectations- do you have expectations? If yes, what?
- Empowerment – Did you feel empowered at your 1st birth? Would you say homebirth is empowering?
- Meaning-
- Nature- Would you say there is a link between Nature and birth and a fortiori homebirth?
- Animal- Would you say there is something animal in birth and a fortiori homebirth?
- Instagram- Are you on Instagram? If yes, do you follow accounts about birth? If yes, would you say it participated to your preparation?

Annex H. List of keywords for each of the ten themes

A.

Animality					
	Group 1	**Group 2**	**Group 3**	**Group 4**	**Total**
Mammifère	0	1	1	0	**2**
Animal	0	0	1	0	**1**
Instinctive	0	0	1	0	**1**

B.

Comfort and Intimacy					
	Group1	**Group 2**	**Group 3**	**Group 4**	**Total**
Confiance	11	2	4	4	**21**
Confort/confortable	8	3	8	10	**29**
Intime/intimité	7	9	14	23	**53**
Cocon	5	8	12	13	**38**
Environment	5	0	0	0	**5**
Serein/sérénité/sereine	3	0	4	9	**16**
Calme	3	1	6	4	**14**
Tranquille/tranquilité	2	3	2	6	**13**
Familier	2	0	2	0	**4**
Chaleur/chaleureux	2	0	2	8	**12**
Bulle	1	3	9	8	**21**
Douce/doux/douceur	1	3	6	9	**19**
Nid	0	0	1	0	**1**
Paix	0	0	0	1	**1**
Amour	0	1	2	2	**5**

C.

Empowerment					
	Group1	**Group2**	**Group3**	**Group4**	**Total**
Puissant/puissante/puissance	3	1	7	9	**20**
Libre/liberté	3	2	5	17	**27**
Actrice/acteur	2	1	6	11	**20**
Capable/capacité	2	0	5	5	**12**
Contrôle	2	0	1	0	**3**
Autonome/autonomie	1	1	1	4	**7**
Empowerment	1	0	0	0	**1**
Décider/décisionnaire	0	0	1	2	**3**
Maîtresse/mâitriser	0	0	2	2	**4**
Vivre (pleinement)	0	0	9	3	**12**
Confiance	0	0	4	4	**8**
(plein) Pouvoir	0	0	1	6	**7**
Réapproprier	0	0	2	0	**2**
Reprendre le contrôle/pouvoir	0	0	0	5	**5**

D.

Respect					
	Group1	**Group 2**	**Group 3**	**Group 4**	**Total**
Respect/respectée	11	10	16	33	**70**
Physiology	6	7	19	17	**49**
Pouvoir boire	3	0	0	1	**4**
Pouvoir manger	5	1	1	1	**8**
Rythme	2	1	0	1	**4**
Besoin	2	2	0	2	**6**
Connectée/à l'écoute	2	0	4	2	**8**
Ocytocine	1	0	3	1	**5**
Liberté de mouvements/bouger	4	2	4	3	**13**

E.

Negative towards hospital and/or medical practices					
	Group 1	**Group 2**	**Group 3**	**Group 4**	**Total**
(sur)médicalisation	15	7	1	21	**44**
Pas respectée	5	3	2	0	**10**
Peur	4	3		7	**14**
Intervention/interventionisme	2	2	2	7	**13**
Perturbations/dérangée	2	2	1	1	**6**
Pas confiance	0	2	2	0	**4**
Protocoles	2	1	5	12	**20**
Pas écoutée	1	0	0	0	**1**
Anxiogène/stress	1	0	0	2	**3**
Non respect du consentement	1	0	0	1	**2**
Violences (obstétricales)	1	0	1	8	**10**
Déshumanisé	1	1	0	0	**2**
Je ne suis pas malade'	2	1	0	0	**3**
Traumatique	0	0	1	2	**3**
Subir/se soumettre/ contrainte/ se voir imposer…	1	0	6	9	**16**
Infantilisée/infantilisation	0	0	3	2	**5**
Pas d'empathie	0	0	1	0	**1**
Pas d'intimité	0	0	1	0	**1**
Procédures pas adaptées à l'accouchement/ professionnels non formés	0	0	3	1	**4**
Dépossséedée/vol/volé	0	0	0	4	**4**
Ne pas avoir à se défendre/se battre/négocier	0	0	0	3	**3**
Ne pas revivre une mauvaise expérience	0	2	8	1	**11**
Ne pas laisser l'aîné.e	0	0	3	3	**6**
Que bébé ne soit pas manipulé/violenté/ soit respecté	2	2	2	3	**9**
Pas à l'aise/ pas aimé l'ambiance /pas en sécurité*	0	0	1	2	**3**

F.

Nature					
	Group 1	**Group 2**	**Group 3**	**Group 4**	**Total**
Nature/naturel/naturellement	11	6	14	28	59
Inné	1	0	2	0	3
Evidence	0	1	2	4	7
Normal/normalement	0	0	0	4	4
Simplicité	0	1	0	0	1
Appel de mon corps	0	1	0	0	1
Mon corps est fait pour ça	0	0	1	0	1

G.

Family - Partner					
	Group 1	**Group 2**	**Group 3**	**Group 4**	**Total**
Papa	1	1	1	5	**8**
Conjoint.e	1	1	1	4	**7**
Mari	1	0	3	7	**11**
Co-parent	1	0	0	0	**1**
Familal/famille	3	1	8	12	**24**
Mes proches	0	0	1	0	**1**
Ma mère	0	0	1	0	**1**
Compagnon	0	0	1	1	**2**
Notre fille/mon fils	0	0	1	3	**4**
Enfants/ aîné.es/ fraterie	0	0	2	8	**10**
Epoux	0	0	1	1	**2**
Père	0	0	0	2	**2**
Chéri	0	0	0	1	**1**

H.

Sécurité					
	Group 1	**Group 2**	**Group 3**	**Group 4**	**Total**
Sécurité / sécuritaire	11	15	6	24	**56**
Moins risqué	1	0	0	1	**2**

I.

Quality of medical care					
	Group 1	**Group 2**	**Group 3**	**Group4**	**Total**
Une sage-femme/ la même sage-femme/ Sage-femme connue/choisie	3	4	7	14	28
Confiance	3	1	0	4	8
Bienveillant/ bienveillance	1	0	0	1	2
Accompagnement global / hyper personnalisé	0	2	1	3	6
Doula	0	1	1	0	2
Consentement	0	0	0	1	1

J.

Rite- Women					
	Group 1	**Group 2**	**Group 3**	**Group 4**	**Total**
Transmission	0	1	1	0	**2**
La femme sait	0	0	1	0	**1**
Expérience de vie/ expérience des femmes/ expérience féminine	0	0	1	2	**3**
Sacré	0	0	0	2	**2**
Ce que ma mère a vécu/ ma mère et ma grand-mère ont vécu	0	0	0	2	**2**
Je ressens un lien avec mes ancêtres et toutes celles qui ont enfanté avant moi	0	0	0	1	**1**
Rite de passage	0	0	0	1	**1**
Reconnectée à ma puissance de femme	0	0	0	1	**1**
Confiance en la capacité des femmes à enfanter	0	0	0	1	**1**

Annex I – Table 4. Recap Chart of questionnaire respondents' characteristics

	Age								
	19-23	**24-28**	**29-33**	**34-38**	**39-44**	**44-48**	**49-53**	**54-58**	**59-63**
Number	8	57	133	75	18	7	3	1	1
%	2,6	18,8	43,9	24,8	5,9	2,3	1	0,3	0,3
	Gender								
	Cis-gender woman	**Trans man**	**Non-binary**	**No answer**					
Number	297	0	2	5					
%	97,7	0	0,7	1,6					
	Sexual Orientation								
	Heterosexual	**Lesbian**	**Bisexual**	**Pansexual**	**Does not know**	**No answer**			
Number	271	4	18	6	1	4			
%	89,1	1,3	5,9	2,1	0,3	1,3			
				Race					
	White	**Black**	**Arab, Maghreb**	**Hispanic**	**Asian, Eurasian**	**Mixed race**	**Racialized**	**No clear answer**	**No answer**
Number	260	5	5	1	3	10	2	15	3
%	86,4	1,7	1,7	0,3	1	3,3	0,7	5	1
	Socio-Professional Category								
	Farmer	**Craftsperson, small business owner**	**Executive, higher intellectual professions**	**Intermediate Profession**	**Employee**	**Worker**	**Without activity/on maternity leave**		
Number	4	29	51	102	73	4	35		
%	1,3	9,7	17,1	34,2	24,5	1,3	11,7		
	Number of Births								
	0	**1**	**2**	**3**	**4**	**5**			
Number	56	117	91	25	12	3			
%	18,4	38,5	30	8,2	4	1			

Annex J – Table 5. Questionnaire's respondents in care work

Activity	Number	%
Stay-at-home mothers	30	10,1
Work with young children (teachers, educators…)	27	9,1
Work with early childhood	17	6,1
Work in care (nurses, physiotherapists, midwives…)	60	20,1

Most common occupations in 3 categories that fit into 'care' activities; plus stay-at-home mothers.

Source: Own data

Annex K – Figure 1. Socio-professional category of respondents compared to national averages 2021.

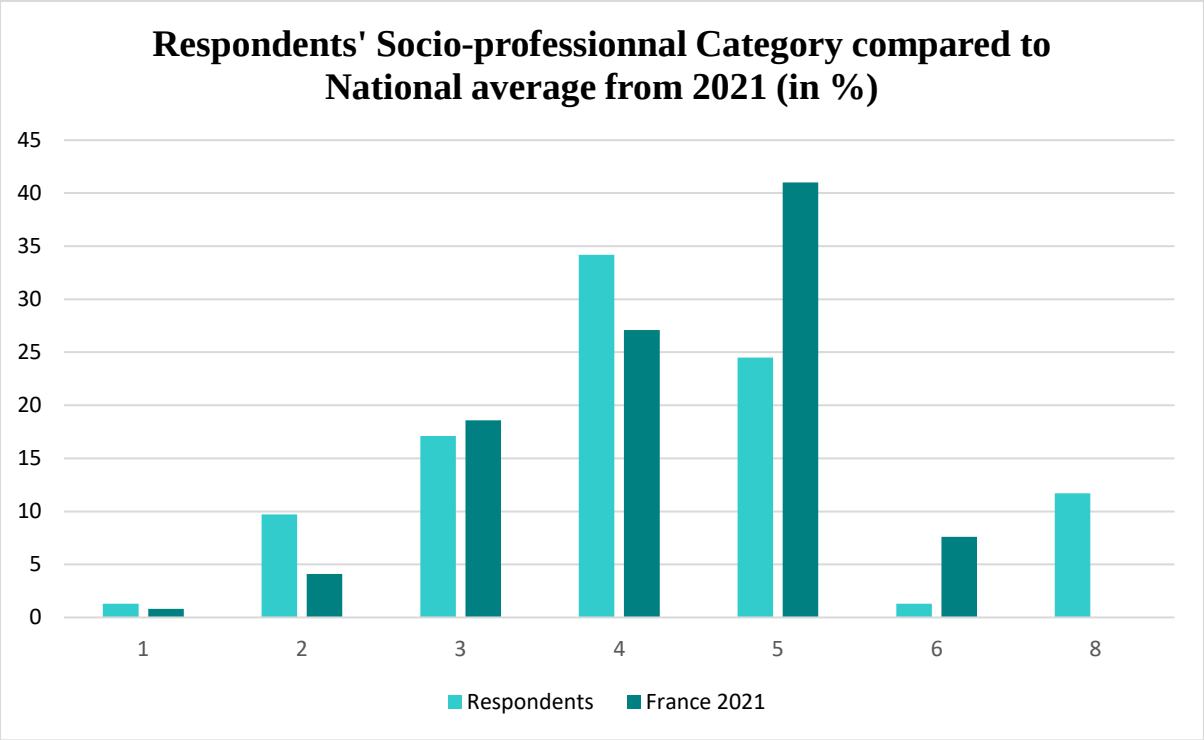

Figure 3: Catégorie Socio-professionnelle des enquêtées comparées aux moyennes nationales 2021.

1. Agricultrice exploitante
2. Artisane, commerçantes, cheffes d'entreprise
3. Cadres et professions intellectuelles supérieures
4. Professions intermédiaires
5. Employées
6. Ouvrières

8.Sans activité (retraite, chômage, ici, dans le cas des mères de l'enquête, principalement des congés maternité/parentaux)
Catégories de l'INSEE (Institut national de la statistique et des études économiques).
Source: own data and Insee for the National average (Insee, 2022)

Annex L – Table 6. Frequency of the ten themes for each group and average in the answers to the question "Why did you consider/choose homebirth?" (in %)

	GROUP 1	GROUP 2	GROUP 3	GROUP 4	AVERAGE
COMFORT, INTIMACY	62,5	75	63	57	63,4
NEGATIVE TOWARDS HOSPITALS	60,7	45,5	45,7	56,1	50,9
RESPECT	37,5	34,1	37	35	35,9
EMPOWERMENT	23,2	15,9	38,3	42,3	29,9
SAFETY	21,4	31,8	6,2	22	20,4
NATURE	19,6	15,9	14,8	23,6	18,5
PARTNER, FAMILY	14,3	6,8	19,8	24,4	16,3
QUALITY OF MEDICAL CARE	10,7	20,5	10	19,5	15,2
WOMEN, RITE	5,4	2,3	4,9	8,1	5,2
ANIMALITY	0	2,3	2,5	0	1,2

Annex M – Table 7. Frequency of the themes in the answers to the questionnaire question "How would you describe your experience(s) of homebirth?" (Group 4)

THEMES	COUNT	FREQUENCE (%)
COMFORT, INTIMACY	69	56,1
EMPOWERMENT	63	51,2

RESPECT	27	22
NATURE	19	15,4
ANIMALITY	18	14,6
PARTNER, FAMILY	16	13
QUALITY OF MEDICAL CARE	13	10,6
WOMEN, RITE	10	8,1
NEGATIVE TOWARDS HOSPITALS	7	5,7
SAFETY	5	4,1

Annex N – Table 8. Occurrence of the themes in relation to birth year in answers to the question "How would you describe your homebirth experience(s)?" (Group 4)

	1999-1990	**1989-1980**	**1979-1970**
Comfort, Intimacy	59,2	**62,5**	37,5
Empowerment	**63,3**	56,3	25
Respect	16,3	21,9	**25**
Nature	20,4	**20,6**	0
Animality	12,2	**14,1**	0
Family, Partner	18,4	**18,8**	12,5
Quality of Care	6,1	14,1	**37,5**
Women, Rite	4,1	14,1	**37,5**
Negative Hospitals	6,1	1,2	**25**
Safety	2	3,1	**12,5**