


# Birth Care Providers' Experiences and Practices in a Brazilian Alongside Midwifery Unit: An Ethnographic Study

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## Abstract

The implementation of a new birthing facility in a country such as Brazil requires an extensive in-depth analysis of the challenges faced. The aim of this study was to explore beliefs, values, experiences, and practices related to the provision of birthing and neonatal care with the implementation of a new birth care facility structure called alongside midwifery units in Brazil. The study utilizes an ethnographic method to evaluate members of a Brazilian public hospital's midwifery unit. The ethnographic study focuses on the cultural theme of "between the proposed and the possible": the following birthing care guidelines require overcoming numerous obstacles, and four other cultural subthemes toward revealing the analyzed birth care team's perspectives. The study found that prior training and preparation of all members of the care team, as well as the provision of adequate institutional infrastructure are essential for the implementation of a new and innovative birthing care center.

## Keywords

midwifery, health care professionals, health care culture, quality of care

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## Introduction

Throughout the last decade, cesarean section (C-section) rates have increased exponentially in Brazil. In 2010, the country's C-section rate was 51.5% for the overall population. In private maternity wards, the proportion of C-sections is especially alarming corresponding to 87.5% of all births (Domingues et al., 2014). The sharp increase in C-sections has led to poor obstetric and neonatal outcomes (Hansen, Wisborg, Uldbjerg, & Henriksen, 2008).

The first freestanding midwifery unit (FMU) integrated to a public hospital in the country was inaugurated in 1998. In this FMU, nurse-midwives or midwives were responsible for birthing care through the implementation of the midwifery model of care (Everly, 2012). In Brazil, nurse-midwives and midwives provide nursing care for pregnant women, and their responsibilities are similar in birth care settings. In this manuscript, both professional categories will be called midwives for convenience. Birthing care provided at this FMU was explored through an ethnographic study. Care at this facility has been described as abiding to the best available care based on scientific evidence (Hoga, 2004).

A previous assessment of birthing care provided by the FMU found positive obstetric and neonatal outcomes (Brocklehurst

et al., 2011). Due to the positive outcomes found in the center, the Brazilian government has described the model of care provided by the institution as a model to be followed in the country (Brazil, Ministério da Saúde, 2011).

After further analysis, however, the Brazilian government recommended alongside midwifery units (AMUs) as the type of structure to be adopted throughout the country, as a birth setting that is described to be intermediary between the current obstetric unit (OU) structure and FMUs (Brasil, Ministério da Saúde, 1999).

AMUs are a type of birthing care facility that stand integrated within existing maternity hospitals, unlike FMUs, which stand alone and are not connected to a hospital system. In the AMU evaluated by this study, midwives are the ones responsible for birthing care (Rowe, The Birthplace in England Collaborative Group, McCourt, & MacFarlane,

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2001), and obstetricians and neonatologists are always available close to the birthing unit when requested by midwives. The Brazilian government also required that the same guidelines adopted by the first FMU in the country be implemented in this new AMU (Brasil, Ministério da Saúde, 1999).

The inclusion of midwives in birth care teams has been described as an essential element in providing quality birthing care (Brocklehurst et al., 2011). This premise assumes special importance in settings where the biomedical paradigm guides obstetricians' education, such as in Brazil. Although individual variations to this premise can be observed, the prevalence of hospital-based and highly medicalized birthing care has been extensively described in the country (Carr & Riesco, 2007).

This study aims to identify strengths and weaknesses related to current practices adopted within an AMU. Data on practices performed at AMU centers are scarce in scientific literature. Most studies have focused on the social milieu in which AMUs have found to be innovative in the provision of birthing care. A greater focus on AMUs as a birth care setting is increasingly important in Brazil, and in other countries, where the C-section rates are higher than the international recommendations.

In England, researchers offered low-risk pregnant women the option to choose their desired birth setting, including the OU, AMU, FMU, or home birth. Planned births in a midwifery unit or at home were associated with fewer obstetrical interventions (Brocklehurst et al., 2011). Lower intervention rates, including C-sections, were found among women who gave birth in non-OUs (Brocklehurst et al., 2011). Based on a collaborative model involving a team of four midwives and one obstetrician from the United States, researchers concluded that a successful birth care setting fundamentally requires close collaboration between obstetricians and midwives (Stevens, Witmer, Grant, & Cammarano, 2012).

Researchers who have focused on different birthing settings in Brazil have concluded that innovation in birth care in the context requires extensive negotiation among players. Historically, obstetricians have assumed the main role in birthing care in Brazil. Changes to this hierarchical structure has been described to require agreements, especially in relation to power (Angulo-Tuesta, Giffin, Gama, d'Orsi, & Barbosa, 2003; Diniz & Ayres, 2001).

The organizational characteristics of AMUs and FMUs allow for greater flexibility in birth care management within this context, in contrast with the dominant Fordist–Taylorist model (Walsh, 2006). In the Fordist–Taylorist model, usually applied in OU settings, patients are often treated as part of a production line, and their personal needs are often ignored. The existence of such a model was observed during a study of a birth center located in England's midlands. The birth center, staffed with midwives and maternity care assistants, catered to around 300 births a year. On the contrary, birth care providers in AMUs tend to prioritize the relational aspect of care, instead of care as a task. A non-bureaucratic

structure characterizes the operational ethos of AMUs (Walsh, 2006). The effect of birth care settings on decisions made by midwives has also been examined. In this study, 104 independent and hospital-based midwives were analyzed to compare the effects of the difference in work settings on behavior and care (Walsh, 2006). Regardless of whether the midwives were working independently or in an OU, similar findings were found in the care provided (Freeman, Adair, Timperley, & West, 2006).

In the few studies in which the management of birth care has been analyzed between AMUs and OUs, both settings showed resistance from birth care providers in the selective use of interventions. On the contrary, in AMUs where care was provided by midwives, better strategies to control the number of interventions performed was found (Campos & Lana, 2007).

In addition, a comparison study between the midwife-led models of care versus other models, including a total of 12,276 women, found higher rates of vaginal birthing and participation of midwives in midwife-led care, as well as lesser rates in the use of regional analgesia, episiotomy, and instrumental delivery. There were no significant differences between groups on overall fetal loss or neonatal deaths (Hatem, Sandall, Devane, Soltani, & Gates, 2008).

Jackson et al. (2003) analyzed outcomes, safety, and resource utilization in a collaborative birth center management model, with care managed by both midwives and obstetricians. The collaborative care setting showed a higher proportion of normal births and lower rates of epidural anesthesia. Among lower risk women, obstetric and neonatal outcomes were safer and similar in both types of care. In the collaborative care setting, the use of medical interventions was found to be lower than normal.

Two main factors have been found to affect relations among birth care staff, the care provider's background, as well as their skills in providing birth care. In this sense, Hatem et al. (2008) and Jackson et al. (2003) observe that obstetrician's confidence in midwives was higher when the obstetrician themselves had enough skills to provide a safe birth care. Moreover, obstetricians with higher client-centered values showed an increased openness to midwives (Blais et al., 1994). The obstetrician's confidence in midwives also depended on how well the professionals knew each other (Blix-Lindstrom, Johansson, & Christensson, 2008).

In Brazil, members of birth care teams have been reported to exhibit long-standing and culturally shaped hierarchies of power, generally with physicians assuming the hegemonic position (Carr & Riesco, 2007). Considering differences in birthing care and health care providers' relations in AMUs compared with traditional OUs prevalent in the country, this study aimed to clarify the following questions: What are the characteristics of the birth care provided at the AMU some years after its implementation as a public policy? What are the beliefs and values permeating in the provision of birth

care in the AMU? And, what are the characteristics of found in the interpersonal relationships established among members of the staff?

With this study, we sought to undertake an in-depth and comprehensive exploration of the current daily practices at the AMU some years after the implementation of this type of birthing care setting as the golden standard. This analysis is crucial in guiding the planning and implementation of future training and education of health care providers. In this sense, this study aims to explore the care team members' beliefs, values, and experiences related to birthing care in an AMU, as well as, the values found among inter-professional groups influencing the care provided in the studied birth care setting.

## Method

This study used ethnographic methodology toward describing and interpreting cultural behaviors among health care providers of an AMU. The ethnographical study of the AMU permitted the observing, understanding, and writing of the ethnographical text. Culture can be inferred from the words and actions taken by the members of a group through the ethnography (Becker, 1999). The ways in which the professionals communicated with each other, provided birth and neonatal care, and took care of pregnant women and their companions, could be understood, interpreted, and reported through ethnography. The unique perspective or the insider's viewpoint could also be accessed through the participant observation (PO) of the AMU's natural environment and daily practices (Becker, 1999).

Study analysis focused on an AMU linked to the Brazilian public health system. In this setting, birth care is available for free to all pregnant women. In Brazil, both public and private health systems are available, and the public system attends the population without a health insurance. The AMU is located inside a public hospital located in the metropolitan area of the city of São Paulo. It was inaugurated in 2007 to provide birth care according to recommendations by the World Health Organization (WHO; 1996). Such recommendations were adopted by the Brazilian government as a public policy to be adopted by the rest of the country. Before 2007, birthing care in this institution was provided by obstetricians and midwives in an OU. Procedures such as episiotomies, the use of pharmacological resources to relieve pain, and the lithotomic position were daily practices in the unit, and the presence of a companion during birthing was prohibited.

The structure of the AMU is composed of one large room divided by curtains into smaller delivery rooms. Showers and restrooms are shared among pregnant women, and are available close to delivery rooms. The AMU attends only pregnant women presenting no clinical or obstetric risk. At the beginning of data collection, the care team was composed of 35 midwives, two obstetricians, and 18 neonatologists.

Each work shift included an average of four midwives, two obstetricians, and two neonatologists, but often the care team was found to be incomplete. All members of the team worked for a period of 12 hours on fixed days of the week. The same professional team worked together on each day of the week. The midwives provided birth care exclusively within the AMU, and were responsible for labor and birthing care.

The obstetricians and neonatologists were responsible for patients in other hospital sites, and thus were not continuously present at the AMU. When requested by the midwives, an obstetrician would go to the AMU to provide support, and the neonatologists would arrive at estimated time of birth. An average of 600 births occurred per month at the AMU.

PO is the primary method for data collection in ethnography (Douglas, 2011). PO sessions were performed beginning with an emphasis on observation, and followed by participative activities. Such sessions were done approximately twice a week, between January 2011 and July 2012, with a total of 51 sessions. Each session lasted from six to 12 hours, with an average of 9 hours.

One of the researchers, a midwife doing her master thesis, participated in the PO sessions. She was not a member of the AMU's professional staff but had a colleague working in the AMU. This previous relationship with a member of the cultural milieu allowed for an easier insertion of the observer into the study setting, and allowed for the first step in the PO process to be shorter than normally required.

During the PO process, the researcher also acted as a midwife, collaborating with the childbirth care. Data collected through observations were registered immediately after each PO session. Data related to birth care events, providers' attitudes, and interpersonal relations were also observed and registered. The researcher's participation in the birthing care increased gradually over time.

During the observation phase, the researcher offered support to pregnant women and their companions. Advice related to how to breathe, do exercises with a Swiss ball, take a bath, and massage to relieve pain was given. The researcher gradually assumed an active role in labor and birth care, collaborating in the recording of the labor process and birth care.

Study informants were randomly selected to participate in the study. Ten midwives, six obstetricians, and six neonatologists were asked to collaborate as study informants, and none refused. The number of informants was decided based on the occurrence of theoretical saturation (Morse, 2012). Repetition of the narrative content was observed prior to ending the inclusion of new study informants.

Among the informants, seven became key informants (KIs), three midwives, two obstetricians, and two neonatologists. All of the midwives, one of the obstetricians, and one neonatologist were female. Informants were members of the culture to be studied, with general knowledge about the issue in focus, and the KIs were those with a deeper knowledge of the cultural beliefs and values related to the studied

topic. KIs were also informants with greater interest and enthusiasm to share their beliefs and values about their daily practices (Becker, 1999). The criteria for choosing KIs was their previous engagement in the provision of birth care since the transition of the center's structure from OU to AMU; their greater interest in becoming a study informant; and their availability to share details about the center's daily practices.

Twenty nursing assistants also worked in the AMU. They were not included as study informants considering their work was restricted to support in women's hygiene and responsible for sheets and towel changes, without any responsibility in birthing care. Although only 22 staff members of a total of 95 participated as study informants, all members of the care staff can be seen as director or indirect collaborators of this empirical study, considering the observations made regarding their daily care practices.

Study informants were approached individually and inquired about willingness and availability to participate. They were informed about the purpose of the study and asked to participate in a face-to-face, tape-recorded, in-depth interview. Interviews took place in a private room at the AMU, before or after work shifts according to the informant's preference. We used descriptive questions to begin the interviews: "Tell me about your current experience as a birth care provider at this AMU" and "Tell me about what daily relationships are like among members of the care team." Additional questions were presented to explore issues brought up by the informants themselves. Interviews lasted from 30 to 65 minutes, or 50 minutes on average. One of the observers' who had previous experience in qualitative research and ethnographic interviews performed all of the interviews, in Portuguese.

The interviewer was also in charge of transcribing all of the interviews, integrally done in the same language. The observer and other authors, all native Brazilians with English as a second language, were involved in the translation of interviews from Portuguese to English. One researcher translated the transcript, and the other verified the accuracy of translations. Data analysis began as data were collected and transcribed. The initial readings of narratives, followed by a detailed reading of interviews and registers of field notes permitted an early identification of cultural symbols. We observed the existence of several cultural symbols throughout the interviews, especially highlights given by the informants regarding some aspect of their daily practices, and the troubles faced. Such highlights were expressed through verbal and non-verbal communication, through changes in voice tone, facial expressions, and blunt statements about everyday occurrences.

Experiences reported were confirmed by the observed occurrences through PO. The data registered in field diaries contributed to the elaboration of preliminary cultural sub-themes (CSTs). As data interpretation progressed, the iterative data reading and discussion process resulted in four CSTs and one cultural theme (CT).

We shared the CSTs, CT, and their main contents to the KIs. The KIs gave their support to the credibility and validity of the study findings, and while doing so, they did not exhibit apprehension in confirming the care team members' beliefs, values, and current daily practices. We have exemplified the main study findings using quotes extracted from the interviews. Informants did not use the same words in their narrative to express an experience. Considering the similarity in meaning, we used the clearest quotes, as examples. The anonymity of study's informants was preserved through the creation of a specific ID code including the professional category (midwife, obstetrician, or neonatologist) for which the informant belonged to, along with a random sequential number. No one except the responsible researcher had access to this data.

Ethical approval was granted after the submission of study plan to a research ethics committee (University of São Paulo, School of Nursing, Research Ethics Committee Registration No. 857). Informed written consent was also obtained for all study informants. We guaranteed confidentiality of study findings and security of all tapes recorded.

## Findings

### *Characteristics of Study Informants*

The KIs were 28 to 46 years old, ranged in experience in birth care between 10 to 26 years, and had 7 to 14 years working in the institution. The obstetricians were 29 to 60 years old, had 3 to 37 years of experience, and 1 to 14 years in the institution. All of them had a bachelor's degree, some a medical degree with specialties in their corresponding area (obstetrics or neonatology), and two midwives had a master's degree.

### *Characteristics of Birth Care Provided at the AMU*

During the PO process, items composing the international birth care guideline were analyzed and identified as (yes/no). The care provider's responsibilities are analyzed in Table 1.

## CT and CST

A CT and four CSTs represent the beliefs, values, experiences, and practices of the team members providing birth care in the AMU. The CT, CSTs, and its main contents are summarized in Figure 1.

### *CST1—Lack of Active Involvement of Pregnant Women and Companions Cause Difficulty in Following Guidelines for Innovative Birth Care*

A strong obstacle found in following the birth guidelines came from a lack or poor familiarity of pregnant women and their companions with the birth care model provided at the AMU. Women and their companions were found to have

**Table 1.** Items of the Birth Care Guidelines, Responsible Professional, Adherence to the Items, and Characteristics of Birth Care.

Items	Professional	Items Followed (Yes/No)	Characteristics
<b>Admission of pregnant women in labor</b>			
Pregnancy >37 and < 41 weeks	Obstetrician	Yes	
Uterine height ≤ 36 cm	Obstetrician	Yes	
Single fetus in vertex presentation	Obstetrician	Yes	
Clear amniotic fluid on amnioscopy	Obstetrician	Yes	
Normal cardiotocography	Obstetrician	Yes	
Full amniotic sac or route < 4 hours	Obstetrician	Yes	
Cervix dilation ≥ 3 cm	Obstetrician	No	Cervix dilation < 3 cm
Regular uterine activity	Obstetrician	Yes	
<b>Reception in the clinical setting</b>			
Self-presentation as care provider	Midwife	No	Absent or incomplete
Presentation of clinical setting	Midwife	No	Absent or incomplete
Advice given to pregnant women <sup>a</sup>	Midwife	No	Incomplete
<b>Birth care</b>			
Clinical and obstetric monitoring	Midwife	Yes	
Strict prescription of oxytocin	Obstetrician	No	Lack of rigorous evaluation
Guidance and stimulus for use of non-pharmacological practices to relieve pain	Midwife	No	No introduction of all resources
Suggestion to adopt semi-sitting or lateralized position during birth	Midwife	No	Suggestions given, inadequate furniture
Practice of episiotomy under rigorous indication	Midwife	No	Lack of rigor in indication
Practice of Kristeller maneuver strictly prohibited	Obstetrician	No	Performed few times
Allowing companions to cut the umbilical cord	Midwife	No	Variety of practices
<b>Neonatal care</b>			
Mother/newborn skin-to-skin contact (15 minutes)	Midwife/neonatologist	No	Variety of practice/time
Avoid aspiration of upper airways	Neonatologist	No	Procedure performed routinely
Support and stimulus of early breastfeeding	Midwife/neonatologist	No	Variety of practices

<sup>a</sup>According to the birth care guidelines, the advice given to pregnant women should include the following topics: feeding, roaming, bathing, exercises on ball, and adopting lateral decubitus during labor resting.

deeply immersed ideals related to traditional obstetric practices as their ideal birth care model. The women and their companions were accustomed to behaving passively under the hegemonic attitude showed by care providers.

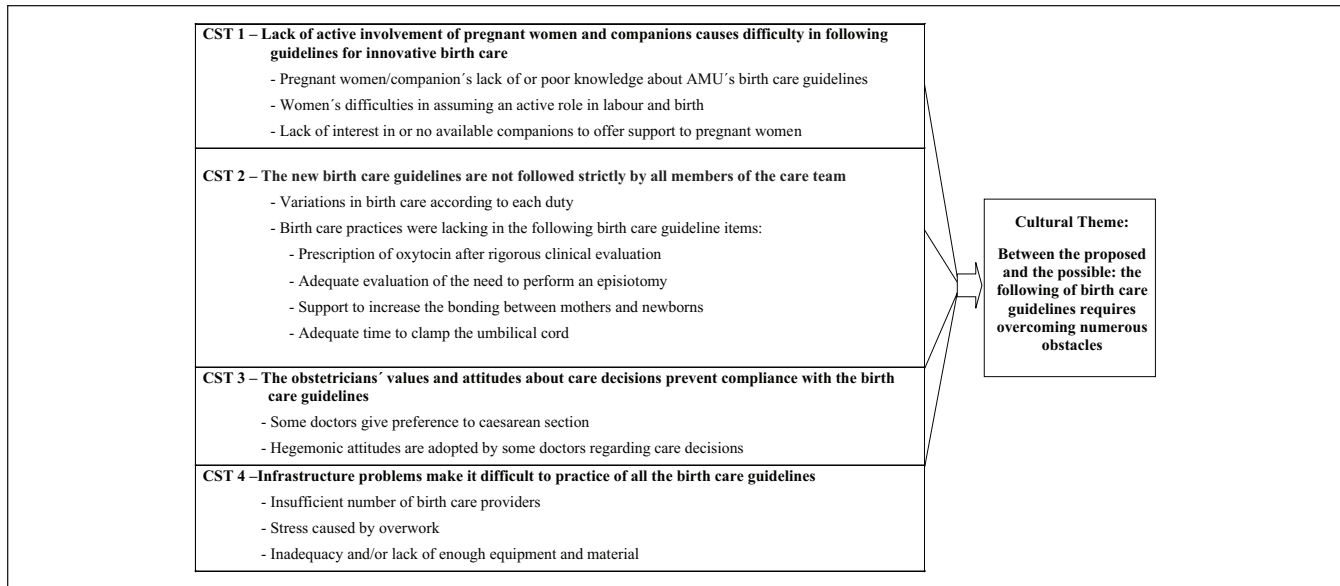
The population has not assimilated the innovative ways to provide birth care in this institution. Changes in birth care are assimilated slowly, and transmitted from one generation to the other. (Midwife and Obstetrician)

Although an innovative paradigm was implemented allowing for the active participation of pregnant women in the birthing process, pregnant women adopted a passive behavior toward labor and birth. An almost automatic behavior, characterized by staying in bed and waiting for orders given by health care providers was observed. A lack of awareness regarding the right to choose a position to take during labor and birthing was also observed. This reality may derive from a women's lack of choice in whether to attend an AMU versus an OU. In the studied setting, the new guidelines were implemented as a public policy, and women without access to

private health insurance are cared at the public maternity closest to them, and not a maternity of choice.

Consequently, the midwives at the AMU had to explain to each woman and their companion about the characteristics of the birth care model adopted by the institution, as well as the paradigm supporting the model and corresponding practices. The midwives explained concepts regarding autonomy in the choice of position during birth, and the importance of adopting an active role in labor and birthing. This new attitude toward childbirth required a change in pregnant women's attitude from passive to proactive.

The possibility to relieve pain and promote physiological labor progression also required detailed explanation. Although women easily learned these procedures, the availability of their companion for support, and women's adherence to an active role in birth was seen as lacking. During the PO process, observers noted women's lack of familiarity with the new birth care model, and resistance by their companions in accepting and supporting the women in this model.



**Figure 1.** Summary of the four cultural subthemes and the cultural theme.

Note. CST = cultural subtheme; AMU = alongside midwifery unit.

If pregnant women knew the model of birth care provided at the AMU and the behavior required from them and their companions, our work would be easier. There is a lack of information so providers need to explain everything. Usually pregnant women are passive, like in traditional hospitals, and have difficulty in assuming an active role in their own birth process. (Midwives 1, 2, 6; Obstetricians 1, 2) Pregnant women learn easily, but their companion, not as much. Fathers are resistant and have a difficult time assuming a role in this new birth care model. (Midwives and Obstetrician)

### ***CST 2—The New Birth Care Guidelines Are Not Followed Fully by All Members of the Care Team***

Strict following of the proposed birth care guideline by the care providers was seen as a big challenge. One factor could be that the care providers did not participate in the proposal and implementation of the guidelines, the guideline was imposed on them as a policy to be followed.

Care providers cited variations in birth care practices according to the duty of each personnel. The person responsible for each shift was most commonly the one to determine the kind of birth and neonatal care provided. The researcher observed when and whether care was being provided according to the guidelines. She observed that the following items were inadequately used:

- Guideline: Prescription of synthetic oxytocin after rigorous clinical evaluation
- Observation: Obstetricians were found to routinely prescribe oxytocin at the admission of women in the AMU, without any analysis for uterine contractions or other clinical conditions (In Brazil, all medication prescribed by a physician must be administered by a nurse or midwife)

Therefore, the nurses must administer it, even when they have information on uterine physiology dynamics. (Midwives)

- Guideline: Adequate assessment related to the need for episiotomy
- Observation: Although interviewees mentioned this guideline in their narratives, episiotomy was observed to be performed in almost all births, and was highly determined by who was in charge

Two midwives reported one particular event in which they could not follow this particular guideline for the use of episiotomy only when necessary: the dean of the hospital determined there was a need to perform a “large episiotomy” to avoid a clavicle fracture in a newborn (the hospital's dean, a neonatologist, was not a member of the professional staff at the AMU, but periodically visited the labor ward). In such visits, the midwives reported feeling intimidated to perform the episiotomy.

I tried to follow the birth care guidelines however, one day, one of the institution's deans arrived and determined that I needed to do a large episiotomy to avoid a newborn clavicle fracture, so I obeyed. (Midwife)

- Guideline: Support to improve the bonding between mothers and newborns.
- Observation: A midwife reported difficulties implementing this practice because she was pressured by a neonatologist who demanded quick delivery of newborns, considering the high number of pregnant women waiting for attention.

The neonatologist asked for a quick delivery of the baby. His argument was the need to perform neonatal procedures early. (Midwife 1) A humanized birth requires time to clamp the cord, but there are many pregnant women waiting. There isn't enough time to follow this item of the guideline. (Midwives)

- Guideline: Adequate time to clamp the umbilical cord
- Observation: Adequate time to clamp umbilical cord was observed, however, the systematic application of this procedure depend on each professional.

There is resistance regarding adequate time to clamp the umbilical cord. However I have talked to the neonatologist about the need to take the time needed before cutting the cord. Otherwise instead of this AMU providing benefit to the child, the early cord clamping can harm the child. The neonatologists know our position regarding this aspect of newborn care, and even so they sometimes don't respect the item of newborn care. (Midwives)

### ***CST 3—The Obstetricians' Values and Attitudes Toward Care Decisions Prevent Compliance With the Guidelines***

A need to obey the obstetricians' method of providing birthing care was reported. Hence, midwives did not have independence over the care they provided, and could not always systematically follow the guidelines, even if they wanted to. Accordingly, obstetricians' values and attitudes toward birthing practices was a substantial obstacle. The presence of some obstetricians for cesarean section as a birthing method was also observed as a large obstacle for following the birth care guidelines. According to midwives, some obstetricians showed insecurity in managing a normal birth. Consequently, for some, mainly younger obstetricians, C-section was seen as a way to avoid medical errors.

Some obstetricians are not adapted to the new philosophy of birth care. I have observed that some of them prescribe cesarean section. I think the choice for cesarean is made to avoid problems such as medical errors. (Midwife)

This hegemonic attitude presented by some obstetricians was reported as a difficult aspect in the provision of birthing care. In cases where the obstetrician did not accept a midwives' opinion, the underlying hegemonic attitude was observed to surface.

I had problems with doctors because many of them are arrogant. They don't accept the opinion of midwives, and do not accept all of the guidelines. (Midwife)

### ***CST 4—Infrastructure Problems Make It Difficult to Practice of All the Birth Care Guidelines***

Care providers cited several problems originated by the inadequacy in institutional structure. The main troubles confronted

were related to the insufficient quantity of care providers, and deficiencies related to equipment. These troubles caused additional problems, such as overload work, stress, fatigue, and gaps in birth care.

I cannot do the best always; I do only what is possible. The materials and quantity of professionals are not enough. (Midwives) The work is hard; I always have insufficient obstetricians during my shift. (Obstetricians) Many babies are born, and I cannot give full attention. The quantity of professionals is not enough. I try, but sometimes I cannot do all I desire. (Neonatologist)

The quantity of appropriate beds, showers, birth balls, and other equipment needed to promote the physiology of labor was insufficient to attend all the women. Inadequate birth care structure, such as the birthing beds without safety bars and narrow tubs was motive of concerns.

We have one birth ball and one shower available. It is insufficient to provide care for all the pregnant women. (Midwife) The bath is inadequate. Its support is narrow, and obese patients face difficulties. (Midwives)

The lack of an adequate care setting also prevented providers from following the birth care guidelines. The need to share the same restroom, the lack of enough distance between the beds, and the consequent lack of privacy were also motive of concerns.

The improvement of care setting's layout is required, including a major distance among beds. (Midwives) There is no privacy because the physical layout is not as it should be. (Midwife)

### ***CT—Between the Proposed and the Possible: The Following of Birth Care Guidelines Requires Overcoming Numerous Obstacles***

The statement "between the proposed and the possible" reflects the need to overcome several obstacles to provide birth care according to the birth care guidelines. The guidelines were developed by care managers and imposed on the care team's members. The members believed that the birth care provided in the AMU was a compromise between the guidelines and what is possible to practice daily. This reality results from the professionals' own beliefs, values, and possible care practices, considering the collaborative nature of working in a team. These elements are associated with the limited institutional capacity to offer the necessary resources to provide birth care.

The professionals assessed the birth care provided in the AMU and concluded that it was not at its highest potential. This reality derived from several elements, including the perspective of pregnant women and their companions' attitudes and backgrounds related to birth care; the care providers'

own beliefs, values, attitudes, and limitations regarding openness to learn about the birth care proposal; and other elements derived from the deficiencies related to the institutional infrastructure.

## Discussion

Through this study, we have observed the existence of complex elements that challenge the effective implementation of a new birth care model within a context that presents deeply rooted paradigms in birthing care. Care providers face several obstacles in following the birthing care guidelines recommended related to pregnant women and their companions, inter-professional relationships, and a lack of or insufficient infrastructure in offering care according to recommended guidelines of care.

Pregnant women and their companions were unaware of the care model adopted in the AMU. This finding indicates a lack in prenatal education and the importance of providing information about the new birth care paradigm being implemented. Advice should include being actively involved in the birthing process, and adopting the role of protagonist in the process. Promoting the father's involvement is also necessary. This measure also contributes to improving the quality of care. Being involved in the birth process has been shown to promote deeper bonding among family members (Fenwick, Burns, Sheehan, & Schmied, 2013).

Some health care providers noted negative experiences regarding the behavior of some women and their companions during the birthing process. These professionals viewed the long period of time needed to teach the philosophy behind the model being implemented at the AMU negatively. This finding indicates that the implementation of a new modality of birth care is not restricted only to the care provider but also requires an active role in the part of women and their companions. Pregnant women and their partners would need to be better prepared to adopt an active and supportive role in childbearing (Longworth & Kingdon, 2011; Premberg, Carlsson, Hellström, & Berg, 2011).

Greater attention to the father's or companion's gap in knowledge throughout antenatal education is important, allowing for the provision of training regarding available strategies to relieve labor pain, for example. An informational booklet may also be an additional resource to support fathers and companions in preparing for their role as companions. Previous knowledge of their own rights as companions in childbirth is needed. Fathers and companions may be able to participate in education projects, watch videos about the companions' role in childbirth, and attend previous visits to the AMU. These strategies could contribute in bringing fathers closer to the childbirth scenery, and promote more effective participation as an active companion.

Health providers also need to be prepared to include companions in labor and childbirth care. It is important to provide continuous training based on the best evidence related

to the companion's active participation in childbirth, including the negative effects when participation is not permitted. Such training can also include the need to overcome negative stereotypes permeating the father's participation in childbirth. Some of the main stereotypes found are the idea that fathers are bothering the health care providers, that fathers take up more time from the health care providers to support them, and complaints about the lack of and insufficient physical space for the father or companion to be present in the birth setting.

According to McCourt, Rayment, Rance, and Sandall (2012) based on an organizational ethnographic case study conducted in England, maternity services need to consider and develop models that provide further integration of staff across hospital and community boundaries. Improving the provision of integrated services to support birth place choice was also recommended.

Furthermore, in this study, we observed a lack of consensus among care providers regarding the appropriate birth care. Midwives were made to comply with obstetricians' preferences and values, and this prevented them from at times following the guidelines. The interaction between obstetricians and midwives were also seen to be strongly influenced by gender and professional relationships, with obstetricians assuming positions of power over midwives (Longworth & Kingdon, 2011). Obstetricians are the authorities in the provision of birth care in this setting, and midwives, especially in a medical-centered setting, are forced to focus their efforts on medical tasks. The provision of care according to the medical model is expected in such birth care settings. These findings demonstrate the strong influence of the care setting on the provision of birth care (Everly, 2012). Obstetricians have the power in decisions about labor augmentation. However, when the ward was led by midwives and obstetricians were only consultants, the midwives did not experience this problem of obstetricians influencing the course of events (Blix-Lindstrom et al., 2008). This approach to working as a team may be a better alternative for midwives. As found in this study, the more harmony is required between obstetricians and midwives in the provision of birth care in an AMU. The dissemination of natural childbirth and humanized birth care provided in the AMU, particularly their incorporation into medical and nursing educational programs, are important measures, considering the required harmony among the members of a birth care team.

In our study, the obstetricians' confidence of midwives depended on how well they knew each other than on the midwives' previous experiences. Hatem et al. (2008) and Jackson et al. (Jackson et al., 2003) recommended the need to disseminate the safety record of the birth care provided by midwives to improve the confidence of obstetricians in relation to midwives.

Furthermore, a structured and collaborative practice of birth care characterized by the multi professional cooperation



incorporated into pre-medical education can contribute to change the current reality. This model should include elements such as responsibility/accountability, coordination, communication, cooperation, assertiveness, autonomy, and mutual trust and respect (Way, Jones, & Busing, 2012). The early contact between nursing and medical students in settings like AMUs and FMUs can provide the familiarity, mainly of the medical students, with the childbirth care model provided in such settings, and as recommended by the WHO (2011). The lack or poor familiarity of medical students and obstetricians regarding the midwives' autonomy and professional prepare to provide birth care can be a motive of the hegemonic attitude adopted by the physicians trained only in traditional obstetrical practices.

Information on natural childbirth and humanized birth care provided in the AMU as well as shared learning programs should be incorporated into undergraduate obstetrics and midwifery courses (Fraser, Symonds, Cullen, & Symonds, 2000). An interdisciplinary and systematic team training need to be offered early to the implementation of an AMU. This training promotes important aspects of highly functional teams, such as leadership, mutual support, effective communication, respect for the input of all members, adaptability, and avoidance of hierarchies (American College of Nurse Midwives [ACNM], 2004).

The birth care guidelines adopted in the AMU are undoubtedly beneficial for mothers and newborns. Positive results highlighted in a Brazilian AMU include low rates of unnecessary interventions, care that is centered on women's needs, and the high levels of women's satisfaction with birth care (Campos & Lana, 2007; Lobo et al., 2010; Morano et al., 2007). In other contexts, results have shown lower rates of interventions (Jackson et al., 2003; Morano et al., 2007; Waldenström, Nilsson, & Winbladh, 1997) and higher satisfaction with birth care provided by midwives (Harvey, Rach, Stainton, Jarrell, & Brant, 2002).

The findings of this study reinforce the need of follow up the outcomes and the daily practices adopted in sceneries where an innovative birth care model is introduced. The continuity of the birth care protocol according to the international recommendation requires investments related to knowledge transfer, possible through systematized and integrated reviews, and its incorporation into care practice's settings.

## Conclusion

The current study identified the strengths and barriers involving the implementing of an AMU through adoption of the midwifery birth care model. The desired changes in the deeply sedimented cultural beliefs, values, and practices become possible when all the members agree on the same principles and act accordingly (Douglas et al., 2014). These efforts assume particular importance when changes in birth care are required (Sleutel, Schultz, & Wyble, 2007).

The members of the multidisciplinary team should to be included actively and systematically in the discussions involving birth care philosophy and care guidelines, before and throughout the implementation of an AMU. This measure is essential to ensure obstetrician's trust in safe birth care provided by midwives and to promote autonomous work for these professionals across the provision of birth care.

As reported by McCourt et al. (2012), several factors influenced the provision of birth care outside the hospital. These factors include organizational culture; midwives' participation in audits, review and institutional processes; midwives' confidence in birth care; and midwives' communication with women about birth outside of a hospital.

The pregnant women, their family members, and companions need to receive advice and be adequately prepared to understand the birth care guidelines, so they could be more active during labor and childbirth. Despite the potential barriers, the midwives have an important role in the promotion of normal birth and the midwifery model of care. Increased knowledge of midwives' work and scope of practice, gained through collaboration in the workplace and interdisciplinary education, can also promote a better understanding of the physicians related to the meaningful contribution these care providers can make to birth care (Everly, 2012).

## Study Limitations

This study's findings are limited to the observed AMU. Other birth care settings could have different cultural beliefs, values, and practices. However, the findings of this research contributes to the discussion of birth care models provided in diverse settings, and to the analysis of relationships established among members of birth care teams in a variety of cultural scenarios.

All members of the center's staff were aware of the ethnographic study being undertaken. Consciousness about the need to incorporate the best available evidence, and follow international recommendations, could have influenced the birth care provider's practices, especially when PO activities were being undertaken. We consider this possible occurrence as a positive development in an ethnographic study.

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