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Mothers' birth care experiences in a Brazilian birth centre

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Abstract

Objective

to explore the reasons why women with previous hospital experience seek care at a birth centre, and their perceptions related to the care received in both settings.

Design, setting and participants

in-depth interviews focusing on the care experiences of 18 women who received birth care in a birth centre of the Brazilian public health system.

Findings

three key themes emerged from the analysis: 'Confrontation with strong problems in the hospital setting', 'Reasons to seek the birth centre' and 'Satisfaction related to birth centre care'. The main aspects that the mothers mentioned in the first and third themes were related to the institutional structure and system of care.

Key conclusions and implications for practice

mothers' narratives suggested that their previous experience of problems in the hospital setting was the main motive for seeking care at the birth centre. The most important components of birth care were attention, meeting personal care demands and establishment of an adequate interpersonal relationship. More sensitive birthing care in the hospital setting is necessary, and this can be promoted through continuing professional education.

Keywords

Birthing centres; Nurse midwives; Qualitative research; Women's experiences; Brazil

Introduction

Birth care principles are based on the hegemonic paradigm in most Brazilian maternity units (Nagahama and Santiago, 2008). This paradigm focuses on medical intervention and technologies, frequently used abusively and without criteria (Davis-Floyd, 2001).

A social movement led by Brazilian midwives and a non-governmental organisation has argued against this situation, particularly the hegemonic attitude adopted by professionals. Many meetings have been held and measures introduced in to academic and government policy (Carr and Riesco, 2007). The movement resulted in the inauguration of the first birth centre in the Brazilian public health system in 1998 (Hoga, 2004).

As this birth centre reported favourable obstetric and neonatal outcomes, federal health authorities elected it as a model for other birth centres (Health Ministry, Brasília, 1999a), and a law was issued authorising new birth centres (Ministério da Saúde, 1999b). In response, some birth centres were established as a new alternative for birth care.

Ethnographic research of the first public birth centre has been undertaken. Nurse midwives working in this setting were mainly concerned with ensuring that pregnant women were cared for as social beings with specific needs and as the centre of the birth care process. Compliance with personal care demands and the humanisation of the care a woman received were respected throughout the birth care process (Hoga, 2004). The birth care model used in this unit (Hoga, 2004) reflected international recommendations (Davis-Floyd, 2001).

The replacement of an interventionist medical model by a humanised birth care model is a current social demand in Brazil (Carr and Riesco, 2007). Researchers and professionals are working to achieve this

ideal. However, despite these efforts, the interventionist model still predominates in many Brazilian maternity settings (Nagahama and Santiago, 2008).

Research focusing on birth centre care is rare in the Brazilian literature due to the recent introduction of these institutions in the country. In other countries, many researchers have looked into this theme. Australian researchers have described perceptions related to the care offered by a birth centre among women with previous hospital experience (Coyle et al., 2001a and Coyle et al., 2001b). Beliefs about pregnancy and childbirth, the nature of the relationship, interactions during care and the care structures were the four main themes of mothers' narratives. The non-interventionist attitude, the relationship of equality between professionals and women, and the preference given to clients' decisions were valued by the women (Coyle et al., 2001a). They particularly appreciated cumulative interactions, the feeling of comfort during moments of interaction, and being understood by professionals (Coyle et al., 2001b).

Other researchers have reported that having control over labour and childbirth (Gibbins and Thomson, 2001; Hildingsson, 2003), the birth environment (Espósito, 1999), using non-pharmacological pain relief, knowing the professional staff, seeing birth as a physiological and social event (Hildingsson, 2003), receiving collaborative support from midwives (Espósito, 1999), being able to receive information about birth, participating in the decision-making process (Gibbins and Thomson, 2001), feeling safe during birth and being treated with dignity and respect (Espósito, 1999) are some of the main reasons why women prefer birth centres.

Reasons why women with previous birth care experience in hospitals seek care in a birth centre, and their perceptions related to birth centre care have not been explored by Brazilian or Latin American researchers. In 2008, 10 years after the inauguration of the first birth centre in São Paulo City, when the birth centre was recognised by the population as an alternative to the hospital, the women who attended this setting reported their birth care experiences. A systematised description of these issues could promote the future quality of care in birth care settings.

Objective

To explore the reasons why women with previous hospital experience seek care at a birth centre, and their perceptions related to the care received in both settings.

Methods

A narrative analysis method (Riessman, 1993) was used as this was deemed to be most appropriate for the naturalistic nature of the birth experience (Morse et al., 2001). The essence of this method consists of accessing the primary experience as represented by the person who has lived it. Researchers need to respect and describe the perspective of the person who is telling the experience as trustworthily as possible. The five steps of the method, integrally developed in this research, were attending, telling, transcribing, analysing and reading the experience (Riessman, 1993).

The first step was carried out at the moment when the research project was proposed, aiming to attend to these mothers' experiences.

The institution focused on in this study is located in São Paulo City, Brazil. It is affiliated with the Family Health Program of the Brazilian Public Health System and provides free birth care. It has the symbolic value of innovation of birth care, and the nurse midwives responsible for birth care in this institution follow the recommendations of the World Health Organization (WHO) (Hoga, 2004). Substitution of the medicalised birth care model predominant in the Brazilian context (Carr and Riesco, 2007) and the dissemination of its symbolic value (Hoga, 2004) were the main objectives when this birth centre was founded.

The second step involved reporting the experience. Prior to this stage, carried out with the completion of individualised in-depth interviews, an explanation of the research project was offered to women, including that approval to undertake the study had been granted by the institutional ethics committee authorised by the National Research Ethics Committee. The mothers signed a consent form that guaranteed the confidentiality of their personal data and authorised the use of data for scientific purposes. Personal data were obtained before the beginning of each interview.

On average, 36 women received birth care at the birth centre every month (Zerbini Foundation, 2005). The mothers´ names, addresses and telephone numbers were obtained from a register. They were contacted two months after the birth. This period was considered adequate as mothers had had enough time to recover from the birth and to reduce the occurrence of the 'halo effect' (Bramadat and Driedger, 1993).

The initial contact with mothers was established by telephone. Some facts were clarified, such as the aim of the research and that the researchers involved were neither members of the birth centre nor governmental staff. Women were asked for their permission to be interviewed, and none of the women refused to collaborate. All women chose to be interviewed in their own homes.

In-depth interviews were conducted, starting with an open-ended question (Kvale, 1996): 'Tell me about your reasons to turn to the birth centre and how you experienced the care in this setting'. When appropriate, additional questions were asked for a deeper understanding of mothers' experiences. An active listening attitude was maintained according to the recommendations of Kvale (1996) in order to preserve the spontaneous nature of mothers' narratives and its sequence.

During the interviews, mothers talked about their experiences of birth care in a hospital setting and in a birth centre. Data collection was performed from February 2006 until March 2007; each interview lasted between 20 and 60 minutes. The criterion used to end the recruitment of women was theoretical saturation or continuous data repetition; this was observed after the 15th interview, but 18 women were included to

guarantee one of the main criteria for rigor in the qualitative method (Morse et al., 2001).

In the third step of the method, transcription of the experience, the recorded interviews were fully transcribed by the interviewers who carried out this research. The sequence of the narratives was not changed, and the characteristics of individual expression were preserved. Grammatical mistakes were corrected. The fourth step of the research was carried out when each narrative was read attentively.

Themes describing mothers' experiences were elaborated according to the stages of data coding as described by Fereday and Muir-Cochrane (2006). A code manual was created, which included identification of the name of the code, definition of what the theme concerns, and a description of how to know when it occurs. The reliability of the codes, or the relationship between the code and the raw information, was verified. Initial themes were identified and summarised. Application of the template of codes and additional coding was performed when meaningful units of the narratives were identified.

Three themes emerged from the narratives. Their titles were meant to express, in the deepest, most comprehensive and trustworthy way possible, the mothers' previous experience of birth care in the hospital setting, reasons to turn to the birth centre and the last birth care experience in the birth centre setting, according to the mothers' narratives.

The content and meanings of the themes are illustrated by quotes, extracted from mothers' narratives. A sequential number was attributed to each mother and the numbers corresponding to the women who expressed a similar experience are displayed after each quotation in order to preserve the personal perspective, considered crucial in the use of the narrative analysis method (Riessman, 1993). The clearest example was quoted to represent all women who expressed a similar experience.

As with all studies, this study has limitations. Due to the subjective nature of this research, the interviewed mothers, mainly those who had negative experiences in the hospital setting, may have reported the negative aspects of hospital care and the positive aspects of birth centre care more strongly. The researchers, may have attributed more evidence to the positive aspects of birth care and to the negative aspects of hospital care during the data analysis process.

In order to guarantee rigor in the data analysis process, a colleague who was not involved in the research was asked to contribute. She read all the narratives and the contents of the three themes, as well as the table, composed to express a summarised version of the findings. She was satisfied with the final product of the data analysis.

Findings

The 18 mothers included in this study were aged 18–36 years; two were single and 16 were married. Their education varied from four to 11 years of study. Twelve mothers were housewives and six had a paid job. All mothers had received previous birth care within a hospital setting at least once, and 10 of the mothers had had more than one birth care experience in the birth centre.

All mothers shared their birth care experiences in the hospital and birth centre settings, and provided a set of data about the two different models of care. Three key themes emerged at the end of data analysis: 'Confrontation with strong problems in the hospital setting', 'Reasons to seek the birth centre' and 'Satisfaction related to birth centre care'.

The main aspects that the mothers focused on in their narratives, in relation to both hospital and birth centre settings, were related to institutional structure and care systematisation, as shown in Table 1.

Table 1.
Mothers' birth care experiences in the hospital setting, reasons for seeking the birth centre and satisfaction related to birth centre care.

		Problems	Consequences
Confrontation of strong problems in the hospital setting	Hospital structure	• Lack of beds • Lack of accommodation for companion • Presence of other patients in the same room • Professional staff included several unknown members	• Had expected a bed • Remained anxious • Felt tired • Did not receive support from companion • Did not have privacy • Felt insecure
		Problems	Consequences
	System of care	• Lack of professional self-identification • Standardised birth care • Carrying out unnecessary procedures • Lack of explanations about care procedures •	• Felt insecure • Felt anxious • Felt like a 'thing' being processed • Doubts remained • Faced difficulties using self-care measures

		• Lack of attention to mothers' questions • Lack of information on pain relief options • Lack of emotional support • Lack of attention to preservation of patients' intimacy • Inadequate interpersonal communication	• Confidentiality neglected • Was treated with disaffection
Reasons to seek the birth centre		Determining factors	
	• Birth centre localisation • Positive references related to the birth centre	• Proximity of birth centre to mothers' houses • Easier access to the birth centre • Recommendations given by professionals • Recommendations given by relatives who had positive experiences	
		Motives of satisfaction	Results
Satisfaction related to the birth centre care	Birth centre structure	• Birth centre's pleasant atmosphere • Better appearance compared with hospital • Familiarity with professional staff • Permission to have a companion • Absence of ill women	• Felt like home • Had conditions to relax • Felt secure with professionals • Received support from family members • Reduced risk of infection
	System of care	• Continuous presence of professionals in the care setting • Familiarity with professional staff • Possibility of eating and using self-care practices during labour • Respect for mothers' choices • Existence of emotional support • Respect to the physiology of childbirth • Use of non-pharmacological interventions to relieve discomfort • Answers to all patients' questions • Adequate interpersonal relationship • Equal attention to all women regardless of social background	• Remained secure in relation to the continuity of care • Kept feeling protected • Had doubts cleared • Birth process permeated by feelings of relaxation and pleasure • Had choices respected • Received emotional support • The nature of birth was respected • Felt affective care • Was respected as a citizen

Table options

Confrontation with strong problems in the hospital setting

Hospital structure

The mothers were confronted with problems related to the lack of beds available for birth care. They had to wait for a free bed without any guarantee of hospital admission, and this situation provoked feelings of anxiety and tiredness:

> It was horrible, I had to wait for a free bed, sitting on the chair. (9, 13, 18)

After hospital admission, the desired support of a family member during labour and birth was difficult because the hospital did not permit the presence of companions in some birth care settings. An additional problem was the lack of adequate accommodation for the companions:

> My husband could not give me support, the hospital did not authorise his presence at any time. (3, 6, 11, 18)

The presence of other patients in the same room, in addition to the problems deriving from professionals' lack of attention to preserve patients' intimacy, provoked the feeling of having their privacy invaded:

> I did not have privacy at the hospital, I stayed in the same room with other patients, professionals did not pay attention to preserve patients' intimacy. (1, 13, 18)

System of care

Lack of contact with care staff prior to hospital admission, professional staff including several unknown members and the lack of professionals' self-identification provoked feelings of insecurity and anxiety:

> I did not know the professionals, I became insecure. (2, 5, 12, 13, 14, 15, 16)
>
> Several unknown people examined me, I had no idea who they were. (16, 18)

Standardised birth care was one of the problems. The mothers reported that they felt like 'processed' things, similar to industrial production. The expression of personal needs was difficult in this care model. On the other hand, the main concern of professionals was to follow the birth care protocols and complete their work as quickly as possible:

> All women were submitted to the same process. (8, 13, 17)
>
> Their main desire was to finish the work as soon as possible, I wanted to, but I did not have opportunities to express my needs, I felt I was being processed on a production line. (10, 14)

Women raised the issue of being subjected to unnecessary procedures, such as trichotomy (shaving of pubic hair), the use of synthetic oxytocin and oral fasting:

> All women were submitted to procedures like trichotomy, infusion of oxytocin, and I did not have anything to eat…I was left lying down the whole day. (8, 13, 17)

Several women reported receiving interventions with no explanation as to why they were needed or their purpose:

> They put the serum [infusion of synthetic oxytocin] without explanations about the need and effects of the medical procedures. (3, 7, 9, 17)

Failure to answer mothers' questions related to the fetus' condition and progress of labour also contributed to increase the level of anxiety in these mothers:

> I asked what was happening to the baby, how the labour was going, but they just told me to wait, I became very anxious. (3, 7, 9, 17)

The lack of information on options for pain relief during labour made it difficult to use self-care practices:

> The pain was strong, but I did not know what I could do for myself, professionals did not offer information about this. (3, 17)

The lack of emotional support and the absence of professionals in the care setting during the labour process provoked the feeling of abandonment. This situation contributed to increase mothers' anxiety:

> They just carried out the procedures without any concern related to information about what they were doing. They did not express concern with emotional support, trying to keep me calm. (9, 13, 17)
>
> They only came to the care setting when the baby was born…I stayed alone. (1, 3, 7, 9, 12, 13, 17, 18)

Mothers evaluated several aspects related to interpersonal communication as problematic. Problems in this scope made them feel like a number or one more 'thing' to be processed:

> The absence of human contact bothered me. (3, 10, 13, 17)
>
> I felt like a number, just one more woman. (11, 15)
>
> They ignored me, I felt like a 'thing'. (3, 7, 9, 17)

Reasons why women sought care at the birth centre

Mothers reported three main reasons why they had turned to the birth centre. One was the recommendation offered by antenatal care staff and by relatives who reported positive care experiences at the birth centre:

> I came to the birth care centre because I received recommendations from prenatal care staff. (5, 7, 11, 12, 13, 16, 17, 18)
>
> My sister told me that the birth centre offers good care. (4, 6, 10, 14)

The other reasons why women sought care at the birth centre were easier access to the birth centre due to its proximity to their homes, and the lack of private health insurance:

> I decided to go to the birth centre because it is closer to my home. (1, 15)
>
> I have asked to come to the birth centre because I lost my health insurance. (4, 14)

Satisfaction related to birth centre care

Institutional structure

The following items related to the birth centre structure made the mothers feel satisfied.

> The pleasant birth centre atmosphere made them feel at home and relaxed:
>
> The birth centre atmosphere was very pleasant. (2, 4, 7, 8, 9, 10, 12, 16)
>
> I could relax, I felt like at home. (6, 7, 8)

The environment of the birth centre, which was very different from the hospital's appearance:

> The environment of the birth centre is better, it does not look like a hospital. (6, 9, 13)

The contact between client and professional prior to admission at the birth centre, increased feelings of security:

> Nurse midwives accompanied my health condition since the 37th week of pregnancy, this familiarity with them gave me more security. (2, 4, 5, 8, 12, 13, 14, 15, 16, 17, 18)
>
> Receiving care in the birth centre creates a strong link between care staff and patients. (4, 11, 12, 13, 16)

Permitting the continuous presence of a companion in the birth centre setting and the possibility of receiving support from a family member:

> Our companion was always close, so we could feel more secure. (2, 3, 8, 11, 15, 18)

The absence of ill women from the birth centre was perceived as reducing the risk of infection:

> The birth centre is better, because there are no ill women there, they increase the risk of infection. (5, 7, 11)

System of care

The positive evaluation of the system care resulted in reports of a feeling of satisfaction with the birth centre. Mothers reported the following as positive contributors to their experiences of care:

The continuous presence of professionals in the care setting, was perceived as permitting more prompt care:

> We were always seen quickly, I felt very secure. (8, 10, 12)
>
> Nurses stayed with me all the time. (2, 3, 4, 5, 7, 8, 9, 13, 14, 16, 17, 18)

The health care professional's respect for the mothers' choices during her labour and birth:

> The nurse gave us the opportunity to choose and respected my choices. (3, 6, 12)

The offering of emotional support which resulted in the feeling of protection:

> I felt protected, as if I were in my mother´s lap. (3)

The offer of food during labour eat and encouragement of self-care practices promoted a feeling of freedom in some of the women:

> You can eat, walk and exercise sitting on the ball, I felt more freedom there. (8, 9)

The absence of oxytocin as a routine intervention and support for the normal physiology of labour:

> They do not put the serum [infusion of synthetic oxytocin] to increase contractions as a routine, they try to preserve the nature of birthing. (2, 5, 6, 8)

The use of non-pharmacological resources to relieve pain made women feel relaxed and pleasant:

> I did exercises on the ball, in the shower, my labour was more pleasant…even though painful. (8, 16, 17)

Professionals answered all of the mothers' questions:

> The professionals explain everything you need, I went home without doubts about self and newborn care. (3, 17)

With respect to interpersonal relationships, the attention offered to women throughout the birthing process promoted feelings of security:

> The nurse gave me attention, I felt secure and calm throughout the whole process. (3, 5, 12, 14, 15)
>
> The warm relationship was very good. (3, 4, 5, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18)

Similar attention was reported as offered to all mothers, regardless of their socio-economic background:

> Everybody is treated here in the same way, people with more or less money. (8)

Discussion

Mothers were dissatisfied with the care they received in the hospital setting which may have provoked the exacerbated negative evaluation of hospital care and the positive evaluation of birth centre care. These are the limitations of this study. On the other hand, the findings and discussion could contribute to promote the quality of birth care in both settings.

The reports of dissatisfaction were predominant in relation to hospital birth care, and conversely the reports of satisfaction were expressed by mothers who received care at a birth centre. The main aspects mentioned in both settings were related to the institutional structure and care systematisation.

Mother´s dissatisfaction related to birth care in hospital setting should be overcome

One of the reasons given for dissatisfaction with birth care in the hospital setting was a lack of beds. In large cities in Brazil, there are sufficient obstetric beds but they are not equally distributed across the different zones of the cities. Beds are concentrated in the downtown area, and women who live in the other zones and who do not have private health insurance, like the mothers in this study, suffer the consequences of this problem (Tanaka, 1995).

Financial obstacles have a deep impact on the use of health services, including birth care (Islam and Nielsen, 1993; Griffiths and Stephenson, 2001; Onah et al., 2006; Osubor et al., 2006; Lubock and Stephenson, 2008). In the context of São Paulo City, opening a birth centre on the outskirts of the city represented an essential public policy as this measure has contributed to reduce the problem of the lack of

beds.

Regarding the problems provoked by the hospital structure, mothers cited a lack of adequate accommodation for companions and care delivery by several unknown professionals. The problems that the institutional structure provoked in birth care were described by Coyle et al. (2001a). Therefore, the organisational barriers inherent to the medical birth care model should be removed, as they contribute to care fragmentation (Coyle et al., 2001b).

Prohibition of the presence of companions and lack of adequate accommodation for companions in care settings show the lack of adherence to the recommendations made by the Brazilian Health Ministry (Brasil, 2000) and WHO (1996). Not all hospitals comply with the Brazilian law (Hoga and Pinto, 2007) that guarantees the presence of a companion in the care setting (Ministério da Saúde, Brasilia, 1999c).

Resistance against the presence of a companion and active involvement of companions in birth care persists among some Brazilian professionals. Adequate incorporation of a companion in birth care settings requires the adoption of institutionalised measures, aiming to prepare professionals and companions and adapt birth care settings (Hoga and Pinto, 2007).

The standardised birth care model should be avoided

The mothers mentioned several problems with the system of care in the hospital setting, one of which was the standardisation of birth care. This care model should be avoided as its procedures are clearly defined and distributed among professionals without concern for patients' personal needs (Walsh, 2006). The consequence is birth care delivery similar to industrial production, which mothers evaluate in a strongly negative manner (Giddens, 2001).

The persistence of an inappropriate birth care model should be fought. The ideal model, however, represented by comprehensive and humanised birth care, involves many factors which overstep the technical preparation of professional staff (Serruya et al., 2004).

One of the problems linked to the adoption of standardised birth care is the composition of the professional staff. Generally, the hospital staff comprise several members, and familiarity between professionals and clients is difficult. This problem was described by Hodnett and Osborn (1989) in a university hospital setting. During the observation of this care setting, it was noted that mothers received care from 16 different professionals within six hours. Despite this, women remained alone for most of the time, and care was restricted to compliance with institutionalised routines. As a result, mothers felt very anxious and a cascade of problems emerged, with harmful consequences.

The care model used at the birth centre is an alternative for the Fordist model of production used by some hospitals. Care based on Fordist principles provokes birth care fragmentation, and meeting individual care demands is more difficult. Walsh (2006) demonstrated that professionals who overcame this care model and used humanised birth care had more job satisfaction. The fact that work was not restricted to the accomplishment of care procedures was the main justification for professionals' satisfaction.

Unnecessary interventions in birth care should be avoided

The use of unnecessary procedures in birth care should be avoided because it is harmful to women's health (World Health Organization, 1996). Reduced use of medical interventions in birth centre settings compared with hospitals has been demonstrated (Jackson et al., 2003; Waldenstrom et al., 2005). In current practice, the reduction of inappropriate practices and the adoption of evidence-based health care remains a challenge to be overcome (Pearson et al., 2005).

Offering trustworthy information about the progress of labour is a fundamental aspect of birth care. This measure promotes mothers' empowerment, which is essential for their own control of the birthing process (Gibbins and Thomson, 2001).

Adequate interpersonal communication is an essential aspect of birth care

Adequate interpersonal communication is also crucial in birth care (Espósito, 1999; Coyle et al., 2001a). Initial contact, with dignity and respect, is essential for a successful interpersonal relationship (Espósito, 1999). The emotional support offered by care providers is equally important as it is one of the main aspects of birth care (Espósito, 1999; Coyle et al., 2001a).

The care model used at the birth centre, different from that used by the technocratic system, tends to be respected and accepted by women, regardless of their social condition. Nevertheless, aspects related to gender, race and social inequality need to be heeded, as there is a trend not to consider these issues when the technocratic cultural power predominates in birth care. The oppressive relationship and the consequent lack of attention to mothers' needs can occur in this care model (Espósito, 1999).

Mothers' reasons for seeking care at the birth centre confirm Walsh's (2006) finding that practical and psychosocial issues were the main reasons why they preferred the birth centre.

A discussion about the safety of care is of crucial importance when recommending the birth centre as an alternative to hospital birth care (Jackson et al., 2003). This aspect, associated with evidence of the birth centre as an economically viable resource as demonstrated by Stone (1995), is fundamental if public policies for birth are to be supported. This issue becomes particularly important in the Brazilian context, with limited financial resources available for health care.

Nurse midwives working in birth centres face a great challenge to carry out their practices guided by their own philosophy and principles. Preserving the heritage built by previous professionals, who were proactive and creative, authentic guardians of birth as a natural and physiological phenomenon of women's life,

should be guaranteed (Barger, 2004).

Conclusion

Professionals involved in birth care should take into account and acknowledge important aspects. The main aspects of birth care mentioned by the mothers in this study were related to the institutional structure and care systematisation. Special attention should be given to the interpersonal relationship between professionals and mothers, as many problems with this were detected in this study. This finding indicates that professionals' subjective views should be addressed, as consciousness in relation to these aspects is essential for the establishment of adequate interpersonal communication between health providers and their clients (Hoga, 2004).

The positive evaluation of care offered at the birth centre focused on in this research is of social importance in the current Brazilian and South American birth care contexts. The birth care model used in this setting, which complies with WHO recommendations (1996) and is evaluated positively by mothers, can be followed by other birth centres. Thus, the birth centre focused on in this research can be considered an adequate setting to train future nurse midwives. Academic programmes need to be based on a clearly defined paradigm, and professionals involved in teaching and education play an essential role in the pedagogic process (Evans, 1999).

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