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SARA FERNANDES PICHETH

# RELATIONS OF POWER AND MULTI-LOGICS FIELD: Analyzing the maternity practices in Brazil and England

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# RELATIONS OF POWER AND MULTI-LOGICS FIELD: Analyzing the maternity practices in Brazil and England

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SARA FERNANDES PICHETH

**RELATIONS OF POWER AND MULTI-LOGICS FIELD: ANALYZING THE MATERNITY PRACTICES IN BRAZIL AND ENGLAND**

Tese apresentada ao Programa de Pós-Graduação em Administração da Universidade Estadual de Maringá, como requisito parcial para obtenção do título de doutora em Administração, sob apreciação da seguinte banca examinadora:

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2020

**“[…] While she holds your hand, you cannot fall; under her protection, you have nothing to fear; if she walks before you, you shall not grow weary; if she shows you favour, you shall reach the goal."**

**Saint Bernard of Clairvaux**

*Ao meu querido irmão (in memoriam) que sempre me emprestou sua fé quando a minha não era suficiente e acreditou nos meus sonhos mais que eu mesma. Você faz parte dessa conquista! Obrigada!*

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## ABSTRACT

Within the institutional logic's perspective, the understandings of the conditions under which heterogeneous practices are enacted are still lacking. To understand that, I focus on the role of power. Contexts that generates institutional multiplicity embraces relations of power as not all actors are able to promote their logics and impose their demands with the same persistence. My key assertation is that the configuration of different outcomes varies depending on the balance of relations of power between actors in the multi-logics field. In order to examine this, I conducted two case studies in the domain of maternity in Brazil and England with the main purpose to comprehend how relations of power shape the adoption of practices in the maternity field in each site. These cases were investigated through predominantly qualitative methodological strategies with the adoption of quantitative techniques complementarily. Data was collected through documental research, online survey and interviews with mothers and health professionals in both sites, following a multistage framework. Analysis of data was firstly conducted separately, adopting descriptive and frequencies analyses and analysis of variance and co-variance for quantitative data and interactive analysis for qualitative data, and then merged for final interactive analysis. In examining these cases, the empirical findings evidence a typology of seven categories of practices variation which showed contrasting effects; disconnection to material distinctions; and fluidity of practices. It also found that variation in practice is contingent on relations of power. Power asymmetries are linked to disruptive practice as an engine of institutional instability that can lead to potential change, through new practices development or the creation of new institutional arrangements, both from an increasing role of agency. On the other hand, power symmetries are linked to reinforcing practices that act as a stabilizer, maintaining the current institutional configuration and demotivating agency to act. It also contributes to practical implications by offering subsidies for a deeper reflection on fostering improved maternity care. Given the relevance of the empirical setting, the findings help to enhance the health care in both countries, but especially in Brazil, where the high incidence of caesarean section is portrayed as a public health problem and women were found with asymmetric relations of power with health professionals.



**Keywords:** Multi-logics field. Practices. Relations of power. Maternity. Birth.

## RESUMO

Dentro da perspectiva da lógica institucional, ainda falta entendimento das condições sob as quais práticas heterogêneas são promulgadas. Para entender isso, eu foco no papel do poder. Contextos que geram multiplicidade institucional abrangem as relações de poder, pois nem todos os atores são capazes de promover suas lógicas e impor suas demandas com a mesma persistência. Meu principal argumento é que a configuração de diferentes resultados varia de acordo com o equilíbrio das relações de poder entre os atores no campo da multi-lógicas. A fim de examinar isso, eu conduzi dois estudos de caso no domínio da maternidade no Brasil e na Inglaterra, com o objetivo principal de compreender como as relações de poder moldam a adoção de práticas no campo da maternidade em cada local. Os casos foram investigados por meio de estratégias metodológicas predominantemente qualitativas, com a adoção de técnicas quantitativas complementares. Os dados foram coletados por meio de pesquisa documental, survey on-line e entrevistas com mães e profissionais de saúde em ambos os locais, seguindo uma estrutura de multi-estágios. A análise dos dados foi primeiramente realizada separadamente, adotando análises descritivas e de frequências e análise de variância e covariância para os dados quantitativos e análise interativa para dados qualitativos, e depois mescladas para uma análise final interativa. Ao examinar os casos, os achados empíricos evidenciam uma tipologia de sete categorias de variação de práticas que mostraram efeitos contrastantes; desconexão com distinções materiais; e fluidez de práticas. O estudo também identificou que a variação na prática depende das relações de poder. Assimetrias de poder estão ligadas às práticas disruptivas como um mecanismo de instabilidade institucional que pode levar a possíveis mudanças, tanto por meio do desenvolvimento de novas práticas quanto da criação de novos arranjos institucionais, e ambos a partir de um papel cada vez maior da agência. Por outro lado, simetrias de poder estão ligadas a práticas reforçadoras que atuam como estabilizadoras, mantendo a atual configuração institucional e desmotivando a agência para agir. O estudo também contribui para implicações práticas, oferecendo subsídios para uma reflexão mais profunda sobre a promoção da melhoria da assistência à maternidade. Dada a relevância do contexto empírico, os achados podem ajudar a melhorar os cuidados de saúde nos dois países, mas especialmente no Brasil, onde a alta incidência de cesarianas é retratada como um problema de saúde pública e as mulheres foram encontradas com relações assimétricas de poder com os profissionais de saúde.



**Palavras-chave:** Campo multi-lógicas. Práticas. Relações de poder. Maternidade. Parto.

## LIST OF ABBREVIATIONS

**ANS:** *Agência Nacional de Saúde Suplementar* (National Agency for Supplementary Health)

**CFM:** *Conselho Federal de Medicina* (Federal Council of Medicine)

**CNDH:** *Conselho Nacional de Direitos Humanos* (National Council of Human Rights)

**Cofen:** *Conselho Federal de Enfermagem* (Federal Council of Nursing)

**CTRG:** Clinical Trials and Research Governance

**CUREC:** Central University Research Ethics Committee

**DREC:** Departmental Research Ethics Committee

**GP:** General Practitioner

**HSCIC:** Health and Social Care Information Centre

**MPF:** *Ministério Público Federal* (Federal Public Prosecution Service)

**NCT:** Nation Childbirth Trust

**NHS:** National Health Service

**NICE:** National Institute for Health and Care Excellence

**NMC:** Nursing & Midwifery Council,

**OAB:** *Ordem dos Advogados do Brasil* (Brazilian Bar Association)

**PHPN:** *Programa de Humanização no Pré-natal e Nascimento* (Antenatal and Birth Humanization Program)

**PNHAH:** *Programa Nacional de Humanização da Assistência Hospitalar* (National Program of Humanization of Hospital Assistance)

**RCOG:** Royal College of Obstetricians and Gynaecologists

**SBS**: Saïd Business School

**SBMFC**: *Sociedade Brasileira de Medicina de Família e Comunidade* (Brazilian Family and Community Medicine Society)

**SUS:** *Serviço Único de Saúde* (Unified Health System)

**VBAC:** Vaginal Birth After Caesarean

**WHO:** World Health Organization

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# 1 INTRODUCTION

Given the increasing prominence of institutional logics in recently academia work (Greenwood, Raynard, Kodeih, Micelotta, & Lounsbury, 2011; Lounsbury & Boxenbaum, 2013; Almandoz, 2014; Ocasio, Loewenstein, & Nigam, 2015; Lee & Lounsbury, 2015), when we think about multi-logics field, an important and enduring issue is the heterogeneous practices enacted (Bertels & Lawrence, 2016; Besharov & Smith, 2014; Greenwood, Díaz, Li, & Lorente, 2010). Institutional logics comprise beliefs, values, rules, and historical patterns that were socially constructed and that give meaning to social reality (Thornton & Ocasio, 1999). They provide individuals with a vocabulary of motive and a sense of self-knowledge (Friedland & Alford, 1991), which frame how individuals make sense of the world and consequently know how to act around it (Cloutier & Langley, 2013). Practices, then, represent how institutional logics are manifested and legitimated (Greenwood et al., 2010; Friedland, Mohr, Roose, & Gardinali, 2014).

Previous researches already acknowledge the relationship between institutional logics and practices. Practices are seen as instantiations or materialization of institutional logics in fields (Friedland et al., 2014; Thornton, Ocasio & Lounsbury, 2012; Greenwood et al., 2010; Haveman & Rao, 1997). Concurrently, fields are also acknowledged to be constituted by multiple and often contradictory logics – institutional complexity-, being characterized as multi-logics fields (Waldorff, Reay, & Goodrick, 2013; Greenwood et al., 2011; Reay & Hinings, 2009, 2005). Several studies reveal how the practices of the actors are embedded in fields enacting multiple institutional logics (Friedland et al., 2014; McPherson & Sauder, 2013) and receive influence from different and simultaneous orders (Goodrick & Reay, 2011). Consequently, organizational responses towards them are unlikely to be uniform (Greenwood et al., 2010). However, the conditions under which heterogeneous practices are enacted still lack understanding (Bertels & Lawrence, 2016; Besharov & Smith, 2014; Greenwood, Díaz, Li, & Lorente, 2010).

Institutional complexity allows a wide range of responses from organizations when they experience contrasting guidelines from multiple institutional logics (Bertels & Lawrence, 2016). It generates challenges and tensions by providing different and competing prescriptions to actors to interpret and respond to (Greenwood et al., 2011; Pache & Santos, 2010). This, in turn, allows responses and practices enactment to be varied. It can lead to both contradictions and conflicts (Zilber, 2002), and collaboration and complementarity (Reay & Hinings, 2009; Goodrick & Reay, 2011; Smets, Jarzabkowski, Burke, & Spee, 2015), resulting in the

heterogeneity of organizational responses (Greenwood et al., 2010; Bertels & Lawrence, 2016). The promulgation of practices (Bertels & Lawrence, 2016; Nicolini et al., 2016) is the result of social interaction among actors involved in a particular field (Thornton, Ocasio, & Lounsbury, 2012).

Thus, it is well established that organizations confront simultaneously incompatible prescriptions from multiple interdependent and contradictory institutional logics (Friedland & Alford, 1991; Reay & Hinings, 2009; Dunn & Jones, 2010). Nevertheless, little is known about the circumstances under which different outcomes arise in consequence in multi-logics fields (Besharov & Smith, 2014). Greenwood and colleagues (2010) state that literature still lacks deepening on how the multiplicity of logics is responded to. Pache and Santos (2010) argued that there was no attempt to systematically predicts the way organizations respond to the conflicts unfolded by such complexity. And, although some efforts have been further conducted to address this gap (*e.g.* Pache & Santos, 2010; Greenwood et al., 2011), yet relatively little is known conceptual and empirically about how organizations deal proactively with this conflict at the micro-level (Smets et al., 2015; Cloutier & Langley, 2013; Kim, Shin, Oh, & Jeong, 2007), overlooking the influence of individual motivations and abilities (Bertels & Lawrence, 2016) in the dynamically negotiation of institutional complexity (Smets et al., 2015).

Thus, this research, in alignment with these claims, is based on the assumption that to varying degrees, actors in multi-logics field experience institutional complexity (Greenwood et al., 2011) which constrains them to align their practices with multiple interdependent and contradictory logics (Friedland & Alford, 1991). However, on the contrary of a deterministic institutional vision, the definition of appropriate action is not merely a passive compliance; instead, I rely on the notion of agency as central to the enactment of institutional logics. In accordance with studies that have looked inside organizations and approached institutions as inhabited by individuals (Hallet & Ventresca, 2006; Pemer & Skjølsvik, 2016; Bertels & Lawrence, 2016), I highlight the importance to analyze actors and especially social interactions as central themes when dealing with institutional logics and responses towards them.

My study considers the need to encompass the macro and micro levels as fundamental to institutional logics (Thornton, Ocasio, & Lounsbury, 2012; Cloutier & Langley, 2013). It follows that the understanding of how organizations respond to institutional complexity and the plurality of logics is intimately linked to the understanding of people in organizations. The influence of institutional logics depends on the relationship between actors or groups. It is their perception, feelings, insights, and actions that will support the logics and animate those

responses (Bertels & Lawrence, 2016; Greenwood et al., 2011), in a way that institutional pressures are beforehand filtered by interpretative processes. Individual characteristics affect how institutional logics are accessible and activated, allowing actors to actively manage the degree of that impact (Bertels & Lawrence, 2016). They affect the promulgation of practices generating a set of decision premises and motivations for actions (Ocasio, 1997), which reinforces its relevance to the institutional logics perspective. Conversely, this analytical perspective has not received much attention in the literature that strives to relate responses promulgated under conditions of multiplicity.

Literatures does offer insights into the way institutional logics enactment are influenced by some actors (Hallet & Ventresca, 2006; Bertels & Lawrence, 2016), and that actors have a role in transforming existing fields (Lawrence & Suddaby, 2006; Greenwood, Suddaby, & Hinings, 2002) through their practices and interactions (Pemer & Skjølsvik, 2016; Thornton, Ocasio, & Lounsbury, 2012; Cloutier & Langley, 2013). Notably, studies point out that there are different levels of influence given the ability of actors. That is, it is contingent to the capacity of actors to enforce (Bjerregaard & Jonasson, 2014), to give voice to a logic and influence it (Greenwood et al, 2011), to their social position in the field (Pache & Santos, 2010) and the key strategic resources and other forms of power they encompass (Lawrence & Suddaby, 2006; Lawrence, 2008). All assumptions that implicitly or explicitly refer to relations of power. Nevertheless, there is still lacking studies that connect the role of power into the arising outcomes, that is, the resulting practices from multiple prescriptions.

Thus, shifting the focus from the macro to the micro-level, a significant issue remains obscure, the relations of power. Although institutional perspective has considered the effects of power and its relations with institutions, it has not been able so far to help to unravel effectively how power operates, how conflicts are resolved at the micro-level and under which conditions and with that consequences institutional logics dominate the field (Cloutier & Langley, 2013; Munir, 2015), a matter of power. I address this gap. My key assertation is that practices enactment, which underpins responses to logics multiplicity, are the result of social interaction and negotiation between actors, which involves aspects of power between actors. While a symbolic identification propels institution arrangements, leading by satisfaction or dissatisfaction with interests, it is also the relative abilities of actors to express and protect those meanings and interests that constitute an important piece in understanding the resulting outcomes (Hinings & Greenwood, 1988). Studies point out the interrelation of social interaction with power (Wrede, 2001, Bjerregaard & Jonasson, 2014; Greve & Zhang, 2017)

in a way that these dimensions impact the outcomes, that is, on the institutional logics' instantiation.

Social interaction among contesting interest groups propel institutional logics instantiation into organizational forms (Hallet & Ventresca, 2006; Bjerregaard & Jonasson, 2014). This, in turn, is linked to the social positions' actors occupy in the field (Wright & Zammuto, 2013) and the relations of power between them (Lawrence, 2008; Clegg, Courpasson, & Phillips, 2006). All of these are activated during the processes of negotiation, interpretation, and promulgation of logics by individuals in interaction (McPherson & Sauder, 2013). It follows that the outcomes of such interactions depend on the strategic resource actors possess and the power balance within the field (Shetzer, 1993). Especially given that there are varying degrees of influence. This means that not all actors are able to promote their logics and impose their demands with the same persistence, also impacting how logic can penetrate a field (Greenwood et al., 2011). Hence, incorporating the role of relations of power and agency into institutional theory may help answer how institutions are created and changed (Seo & Creed, 2002) as well as why responses are not uniform among different organizations (Goodrick & Salancik, 1996; Greenwood et al., 2011).

Therefore, in this research, I build on relations of power to explore why heterogeneity of practices happen within multi-logics fields. I argue that **the configuration of different outcomes will vary depending on the balance of the power relationship established between actors in the multi-logics field.** Figure 1 illustrates this argument. The straight arrows represent insights literature already provides, as previously discussed. First, the multi-logics fields influence the variations in practices. They work as social prescriptions that guide action (Thornton, Ocasio, & Lounsbury, 2012) and are based on actualizing the practices of its practitioners (Friedland et al., 2014). In turn, practices also have a role in affecting the multi-logics field. Different types of practices performed can interfere in both reproducing and changing institutions (Harmon, Green Jr. and Goodnight, 2015; Feldman & Orlikowski, 2011; Lawrence & Suddaby, 2006; Maguire, Hardy, & Lawrence, 2004). However, within institutional research, these recursive influences of the institution over practice and practice affecting institutions are mostly theorized in ways that accept the inherent power differentials as given (Munir, 2015). Hence, in this thesis, I propose to look at the dotted line that is still lacking, the understandings of the role of relations of power between this relationship.

In order to examine this theoretical framework, I focused on the maternity field. The maternity field can be regarded as a conflictual arena where diverse actors - mothers, family, state, physicians, nurses and doulas - following different institutional logics meet and struggle

to agree on which practices to enact (Davis, 2012; Wrede, 2001; Ross, 1993). Due to that, we can state that maternity deals with what Greenwood and his colleagues (2011:317) call institutional complexity, that is, the exposure to "incompatible prescriptions from multiple institutional logics", being considered a multi-logics field. Consequently, it is an appropriate empiric case to analyze.

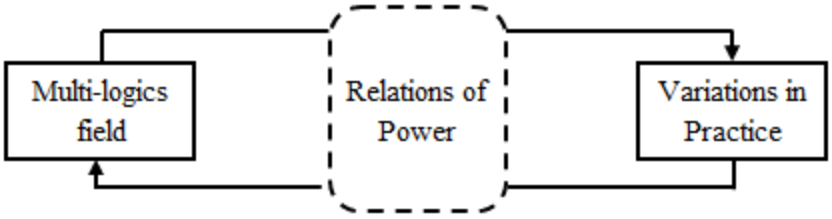


*Figure 1*. Proposed framework of the role of power in the adoption of practices in multi-logics field
Source: elaborated by the author.

As it can be considered a domain of contestation (Wrede, 2001), the maternity field also depicts the effects of relations of power as highly affecting the relationships between institutional logics carried by actors and the maternity practices promulgated. For instance, many empirical studies have shown that most Brazilian pregnant women have the preference for normal birth (Hopkins, 2000; Potter et al., 2001; Dias et al., 2008; Leal & Gama, 2012). A national research conducted between 2011 and 2012, among 191 Brazilian cities, has shown that 70% of women wanted a normal birth in early pregnancy. However, despite the initial preference, it was observed that during the pregnancy, there was a change of decision regarding the type of delivery, which was not linked to the occurrence of problems and complications. According to the research, this evidence suggests that prenatal orientation may be inducing women to have caesarean delivery (Leal & Gama, 2012).

Similarly, the study of Freire and colleagues (2011) highlighted that the hegemony of knowledge by physicians leads to disempowerment among mothers. They argue that as the reports and the communication are conveyed by physicians in technical and medical terms, this privileges only one side of actors. Scholars have also noted that the frequent lack of expertise (Hopkins, 2000), misinformation, and lack of knowledge regarding normal birth among women (Pereira, 2006), allied to the hegemonic position doctors traditionally occupy in the maternity care lead to a unilateral decision. All of these reinforces the asymmetries of power and, consequently, the lack of preferences met in regards to birth preferences.

In this context, institutional studies limit the explanation of the impacts of institutional practices and effects on peripheral actors. From an institutional perspective, it is recognized that it is important to embrace the power of professional associations and the actors that occupy

the respective roles because they are responsible for enacting the routines involved, such as doctors and midwives. However, other actors may not be part of the creation and design of institutionalized practices and structures, such as patients, family members, health policymakers, but are equally impacted, despite being less involved in institutional research (Lawrence, 2008). The mentioned empirical studies illustrate that by pointing to the lack of choice of mothers, which supports my choice in regards to the maternity field as the focus of research.

Additionally, because comparative cases are essential to develop a deeper understanding of how and why we observe some outcomes in one case, but not others (Micelotta, Lounsbury, & Greenwood, 2017), helping to comprehend different responses to institutional complexity, I aimed to address this issue comparing Brazilian and English maternity care. Brazil is acknowledged to have a technocratic model of childbirth attention. This is characterized by the supervaluation of science and technology, the large use of aggressive interventions with the emphasis on short-term results (Davis-Floyd, 2001; Rattner, 2009a). As a result, a planned or elective caesarean section has become a routine practice. In this type of birth, the procedure is scheduled for a particular date, allowing parents to know and even choose exactly when their baby will be born. Current figures indicate that Brazil leads the second-highest worldwide incidence, with 55.6% of total births happening surgically (Valadares, 2017; Bétran et al., 2016). In the private sector, it increases to an average of 86%, reaching 100% among several health insurances (Taxas, 2017).

Conversely, a growing movement, reckoned as the movement for the humanization of childbirth and childcare, has been acting since the 1980s and more strongly from the 2000s. It claims for the restoration of natural birth, less intervention, and respect of woman choices (Diniz, 2005; Ministério da Saúde, 2001), defending that babies should be born once they are ready, after women entering into labour. Its claims stem from an intense concern about the high rates of caesarean in the country, frequently portrayed as a "caesarean epidemic", and the intense use of interventions, mostly perceived as unnecessary and violent, and only for physicians' convenience, being portrayed as obstetric violence (Rattner, 1996; Freitas et al., 2005; Mendoza-Sassi et al., 2010; Barros et al., 2011). Besides, this excessive incidence also incurs in higher costs and longer stay at the hospital which demands more resources from the government (Faúndes and Cecatti, 1991).

One of the main arguments of that movement lies in the fact that Brazil is far from the percentage recommended by the World Health Organization (WHO). Since 1985, WHO has established the ideal rate for caesarean to be between 10 to 15%. More recently, through a

systematic study considering a country-specific evaluation, the WHO adjusted this reference rate for Brazil to 25-30% (Betrán et al., 2015; WHO, 2015), still much lower than the actual scenario. The establishment of such figures has been based on diverse studies that showed that not only there are no benefits of caesarean delivery for women and infants beyond this range, but there is also an association with increased risks, such as difficulty breathing, puerperal infections, anaesthetic complications, and higher rates of maternal and neonatal mortality. (WHO, 2015; Ye, Zhang, Mikolajczyk, Torloni, Gulmezoglu, & Betran, 2015; Betrán et al., 2007; Villar et al., 2006; Faúndes & Cecatti, 1991). These risks can also extend beyond the current delivery, affecting the health of the woman and her child and future pregnancies (WHO, 2015).

Consequently, the excessive incidence of this mode of delivery in the country has been considered a public health problem (ANS, 2015) and diverse actions have been taken by organs of public and private authority (Ministry of Health, the National Agency for Supplementary Health (ANS) and the Federal Council of Medicine (CFM)) in order to reduce the number of unnecessary surgeries (ANS, 2015; Frasão, 2016). Simultaneously, many social movements and groups of women have been created and acted in society as part of the humanization movement. They encourage and propagate a higher incidence of natural childbirth, humanization of childbirth, and evidence-based medicine (Diniz, 2005; Goer, 2004; Ministério da Saúde, 2001), indicating that more than one institutional logic exists in the maternity field, a more medicalized and interventionist one, and other more natural.

England, on the other hand, evidences a very contrasting scenario. Its caesarean rates are 26.2% (HSCIC, 2015), with only 10.7% being elective caesarean, and it is classified as having a humanistic obstetric model. This model is characterized by being less invasive, utilizing technology when necessary, and having continuous monitoring of the process of parturition by midwives. The physician acts only on the detection of some problem, or in emergent cases, opposite to the technocratic model predominant in Brazil (Rattner, 2009a), where only 15% of births are assisted by nurses and midwives. In terms of intervention, 40% of normal deliveries occur without any intervention, a rate well above the 5% observed in Brazil (Leal & Gama, 2012).

Another very contrasting aspect between both countries concerns the place of birth. While there are government initiatives to stimulate home birth in England (Relph, 2006), in Brazil, this is still in its early stages, being considered sometimes as retrocession. Given the advances in technology, modernity, and resources available in hospital and maternity units, it

is frequently, among Brazilian society and some physicians to consider home birth as placing the health of the woman and the newborn at risk (Sanfelice & Shimo, 2014; Paciornik, 1985).

Therefore, with this research, I propose to adopt relations of power as a touchstone to comprehend the variation in practices stemming from the maternity multi-logics field in different sites, Brazil and England. I argue that by analyzing and comparing these two cases, we could have a richer study of how the relations of power between actors involved in the field influence the enactment of maternity practices in response to institutional multiplicity, and thus, help to comprehend why Brazilian scenario is so distant from a global pattern. Adopting relations of power as lens provides a useful foundation to examine issues of inequality discrimination and oppression (Lawrence, 2008:192), aspects pointed to be presented in the maternity field in Brazil given the lack of respect for women's choices and the excessive technification imposed on birth, with high incidence of interventions, aspects frequently considered obstetric violence (Leal & Gama, 2012).

Also, by investigating that, I aim to contribute to having a more concrete and deepen conceptualization of the relationship between individuals and institutional logics (Bertels & Lawrence, 2016) and their impact on the types of practices enacted from the integration of the relations of power between several and interrelated actors following different logics. This is the focus of a central domain in institutional theory (Oliver, 1991; Pache & Santos, 2010; Greenwood et al., 2011).

Hence, in the light of the analytical lenses underlying this study, the research problem that I seek to answer is: **How do relations of power shape the adoption of practices in multi-logics field?** Based on this question, the present research has the general objective to *comprehend how relations of power shape the adoption of practices in the maternity field in Brazil and England.* To this end, specific objectives were formulated to guide the research, which they are:

a) Identify the multi-logics that are enacted in the maternity field in Brazil and England.

b) Identify the maternity practices adopted and their variations in Brazil and England.

c) Comprehend how the maternity fields in Brazil and England are configurated in terms of actors and relations of power among them.

d) Comprehend how relations of power shape the variation in maternity practices stemming from the multi-logics field in Brazil and in England and what are the implications of that.

In doing so, it aims to bring several contributions to the existing literature. Comprehending how actors' respond to multiple institutional demands has significant

implications for social legitimacy and access to critical resources, especially in the face of incompatible prescriptions, when some interests are inevitably prioritized at the expense of others (Greenwood et al., 2011). Thus, this conceptualization justifies by being indeed relevant for theoretical and practical matters.

The theoretical assumptions and findings expand the understanding of variations in practices in multi-logics field in three ways. First, I theoretically integrate predictions from power and institutional perspectives to show the recursive interplay between institutional multiplicity in fields and relations of power in the enactment of the resulting practice to help to understand how the multiplicity of logics is responded to and under which conditions we found variation in these responses. Also, this variation unravels how the conflicts between actors interacting with different and often contrasting institutional logics are unfolded. Then, I contribute to the study of institutional logics by defining more clearly the role of agency and power in the enactment of institutional logics.

Through the examination of relations of power, this study deepens the explanation of how multiple institutional logics are negotiated and embodied in an institutional field. Although institutional logics constrain actors to instantiate them, this should not be seen as given to actors' compliance but subject to strategic choices that can lead actors to an opportunity set (Durand et al., 2013; McPherson & Sauder, 2013). Stated differently, depending on its competence, which here I selected in terms of relations of power, actors have the latitude to modify institutional logics' instantiation strategically (Kim et al., 2007; Ocasio & Radoynovska, 2016). Thus, agency and power serve here as mediating aspects of processes of social interaction, helping to explain why different responses are given in regarding the experience of institutional complexity.

The dimension of relations of power serves as mediating aspects of processes of negotiation and social interaction, helping to explain why different responses are given in regarding the experience of institutional complexity. Furthermore, an analysis of the existing literature was made, and no study was identified that examined the direct interplay between power and the heterogeneous responses actors can enact, even though such analytical perspectives have been acknowledged as relevant (Bertels & Lawrence, 2016; Cloutier & Langley, 2013; Hallet & Ventresca, 2006) and power is positioned as central by many institutional researches when discussing social interaction and institutional logics instantiation (Greenwood et al., 2010; Bjerregaard & Jonasson, 2014; Greve & Zhang, 2017), aspects intrinsically related to practices enactment. For that reason, as the main contribution, this study is also significant as it develops an analytical framework by combining important elements that

can be applied in further studies to deepen this issue. It reflects the core assumption of the institutional logics perspective focusing on political factors, such as agency and power, that have been infrequently discussed (Kim et al., 2007).

While this perspective may have influence from resource dependence theory, it is important to ratify they do not equalize themselves. The critical determinant of power for resource dependence view is resource control (Lawrence, 2008). Moreover, although institutional theory recognizes the resource control as a mechanism of power (Ranson, Hinings, & Greenwood, 1980; Hinings, & Greenwood, 1988), it is not restricted to it. Institutional perspective considers coercive and resource-based forms of control, but it also focuses on the symbolic aspects, including social and professional norms, and taken-for-granted assumptions (Lawrence, 2008), that is not necessarily consistent with market exigencies (Greenwood & Hinings, 1996). Therefore, although both theories constitute overlapping domains that can complement each other, they also include non-overlapping areas of interest (Lawrence, 2008; Greenwood & Hinings, 1996), which distinct the focus of the research here to an institutional perspective.

Second, I contribute to the study of institutional logics by also investigating the relationship between multiple logics and practices. Observing the variation of practices enacted can help to understand the influence received from different logics and the carrying dynamic and contingent roles that can lead to both institutional maintenance and change as social systems unfold over time (Colyvas & Maroulis, 2015; Waldorff, Reay, & Goodrick, 2013). Also, as a study gap, practices that are backed by formal rules or legal sanction but are not prevalent - such as normal birth in Brazil -, are rarely studied (Colyvas & Jonsson, 2011), corroborating the theoretical importance of the empiric object adopted.

Finally, I also adopt the logics perspective to augment individual-level analyses emphasizing the possibility of approximation of macro and micro levels of analysis. Despite there is a prominence of institutional logics in recently academia work, institutional researches still lack to acknowledge how conflicts and tensions provided by institutional multiplicity are unfolded and dealt at the micro-level (Pache & Santos, 2010; Smets, Jarzabkowski, Burke, & Spee, 2015; Cloutier & Langley, 2013; Kim, Shin, Oh, & Jeong, 2007), overlooking the ability of individuals and the influence of individual characteristics and backgrounds (Bertels & Lawrence, 2016; Smets et al., 2015). Complementary, Friedland et al. (2014:346) state that studies that rely on individuals as sites in and through which institutional logics are operative have been absent.

In summary, my findings suggest that institutional logics may act at different levels to influence and guide actions but also that this influence is dependent on the support and capability of actors to promote it. Thus, the research suggests that the study of responses to multi-logics field may be incomplete without acknowledging the role of broader relations of power. Focusing attention on how power is balanced and perceived between the actors involved in the field enhance our understanding of under which conditions heterogeneous responses are animated towards institutional multiplicity. This understanding provides the potential for a more integrated and coherent approach to the study of multi-logics field (Lawrence, 2008).

Besides those, this research also matters for practical reasons. Particularly, it addresses as the empirical investigation to a Brazilian public health problem, the high incidence of caesarean and the intense difficulty of the emergence of a natural pattern, which is dominant in most countries of the world. In a civil lawsuit filed by the Federal Public Prosecutor's Office, a renowned obstetrician reinforced the importance of this issue by addressing it as the "*astounding rate of Brazilian Caesarean section*". According to him:

> what scares us is finding that in high-risk obstetric centres in first world countries, where legal implications of neonatal and obstetric complications are costly for the physician, the incidence of the caesarean section is around 15%, while in our midst, even in low-risk pregnancies, we reach close to 100% (MPF, 2010, p.3).

In this sense, when observing that this scenario has extrapolated so much in Brazil, especially in relation to other countries, it underpins the relevance of the present study, that is, in understanding why more interventionist practices are so strong in Brazil and why the natural pattern faces so much resistance to become institutionalized while it is the majority model in most of the world. Hence, comparing and contrasting this context with another country, considered a reference by many Brazilian groups - the English system - may help to understand this scenario. The use of comparative studies that cross international boundaries (Waldorff, Reay, & Goodrick, 2013) contributes to immersion in a different context in order to deepen the understanding of Brazilian barriers.

The high rates of caesarean section and the several incompletely accomplished actions adopted to reverse them, evidence that this issue has been difficult to deal with once it involves high resistance from various interest groups. On the other hand, it is strongly recognized that it is an urgent matter since the excessive use of caesarean, especially without obvious medical reasons, generates greater risks for women and their babies, as well as economic consequences for the country. The costs incurred with caesarean sections are higher than with normal delivery because it requires a longer stay in the hospital and greater use of drugs and other medical

consumables. The difference in costs between them is about 50% higher for caesarean sections (Faúndes and Cecatti, 1991). So, overturn this context also impacts on improving conditions in the country as a whole.

Therefore, the investigation of this empiric object through institutional logics lenses leads to significant implications in theoretical and practical terms. The understanding of how actors respond to institutional logics can help policymakers interpret the forces that shape behaviour in a variety of settings, such as the health care system and hospitals, and thus assists them to design and implement more appropriate regulations (Greenwood et al. 2011), and predict outcomes (Besharov & Smith, 2014), that may indeed reverse the Brazilian scenario.

Finally, regarding the structure of this thesis, it is configurated around six parts. In addition to this first introductory section, the next one presents the theoretical background that supported the main assumptions of the study, as well as allowed developing the theoretical research questions that were evaluated from the empirical data. The main discussions carried out in the second part refer to the analytical categories here studied: multi-logics field, practices, and relations of power. Still, at the end of the section, these topics were conjugated to elaborate two main theoretical research questions that directed this study and the propositions further proposed. They were drawn on a variety of cognate literature previously discussed in the section.

The third section describes the methodological procedures adopted in order to enable the collection, analysis, and description of the empirical data and its relationship with the framework formulated from the considerations developed in the second one. The objectives proposed were pursued through predominantly qualitative methodological strategies with quantitative descriptive data in support. In the fourth and fifth sections, I present the main findings and discuss the implications of those, answering the empirical and theoretical research questions proposed. Lastly, I introduce some concluding points and point limitations of the research and suggestions for future studies.

Taken together, it is expected that this research represents a contribution not only to the analysis of the institutional logics in the process of relationship between relations of power and the practices enacted in multi-logics field but also to the discussion of the Brazilian maternity care that has shown difficulty in obtaining improvements in the face of several initiatives. Lastly, it is also expected that the answers obtained to the central question of the research allow highlighting the validity of the discussions made and with this, to further new studies so as to deepen its implications in this and other academic fields.

# 2 THEORETICAL BACKGROUND

In this section, I examine existing research that can provide insight into the role of relations of power in the enactment of practices in multi-logics field, in order to develop in more detail, the research questions that guided this study. To do so, I first draw on the literature on institutional logics, which provides a detailed understanding of the concepts of multi-logics fields and practices. I then draw on existing literature on power, which provides a basis for conceptualizing relations of power and provides a set of dimensions to consider in terms of its effects on the adoption of practices in multi-field logics.

## 2.1 PRACTICES IN MULTI-LOGICS FIELDS

### 2.1.1 Multi-Logics Fields

To explore why the heterogeneity of practices happen in multi-logics field, I first review the existing knowledge on multi-logics fields rooted in institutional logics perspective. Central to the concept of multi-logics fields is the understanding of institutional complexity which highlights the constraints and opportunities to access alternatives to institutionalized practices. In this sense, there are three key issues that I will highlight here: the understanding of institutional logics and institutional complexity concepts and from that how can we comprehend multi-logics field; the refraction of these phenomena into fields (the relationship and condition); and the implications and the challenges of a field with multi-logics from the existing research.

Initially, an understanding of multi-logics field first requires a conception of institutional logics. Institutional logic has become a dominant perspective in organizational institutionalism providing a theoretical lens that enables the integration across ideas and approaches (Micelotta, Lounsbury, & Greenwood, 2017). Friedland and Alford (1991) were one of the first authors to systematically deal with its concept. For them, logics, defined as sets of material practices and symbolic constructions, are the organizing principles made by organizations and individuals. More recently, Friedland and colleagues (2014) extended this concept, defining institutional logics as an order of production that unifies objects, subjects and practices in sets whose referentiality is internal. That is, orders in which an institutional substance is constantly enacted by the institutionally oriented practices themselves.

In this thesis, I adopt the concept of Thornton, Ocasio, and Lounsbury (2012:2) who describe institutional logics as "the socially constructed, historical patterns of cultural symbols and material practices, including assumptions, values, and beliefs, by which individuals and organizations provide meaning to their daily activity, organize time and space, and reproduce their lives and experiences". Institutional logics, in this way, represent sets of expectations for social relations and behaviour (Goodrick & Reay, 2011), that shape organizational structure, action, and beliefs (Bertels & Lawrence, 2016). Its perspective provides an integrative lens for analyzing the interrelationships among institutions, individuals and organizations behaviours occurring at multiple levels of analysis with potential for cross-level interaction effects (Micelotta, Lounsbury, & Greenwood, 2017; Thornton, Ocasio, & Lounsbury, 2012). This means that we can comprehend individuals and organizations as inserted in a wider interinstitutional system being influenced by its context.

Thus, through these lenses, it can account for multiple social locations in an interinstitutional system. Actors are conceived at higher-order levels - individual, organizational, societal - which causes institutions to be in conflict since multiple logics become available to individuals and organizations (Friedland & Alford, 1991). When a multiplicity of simultaneously interdependent and contradictory institutional logics encounter, Greenwood and colleagues (2011) address it as institutional complexity. This exposure generates challenges and tensions that over the time unfold and create different circumstances to which organizations must respond.

By drawing on these concepts, multi-logics fields can be characterized by fields exposed to institutional complexity, that is, to "incompatible prescriptions from multiple institutional logics" (Greenwood et al., 2011:317). Fields here refer to the totality of different and interdependent actors who constitute a recognized area of institutional life (DiMaggio & Powell, 1983). It represents the domain in which participants partake shared meaning system and interact more frequently with each another than with actors from outside (Scott, 1995:56).

The focus on fields supports a mean of understanding the rationalization process of its participants as sites where the interaction processes happen (Wooten & Hoffman, 2017). One of its salient features is that participants share a common meaning system (Quirke, 2013), and their actions in a field are influenced and guided by organizing principles (Scott, 1995; Friedland & Alford, 1991; Thornton, Ocasio, & Lounsbury, 2012) culturally-rooted for action (Battilana, Besharov, & Mitzinneck, 2017).

While the prevalence of institutional logics multiplicity in fields is clearly recognized by researchers, a second important point to consider is that the implications on this on the

organizations have still been confusing. Multiple logics are unlikely to be equally central (Besharov & Smith, 2014). While primary logics have a dominant influence on the organization's objectives and practices, minority logics play a lesser role in informing those aspects (Perkmann, McKelvey, & Phillips, 2018), although still important and impactive. Aiming to explore this research lacuna, Besharov and Smith (2014) propose a theoretical framework to delineate the types of logic multiplicity in organizations. They draw four different types considering two critical dimensions: the degree of logic centrality and the logic compatibility as illustrated in Figure 2.

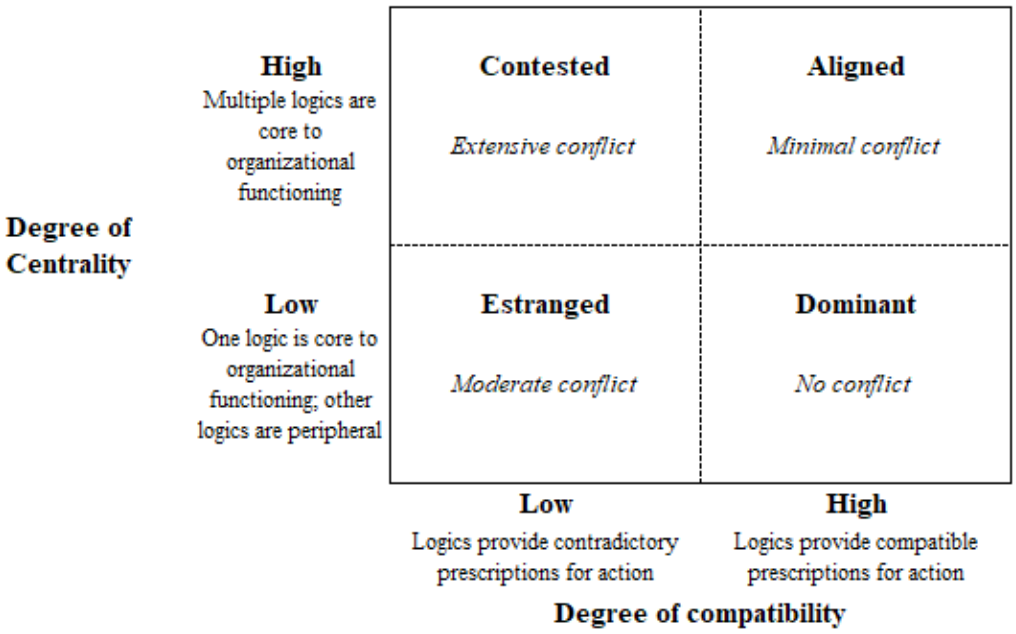


*Figure 2.* Types of Logic Multiplicity.
Source: Besharov and Smith (2014:371).

The degree of logic centrality addresses the extent to which the multiple logics are core to the organizational functioning. When the field is characterized by a higher centrality, multiple logics are instantiated in core organizational features and, as a result, there is a higher dispute. On the other hand, in a lower degree, a single logic is central whereas others manifest in peripherical activities. Consequently, there is less ambiguity and complexity in relation to which logic will mainly guide. The logic compatibility, in turn, refers to the extent to which those logics provide consistent prescriptions for action. A low degree of compatibility means that inconsistent implications are faced, generating higher confront and competing expectations, while a high degree of compatibility indicates consistent goals for action (Besharov & Smith, 2014).

The interaction of different levels of logic's centrality and compatibility implicates that organizations face different levels of conflict and four ideal types of logic multiplicity. Contested organizations exhibit multiple logics with high centrality and low compatibility, facing extensive conflict in disputing the core of the organization. The second type, estranged organizations, embodies multiple logics with low centrality and low compatibility, resulting in a moderate conflict since differences are resolved in favour of the dominant logic. Aligned organizations, in turn, instantiate logics with high centrality and compatibility, hence as the core of the organization is united, conflicts are likely to be minimal. Finally, dominant organizations instantiate one central logic, low centrality, but logics are highly compatible, so limited or no conflict arises from logics multiplicity (Besharov & Smith, 2014).

Thus, multi-logics fields enable different circumstances in which the interdependent actors must respond (Greenwood et al, 2011). Such responses are conceptualized and acted upon alternative views of rationality (Thornton, Ocasio, & Lounsbury, 2012) from different scenarios (Besharov & Smith, 2014). My interest in multi-logics fields here is to understand how these social-cultural orders influence on how actors behave in response when the shared systems of meaning provide inconsistent expectations. When these fields are embedded in multiple and concurring institutional logics, this may cause its participants to be in conflict since multiple orders become available to individuals and organizations (Friedland & Alford, 1991; Greenwood et al, 2011). As a result, the field's members dynamically interact to reconcile the contradictory institutional arrangements (Seo & Creed, 2002).

Due to this concurring aspect, initially, this institutional complexity was considered problematic with a large emphasis on the conflicts between contradictory logics. Generally, previous studies on institutional complexity tended to highlight tensions between contradictory logics, often suggesting a struggle when dealing with competing demands (Oliver, 1991, Pache & Santos, 2010). The relationship between logics was mostly treated through aspects of domination and succession. Multiple conflicting logics exist until a prevalent logic was substituted by another (Thornton & Ocasio, 1999; Dunn & Jones, 2010). Alternatively, studies are addressing desirable and beneficial aspects of one positively affecting the other (Smets et al., 2015).

Recent work has extended this direction, showing cases of coexistence (McPherson & Sauder, 2013), in which the multiplicity of logics endures for a long period and can provide opportunities (Reay & Hinings, 2009; Nicolini et al., 2016; Greve & Zhang, 2017). Such endurance could be manifested through merging different viewpoints, as cases of blending (Binder, 2007) and hybridization (Battilana & Dorado, 2010), or yet by each order promoting

its own values and practices (Greve & Zhang, 2017). Also, studies have extended the focus on dominant logics (Lounsbury, 2007) to nondominant logics (Goodrick & Reay, 2011) and newly emergent ones (Bertels & Lawrence, 2016), evidencing efforts of collaboration and complementarity among the plurality of logics, from local negotiations.

Researches on multiple logics have also been conducted in a varied of fields, including health care (Reay & Hinings, 2009; Dunn & Jones, 2010; Nigam & Ocasio, 2010; Goodrick & Reay, 2011); financial sector (Lounsbury, 2002, 2007; Marquis & Lounsbury, 2007); education (Thornton & Ocasio, 1999; Thornton, 2002; Bertels & Lawrence, 2016); music (Glynn & Lounsbury, 2005); manufacturing (Greenwood et al., 2010); chemical industry (Hoffman, 1999); and corporations (Lok, 2010). These studies have brought forward the relationships and dynamics among the logics and the field (Goodrick & Reay, 2011; Waldorff, Reay, & Goodrick, 2013). The type of field has also been recognized in relations to logics endurance. Some fields are accepted to lean towards institutional multiplicity (Greenwood et al, 2011). The health sector, focus of this research, is one of them (Reay & Hinings, 2009; Goodrick & Reay, 2011; Waldorff, Reay & Goodrick, 2013). This field involves delivering professional services provided by a huge variety of occupations which tend to be motivated and conditioned by different logics (Greenwood et al, 2011), hence pushing to institutional complexity.

For example, in the context of a medical school, Dunn and Jones (2010) studied the question of endurance. According to the authors, this profession resides at the interstices of two different logics that coexist and co-evolve with the profession. There is a science logic - which focuses on the knowledge of diseases, research and innovative treatments -, and a health care logic – focusing on the skills to treat patients and improve health conditions. Over time these plural logics fluctuate, moving through periods of balance and imbalance and creating dynamic tensions on how to carry medical education (Dunn & Junes, 2010).

Nicolini, Delmestri, Goodrick, Reay, Lindberg and Adolfsson (2016)'s study also looked at the institutional logic's multiplicity in the health field. The authors focused on what happens to institutional arrangements when dealing with ongoing conflicts between competing logics. The study examined historical changes in the ownership and control of pharmacists in four different countries, the UK, Italy, Sweden and the USA, and found out that even though tensions among conflicting logics can be temporarily solved, institutional arrangements can reflect the heterogeneity of logics without necessary resulting in logics' hybridization or dominance.

Finally, from these studies, an also important stream of research "foregrounds the dimension of agency that is required for the combination of logics at the field level" (Nicolini

et al., 2016:244). Greenwood and colleagues (2011) point that researches on the enduring field-level complexity, that is, on multi-logics field, has been increasingly interested in the implications it causes for individual actors. And, according to the authors, this interest places in two main lines of research. The first focus on the different strategies that organizations adopt to respond to institutional multiplicity, such as how organizations tend to respond when face institutional complexity (i.e. Oliver, 1991; Pache & Santos, 2010). The second focus on how the institutional multiplicity are reflected into practices, looking at the outcomes of institutional complexity (Greenwood et al., 2011), such as institutional change driven by practices in the everyday work of individuals (Smets, Morris, & Greenwood, 2012), and creation of hybrid organizations (Battilana & Dorado, 2010). My interest lies in the second.

The plurality of logics enables and directs to divergence and multiplicity responses to environment pressures (Pache & Santos, 2010; Lee & Lounsbury, 2015; Greenwood et al., 2011), and to the influence that logics have on individual and group behaviour within and among organizations (Lounsbury & Boxebaum, 2013). However, since this influence is latent but not always manifest, and considering different types of multiplicity, organizations experience it differently and in different degrees at a particular point in time. Institutional processes in the field are filtered and promulgated differently, which, in turn, leads to differences in prescriptions among the diverse institutional logics (Ocasio & Radoynovska, 2016; Greenwood et al., 2011).

Despite recognized that multi-logics field leans institutional complexity emergence (Greenwood et al., 2011; Battilana, Besharov, & Mitzinneck, 2017), the resulting responses towards it are "largely structural" (Smets & Jarzabkowski, 2013:1283) implying agency reflection (Bertels & Lawrence, 2016) and institutional work (Lawrence & Suddaby, 2006; Smets & Jarzabkowski, 2013; Nicolini et al., 2016). However, institutional approaches usually account individual agency towards logics complexity over-simplistic, as an automatic selection for the favourable alternative, overlooking cases in which responses are developed (Smets & Jarzabkowski, 2013), thus lacking to explain the reflection of institutional multiplicity into logics from internal negotiation and social interaction.

Therefore, the institutional logics perspective stands out by allowing to reexamine pathways which in large measure remained attached to central issues as isomorphism, homogeneity (Greenwood, Hinings, & Whetten, 2014) and institutions as independent variables. The core interested in institutional theory has mainly been directed to organizations compliance with social expectations in the search for social legitimacy. This resulted in institutional phenomena reflected in stability and inertia (DiMaggio & Powell, 1983;

Greewood & Hinings, 1996), with individual forces seeming to push the field to homogenization (Smets. Aristidou, & Whittington, 2017).

On the other hand, institutional logics approach develops the possibility of divergence regarding predominant patterns through multiple and varied responses to institutional pressures, usually as result from multi-logics field (Pache & Santos, 2010; Greenwood et al., 2011; Lee & Lounsbury, 2015; Ocasio & Radoynovska, 2016), being in this sense, enriching lenses to comprehend the heterogeneity of practices within a field. Therefore, looking at multi-logics fields allows examining not only an aggregation of influential actors but especially a centre of negotiation and discussion. It brings together members with different purposes and perspectives interacting (Wooten & Hoffman, 2017) to negotiate competing logics.

### 2.1.2 Practices

In relating to institutional logics perspective, one of the key questions to comprehend how logics work, addresses to how these organizing principles are actualized into actor's practices (Smets, Aristidou, & Whittington, 2017). By practices, I mean the repetitive performance actors do that allows particular actions to become recurrent, habitual or routinized (Jarzabkowski, 2004). Although symbolic constructions (Friedland & Alford, 1991), values and beliefs (Thornton, Ocasio, & Lounsbury, 2012) are pointed as crucial to institutional functioning, institutional logics do not necessarily require an explicit belief, they are based on actualizing the practices of its practitioners (Friedland et al., 2014).

Practices are described as "patterns of activities that are given thematic coherence by shared meanings and understandings" (Smets, Morris, & Greenwood, 2012:878). They refer to "forms or constellations of socially meaningful activity that are relatively coherent and established (…) and informed by wider cultural beliefs" (Thornton, Ocasio, & Lounsbury, 2012:128). So, despite they may seem trivial, due to its meanings they evidence how activities should be done, being characterized in this sense, as material enactments of institutional logics (Friedland, 2014; Smets, Morris, & Greenwood, 2012; Sahlin & Wedlin, 2008).

This view aligns with traditional perspectives that describe practices as "embodied, materially mediated arrays of human activity centrally organized around shared practical understanding" (Schatzki, 2001:11). As viewing practices as an embodiment, it states that both the sharing values and the activities are constituted within practices. Hence, reflections on the incarnation of institutional logics in organizational forms (Haveman & Rao, 1997), or its instantiation, have brought, according to Smets, Aristidou and Whittington (2017), increasingly

focus on the practice perspective by institutionalist researches (Lee & Lounsbury, 2015; Lounsbury & Boxenbaum, 2013; Reay, Goodrick, Casebeer, & Hinings, 2013b; Smets et al., 2012).

The adoption of the practice perspective permits to focus not only on the sole actions, but also on the actors involved and on what they do from the social constructions and sharing within a specific context (Smets, Aristidou, & Whittington, 2017; Jarzabkowski, Smets, Bednarek, Burke, & Spee, 2013; Schatzki, 2001). It presents a situated, relational and enactment aspects. First, it is situated in the sense that all action is located within a wider social context. Practice focuses on producing and reproducing the dynamics of a specific context (Jarzabkowski, Smets, & Bednarek, 2013) that makes sense in a particular situation. And in examining that, it also highlights the relations of the elements involved, the relational aspect. Practice, actors and structure are interconnected in a continuous relation of reciprocity (Smets, Aristidou, & Whittington, 2017; Friedland et al., 2014; Thornton, Ocasio, & Lounsbury, 2012). The understandings of the practitioners influence on what and how the actions they select as adequate will be performed in the given situation (Smets, Aristidou, & Whittington, 2017). Finally, central to that is the idea of practice as the ongoing locus of production and reproduction of these relations (Østerlund & Carlile, 2005; Feldman, & Orlikowski, 2011). Practice consists of the material enactments of shared beliefs (Friedland, 2014; Thornton et al, 2012), in which the social is embodied (Schatzki, 2001).

Practice perspective is considered a broad intellectual area with diverse applications. But, in a general way, Feldman and Orlikowski (2011) defend three core principles that are relatively common within scholars. Firstly, practice is described under a consequentiality theorizing, that is, situated actions are consequential in producing social life (Feldman & Orlikowski, 2011). Everyday actions follow as an important effect in the production of practice, it is the engagement of the action that results in an effect and in the achievement of an outcome (Lawrence & Suddaby, 2006).

Scholars vary in how and what outcomes results in a consequence. Giddens (1984), for example, argues that social practices are recursively produced and reproduced in interaction with social structures. Smets, Morris and Greenwood (2012) evidence that over the course of practice improvisations and everyday work of individuals, field-level change can be originated, another alternative that extant research has neglected. For Bourdieu (1989, 2007), social fields constitute a space of objective relations, in which there is competitiveness by domination, and the positions are causes and at the same time results of the habitus, according to what it indicates about the class and the subclass in which the agent is positioned.

The principle of consequentiality also foregrounds aspects as the strong orientation to human agency (Feldman & Orlikowski, 2011), highlighting intentionality and purposeful actions (Lawrence & Suddaby, 2006; Smets & Jarzabkowski, 2013). Moreover, recently researches call attention to the role of non-human artefacts, such as emerging technologies. The adoption of new devices and technological innovations may trigger disruptive practices and organising processes (Barrett, Oborn, Orlikowski, & Yates, 2012), re-configuring institutional arrangements.

The second principle involves the rejection of dualism over the recognition of the inherent relationship of elements normally treated in a dichotomous way (Feldman & Orlikowski, 2011). The split between subjective and objective views tends to ignore the effects of one in the other, usually assuming them to be analytically separated. These perspectives either lead to focus on the individuals and their action, leaving the social world and the environment where they are immersed unexplored or to take the social structures as external and existing as uniform entities (Østerlund and Carlile 2005). Practice lenses, then, help to overcome the dichotomy between structure and action and by doing that, again, bring agency as central to the institutionalization process (Feldman & Orlikowski, 2011, Østerlund & Carlile 2005, Giddens, 1984). Including a practice view, transcend this opposition and conceive practice as beyond problematic dualisms but as a recursive relationship (Østerlund & Carlile, 2005; Schatzki, 2001; Giddens, 1984).

Related to that, the final principle states a mutual constitution (Feldman & Orlikowski, 2011). The elements of a phenomenon do not exist independently, instead, they are mutually constituted in a recursive relationship, one in relation to the other (Østerlund & Carlile, 2005; Schatzki, 2001; Giddens, 1984). The inherent recursiveness of practice is constructed from the social interaction arising between actor and social institutions (Jarzabkowski, 2004). This recursive nature makes it possible to visualize human activities not as being created by social actors, but as continually being recreated by them through the very means by which they express themselves as actors (Giddens, 1984). No social orders can be understood without involving the actor who produces them, and, in turn, agency also cannot be defined as just human action, but similarly configurated by structural conditions in a dual relationship (Feldman & Orlikowski, 2011).

The study of practice can be conducted in three different ways: theoretical, philosophical and empirical. In the theoretical approach, researches focus on how actions are enacted. The motivation is to comprehend and explain the stablished relations among actor, action and structure. For the philosophical approach, the social world is conceived as socially

constructed by human action through daily activity. Its focus, then, is in the role of practice as the basis for social reality. Finally, by adopting an empirical approach, researches concentrate on the actions employed and recognize the importance of the agency for organizational functioning. Practices, whether routine activities or improvisations, play a central role in the organizational outcomes. Thus, through this lens, the capacity of the human agency in influencing organizational and institutional level is reaffirmed (Feldman & Orlikowski, 2011). My study adopts this approach.

The practice empirical perspective helps to address criticism made regarding the lack of agency within institutionalism studies (Greenwood, Hinings, &Whetten, 2014; Suddaby, 2010; Seo & Creed, 2002). By moving from a macro view on fields and institutions (Meyer & Rowan, 1977; Scott, 1995) towards an emphasis on individuals (Suddaby, 2010; Seo & Creed, 2002), the mutually constitutive relationship among institutions and individuals remained less explainable. The microdynamics involved in how actor's practices interfere in the institutions and their role in both reproduce and change has become less central (Feldman & Orlikowski, 2011). On the other hand, this topic is pointed as critical by being at the core of how organizational order is maintained at individual organizational and inter-organizational field levels (Leblebici, Salancik, Copay, & King, 1991).

Studies have shown that the different types of practices performed may have different implications. Practices enacted by actors might result in the creation, maintenance and change of institutions (Harmon, Green Jr. and Goodnight, 2015; Lawrence & Suddaby, 2006; Maguire, Hardy, & Lawrence, 2004). Lawrence and Suddaby (2006), for example, examined extensive empirically-based institutional researches to illustrate the sediment of institutional work in the existing literature. From this exhaustive overview, they identified different types of practices performed by actors that resulted in creating, maintaining and disrupting institutions.

In the first group, Lawrence and Suddaby (2006) identified that the engagement of ten different sets of practices by actors implicated in the creation of new institutions. These practices reflected three categories of activities. First, the overtly political work of reconstructing rules, property rights and boundaries, which grant access to material resources, being divided into vesting, defining and advocacy practices. Second, the reconfiguration of actors' belief systems, represented by constructing identities, changing norms and constructing networks practices. And, lastly, practices such as mimicry, theorizing and educating, that changed abstract categorizations and, consequently, the boundaries of meaning systems.

In the second group, the authors focused on practices that actors engaged in that resulted in the maintenance of institutions in organizational fields. According to them, this type of

practices has received less attention from scholars as the issue of maintaining institutions can often be taken as an automatic mechanism. However, they argue that, on the contrary, it is just as important as the other groups given that self-reproducing hardly consists of automatic mechanisms, instead it involves the support, repair or recreation of social mechanisms to ensure compliance, thus, the maintenance of institutions. Hence, by reviewing the empirical institutional literature, Lawrence and Suddaby (2006) present six different types of practices, three that ensure adherence to rule systems: enabling, policing and deterring; and three that focus on reproducing existing norms and beliefs systems: valourizing/demonizing, mythologizing, and embedding and routinizing.

Finally, in the last group, Lawrence and Suddaby (2006) identified practices aimed at disrupting institutions. According to the authors, not always actors have their interests served by the existing institutions. As a result, actors can often engage in practices that attack or undermine the mechanism the lead to institutional compliance. The authors identified three different sets of practices: disconnecting sanctions, disassociating moral foundations, and undermining assumptions and beliefs. Such practices involve both engaging through state apparatus and the judiciary to invalidate previously powerful institutions or disconnect rewards and sanctions, and to disassociate the practices from the moral foundations of institutions and the costs and risks of replacing existing templates, innovating and differentiating.

Still looking at the macro and microdynamics, the study of Reay and Colleagues (2013a) analysed how practices are created from new ideas. The authors found out that macro and micro-level processes are critical and interdependent. So, in order to the institutionalization of new practices be accomplished, they need to be connected. Also, through these processes, the manager plays a fundamental role in connecting the levels. According to the authors' proposed model, the transformation of new ideas into practice happens through three phases: micro-level theorizing; encouraging 'trying it'; and facilitating collective meaning-making. The managers, then, have an important role in connecting the macro theorizations of teamwork to the micro-level of front-line professional into micro-theorizing. They translate the ideas through framing and justifying the new practices in relation to local circumstances. Following this phase, the creation of new practices is accomplished when managers focus their efforts on encouraging professionals to change their behaviour and try the new practice. By doing that, managers facilitate individuals to de-habitualize established behaviours and develop their own new meaning of the new practice as they tried doing it.

Under this perspective, institutional logics researches also looked at practice change and variation. In the study of Bertels and Lawrence (2016), the authors identified two other

dimensions along which practices varied. The first dimension reflects the forms of action, how actors instantiated the logics into their actions. They distinguished between actions that involved predominantly a discursive nature from those that put more effort in terms of practical action. Thus, when actors addressed institutional logics mostly through talk or text, it constituted a discursive practice, whereas, when they included more effortful, practical and explicit action, it configures as a practical action. In the second dimensions, the authors differentiated the practices by the scope of action in which actors engage. They distinguished between confined practices, when actors' action restricts the impact of the involved issued on other issues or practices, and expansive practices, when actions increase connections between the issue itself and other issues and practices.

Within these findings, one value contribution of the authors' research is that the variation of practices is affected by individuals in organizations. Both dimensions of practice variation were influenced by individuals' characteristics, which Bertels and Lawrence (2016) distinguished as surveillance and individual biographies. The first group refers to the level of external surveillance which creates visible performance gaps. Exposition to higher levels of external surveillance surfaced performance gaps that trigger sensemaking on actors to incorporate more practical actions. In opposition, lower levels triggered more discursive actions. In turn, individual biographies of actors involved prior family history, personal and professional experiences which contribute to the actors' identification to an institutional logic. Hence, they can fuel the actors' willingness to engage or not to political actions, consequently leading to more confined or expansive practices.

Looking across the extant literature, therefore, we can state that adopting a practice perspective has significantly potential to contribute to institutional theory (Lawrence & Suddaby, 2006; Smets, Aristidou, & Whittington, 2017), especially in theorizing institutional maintenance and change (Colyvas & Maroulis, 2015; Waldorff, Reay, & Goodrick, 2013; Feldman & Orlikowski, 2011). Practice interconnects actor, action and structure as the central unit of analysis, so that such elements exist in a reciprocal relationship of constant interaction (Smets, Aristidou, & Whittington, 2017; Jarzabkowski, Smets, & Bednarek, 2013; Smets, Morris, & Greenwood, 2012), enabling the dynamics of macro and micro level of analysis.

### 2.1.3 Practices in Multi-Logics Fields

An important but under-examined issue within institutionalism and practice streams is the understandings of the conditions under which different outcomes arise (Besharov & Smith,

2014:365). Until recently, institutional logics scholars tended to ignore how actors translate institutional logics into practices and how these micro-level activities in turn impact on the organizational structures' reproduction or change (Currie & Spyridonidis, 2016). It was also underemphasized actors and their interests in regard to institutionalized practices (Goodrick & Salancik, 1996). More specifically, in regards to multi-logics fields, even though it is agreed that coexisting logics can have more permanent relationships (Reay & Hinings, 2009; Nicolini et al., 2016; Greve & Zhang, 2017), the consequence of these relations into practice has not been well explored.

Practices are usually conceived to be aligned with one logic, not both of the relevant logics presented in the relationship in multi-logics fields. Deepen into these aspects, thus, is indeed important since practices reflect the actualization of logics, that is, their incarnation into organizational forms (Haveman & Rao, 1997). According to Lee and Lounsbury (2015:847), "values and associated beliefs are not free-floating; they are concretely instantiated in the practices and patterned behaviours of actors who act as carriers of logics in specific contexts". It follows that are those organizational forms that actualize and materialize the same institutional logics that provide legitimacy to organizations (Haveman & Rao, 1997). Looking at the practice, then, develop a better understanding of the proliferation of institutional logics (Smets, Aristidou, & Whittington, 2017).

Also consistent with the institutional approach, practice perspective takes the field as the location of the social, where the material practices are organized around shared beliefs (Schatzki, 2001; Lawrence & Suddaby, 2006). According to Schatzki (2001), the field is the space where practices and all the related components connected to them - meaning, knowledge, human activity, social institutions and transformations- occur. And, by treating it as central, enables to connect micro and macro look, previously pointed as fundamental in institutional researches. Practices allow values to cross from the field to organizations and individuals and vice and versa, in a sense that more peripherical practices can be accumulating and diffusing values to all the field (Smets, Morris, & Greenwood, 2012).

The alignment of the approaches grants the possibility to examine within the processes and to analyse the interaction and negotiation of elements through which social order is created, reproduced or changed (Lawrence & Suddaby, 2006; Smets, Aristidou, & Whittington, 2017). Especially, mainly in the face of competing understandings (Jarzabkowski, Smets, & Bednarek, 2013) - multi-logics field, to investigate how the shared understandings are produced (Schatzki, 2001) and selected (Feldman & Orlikowski, 2011) from the multiple prescriptions, resulting in

a heterogeneity of practices. And, simultaneously, encompassing the macro and micro levels of analysis. Figure 3 aims to present this approximation.

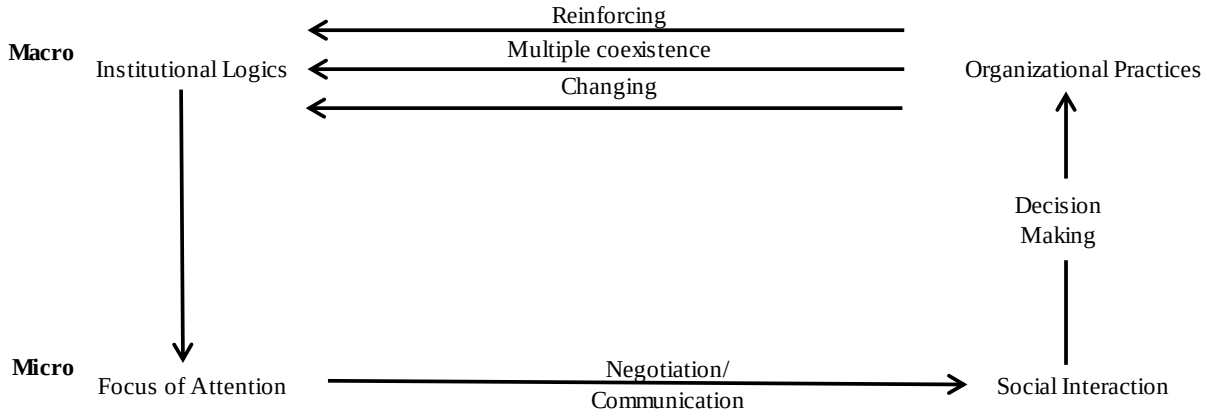


*Figure 3.* Macro-micro model for analyzing institutional logics
Source: Adapted from Thornton, Ocasio, and Lounsbury (2012:85).

Institutional logics, at a macro perspective, represent frames of reference that influence how rationality is perceived, cognition is structured, and decisions are made by actors. Consequently, they shape the focus of attention of actors (Thornton, Ocasio, & Lounsbury, 2012; Lounsbury, 2007). Following to a micro perspective, the focus of attention, in turn, activates some characteristics of the actors, which reflects the dynamics between actors and institutional logics (Thornton, Ocasio, & Lounsbury, 2012; Ocasio, 1997). Institutional logics act as a trigger that leads to a local process of interpretation and influences the corresponding action. However, inasmuch as institutional logics influence and shape how actors perceive, assess and respond to environmental pressures (Almandoz, 2014; Pache & Santos, 2010), actors adopt institutional logics in their organizational practices (Lounsbury & Boxenbaum, 2013).

The selection of practice is influenced by processes of negotiation and communication among contesting interest groups. In order to decide how institutional forms will be enacted, actors socially interact with each other. The enactment of institutional logics as materially practices are actively negotiated and experienced through social interactions (Hallet & Ventresca, 2006; Thornton, Ocasio, & Lounsbury, 2012; McPherson & Sauder, 2013), through which actors communicated and negotiate their preferences in corresponding to the multiple logics available. It is through these processes that actors interpreted institutional demands and carry the underlying meanings. Consequently, variations in practices may happen as these processes run through between actors embedded in different logics (Goodrick & Salancik, 1996; Bjerregaard & Jonasson, 2014; Greve & Zhang, 2017).

Hence, the model highlights the process in which institutional logic provides cognitive and symbolic constructs for actors to employ into social interactions which in turn has also an effect on the dynamic of institutional logics multiplicity. The enactment of diverse practices allows the reproduction of automatic behaviours taken as certain, which, consequently, can reinforce the dominant logic (Thornton, Ocasio, & Lounsbury, 2012). It also opens opportunities for institutional change (Thornton & Ocasio, 1999), modifying institutions, or yet allowing the coexistence of multiple logics (McPherson & Sauder, 2013, Reay & Hinings, 2009, Nicolini et al., 2016) by the creating of new forms of organization (Battilana & Dorado, 2010), driving institutional change (Smets, Morris, & Greenwood, 2012; Dunn & Jones, 2010), or altering institutional arrangements and its potential reversibility (Nicolini et al., 2016).

However, when looking at multi-logics fields, it still lacks a more deepen understanding into how actions can be both constrained and yet at the same time facilitated (Waldorff, Reay, & Goodrick, 2013), whether the coexistence leads to the emerge of hybrids or to stability (Nicolini et al., 2016), and how it is translated in stability for actor in their daily work (Reay & Hinings, 2009), that is, how the conflicts of multiple and contractions prescriptions result into practice. Ocasio and Radoynovska (2016) also argue that the effects of institutional complexity and pluralism on organizations' strategic choices have been underexploited.

While focusing on a dominant logic highlights how logic constraints actors' behaviour, the focus on multiple logics expand this vision by providing understanding on how the agency can be both constrained and facilitated simultaneously. Institutional contradictions can trigger change in actors' cognition and open alternative logics of action (Seo & Creed, 2002). This increases attention towards social actors (Waldorff, Reay, & Goodrick, 2013) and the way they instantiate those logics into practices (Lee & Lounsbury, 2015) since the focus is then how actors deal with these contradictions and what and how institutional logics multiplicity are instantiated.

Given that these sharing meanings are not necessarily consensual, multi-logics fields can be conceived as spaces of strategic action where actors relate and negotiate to each other (Wooten & Hoffman, 2017). Under these conditions, strategic organizational commitments to logics become subject to reinterpretation and (re)framing. Organizations adopt particular interpretations of the contradictions among logics to which they previously made a commitment (Ocasio & Radoynsvk, 2016). And these interpretations are not likely to be uniform.

The study of Reay and colleagues (2013b) evidences this. The authors investigated eight Primary Health Care innovation sites in Canada that were set up to change from an independent,

physician-focused model to a model of interdisciplinary care provided by a team approach. According to their findings, only five sites changed their professional practices despite all of them had operated in the same context, started the process at the same time, were funded in the same way, and managed under the same structure. The authors identified that change occurred only in the sites where managers explicitly facilitated behaviour change by engaging action strategies instead of only verbal support for the new practices.

When these managers designed strategies that made the new behaviour the easiest alternative, they provided a framework that helped the change of behaviour by physicians. These active efforts were fundamental to legitimation as connected theorizing the new ideas with actually trying it, which were core to disrupt the relationship between the old established practices and the institutional context that supported them. On the other hand, in the sites where physicians did not identify any effort to try the new practices, they continued to act according to the previous model of care (Reay et al., 2013b).

Therefore, practice builds from process thinking (Østerlund & Carlile 2005). Experiencing these contradictions makes actors aware of alternative institutional arrangements or yet to reflexive processes to might consider alternative possibilities (Smets, Aristidou, & Whittington, 2017). It enables a new look, moving forward to aspects of improvisation and innovation, as actors explore the sets of values, beliefs, and practices into new combinations (Bertels & Lawrence, 2016; Smets et al., 2015). These broader possibilities highlight not only the variation in the way actors respond to institutional plurality, but also the potential for institutional logics to be constructed and instantiated into practices divergently. In this way, responses to institutional complexity are no more considered to focus on meanings of one or other logic but are the subject of local negotiations (Bertels & Lawrence, 2016).

Yet, how the modes of the agency are unfolded through the process thinking are still lacking empirical understanding (Smets & Jarzabkowski, 2013). Not all actors adhere to and support their logics with the same insistence and demand for compliance, nor are they able to (Greenwood et al., 2011). The key point here is to highlight that despite it is reckoned that the agency influences the variation in how multiple logics become instantiated, the motivation and capability of social referents to enforce their demands have varying degrees of influence (Besharov & Smith, 2014; Ocasio, 1997; Wright & Zammuto, 2013).

The way institutional logics are incarnate (Haveman & Rao, 1997) depends on how actors make sense of, interpret and enact institutional prescriptions (Lee & Lounsbury, 2015; Greenwood et al., 2011; Binder, 2007; Hallett & Ventresca, 2006), in a sense that the processes thinking are built on clusters of differences and dependencies, and asymmetrical relations

(Østerlund & Carlile, 2005). In this thesis, in alignment with Østerlund and Carlile (2005), I propose that a helpful tool for identifying these differences is the relations of power (Ranson, Hinings, & Greenwood, 1980; Bjerregaard & Jonasson, 2014; Greve & Zhang, 2017), discussed in the following topic.

## 2.2 POWER AND PRACTICES IN MULTI-LOGICS FIELDS

In order to understand why there emerges a heterogeneity of practices in multi-logics fields, I focus on the role of power. Many studies on responses to institutional complexity conceive actors as unitary lacking to insert them in a wider context, subject to institutional dynamics in filtering and resolving conflicts (Pache & Santos, 2010). My research tries to fill this gap and examine practices into a larger dynamic within institutional multiplicity. I argue that one way to understand the heterogeneity of practices in multi-logics fields is by paying attention to the relations of power that mediate the interaction among disparate actors. By examining interactions among diverse groups of actors in a field, it provides a contributing lens to understand the pluralism in meanings that untangle in convergence or struggles over meanings from contested states (Leibell, Hallet, Bechky, 2018).

Thus, to do so, I organized this topic in two main steps. In the first, I review theories of power, highlighting different ways power can be expressed and can mediate interaction among actors, hence, stressing some of its dimensions that underpin the empirical investigation. I then apply these theories of power to my question, asking how do relations of power shape the adoption of practices in multi-logics field. Here, there are three main issues I want to highlight. First, I discuss how multi-logics fields are linked to power dynamics, being configured as arenas of power and evidencing why it is important to research their connection. Second, I highlight how the selection of practices as a result from the local negotiations of multiple logics is mediated by the actors' capacity to defend and impose their logics and preferences, putting forward the macro and micro interrelationship of analysis. Third, I focus on how these outcomes have a corresponding effect on the dynamics of the multi-logics field. Finally, I present the theoretical research questions that guided this study and that I aimed to advance to the so-far literature on institutional logics and practice perspectives.

### 2.2.1 Power

Although it has not been examined directly in the study of institutional logics, looking at the literature on power, it suggests that power relations have influence on social interaction and decision making (Lukes, 1974; Clegg, Courpasson, & Phillips, 2006; Emerson, 1962), processes that, as discussed in the previous section, are central to the logics instantiations and practice enactment (Thornton, Ocasio, & Lounsbury, 2012). The critical reason to connect relations of power to practices in multi-logics field is that scholars recognize that power and agency have effect in institutions (Lawrence & Suddaby, 2006; DiMaggio, 1988). Literature does offer insights into the way practices are enacted and influenced by actors who present different levels of influence, assumptions that refer to power (Avelino & Rotmans, 2009). Yet institutional understandings of how power operates remain largely ignored (Cloutier & Langley, 2013, Munir, 2015). Therefore, in this section, I focus on existing literature on power to provide a detailed understanding of its implications on multi-logics fields' practices.

It is well acknowledged that power is an element imbricated in the various modes of social relations (Emerson, 1962; Lawrence, 2008), being portrayed in such different contexts, that is hardly managed to be comparable (Dahal, 1957). Power reflects the motivation and capability to obtain the outcomes that are desired, that is, to enforce one's preferences (Etzioni, 1964; Salancik & Pfeffer, 1978; Ranson, Hinings, & Greenwood, 1980; Greenwood et al., 2011; Kashwan, 2016). It is related to the expression and defence of interests (Ranson, Hinings, & Greenwood, 1980; Salancik & Pfeffer, 1978); the ability to provoke the acceptance of orders (Etzioni, 1964); the control of scarce critical resources and the placement of allies in key positions (Salancik & Pfeffer, 1978); and consequently the struggles, decision making and affectability to strategic decisions (Child, 1972; Lukes, 1974; Ranson, Hinings, & Greenwood, 1980; Bjerregaard & Jonasson, 2014; Greve & Zhang, 2017). Hence, concepts of power range from an actor-specific resource, related to the self-interest pursuit, to the capacity of a social system to achieve collective goals (Avelino & Rotmans, 2009).

Despite the dynamics of power has been addressed in many researches (Pemer & Skjølsvik, 2016; Wry, Cobb, & Aldrich, 2013; Casciaro & Piskorski, 2005; Pfeffer, 1981), in much of the work on organizations its theme has not been at the forefront of interest (Clegg, Courpasson, & Phillips, 2006). Its focus has been broad and diverse (Dahal, 1957), its concept is hard to define and have been neglected and trivialized among many organizational discussions (Clegg, Courpasson, & Phillips, 2006). Also, it is still lacking a clear empirical

understanding of how actors, at micro level, experience, manage and respond to diverse and conflicting institutional demands (Cloutier & Langley, 2013; Pemer & Skjølsvik, 2016).

Looking across the literature it is possible to identify different conceptions of both power and organizations, and, at the same time, many overlapping topics among them. Starting from a more closed system view, Weber (1978) conceived organizations as black boxes, closed to external contingencies. He contributes to understanding single forms of organizations and consequently, single forms of power and authority. His writings have influenced later approaches (Emerson, 1962; Pfeffer & Salancik, 2003; DiMaggio & Powell, 1983), that starting unpacking organizations and considering it embedded in wider and open environments.

In this context, here I review some organizational theories to capture how power is portrait among them and compare the role of power through three different perspectives: relational, resource control and institutional politics. Figure 4 presents an overview of the varied and nuanced ways that power can be approached and are better discussed in the sequence.

| Power perspective | Authors |
|---|---|
| **Power as a relational phenomenon** | Weber (1978); Dahal (1957); Lukes (1974); Emerson (1962); |
| **Power as resources control** | Salancik and Pfeffer (1977); Pfeffer and Salancik (2003) |
| **Power as institutional politics** | Lawrence (2008) |

*Figure 4.* Perspectives of power
Source: elaborated by the author

First, one of the main perspectives of power describes it as a relation. Power is not conceived as a property of an individual, something an actor has, but it belongs in the established relationship between actors (Østerlund & Carlile 2005; Lawrence, 2008; Clegg, Courpasson, & Phillips, 2006). Power derives from the interaction of the powerless with the powerful, with both parties contributing to its existence. Such relationship exists among actors in the face of asymmetry or dependence (Emerson, 1962); being linked (Dahal, 1957) or not (Weber, 1978; Lukes, 1974) to a mandatory presence of conflict.

This perspective connects power to an imbalance relation. According to Emerson (1962:32), "power resides implicitly in the other's dependency". Thus, one can exert power through someone else by the extension that he has control over things valued by the other part. It is a relational function permeated by mutual dependence. Therefore, in order to consider that one detains power over someone else, there must be a change in the other part's conduct, caused by the former's demand (Emerson, 1962; Dahal, 1957). In this sense, along with it, we can

highlight the concept of resistance as well. Resistance appears as a condition to be overcome so that power becomes observed. On the other side, the tensions involved in the unbalanced relation do not need to endure for long. Such dependence can be reduced by the weaker side, either altering its configuration but maintaining vulnerability to new demands or altering the power relation itself (Emerson, 1962).

The expression of power relations can vary according to different views. For Dahal (1957), power implies a mandatory presence of conflict, being intentional, deliberate and visible. In this sense, in order to a power relationship happen, there must be a time lag between the exercise of power and the response action, which, in turn, envisage the role of decision making as a central task. Decision-making processes are the spaces of power. Multiple groups are involved in the decision arena, and by identifying who prevails in decision making, in the definition of policies, that is, the actors who govern and can command, it is possible to determine which actors have more power in the social relation. The conflict, in this case, will be the result of differences of preferences among the parties involved, through the cases where decisions have been made, which are open and observable. In this view, power is conceived in a pluralist way, as it can provide a comparative view of power (Lukes, 1974). The focus is on the behaviours of the actor as a response to decision making over issues that involve observable conflicts due to disagreement in preferences.

On the other hand, some critiques defend that this pluralist view of power can also ignore less visible ways through which a pluralistic system can also bias in favour of specific groups, such as polities involving non-decision-making, indirect influence, and failed attempts of penetration (Lukes, 1974). Power, according to this critic, can also be expressed as a relation in a hidden manner from the perception of those to whom it is subjugated. It cannot be restricted to prevail over others in a conflict of interests or yet in determining such conflicts – as the previous dimensions-, but it also encompasses dependence, adherence, alliance or even complicity, even in the cases where there is no need for the exercise or presence of conflict. Conflict, in this sense, can be expressed openly, but also as potential or latent conflicts. Power, then, can be present exactly in the ability to prevent conflict from arising in the first place and in the repression to the manifestation of interests (Lukes, 1974).

Therefore, in this perspective, power also manifests itself in the conformation of preferences in the existing order of things, both for not conceiving another alternative and by seeing it as natural. Interests are real but also subjective. In a way, this can be associated with Marxism idea of alienation. The fact that the one less powerful is willingly to behave in ways contrary to his interests and along with the powerful wishes without the need of coercion or

forcible constraint, makes it possible to create an ideology system. This system deals with a latent conflict, in which the latter may not express or even be aware of their own interests. The structure of power relations, hence, is fully legitimized by a system of cultural and normative assumptions (Lukes, 1974).

Independently of a difference in how power is manifested and if it involves a conflict or not, looking across these views, the relational perspective on power points to the importance of two key aspects. First, power occurs through subjective relations which implies a mutual and imbalance dependence that over time can both constraint and enable action (Feldman & Orlikowski, 2011; Giddens, 1984). It is the ability to mobilize people (Avelino & Rotmans, 2009). Second, due to this capacity to specify differences and dependencies, power discussions are a useful tool to practice theorizing. The asymmetry of relation is fundamental to identify the relational force at play and is an integral part of the resulting practice (Østerlund & Carlile 2005).

The second perspective presents a different relation of power. Someone can have more power than others in the sense that one has more ability to mobilize resources or yet can mobilize more resources than someone else (Avelino & Rotmans, 2009). In this case, the power relationship is expressed in regards to resource dependence and resource mobilization (the act of power). The resources dependence theory was introduced by Pfeffer and Salancik (2003) with influence on the concepts of Emerson (1962) applied to the organizational context. Based on an open system view of organizations, this theory posits the interdependence of actors due to a scarcity of resources and uncertainty of the environment.

The external environment comprises many different organizations, each with its own interests. In the face of a need for resources from the environment, organizations become potentially dependent on the external sources of these resources (Pfeffer & Salancik, 2003; Wry, Cobb, & Aldrich, 2013). In this sense, the critical determinant of power for resource dependence view is the control of these resources which is considered strategic (Salancik & Pfeffer, 1977; Pfeffer & Salancik, 2003; Lawrence, 2008).

The list of resources can be infinite inasmuch as different phenomena can become resources in different contexts. They may include, though are not limited to, monetary and physical resources, information, expertise, credibility, position, and social legitimacy (Clegg, Courpasson, & Phillips, 2006; Wry, Cobb, & Aldrich, 2013). Avelino and Rotmans (2009) define resources as five distinct types: human resources (human leverage, i.e. staff, clients, voters, supporters, etc), mental resources (information, expertise, concepts and ideas), monetary (cash, funds and stocks), artefactual resources (products, construction, infrastructure,

apparatuses) and natural resources (raw materials and physical resources such as land and organic life).

There is no established hierarchy of relevance between these different types of resources (Avelino & Rotmans, 2009). The definition of which resource is critical has contextual boundary conditions. Its effect has to be considered for the value appropriated in the relationship (Gulati, & Sytch, 2007). Each type of resources can be an object of power in different extensions depending on the particular context of the empirical question (Avelino & Rotmans, 2009).

The expression of power, then, is defined as a product of control over resources that are valuable to the ongoing operation of other actor and cannot be available elsewhere, its lack of access to alternative resources, and its lack of counterparts to balance the relationship (Pfeffer & Salancik, 2003). As a result, through control of scarce critical resources, power is related to advantageous outcomes for the ones who hold them, evidencing opportunity to constrain other's behaviour (Wry, Cobb, & Aldrich, 2013), to enhance their own survival, to place allies in key positions, to define organizational problems and policies (Salancik & Pfeffer, 1977) and to improve performance (Gulati & Sytch, 2007; Casciaro & Piskorski, 2005).

Power here grants the ability to lead the outcomes desired and enables the organization to become more aligned with their environment and the realities it faces, facilitating its adaption (Salancik & Pfeffer, 1977). In this context, the environment is the underpinning for both creating opportunities and monopolizing resources, and coping uncertainties (Pfeffer & Salancik, 2003). It is the environment who will mark out what is critical or not so that the holding of such resources becomes an advantageous power relationship.

However, despite power and dependence are putting together, they do not consist of a unilateral relation. Actors can have power over the other (Wry, Cobb, & Aldrich, 2013). Dependencies ties can be reciprocal and indirect (Pfeffer & Salancik, 2003). Joint dependence, in this sense, improves the weaker actor's capacity to deal with the resistance of the more powerful ones (Gulati & Sytch, 2007; Casciaro & Piskorski, 2005). Thus, organizational choice is also addressed from a political point in which for a deeper understanding of power relations is necessary to identify setting boundaries, unit actors, and distributions of power, interests and resources among them, being a certain resource always key to these relations (Pfeffer & Salancik, 2003; Clegg, Courpasson, & Phillips, 2006).

It can be said, thus, that power derives from activities rather than individuals and, due to that, it is situationally dependent. Power is never absolute or constantly permanent but will derive from the context it situates itself. The conflict or competition established between the

actors in the relationship depends on the extent that their goals in the face of the exercise of power are mutually exclusive (Avelino & Rotmans, 2009).

Finally, the last perspective refers to the roles of power from an institutional politics perspective, connecting power to the relationship between institutions and actors. Power pervades this relationship through a recursive relation. While institutions are connected to power by influencing actors' beliefs and behaviours, actors, in turn, are connected through strategies of action and resistance intended to transform institutional arrangements (Lawrence, 2008). Here, similar to the first perspective, power is also a relational phenomenon. It is not property from an individual, something an actor has, but an effect of relationships (Lawrence, 2008; Clegg, Courpasson, & Phillips, 2006). It concerns the way that behaviours and opportunities of an actor can be affected by another actor, system or technology as an enacted phenomenon (Lawrence, Malhotra, & Morris, 2012).

From this definition, two basic modes in which power operates can be pointed – episodic and systemic – which underlies the institutional politics situation (Lawrence, Mauws, Dyck, & Kleysen, 2005; Lawrence, 2008; Lawrence, Morris, & Malhotra, 2012). Episodic power refers to "relatively discrete, strategic acts of mobilization initiated by self-interested actors (Lawrence, Winn, & Jennings, 2001:629). It involves the connection between power and agency, the classic notion of an actor's capacity to influence the actions of another actor (Lawrence, Morris, & Malhotra, 2012). In contrast to this mode, systemic forms of power "work through the routine, ongoing practices of organizations" (Lawrence et al., 2005:182). Rather than being exercised by actors, it is diffused through social systems and can be associated to a socialization and accreditation processes, and cultural and technological systems, thus, usually not visible forms of power (Lawrence et al., 2005; Lawrence, 2008; Lawrence, Morris, & Malhotra, 2012).

The episodic and systemic modes of power underpin the dimensions of institutional politics. According to Lawrence (2008), institutional politics has three dimensions that interplay and through which is possible to understand the roles power play in shaping the relationship between institutions and actors (see Figure 5). The first role, institutional control, portrays the influence of institutions in actors' beliefs and behaviours. Power is manifested as a relation effect that institutions have on actors. Here, it is important to compare and contrast with the resource dependence perspective. Despite institutional control also considers resource flows as a mechanism of control (Ranson, Hinings, & Greenwood, 1980; Hinings, & Greenwood, 1988), it is not restricted to it. Institutional control considers coercive and resource-based forms of control, but it is not restricted to it. It also focuses on the symbolic

aspects, including social and professional norms, and taken-for-granted assumptions (Lawrence, 2008) that are not necessarily consistent with market exigencies (Greenwood & Hinings, 1996).

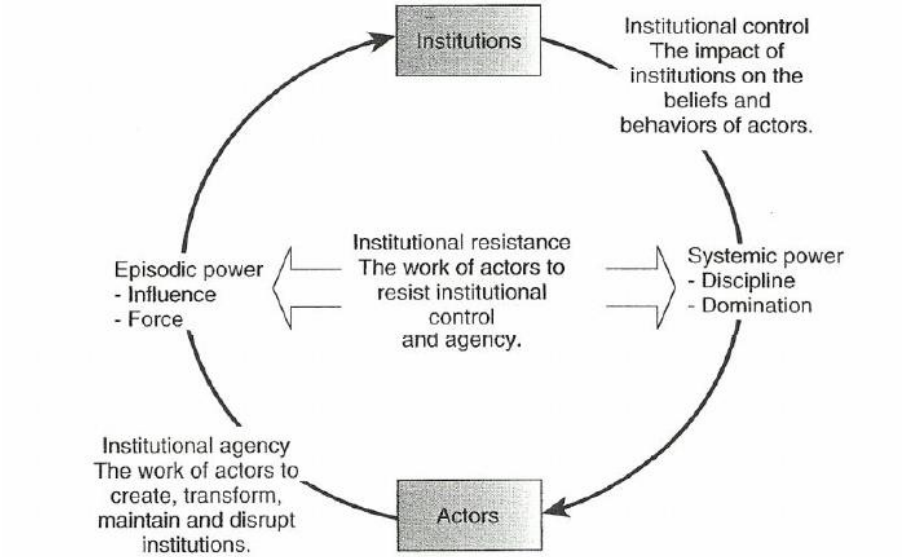


*Figure 5.* Institutional politics – the interplay of institutional control, agency and resistance
Source: Lawrence (2008:173)

This role is associated with systemic forms of power, as can be seen in figure 5. It corresponds to automatic forms of power that manifest mostly indirectly as the enforce compliance of actors to rules and norms. Describing it as automatic aims to evidence that actors are also subject to forms of power that operate independently of any agent or the interests of an agent. It can also work through courts, professional associations, language, social customs and the roles that actors occupy within these structures and by enacting these routines and ongoing practices (Lawrence, 2008).

Looking at the relationship between institutional control and systemic forms of power, two major forms are highlighted: discipline and domination (Lawrence, 2008). The first one refers to shaping the formation of the subject. It works as a mechanism that inscribes and normalize actors. It constructs a pattern of subject through which allows moving actors toward uniformity, to enable and forbid appropriate and inappropriate behaviours, and to recognize deviants (Clegg, Courpasson, & Phillips, 2006; Lawrence, 2008). Domination, in turn, corresponds to the restriction of the effects of action rather than the action itself. It is a form of power that alters the range of options available to actors (Lawrence, 2008).

The second role of power is institutional agency. It represents the influence of actors on institutional arrangements through individual and collective actions that can create, maintain, change or disrupt institutions (Lawrence, 2008). Here, power is expressed more explicitly, it is

seen through the agency that responds to institutional pressures (Lawrence & Suddaby, 2006; Greenwood & Suddaby, 2006; Lawrence, Suddaby, & Leca, 2011). In institutional research, the role of agency gained a fresh focus in relation to institutional entrepreneurship and social movements. While the first highlights the strategies and positions of individual actors, social movements focus on collective action (Lawrence, 2008).

Institutional agency is supported by episodic forms of power as it requires actors to enact strategic acts of mobilization. Such acts may be as diverse as mobilizing resources, engaging in contests, and enacting support or attack forms of discourse and practice. It involves two main forms of episodic power – influence and force. Influence corresponds to the ability of an actor to enforce compliance of another actor, that is, the ability to persuade an actor to do something they would not do. It involves tactics such as negotiation, convincing, moral suasion, exchange. In turn, the use of force is associated with attempts to disrupt or maintain institutionalized practices and arrangements. Force does not account for the will but in the achievement of an end despite that will. Consequently, it implies a greater loss of autonomy and the actor's identity (Lawrence, 2008).

Lastly, institutional resistance configures as the limits imposed by the work of actors in the former two roles. The outcomes of power relations run through the limitations put on power in which resistance operates. The complexity, flux and uncertainty tied to the dimensions of institutional control and agency cleave potential for creative and effecting strategies of resistance (Lawrence, 2008). Resistance may consolidate as a new fixity in the representation of power or in questioning the exercise of the power in itself (Clegg, Courpasson, & Phillips, 2006; Lawrence, 2008). Hence different forms of resistance can be engendered in the face of different forms of power such as compromise, avoidance, defiance, and co-optation (Oliver, 1991; Lawrence, 2008). The involvement of third-parties is also a relevant form of institutional resistance by affecting the actions of other actors. Social movements, for example, may alter institutional arrangements as their influence on the state may lead it to promulgate new rules and legislations (Lawrence, 2008).

To sum up, as figure 4 showed, a great deal of work has been done connecting power to organizational studies. Considering these researches and the aims of this thesis, the perspective adopted here is to bring power into the institutional analysis. Institutional perspective comprises overlapping domains of the former two perspectives. It conceives power as a relational phenomenon – as the first perspective -, that includes mechanisms of resource control – similarly to the resource dependence perspective. But it also goes beyond by embracing "resources" outside ownership, such as rules, laws, cultures and traditions that also

play a role in the exercise of power (Avelino & Rotmans, 2009), resulting in the intersection of power, institutions and actors. Hence, the interplay of institutional control, institutional agency and institutional resistance provide an integrated approach to understand the institutional dynamics of organizational fields focusing in all the dimensions and the limits of each (Lawrence, 2008).

### 2.2.2 The Role of Power in Practices in Multi-Field Logics

The last step in developing the theoretical foundations for this study involves asking how power shapes practices in multi-logics fields. To do so, I revise how power dynamics are related to institutional logics and practice perspectives, presenting some studies in which this recursive relationship is evident and what are the implications in this, which, in turn, provides opportunities and gaps to study.

The issue of power and politics has been contemplated by many institutionalist studies (Ranson, Hinings, & Greenwood, 1980; DiMaggio, 1988; Pache & Santos, 2010; Greenwood et al., 2011; Nicholls & Huybrechts, 2016), long acknowledging its importance to organizational dynamics. Especially multi-logics fields contribute to highlight these issues (Greenwood et al., 2011). Contexts that generates institutional complexity embraces power relations in how and when working with these potential contradictions (Jarzabkowski, Smets, & Bednarek, 2013).

As previously discussed, institutional complexity lead actors to contend for multiple conflicting demands (Greenwood et al., 2011). Actors immersed in different institutional logics activate different goals in the face of the same situations (Thornton, Ocasio, & Lounsbury, 2012). This activation can be that basis of consensus as much as of cleavage (Ranson, Hinings, & Greenwood, 1980), which, consequently can lead to conflicts, power struggles and power resistance (Clegg, Courpasson, & Phillips, 2006) in social interactions (Thornton, Ocasio, & Lounsbury, 2012). Multi-logics fields, thus, become arenas of power in which their constituents compete in defining issues and practices that will guide the functioning of the field (Hoffman, 1999; Reay & Hinings, 2005).

The idea is that institutional demands do not just influence organizations; rather they are interpreted and represented by actors who occupy structural positions and have different preferences. Actors import to the field the meanings of institutional logics which they experience and get identified, in a way that the interpretative frames consist of the expression of their values and interests (Ranson, Hinings, & Greenwood, 1980; Greenwood et al., 2011).

The result of these expressions is mediated by how actors are able to defend and enforce such values and interests among other actors involved in the field who may or may not be identified with a distinct logic.

As divergent interests will impact, responses to institutional complexity are actively negotiated and experienced through social interactions (Hallet & Ventresca, 2006; Thornton, Ocasio, & Lounsbury, 2012; McPherson & Sauder, 2013). They will depend on how "social interactions suffuse institutions with local force and significance" (Hallett & Ventresca, 2006:213). This resolution, however, is typically the privilege of some actors (Ranson, Hinings, & Greenwood, 1980), as actors "have differential power" (Hinings & Greenwood, 1988:56).

Within a field, actors do not have the same capacity to defend institutional logics. So, the responses to the multiplicity of logics it is not just about giving voice to one logic within a field, but it is about the ability of a voice to be heard and to influence it, gaining legitimacy over the remain (Greenwood et al., 2011). The central point is that not all actors in field police or are able to police their logic with the same insistence and demand for compliance. The extent that the institutional logic can affect an organization and their demands will be enforced on it, embraces the power balance between positions and groups and their capacity to impose (Pache & Santos, 2010; Greenwood et al., 2011; Bjerregaard & Jonasson, 2014).

Multi-logics fields can be understood, then, as positional systems (Smets, Aristidou, & Whittington, 2017). The social position the members of the field occupy and the unequal relationships that permeate their interaction influence the actors' motivation and ability to act. Therefore, bringing relations of power into the discussion of practices enactment in multi-logics fields become essential. Differences of power lead to coercive enforcement to be distributed unevenly among different groups within a field. Consequently, outcomes will be the result of the conflict of subjective preferences, interacting in order to serve the dominant interests (Lukes, 1974; Kashwan, 2016).

The selection of practices, that is, which and how institutional logic will be instantiated in the attempt to balance coexisting logics in a field is influenced by the negotiations of contesting interest groups. Stated differently, the groups' dynamics moderate how forms of institutional logics emerge because individual interests frame strategic choices underlying it. Thus, practices variations may happen as actors pursue their interests (Goodrick & Salancik, 1996; Bjerregaard & Jonasson, 2014; Greve & Zhang, 2017).

As the enactment of practices results from process thinking and social interaction, it, in turn, also builds on clusters of differences and dependencies of the actors involved (Østerlund & Carlile, 2005). So, relations of power accentuated by asymmetrical action capacities,

different access to resources and resistance (Feldman & Orlikowski, 2011) permeate this decision process. Institutional forms are the products of political struggles among actors with divergent interests and asymmetric power whose establishment and reproduction are unlikely to satisfy all interests, especially the ones of the less powerful actors (Seo & Creed, 2002; Bjerregaard & Jonasson, 2014; Pemer & Skjølsvik, 2016).

The process of choosing one practice over others is not simply a function of who participates. It follows that the degree of influence of an actor or a group within the field also impacts on it. Some groups are more powerful than others, as a result, they are able to exert more influence on strategic choice. Logics incarnation, thus, are likely to reflect their interests (Ocasio, 1997; Greenwood et al., 2011; Nicholls & Huybrechts, 2016; Ocasio & Radoynovsk, 2016), since the greater power backing an institutional logic makes its incarnation more likely to occur (Greve & Zhang, 2017; Greenwood et al., 2011; Seo & Creed, 2002).

While the powerful group of actors always try to impose its logics upon the less powerful ones (Nicholls & Huybrechts, 2016), less powerful groups of a field often rely on the relatively more powerful ones, in order to pursue and sustain collective endeavours (Kashwan, 2016). As a consequence, those with power are likely to dictate which logics to prioritize and, consequently, to determine organizational responses to multiple logics, in a way that reflects their interests (Greve & Zhang, 2017; Greenwood et al., 2011; Seo & Creed, 2002). In this line, practices are likely to reflect the majority of the prevailing logic and the interest of the dominant actors.

Institutional studies on multiple logics evidence this relation of power dynamics by focusing on the competition of actors defending alternative logics. Inside the health care field, Reay and Hinings (2005)'s study provides an empirical description of this. Their study of health reform initiative in Alberta (Canada) showed the competing logics of medical professionalism versus a business-like health care logic, driving a change in the organization field, leading to its recomposition. The authors described the field as a battlefield, where actors engaged in power struggles using all available sources of power. The recomposition of the field consisted of the change of the dominant logic (medical professionalism) initiated by the actions of the government and the calculated responses of the physicians. But in order to accomplish that, the government needed to manifest active and intentional use of power through the entire change process.

On the other hand, an important issue to note in their study is that despite the structure of the field and the dominant logic changed, the previously medical professionalism logic was not eliminated, it remained embedded in physicians. The medical professionalism logic

continued as an alternative view, strongly supported by physicians. Power, then, become divided between the two key actors, physicians and government, expressed in a stable tension. According to Reay and Hinings (2005)'s findings, even in the face of a dominant logic change sustained by powerful actors, sub-logics can maintain a strong presence in the field being support by the capacity for action (use of power) of key actors. Therefore, as previously discussed in the latter topic, diverse dimensions of power can be manifest in order to enforce and, in turn, respond to demands. Actors can be enforced but also can react and enact strategic acts of mobilization (Lawrence, Winn, & Jennings, 2001) in resistance or influence to institutional control and other forms of power, even if they do not achieve dominance of the field.

In line with this, looking at the other side, when the field is characterized by low differences of power, there is not a clear leadership among the groups (Besharov & Smith, 2014). The lack of a central practice to lead let multiple groups and their subjacent interests to coexist and fight for dominance within a field (Pache & Santos, 2010). As a result, this can evidence efforts of collaboration and complementarity among the plurality of logics, from local negotiations. When actors have equal power balance, they are more likely to reach agreements with higher joint gains (Mannix & Neale, 1993). So, it is likely that institutional logics will be combined and reconfigured (Greenwood et al., 2011), resulting, for example, in the creation of hybrid practices (Goodrick & Reay, 2011).

Reay and Hinings (2009) and Goodrick and Reay (2011)'s studies provide empirical support for this context. Reay and Hinings (2009) in another study of the healthcare field of Alberta (Canada), showed that competing logics can co-exist and that rivalry between logics can be managed through the development of collaborative relationships. In this way, new institutional arrangements can be created in an organizational field in the face of coexistence of more than one logic guiding actors' behaviour. In turn, Goodrick and Reay (2011)'s study of U.S pharmacists, through understanding the dynamics among logics within a constellation, focused on how work practices reflected the interaction of one logic with others. They also found evidence for competitive as well as cooperative relationships among the logics.

Therefore, in this research, I aimed to go beyond and enhance not just the idea of actors as responsible to import into an organization the meanings of logics (Greenwood et al., 2011), but also and especially as determinants of negotiation processes, engaged among contesting groups who strategically manoeuvre logics over their interests (Bjerregaard & Jonasson, 2014) and that are constituted by asymmetrical relations of power. This focus is important, especially when considering the dynamic political processes in which groups of actors get involved. In

these circumstances, each one promotes their own goals, interests and institutional logics. Actors willingly invest resources, effort, and power to promote their own logics and, consequently, the organizational forms and practices that incarnate those (Kim et al., 2007).

The responses enacted, thereby, is hardly homogeneous, since power effects have varying degrees of influence. Consequently, the use of power associated in the resulting practices has a recursive relationship into the field itself, as its enactment engender maintenance or disrupting effects into the established institutional arrangements, as could be noticed, for example, by the study of Reay and Hinings (2005) which resulted into changes in the dominant logics, in the corresponding practices and the structure of the field.

In closing, multi-logics fields allow the agency to commit with particular subsets and combinations of these logics (Greenwood, Díaz, Li, & Lorente, 2010; Greenwood et al., 2011; Ocasio & Radoynovska, 2016). However, subjacent to this, social negotiation over interests (Goodrick & Salancik, 1996; Ocasio, 1997; Wright & Zammuto, 2013; Greve & Zhang, 2017) lined by relations of power (Seo & Creed, 2002; Bjerregaard & Jonasson, 2014; Pemer & Skjølsvik, 2016; Greve & Zhang, 2017) impact on the promulgation of the different types of practices adopted and, consequently the incarnation of logics, which lead to heterogeneity of responses. Such aspects, thus, are important to be analyzed because the promulgated responses have major implications for legitimacy and access to resources, which in turn are linked to organizational survival (Greenwood et al., 2011). These issues thus were examined in the empirical context followed in the next topics

### 2.2.3 Theoretical Research Questions

To summarize, from the above discussion underpinned by the literature review, I present two theoretical research questions that guided the study and were examined through the empirical case. These research questions were motivated by the issues that seemed very important though underexamined, as I looked across the researches on institutional logics, practice perspective and theories of power.

First, I could notice that multi-logics fields stand out by providing a broader range of alternative rationales to actors to act. The type of logics multiplicity leads to more or less conflict, and as an implication, it increases actors' responsiveness (Besharov & Smith, 2014). At the same time, as the field constitutes a positional system (Smets, Aristidou, & Whittington, 2017), in which, actors socially interact between each other having varying degrees of power, practice enactment is unlikely to be uniform (Greenwood et al., 2010). Moreover, I also found

that there is a growing interest in the literature for understanding organizational responses to the multiplicity of logics (Oliver, 1991; Pache & Santos, 2010; Bertels & Lawrence, 2016), configuring it as an important stream of research. So, knowing that practices are enacted in heterogeneous ways but the conditions under these arise remain underdeveloped (Besharov & Smith, 2014), I wonder how these diverse ways are expressed, aiming to understand this variation. Therefore, based on this, and considering that the focus of the present study is the multi-logical fields, I further question: **(1) What are the variations of practice within multi-logics field?**

Secondly, sustained by the theoretical foundation, I discussed that variation in practices in multi-logics field is influenced by the different relations of power expressed between the actors involved in a field. Power leads to differences in the ability of actors to negotiate and decide. Thus, actors use intentional and active power and capacity to act in order to enforce their preferences and defend their logics (Reay & Hinings, 2005). Nevertheless, the understandings on how actors deal with these struggles, how conflicts are resolved and how this impact in the practices are still lacking (Greenwood et al., 2010; Cloutier & Langley, 2013; Besharov & Smith, 2014; Munir, 2015). Also, extant literature shows us that the outcomes of such process of negotiation and interaction, that is, the instantiation of institutional logics into practices implicate, in turn, into different effects in the institutions, being able to create, maintain and disrupt existing institutional arrangements. Considering all that at once, I further question: **(2) How do relations of power shape the adoption of practices in multi-logics fields and, consequently, how these effects implicate in the dynamic of multi-logics field?**

# 3 METHODOLOGICAL PROCEDURES

In this section, I outline the methodological procedures that were carried out in the research. In order to achieve its purpose, I sought in this section to align the research methodologically with its objectives, so there is coherence between the research questions and the methods proposed (Lewis, 2003). To this end, I begin presenting the research questions that this study sought to answer and the definitions of the main analytical categories. Sequentially, I describe the research design adopted, followed by presenting the procedures for the data collection and data analysis.

## 3.1 RESEARCH QUESTIONS

Having defined the aims this research sought to achieve, the research questions were defined in order to meet some requirements as: be empirically accessed, connected to existing theory, with a potential to make an original contribution, and relevant in practical and theoretical terms (Lewis, 2003). From these issues, the following questions were established to guide the data collection and analysis:

1) What are the multi-logics in the maternity field enacted in Brazil and England?

2) What are the maternity practices adopted and their variations in Brazil and England?

3) How is the maternity field in Brazil and England configurated in terms of actors and relations of power among them?

4) How do the relations of power shape the variation in maternity practices stemming from multi-logics field in Brazil and England and what are the implications of that?

These research questions (RQ) were motivated by the theoretical questions (TQ) previously presented. They are the translation of the theoretical questions into the method and research context adopted, the maternity field in Brazil and England. So, in order to define these questions, the theoretical questions were unfolded as to applicate them into an empiric case. Figure 6 presents the relationship between both types of questions.

The research questions (1) and (2) are related to the first theoretical question - What are the variations in practice enactment from multi-logics field? In order to comprehend the heterogeneous ways that practices are promulgated in multi-logics field (Greenwood et al., 2010. Bertels & Lawrence, 2016) it is essential to comprehend how is this field configurated (Besharov & Smith, 2014), i.e., what are the institutional logics presented in the field, how they relate between each other and how they are instantiated into organizational forms, material

practices and symbolic constructions (Friedland e Alford, 1991; Greenwood et al., 2010; Thornton, Ocasio & Lounsbury, 2012). So, by analyzing specifically how different practices are enacted empirically in the maternity field and from what institutional logics they stem and backed from the literature present, it helps us comprehend in a more abstract way and, thus, theorize more generally how variations in practices can be expressed in a field in the face of multiplicity of logics, allowing to investigate in different field settings later on.

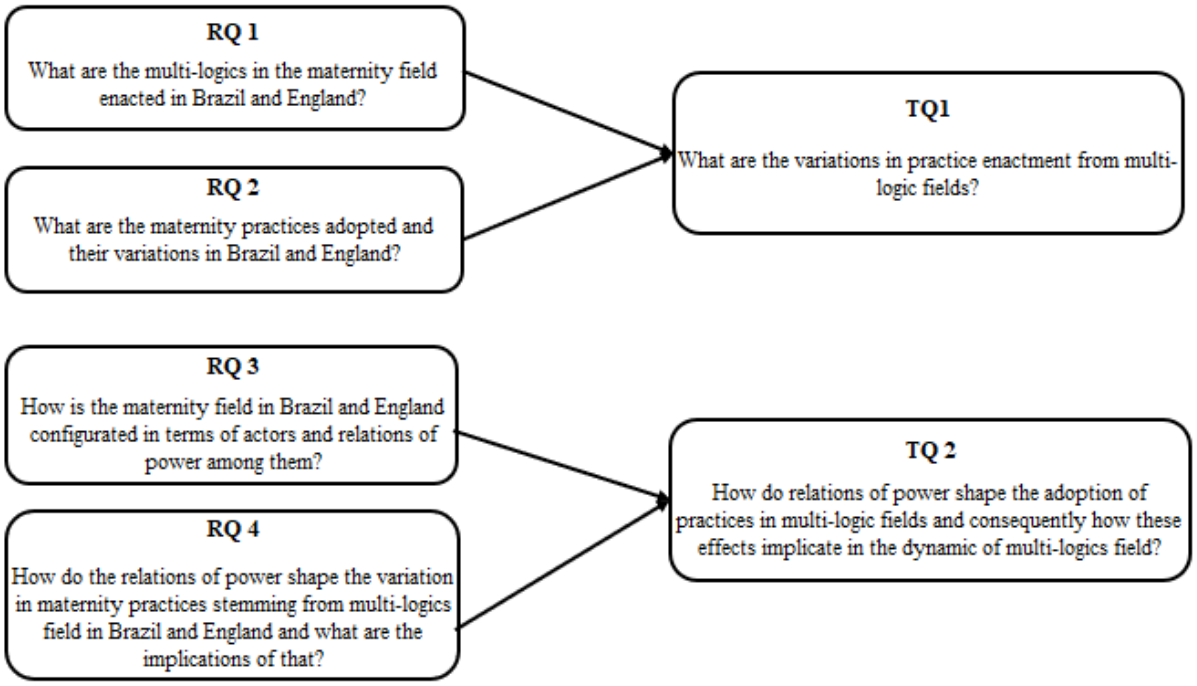


*Figure 6.* Relationship between the research and theoretical questions

In turn, the research questions (3) and (4) are related to the second theoretical question – How do relations of power shape the adoption of practices in multi-logics field and consequently how these effects implicate in the dynamic of multi-logics field? The understanding of how the maternity field is structured in terms of relations of power and actor position in both Brazil and England allows us comprehending how the social interaction and negotiation of actors, given these configurations, impacted the practices adopted. Also, observing how these practices influenced the field setting – maternity - enables to theorize how this interplay generally affects the institutional field dynamics. Thus, the aim proposed by the establishment of these questions is both to comprehend theoretical gaps within a specific empirical context and also, from these findings, connect and expand previous researches to theorize for further studies in different empirical contexts.

## 3.2 MAIN ANALYTICAL CATEGORIES

From the theoretical basis previously discussed, the main analytical categories that support the research were delimited in this section. Conceptual (C.D.) and operational (O.D.) definitions of each category are presented in order to organize the data, facilitate the use of concepts and perceive the relations between them (Selltiz, Wrightsman, & Cook 1976). The conceptual definition refers to the general meaning transmitted. They are defined in abstract terms in order to transmit the concept of the category. The operational definitions, in turn, are more specific. They represent how such categories were empirically accessed in the research, bridging the concepts to observations (Kerlinger, 1980).

- **Institutional Logics**

**C. D.:** "The socially constructed, historical patterns of cultural symbols and material practices, including assumptions, values, and beliefs, by which individuals and organizations provide meaning to their daily activity, organize time and space, and reproduce their lives and experiences" (Thornton, Ocasio, & Lounsbury, 2012:2).

**O.D.:** The institutional logics were analyzed through the documentary research and primary data on the maternity field of Brazil and England. The category was operationalized, in addition, by reconstituting the motherhood's trajectory, identifying the dominant practices and symbols guiding maternity through it. It was empirically accessed the practices desired and employed in relation to antenatal, labour, child delivery and postnatal care and the sense and meaning underlying them, according to each actor involved in the field.

- **Practice**

**C. D.** "Practices are patterns of activities that are given thematic coherence by shared meanings and understandings" (Smets, Morris, & Greenwood, 2012:878). They refer to "forms or constellations of socially meaningful activity that are relatively coherent and established (…) and informed by wider cultural beliefs" (Thornton, Ocasio, & Lounsbury, 2012:128). Practice indicates how activities should be done corresponding to material enactments of institutional logics (Friedland, 2014; Smets, Morris, & Greenwood, 2012; Sahlin & Wedlin, 2008).

**O. D.:** The maternity practices enacted in Brazil and England were defined by the identification of the recurrent patterns of activities in the field that have guided motherhood. It

was inferred especially through questionnaire and interview data, based on the types elaborated by the WHO (OMS, 1996).

- **Power**

**C. D.:** Power is configured as the capacity of actors to determine the outcomes they desire and intent (Salancik & Pfeffer, 1978; Ranson, Hinings, & Greenwood, 1980; Giddens, 1984; Hinings & Greenwood, 1988; Finkelstein, 1992; Kashwan, 2016) and to exert influence over other actors and future events (Greenwood et al., 2011). It is constituted by means of social relations, a relational phenomenon. Power embraces the relationships in which there is an effect (Lawrence, 2008). Its effects, though, have varying degrees of influence. The outcomes determined vary according to the power balance between groups (Pache & Santos, 2010; Greenwood et al., 2011; Bjerregaard & Jonasson, 2014).

**O. D.:** This category was operationalized from the verification of the relations of power between actors involved in the maternity field, so to identify how was the power balance of the field. Based on Lawrence (2008) and Clegg, Courpasson, and Phillips (2006), power was empirically accessed through three dimensions, namely: relational, resources and institutional. The relational dimension referred to the relationship between the actors and the distribution of positions, it involved authority relations among different actors and the responsibility for decision making. The second dimension, resources, comprehended the control of resources and acts of mobilization to enforce the preferences. It comprised the functional experience (specific knowledge and experienced practices) in specific areas, in this case, maternity, that enhances the ability to deal with critical contingencies and search for means and other resources that are asymmetric. And the last one referred to the institutions, norms and rules that fix relations and conduct, and other social actors involved that may impact, such as networking. Thus, this category was identified through the documentary research, analyzing the maternity assistant care model of each country, its constitution, relations, main actors and roles, and through the interview and questionnaire data, through which these dimensions could be empirically accessed.

## 3.3 RESEARCH DESIGN

To answer the research questions proposed, I conducted two case studies in the domain of maternity in Brazil and England. The maternity field represents an appropriate research context because being the maternity characterized as both a cultural and a biological state, in

which a variety of discourses and practices from different areas meet (Davis, 2012; Ross, 1993), mean that its field is configurated by institutional logics multiplicity, that is, a multi-logics field. The context is also appropriate because it is a domain in which the role of relations of power is central: practices enacted directed towards mothers involve social interaction and negotiation with other actors that may have different interests. Moreover, particularly in Brazil, the issues related to the public health problem, high incidence of caesarean section, are portrayed by many researches as due to power and asymmetries of resources matters (Leal & Gama, 2012; Freire et al., 2011; Pereira, 2006; Hopkins, 2000). So, for the research strategy, a comparative case study was conducted between maternity care in Brazil and in England.

The aim to comprehend a complex social phenomenon, the public health problem, maintaining its holistic characteristics and particular nature, qualified this method as appropriate to the present study according to Yin (2001) and Bryman (2012). Also, comparative studies are relevant to a better understanding of how and why distinct results are observed in a specific institutional context (Micelotta, Lounsbury, & Greenwood, 2017). This design embodied logic of comparison that the phenomenon is better understood once compared in relation to contrasting cases (Bryman, 2012). The choice of these countries reflects the desire to capture the variation in the maternity institutional logics' multiplicity. This variation is supported mainly by the opposing model of maternity care and empirical settings. Whereas Brazil embraces a technocratic model of maternity care, in England, prevails the humanist model (Rattner, 2009a). Exploring two cases brings the conjoint benefits of providing the potential for broader insights and the possibility of systematic comparison than would a single case, and yet, to gain deeper understandings of the cases than a larger set of cases (Lawrence & Dover, 2015).

Thus, the conduction of the research focused on the divergent peculiarities of each system that configure the maternity institutional logic so differently. What is more, other benefits of cross-cultural research are to reduce the risk of the research findings being culturally specific (Bryman, 2012), and to enhance generalizability (Bryman, 1989), both limitations attached to this type of method. Still, on the critique of generalization, Yin (2001) points out that case studies are generalized to theoretical propositions, that is, their purpose is to expand theories rather than enumerate frequencies, which is intended here through the proposed framework and theoretical questions, previously exposed.

The study is also predominantly qualitative because of its objectives, which are linked much more to the understanding and interpretation of a given phenomenon. Considering that institutional logics are manifested in symbols and material practices (Friedland & Alford, 1991;

Thornton, Ocasio, & Lounsbury, 2012) and constitutes a complex social process, the causal dynamics of social interaction is not immediately evident (Currie, Spyridonidis, 2016) and its nucleus of understanding is found in insights about meaning (Thornton, Ocasio, & Lounsbury, 2012). Qualitative data and methods that demand immersion in the phenomenon are naturally more appropriate to the present study (Reay & Jones, 2016; Thornton, Ocasio, & Lounsbury, 2012) and were central to it. As a result, the objectives here proposed were pursued through predominantly qualitative methodological strategies with the adoption of quantitative techniques complementarily. A key strength of qualitative studies is its flexibility as to processual terms. It is not a fixed stage but it enables to explore unanticipated issues as they emerge, thus undergoing adjustments and modifications in the course of the research process (Bryman, 2012; Lewis, 2003; Maxwell, 1996; Miles & Huberman, 1994). Yet, it can be developed to incorporate quantitative procedures as support for data collection and analysis, which was done.

So, this study also employed quantitative techniques, but only complementarily and, especially, in what concerns the identification of the relations of power and maternity practices. The adoption of this kind of techniques expanded the scope and reached greater representativeness by making contact with actors from several states of Brazil and Counties of England. Thus, quantitative instrumentation – questionnaire -, was adopted and its findings were also further deepened and systematically compared with the qualitative work (Miles & Huberman, 1994). The use of qualitative and quantitative approaches benefited the research. When used together, they offer a powerful resource to inform and illuminate practices and develop richer details for analysis (Bryman, 2012; Ritchie, 2003; Miles & Huberman, 1994).

The study is also characterized as non-experimental because it sought to analyze the phenomenon ex-post facto and did not intend to manipulate the analytical categories (Kerlinger, 1980). Regarding the ends, it is also descriptive. Its aspiration to provide greater familiarity with the maternity field and to investigate how the association between different groups' interests manifests and influences the institutional logics incarnation, according to Selltiz, Wrightsman, and Cook (1976) and Cervo and Bervian (1996), characterize it in this way. Such classification would be given by the joint intention, consistent with what was established in the present research, of describing a phenomenon with depth, seeking to relate and analyze it through data collected from the reality itself and to develop theory without manipulating or inducing it.

Additionally, in relation to the time perspective, this research has a longitudinal inspiration, but it is not characterized as so. The limitation of time to conclude this study and

especially to be able to collect the data abroad made the longitudinal study unfeasible. However, since encompassing the historical context was indeed relevant to understand the Brazilian and English maternity care and how their institutional logics are incarnate, this research adopted the sectional frame with a longitudinal evaluation as time perspective. According to Vieira (2004), this type of frame consists of collecting the data at a given moment but recovering it from other periods. The focus was on the phenomenon at the time of collection, but the data retrieved from the past were usually used to explain its current configuration. Finally, it is worth to point that the initial conception of this research was slightly changed during its conduction. The initial project was altered in some general points having some initial analysis and aims reframed.

## 3.4 DATA COLLECTION

The research followed a multistage quali-quanti methods framework (Fetters, Currie, & Creswell, 2013). I combined two approaches in the data collection, divided into two stages: exploratory sequential and convergent (Creswell, 2007; Fetters, Currie, & Creswell, 2013; Guetterman, Fetters, & Creswell, 2015), figure 7 illustrates this framework. In the first stage, I utilized the exploratory sequential design to collect qualitative data from documents and semi-structured interviews using open-responses. Based on the knowledge and on the reading of the empirical context and aligning it to the objectives of the thesis, I developed interview guides to be conducted with mothers and with health professionals (doctors, nurses/midwives and doulas). I designed the guides built on the dimensions to be analyzed, based on their constitutive definitions and how they would be operationalized. These definitions aided to delimit how they would be identified and what questions would be asked.

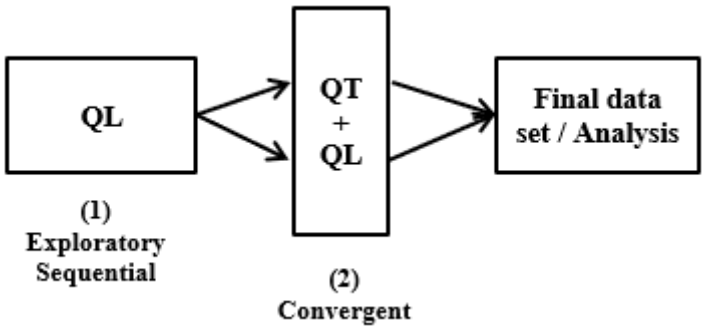


*Figure 7.* Multistage quali-quanti methods framework
Source: Elaborated by the author based on Creswell (2007), Fetters, Currie, and Creswell (2013), and Guetterman, Fetters, and Creswell (2015).

Sequentially, I presented the interview guides to two mothers. My aim was to discuss and verify if the questions were clear, if the terms were understandable and what they found relevant to discuss about the proposed theme. It is noteworthy that for greater consistency of the script with the theory, one of the women was also a researcher of the line of organizational studies. From this, I conducted interviews with two other mothers using the established guides. I used this qualitative data to validate and build the data collection approach of the survey procedure and to reassess the established interviews scripts. This primary analysis and qualitative data helped me to identify and validate the constructs, to verify if the questions, in fact, made it possible to identify the desired theoretical dimensions and to adapt the language used by the research participants.

Having validated the questionnaires and interview guides, the second phase was structured in a convergent or concurrent design (Creswell, 2007; Fetters, Currie, & Creswell, 2013; Guetterman, Fetters, & Creswell, 2015). In this stage, I collected the qualitative (QL) and quantitative (QT) data concurrently during a similar timeframe. The respective data collected then were brought together at the interpretation level in an interactive approach to compare and complement the findings – which I better explain in the data analysis section.

I collected the data in two sites, Brazil and England, each in its own language. I started the data collection in Brazil because it was more suitable in relation to time frames and it would also help initially to explore the maternity field and verify the effectiveness of the instruments adopted since the time in England was more restricted. Data in Brazil was later translated to English for this thesis. In England, in turn, the gathering process was conducted during the period as a recognized student at Saïd Business School (SBS), in the University of Oxford, under the supervision of Prof. PhD. Tom Lawrence. To conduct the research there, I requested the ethical approval in two domains, one related to mothers and another to the health professionals.

First, to conduct the research with the mothers, I submitted an approval request to the Saïd Business School Departmental Research Ethics Committee (SBS DREC). In order to achieve it, I submitted the following documents: (a) the CUREC (Central University Research Ethics Committee) checklist: an approval form document explaining the research and its objectives, how the research would be conducted and how the ethical issues would be addressed in it. This document was also due to be supported and signed by the Supervisor Professor (Prof. Tom Lawrence) and the Head of Department (Prof. Michael Smets – Convener for the DPhil in Management Research); (b) the interview script and online questionnaire; (c) the participant information sheet: a document explaining the research for the potential participants and

providing my contact details in case they need any further information; and (d) the participant consent form. This process took a little bit longer to get approval, around one month, because it was undertaken around the holidays period (Christmas and New Year's).

In the second domain, as most of the health professionals in England are linked to the health provider institution, the NHS - National Health Service, to research these actors I also submitted ethical approval to the central university Clinical Trials and Research Governance team (CTRG). As the research intended to understand the antenatal and delivery care in the UK, not the NHS itself, the CTRG stated that I would not need the ethics approval and the NHS governance to conduct my research. So, instead, I had to ask for individual consent prior, handling the potential participants the following documents (a) invitation and information sheet: explaining the research and how the ethical issues were addressed; and (b) consent form. Since it was within healthcare, I elaborated these documents from the Medical Sciences IdREC templates. All these documents were then analysed and validated by the Senior Clinical Research Support Manager of the CTRG and the Manager of the Medical Sciences REC to ensure they were set properly. All this process took around two weeks.

The data I gathered was based on two sources, primary and secondary data within three different sources:

**(1) Documents:** the first main source of data was documents and other media. This source was particularly important in the early stages to help summarize the main issues, providing a general picture, delimiting and mapping the field and designing the tools for the collection of the other sources of data (interviews scripts and online questionnaire). It started in the exploratory sequential stage, especially to support the later stages, but it lasted along the whole data collection process. It included: books, papers and medical reports, especially from Medical Journals and specific database (Web of Science, Medline and PubMed); news published by the media, such as Which?, Birth Choice UK, Daily Mail, The Guardian, BBC, Folha de São Paulo, Globo; social movements and NGO's communities and websites, and regulations and laws promulgated by governments and bodies of interest. I also accessed websites of the main institutions related to maternity care in both countries such as the Ministry of Health, the National Agency for Supplementary Health (ANS), the Federal Council of Medicine (CFM), in Brazil, the National Health Service (NHS); the Royal College of Obstetricians & Gynaecologists (RCOG); the National Childbirth Trust (NCT), the National Institute for Health and Care Excellence (NICE), in England, and the World Health Organization (WHO). Finally, the documentary research also included online social networks groups, mainly of Facebook and BabyCentre of both sites. This type of source besides being

useful to gather data, it was also highly essential to disclose the online survey on the later stage. The Baby Centre community was chosen for being one of the largest social groups among mothers and bringing together women of diverse profiles, who desire and have different modes of delivery.

It is valid to point out that the social networks were analyzed as a static text, that is, I did not have interaction with the participants. So, this approach was particularly useful because it required no physical travel on my part, being less time consuming and expensive than traditional face-to-face methods. And, at the same time, it ensured greater data coverage by enabling to reach groups from many regions of the countries. Also, as social media discussions are generally archived, it provided access to current and past discussions, increasing the research temporal scope (Lynch & Mah, 2017). In addition, its possible disadvantages, such as data quality and trustworthiness, I aimed to lessen through triangulation with other data, such as documentary research from other sources and primary data. Furthermore, although these social media were public, given the intricate relationship between informed consent and privacy concerns in an online environment, I first requested permission from the administrators to use messages contained therein and make members aware of the investigation (Mare, 2017).

**(2) Interviews:** the interviews were an iterative process through which I could deepen the topic especially on the symbolic sphere. The guiding questions are attached in Appendix A and B (mothers) and C and D (health professionals). They consisted of broad open-ended semi-structured questions that allowed the respondents to express themselves freely as they wish and that was flexible in nature so to have a natural flow of conversation. This type of interview was appropriate because it enabled to obtain the social and personal context of the respondents' beliefs and values, which were essential for the purpose of the research (Selltiz, Wrightsman, & Cook, 1976).

The established questions for both the guides as well as the questionnaires were designed to reflect the maternity practices promulgated in each country and their underlying symbols; and the relations among the several actors involved in the field along with their respective relations of power. Specifically, the semi-structured interview protocol for the health professionals consisted of asking them to share recently cases of their typical experience and routine with birth assistance. The aims were to identify, through the stories, the practices and symbols involved and enacted by the professionals, as well as their connections with their preferences and with the other actors' preferences. The protocol for the mothers intended to identify their own experience with the birth of their babies and how it was influenced by the

other actors involved, the conversations and negotiations on how it was supposed to happen and how it actually did.

Before the beginning of the interview, I explained again the research's objective and the desire for the respondents to speak freely about the interesting topics, asked authorization to record the interview, justifying the procedure and ensuring again the anonymity of the interviewees and the confidentiality of the information provided, and, finally, summarizing this, I handed the consent form, explaining all these points. All of the interviews were conducted after obtained informed consent. In total, I conducted 46 interviews, with 45 different people between May 2018 and March 2019. In England, I conducted an extra interview with a midwife to discuss and check the pregnancy book and detail how the appointments were like and what were the normal procedures/exams/conduct antenatally, during birth and postnatally. Most of which lastly approximately 50' and all of which were transcribed in full in its original language.

The sampling technique was non-probabilistic and for convenience (Ritchie, Lewis, & El am, 2003). Interviewees were chosen based on previous knowledge of the cases and by indication of other interviewees and related people, such as researchers of the healthcare. In Brazil, the interviewees were mothers, obstetricians, obstetric nurses and doulas, as the main actors identified in the field. In England, the interviewees comprised mothers, physicians (both obstetricians and general practitioners (GP's)) and midwives as the main actors. The interview with the healthcare researcher was the first conducted and had the aim to obtain a general understanding of the English maternity field and its particularities to start the remain interviews. Doulas were not interviewed in this site because it was not found so common their presence in birth.

I conducted most of the interviews in loco. Only in three cases in Brazil, it was not possible to do a face-to-face interview due to longer distances. In those cases, I then conducted through Skype. Table 1 summarizes the interviews by the groups of actors, presenting also the codification it was made in order to ensure the anonymity of the interviewees. The codification comprises the first letter of the country (B – Brazil *versus* E – England) followed by the letter of the type of actor (M – mother; P – professional; R - researcher). As the health professionals encompassed more than one type of group, it was added another letter to identify each one (P – physician, N – nurse, D – doula, MW – midwife). Finally, it was added a number to differentiate each other.

*Table 1.* Interviews by Group of Actor

| **Brazil** | **Number of Interviews** | **Number of interviewees** |
|---|---|---|
| Mothers (BM) | 9 | 9 |
| Obstetricians (BPP) | 5 | 5 |
| Nurses (BPN) | 3 | 3 |
| Doulas (BPD) | 2 | 2 |
| **England** | | |
| Mothers (EM) | 10 | 10 |
| Physicians (EPP) | 6 | 6 |
| Midwives (EPMW) | 10 | 9 |
| Health Care Researcher (ER) | 1 | 1 |
| **Total** | **46** | **45** |

The sample chosen was composed of all the groups of actors involved in the field: mothers and health professionals related to the maternity system - physicians, midwives, obstetric nurses and doulas. In relation to the mothers' sample, in order to get a full sample, I strove to obtain different profiles of interviews, diversifying by number of kids (one, two, three or more), birth experience (normal birth and caesarean section), type of care (public and private), place of birth (home, public hospital, private hospital, birth centre), main care provider (physician and nurse/midwife). Table 2 depicts the profile of the interviewees and birth experiences.

*Table 2.* Profile of interviewees and birth experience

| **Profile of interviewed mothers** | **Brazil** | **England** | |
|---|---|---|---|
| **Number of kids** | | | |
| 1 | 3 | 7* | |
| 2 | 3 | 3 | |
| 3 | 2 | | |
| >3 | 1 | | |
| **Type of Birth** | | | |
| Normal Birth | 8 | 8 | |
| Caesarean Section | 13 | 5 | |
| **Type of Care** | | | |
| Public | 4 | 12 | |
| Private/Health Insurance | 14 | 1 | |
| Hybrid | 3 | | |
| **Birth Experience by Region / County** | | | |
| South | 6 | Oxfordshire | 11 |
| Southeast | 2 | Greater London | 1 |
| Central-West | 2 | Buckinghamshire | 1 |
| North | 1 | | |
| Northeast | 1 | | |

Note *: two of them were pregnant of the second baby who was due soon, so interview comprised the antenatal care experience and projections for birth.

As most of the mothers had more than one baby, the aspects assessed on the table 2 encompass the total birth experiences instead of as the number of interviewees.

**(3) Survey:** Finally, in the convergent stage, I also conducted a cross-sectional survey with women who had birth in both sites. The questionnaire was elaborated by me based on the first qualitative phase (exploratory sequential stage). Through the analysis of the initial interviews and the documentary research, I created a score that quantified the relation of power and maternity practices. Based on this prior knowledge of the empirical context and the thesis' objectives, I defined a series of common maternity situations to quantify the power balance of mothers in the field and the maternity practices enacted, capturing issues such as mothers' preferences, social interaction, decision making, and resources and means mobilized. As depicted in appendix E and F, the developed questionnaire was structured and self-applied, consisting of open-ended questions and predetermined fixed alternatives. It is noteworthy that the initial project elaborated for this thesis was slightly changed after my period as a recognized student at the University of Oxford. As a result, some questions previously developed for a specific analysis were not analyzed accordingly to the previous design.

The final sample consisted of 411 respondents in Brazil and 196 in England. These responses were codified as BMS and EMS followed by the number of the order of response. The sampling technique was non-probabilistic and for convenience (Creswell, 2007), which is suitable for qualitative researches, since it is not intended to be statistically representative but to reflect particular features of the sampled population (Ritchie, Lewis, & El am, 2003). The sample chosen were mothers who had their children in Brazil and in England, without restriction regarding the number and type of delivery. The questionnaire was made available online and in the respective languages of each country. It was disseminated through the internet, in groups of social networks from different states of each country in order to embrace a wide range of regions, especially within the communities of BabyCentre Brazil and BabyCentre UK.

In order to ensure the questionnaire validation, the following steps were performed. First, based on the constitutive definition and operationalization, I delimited the constructs that would be assessed and how they would be identified, i.e., which questions, and how they would be measured from the possible answers. I then discussed the first draft of the questionnaire with two mothers, in order to verify whether the questions were clear and whether the terms were understandable. Again, for greater consistency of the script with the theoretical framing, one of the women was also a researcher of the line of organizational studies. Sequentially, I reassessed the questionnaire based on these discussions and on the analysis of the two prior

qualitative interviews. In this stage, I performed some changes and additions of questions from the analysis of the collected data.

From this, I met with a professional quantitative expert to evaluate the instrument and the constructs developed. The professional assisted me in evaluating the questions in relation to the dimensions to be measured and gave me several suggestions for its improvement. So, sequentially, I reviewed and edited the questionnaire again. Having a new version, I conducted a pre-test with seven women in June/2018. I selected the participating women randomly. The pre-test was conducted on a Sunday day in a park in Maringa city where many families spend the day. In these cases, I personally applied the questionnaires and after made a previous analysis of the data to certify the effectiveness of the instrument and understanding of the questions by the participants.

After that, I finally disclosed the questionnaire online through Google Docs and first published its link in some WhatsApp mothers' groups in Brazil, asking for referrals from women involved in the groups. I then performed a pilot test with 63 respondents at the time to verify the analysis tests and check whether any changes would be needed. To this end, I met again with the quantitative expert researcher to do a pilot analysis. Once everything was settled, I entered in touch with one of the largest maternity sites in Brazil, Baby Centre, asking for disclosure of the research, which was attended. The link was available online between July 2018 to September 2018, gathering 414 responses, of which only 411 were considered as the final sample for Brazil. Among those responses, the sample comprised birth experiences in all the regions of Brazil, within most of the Brazilian states with the exception of three: Amapá, Alagoas and Sergipe. Table 3 illustrates the profile of the participants and Table 4 the type of maternity care they received.

*Table 3.* Profile of mothers in Brazil from the Survey

| **Profile of mothers from the survey** | **Brazil** |
|---|---|
| **Region of Brazil** | |
| North | 14,11% |
| Northeast | 9,00% |
| Central-West | 8,76% |
| Southeast | 40,63% |
| South | 27,49% |
| **Education** | |
| Incomplete elementary school | 0,24% |
| Complete elementary school | 1,46% |
| Incomplete high school | 2,43% |
| High school | 19,46% |

| | |
|---|---|
| Undergraduate | 33,58% |
| Postgraduate | 42,82% |
| **Income** | |
| Up to R$954,00 | 4,87% |
| R$ 955,00 to R$ 2.862,00 | 19,22% |
| R$ 2.863,00 to R$ 5.724,00 | 28,47% |
| R$ 5.725,00 to R$ 9.540,00 | 21,41% |
| R$ 9.550,00 to R$ 13.356,00 | 11,68% |
| Above R$ 13.400,00 | 14,36% |
| **Age** | |
| 16 to 19 years old | 2,68% |
| 20 to 24 years old | 13,38% |
| 25 to 29 years old | 26,28% |
| 30 to 34 years old | 28,95% |
| 35 to 39 years old | 22,63% |
| 40 to 49 years old | 4,62% |
| Over 50 years old | 1,46% |

*Table 4.* Type of maternity care received in Brazil

| **Type of Care** | **Antenatal** | **Birth** |
|---|---|---|
| Private | 13,63% | 13,14% |
| Health Insurance | 50,61% | 46,96% |
| Public | 21,41% | 27,49% |
| Health Insurance and Private | 6,81% | 10,22% |
| Health Insurance and Public | 3,65% | 1,95% |
| Public and Private | 3,65% | 0,24% |
| Public, Private and Health Insurance | 0,24% | 0,00% |

Having concluded the survey in Brazil, I translated the questionnaire into English to start the process in England. There, the same steps were followed before release it. I first conducted a pre-test with two mothers, both researchers, in which I personally applied the questionnaires to discuss and check the language and the proper expressions in English. Next, I also entered in touch with the community of Baby Centre UK to disclose the link of the survey, which was also authorized. In England, the questionnaire was available online for answer from January 2019 to August 2019 which gathered 196 responses. Among those, almost all of the 47 counties in England were contemplated with exception of eight: Herefordshire; Isle of Wight; Lincolnshire; Northumberland; Rutland; Suffolk; Warwickshire; Wiltshire. Table 5 illustrates the profile of the participants and Table 6 the type of maternity care they received.

*Table 5. Profile of mothers in England from the Survey*

| Profile of mothers from the survey | England |
|---|---|
| **Counties** | |
| Bristol | 3% |
| Cambridgeshire | 3% |
| Chesire | 4% |
| Essex | 4% |
| Greater London | 8% |
| Greater Manchester | 4% |
| Kent | 4% |
| Lancashire | 4% |
| Nottinghamshire | 3% |
| Oxfordshire | 12% |
| Somerset | 3% |
| South Yorkshire | 3% |
| West Midlands | 6% |
| Others | 47% |
| **Education** | |
| Incomplete elementary school | 0% |
| Complete elementary school | 3% |
| Incomplete high school | 1% |
| High school | 17% |
| Undergraduate | 31% |
| Postgraduate | 49% |
| **Income** | |
| Up to £1,331.00 | 3% |
| £1332,00 to £3,993.00 | 11% |
| £3,994.00 to £7,986.00 | 9% |
| £7,987.00 to £13,310.00 | 3% |
| £13,311.00 to £18,634.00 | 5% |
| Above £18,634.00 | 70% |
| **Age** | |
| 16 to 19 years old | 1% |
| 20 to 24 years old | 4% |
| 25 to 29 years old | 20% |
| 30 to 34 years old | 33% |
| 35 to 39 years old | 33% |
| 40 to 49 years old | 9% |
| Over 50 years old | 0% |

*Table 6.* Type of maternity care received in England

| Type of Care | Antenatal | Birth |
|---|---|---|
| Public | 97% | 98% |
| Public and Private | 2% | 1% |
| Private | 1% | 1% |

## 3.5 DATA ANALYSIS

While data collection and data analysis are presented separately, as individual phases, this separation is only for discussion purposes. On the conduction of the thesis, both processes had concurrent and overlapping phases. Overlapping these processes was advantageous because not only gave a head start in the analysis but also allowed me more flexibility to data collection, especially given the different types of data. So, conducting research in this way enabled me to make additional adjustments to data collection instruments, such as adding new questions or interviews, probing emergent themes or taking advantage of special opportunities that may be present in a given situation (Eisenhardt, 1989).

Given the design of the research, having mixed data, and based on Fetters, Currie and Creswell (2013), the data analysis followed three steps. Initially, as previously mentioned, the exploratory sequential step consisted of qualitative data collection and prior analysis that led to the main step, the convergent phase. In this, the analysis of the qualitative and quantitative data was firstly conducted separately and then merged so a final and interactive analysis was proceeded (Fetters, Currie, & Creswell, 2013), the last stage. Figure 8 describes the processes conducted in all the data analysis.

Initially, the quantitative data gathered from the survey was organized using a Microsoft Excel spreadsheet to build a general picture of the maternity experiences in each site. That data then was analyzed through two main steps. First, close-ended questions were used for statistical analysis. In a simpler manner, I conducted descriptive and frequencies analyses to obtain information about the interviews' profile and birth experiences, the types and incidence of maternity practices and their variation, among others. Also, looking for more advanced analysis, I further conducted the analysis of variance and co-variance, ANOVA and ANCOVA, to identify the level of power of the mothers in each site.

From the closed-ended questions that presented common situations related to birth and maternity care, I quantified if the mothers' preferences were met and if any measure was needed in order to obtain such outcome. To do that, I initially used the Excel spreadsheet, and then, I imported the final means into Jasp 0.8.0.4 and used for the advanced analysis. The analysis of variance ANOVA aimed to identify if the means of power between the sites were statistically different, so we could state that mothers in Brazil and in England had different relations of power. In turn, the analysis of covariance, ANCOVA, aimed to remove variation due to the influence of another variable, the acts of mobilization (Field, 2005). That is, in a second moment, I analyzed if mothers had to take any measure to make their preferences met and if

they did if these measures had influence in their level of power. Finally, I also conducted some post hoc test to control familywise error and assure the statistical power of the tests (Field, 2005). In a second moment, as the questionnaire also comprised of open-ended questions and I also received a lot of additional comments from respondents, I further conducted some qualitative coding (Lefsrud & Meyer, 2012). This process followed the same steps used in the qualitative data through an interactive process (Eisenhardt, 1989).

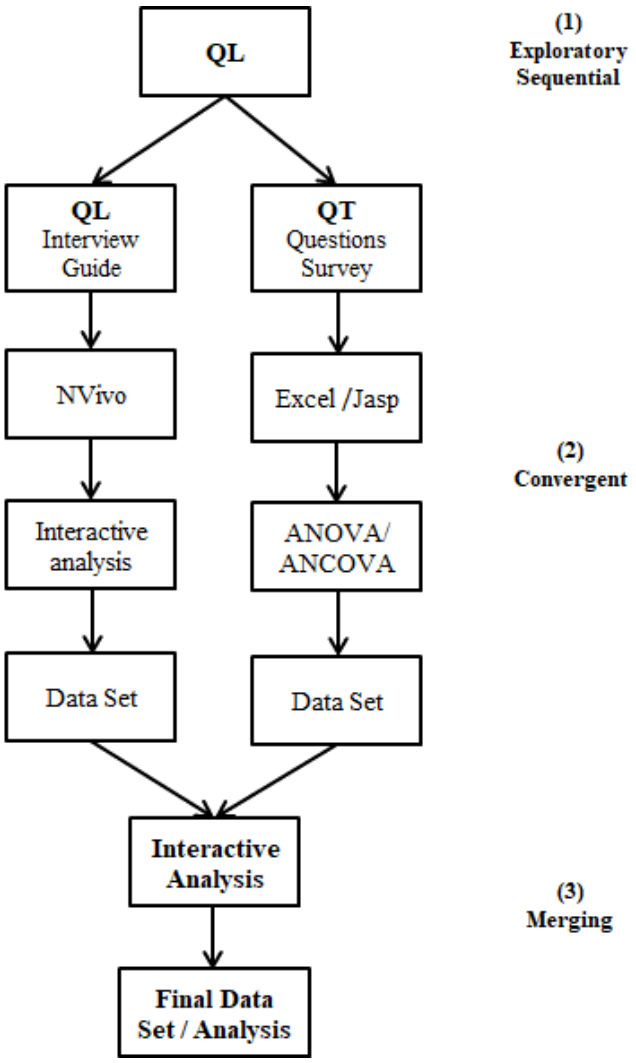


*Figure 8.* Data analysis
Source: Elaborated by the author based on Driscoll, Appiah-Yeboah, Salib and Rupert (2007), and Fetters, Currie, and Creswell (2013).

Qualitative data gathered from the interviews and the questionnaire was transcribed in full and imported into the NVivo 10. They were engaged with the theoretical framework for further refined and applied to code using the software. I conducted data analysis inductively through an interactive process and strongly linked to the empirical evidence (Eisenhardt, 1989; Reay & Jones, 2016), in order to identify clear and recurring patterns from the field data. The

inductive approach to the relationship between theory and research is pointed out as appropriate for case studies whose predominant research strategy is qualitative (Bryman, 2012).

So, at first, I sought for a general sense of the data by reading it many times, in order to develop a better understanding and gain more familiarity with the information gathered. During these, I affixed notes and remarks, as well as previously codes in the margins, as suggested by Miles and Huberman (1994) and Eisenhardt (1989). My aim here was to immerse in the data, examining and developing categories through reflective engagement with the text segments and thus identify patterns of behaviours and symbols associated with particular logics in each case (Reay & Jones, 2016). My interest was centred in what practices the actors were enacting, who was involved, what were their preferences, what they were saying about the different types of delivery and what logics they were invoking. All of these through a process of constant interaction backwards and forward between steps to provide new insides and define preliminary coding (Bertels & Lawrence, 2016; Eisenhardt, 1989).

Having a data set from each phase, qualitative and quantitative, the final step consisted of merging the data sets and conducting an interactive analysis. In this analysis, the steps I followed can be aggregated in a three-phase approach. Initially, my aim was to get *preliminary coding*. The preliminary coding was defined gradually to cover the consistencies identified in the database. I intended to identify the relevant categories and main themes and then cluster text segments in meaningful categories according to its relationship. So, in the first stage of analysis, I aimed to get a general picture of what was going on in each maternity site. To do so, I started reading all the transcripts of the two sites (Brazil and England maternity fields) to build an general understanding of how the maternity system in each site works, focusing on the similarities and differences and also looking at the context setting of each maternity field to understand how each mode of care become institutionalized, why I received such different reactions from the actors interviewed and how these settings could influence the current data.

I then conducted preliminary coding to identify relevant categories and initial themes. At this stage, my focus was to understand: how was the maternity field in each site? Who were the main actors involved? What institutional logics were they invoking? What were the main maternity practices enacted? And how were the relations of power among them? In order to do that, I also went back to the theoretical framework to assist in the preliminary coding. Hence, looking at the institutional logics, I aimed to analyse not only which institutional logics were invoked, but also how were the relationship between them, if they had a collaborative or competition relationship (Reay & Hinings, 2009; Goodrick & Reay, 2011), and how were their level of centrality and compatibility (Besharov & Smith, 2014). As the relations of power, I

focused on how they seem to be expressed along the diverse dimensions of power, such as in resource, relational and institutional spheres (Lawrence, 2008; Clegg, Courpasson, & Phillips, 2006). And relating to the practices, I looked at what practices were enacted, how they variated among themselves and within the sites, and how they were consisted of, both in material and symbolic dimensions (Zilber, 2002; Friedland et al., 2014).

In the second stage, my aim was to *coding for practices*. Given the interest in the variation in practices in the maternity fields, I first drawn to the practices enacted in the maternity fields and conducted more detailed coding for them. Using tactics such as those outlined by Eisenhardt (1989) and Miles and Huberman (1994), I used this coding to interact with the extant body of knowledge and from that to generate detailed data tables with extensive representative quotes. This phase had two main elements: identifying the practices and analysing their implications, that is, how the enactment of these practises impacted in the field? To do that, I classified the practices into seven key categories (embedding and routinizing; enabling work; valourizing and dissuasion; policing; educating; reframing; and constructing networks) and two main effects. The categories that I chose were consistent with the theoretical framework I reviewed from the literature on institutional theory. The literature posits that practices may have divergent implications on institutions, such as creating, maintaining and changing (Harmon, Green Jr. and Goodnight, 2015; Lawrence & Suddaby, 2006; Maguire et al., 2004). Thus, by grouping and comparing the codes, I classified them according to the implication of action that involved predominantly "reinforcing" versus those that involved more "disrupting" effect on the field.

Finally, in the last stage, I looked for *coding for explanatory factors.* Based on the structure of each maternity field, I looked across the narratives with regard to their configurations of practice, so I could clearly compare the different trajectories that emerged in each site analysing the relations of power within each. I focused on the relations of power to analyse how these relations shaped the practices variation and in turn how these relationships affected the institutional arrangements. Through this process, I identified three different relations dimensions along which the seven types of practices varied leading to a more symmetric or asymmetric relation and consequently motivated or demotivated the maternity practices identified. Comparing the sites on these two relations, it was noticed potential explanatory factors from the implications of these dynamics, which are better detailed in the findings and discussion sections.

The comparative analyses were conducted as a constant process and happened in two ways. Firstly, I compared the findings within and between the cases, looking for similarities

and differences (Bertels & Lawrence, 2016; Reay & Jones, 2016) between Brazilian and English maternity fields and also within each country, as to identify how they led to practice variation and how the relations of power had influence on this. At the same time, I also compared theory and data, confronting those findings with the extant body of knowledge (Eisenhardt, 1989; Miles & Huberman, 1994). In general, these stages reinforced the necessity to go beyond initial impressions and enhance the probability to capture novel findings in the achievement of the final themes (Eisenhardt, 1989).

In closing, as to grant greater reliability and validity of the information obtained, the triangulation strategy was also employed. As could be seen from this section, I used different methods and sources of data which have different biases and strengths that can complement each other. As a result, the triangulation of information helped me to check the integrity, extend inferences drawn from the data, confirm and improve the clarity of the research findings (Ritchie, 2003; Yin, 2001; Miles & Huberman, 1994), providing robustness of the findings. The triangulation of data was used by different sources, including different angles of the field (involving different actors' perception). Hence, it provided a convergence of investigation between the data and its conclusions.

# 4 EMPIRICAL CONTEXT: THE MATERNITY FIELD

Before I address the main findings, I provide a summary of each case, to comprehend the empirical context of each maternity field. Each description was built based on documentary research, websites from health care systems of each country and information from the interviews with key actors of the maternity fields.

## 4.1 BRAZIL

The maternity care in Brazil works as a hybrid system, based on the simultaneous operation of a public and expenses free care, and a private one, which acts in a complementary manner (Pense SUS, s.d.). More than 150 million people are assisted by the SUS (Unified Health System) (Mendonça, 2015). However, given the lack of its financing, the unequal distribution of medical professionals in the Brazilian territory (Scheffer et al., 2018) and the restrictions on services and resources invested by the state to meet the health demands of the population, the search for private care is significantly (Pense SUS, s.d.; Mendonça, 2015).

The private sector has been operating in the form of health plans and insurance, as well as hospitals, clinics, laboratories and private practices (Mendonça, 2015; Pense SUS, s.d.). Around 50 million people are assisted by it, which spent one and a half times the amount of money allocated for SUS (Mendonça, 2015). Specifically, in relation to childbirth care, the private system is still usually divided between services funded by health insurance plans and by the user itself. Normally, antenatal care and hospital expenses are funded by the health insurance but an extra charge for delivery is required by physicians as their availability to perform the procedure at any time, regardless the method of delivery (Almeida, 2017).

According to information from the SUS website and the antenatal file, every pregnant woman should have at least six appointments during the antenatal care. It is recommended that the appointments should be held monthly until the 28$^{th}$ week, from the 28$^{th}$ until the 36$^{th}$ week biweekly and from the 36$^{th}$ until the 41$^{st}$ week weekly. In the public domain, these appointments are usually interspersed between physician and nurse. In the private, all care is done by the obstetrician chosen by the woman (Brasil, 2012). Data from a national research carried on in 2011-2012 – *Nascer Brasil* - evidences that 75.6% of pregnant women were assisted by a medical professional, and the older and the higher educated the pregnant woman was, the higher the proportion of medical attendance (Viellas et al., 2014; Leal & Gama, 2012). The maternity system in Brazil is centred on medical authority. The physician is acknowledged and

legally supported to decide the best care and treatment for the mother/fetus binomial. The mother's act of will may be characterized abuse of right in relation to the fetus, in which case the physician has the right to not accept the woman's therapeutic refusal (CFM, 2019).

Antenatal care also involves the assessments of blood tests and ultrasound scans. According to the SUS card, it is recommended at least three or four scans. The first one in the beginning of pregnancy, around 5 to 8 weeks, to check how many weeks the woman is and the quantity of embryos; the second is around 11$^{th}$ and 14$^{th}$ week to check any possible condition as genetic diseases; the third between the 20$^{th}$ and the 24$^{th}$ week to check any malformation, genetic diseases and the baby's gender; and the fourth between the 28$^{th}$ and the 32$^{nd}$ week to verify the baby's growth and weight and the placenta location. On the other hand, in the private domain, as many obstetricians have an ultrasound device in their own office, it is very common for the scan to be part of many, if not all, antenatal appointments (Pinheiro, 2019).

Although childbirth care has almost a universal coverage, the survey *Nascer Brasil*, conducted throughout Brazilian territory found that its adequacy was still low, 60% of pregnant women started their antenatal care late, after the 12$^{th}$ week of pregnancy and a quarter did not receive the minimum of six consultations recommended by the Ministry of Health. On the other hand, most of them, 98.2% reported having performed ultrasound scans (Leal & Gama, 2012; Viellas et al., 2014).

In relation to the delivery, the majority of births are assisted by obstetricians and funded by the SUS (Scheffer et al., 2018). In 2012, 80% were paid by the SUS, which happened in public and mixed hospitals. The remaining (20%) happened in the private sector being funded by health insurance plans or directly by the person. As the mode of delivery, despite almost 70% of pregnant women prefer normal birth, only a few were supported in their choice. Within private services, the incidence was only 15% for the women having their first baby (Leal & Gama, 2012). Current figures show that 55.5% of births happen surgically (Valadares, 2017). In the private sector, the situation is even more alarming, 88% were born by caesarean section (Leal & Gama, 2012), reaching 100% among several health insurances (Taxas, 2017). These high incidences are mostly considered without clinical justifications (Leal & Gama, 2012).

Besides having a low incidence, normal births in Brazil are also characterized by extreme medicalization and intervention and to ignore available scientific evidence. Interventions such as bed restraint, no stimulus to walk, no feeding during labour, use of medication to accelerate contractions, episiotomy, giving birth lying on the back, with someone squeezing the belly (Kristeller manoeuvre) were performed in most women. Only 5% of women experienced normal birth without interventions. And most of these interventions are

procedures not recommended to be performed routinely and some even are not recommended at all according to the WHO (Leal & Gama, 2012).

The performance of caesarean sections happens majority without woman entered into labour. Data from the *Nascer Brasil* survey shows 34.1% of caesarean sections without labour against 17.7% with labour. These incidents raise increased concern due to the high proportion of premature births (before 37 weeks), 11.3%, 55% higher than England and the high proportion of babies being born with 37 or 38 weeks. Although babies born within this period are not considered premature, they could benefit from gaining more weight and maturity if they were born with 39 weeks or more (Leal & Gama, 2012).

The high incidence of caesarean sections in the country has been identified as a public health problem (ANS, 2015; WHO, 2018). Not only this trend has not been followed by significant maternal or perinatal benefits, but also there is evidence that, beyond a certain threshold, increasing caesarean section rates may be associated with increased maternal and perinatal morbidity and short- and long-term risks (WHO, 2018). Consequently, actions have been required by the Brazilian government to reverse this situation (Chade, 2018; Atualização ..., 2015). In 2000, the Ministry of Health established the National Program of Humanization of Hospital Assistance (*Programa Nacional de Humanização da Assistência Hospitalar* - PNHAH). In the same year, the Antenatal and Birth Humanization Program was also instituted (*Programa de Humanização no Pré-natal e Nascimento* - PHPN) and included the theme humanization in the agenda of the 11$^{th}$ National Health Conference. These programs prioritize normal delivery, non-medicalization of delivery and reduction of surgical interventions (Griboski & Guilhem, 2006). In 2005, it was enacted the Law No. 11,108, known as the Companion Law that guarantees the parturient the right to be accompanied by the person of her choice during labour, delivery and the postpartum period (Brasil, 2005a).

In 2015, the National Agency of Supplementary Health (ANS) enacted Resolution No. 368. This regulation provides the right of access to information for beneficiaries of the percentages of caesarean and normal deliveries by operator, by health facility and by physician, and the mandatory use of the partograph, the pregnant woman's card and the information to the pregnant woman of both risks and benefits of methods of delivery (Brasil, 2015). In 2016, the ANS promulgated the Normative Resolution No. 398, establishing the mandatory accreditation of obstetric nurses by operators of private health care plans and hospitals that constitute their networks (Brasil, 2016). Still in 2016, the Federal Council of Medicine (CFM), through the Resolution No. 2444 decrees that caesarean section by maternal request can only be performed from the 39th week of gestation (CFM, 2016).

However, such actions have shown little effect and evidenced some lack of integration. Firstly, despite all regulations, the incidence of caesarean section has constantly increased in the country. From 31% in 1980, it reached 50.1% in 2009, the rate that made Brazil the first country to have more than half of babies being born surgically. Current figures configure the country as the second highest incidence in the world (Valadares, 2017). Also, in parallel with those incentives, some actions established by the Ministry of Health and the CFM were extremely questioned and criticized. In May 2019, the Ministry of Health has issued an order defending to abolish the use of the term "obstetric violence" from public policies and norms. According to it, the term has an inadequate connotation, does not add value and impairs the pursuit of humanized care in the pregnancy-childbirth-puerperium continuum (Cancian, 2019).

Although this decree has been supported by some doctors, as the São Paulo Regional Medical Council (Cremesp, 2019), it was intensively criticized on social networks by diverse pregnancy support groups and different organs and institutions such as the National Council of Human Rights (CNDH) (CNDH, 2019), the Brazilian Bar Association (OAB) (OAB…, 2019), the Federal Council of Nursing (Cofen) (Cofen…, 2019), the Brazilian Family And Community Medicine Society (SBMFC) (Nota…, 2019), among others. The Federal Public Prosecution Service (MPF) has also intervened recommending the Ministry of Health to clarify by a note that the term "obstetric violence" is an expression already established in scientific and legal documents and commonly used by civil society and that may be used regardless of other Federal Government preference terms. The MPF gave 15 days for the Ministry of Health to respond to this recommendation (MPF ..., 2019), which was later followed. In the next month, the Ministry of Health recognized the legitimate right of women to use the term obstetric violence to represent experiences experienced during childbirth and birth that constitute disrespect and abuse of parturient women. (Após ..., 2019).

Later, the same year, in July/2019, the CFM disclosed the Resolution nº 2232 determining legal support for physicians to define the best care and treatment for the mother and baby. This resolution states the impossibility of refusal of treatment by pregnant women if health professionals see harm to the fetus (CFM, 2019). Again, the MPF has intervened, contesting this resolution. In September of the same year, the MPF issued a recommendation in which it asks the CFM to revoke the topics on the resolution that addresses to maternity care, recognizing that only in cases of imminent risk of death physicians are allowed to act contrary to maternal desire, however without any substantial change so far (Blower, 2019).

The MPF and other obstetricians also against the resolution argues that the enactment of the new rules tends to favour caesarean sections and unnecessary procedures, to legitimize

practices no longer indicated by the WHO and considered ineffective or yet that may be used as justification for procedures that shorten the period of labour against the women's will, and to eliminate the women's power of choice, threatening their autonomy (Blower, 2019). Possibilities that are contrary to the recent WHO recommendations (WHO, 2018).

The WHO recently published a guide of recommendations to stop the incidence of caesarean sections. Among them it is supported better communication between health professionals and mothers, allowing women to also express their opinion on procedures and techniques during labour and delivery and letting her aware of all the information. In the health agency's assessment, the women's involvement in labour decisions is the key to change this reality. Among the recommendations, the organization asks physicians to inform women about the childbirth (WHO, 2018; Chade, 2018)

Given all this context, there is a strong and growing participation of women's movements and social groups (Picheth, Crubellate, & Verdu, 2018; Diniz, 2005; Tornquist, 2004). The humanized childbirth movement has emerged claiming for changes of medical conduct and procedures adopted in maternity care. Based on the WHO guidelines (WHO, 2018; OMS, 1996), it defends a humanist model of care, evidence-based medicine, with greater protagonism and respect for women's decisions and higher incidence of natural and humanized birth (Brasil, 2001; RNFS, 2002; Diniz, 2005; Griboski & Guilhem, 2006; Rattner, 2009a; Felix, 2016). This movement also has strong action through campaigns, events, actions, petitions and hearings requested and held with the MPF, discussing issues such as obstetric violence, high incidence of caesarean sections and humanization of birth (RNFS, 2002; Tornquist, 2004; MPF, 2010; Felix, 2016; Picheth, Crubellate, & Verdu, 2018).

As a reflection of this movement, there is the diffusion of a new model of delivery, the humanized childbirth, in which birth centres and home births stand out as new places of birth. These places are better structured and adequate for labour and normal birth, usually providing Pilates ball, showers, bathtubs or plastic pools. There is also the emergence of other key actors in the maternity field, such as support groups for pregnant women - who offer preparatory courses for birth; doula - a professional without formal training who offers the pregnant woman information and physical and emotional support during pregnancy and birth; physiotherapists - who provide assistance with Kegel exercises, yoga, Pilates, and acupuncture for birth; breastfeeding consultants; and obstetric nurses, who often returns the role of midwife, more common before the 1970s in Brazil ( Picheth & Crubellate, 2019; Felix, 2016).

Considering all this panorama and the characteristics of maternity care, the anthropologist Davis-Floyd (2001) describes the maternity system in Brazil as a technocratic

model of childbirth attention. This model characterizes by the super-valuation of science and it is strongly affected by technology (Davis-Floyd, 2001; Rattner, 2009a). It constitutes a wide use of aggressive interventions, emphasis on short term results and convenience of healthcare professionals. As a result, it is observed that most of the routine obstetrical procedures have little scientific evidence to justify them and it is performed not by scientific sense but by cultural sense (Davis-Floyd, 2001; Rattner, 2009a), as could be seen by the high incidence of caesarean section rates and interventionist births, many stated as no clinical justifications (Leal & Gama, 2012; Valadares, 2017; Taxas, 2017)

This model also configures by the separation of body and mind and the body seem like a functioning machine, a mechanical process. Thus, often practitioners do not engage with their patients, avoiding lengthy conversations and preferring short visits. The maternity system is also characterized by hierarchical and standardized care. There is a rigidly hierarchical power to the physicians as a group, who is in charge of authority and decision making, the subordination of individual needs to standardized practices and routines, and emphasis on the speciality care over primary care. The standardized practices can be noticed by the hospital gown women are dressed, the movement by wheelchair as entering the hospital, an intravenous needle inserted, and periodic vaginal exams (Davis-Floyd, 2001).

These characteristics could also be illustrated by the resolution Nº 2232, enacted by the CFM (CFM, 2019), and by the claims of the humanized movement for women's protagonism, more humanized care and fewer interventions (RNFS, 2002; Tornquist, 2004; Rattner, 2009a; Felix, 2016). Also, according to Freire and colleagues (2011), Pereira (2006) and Hopkins (2000), one of the reasons of such discrepancy between women's preference for birth and the rates of the method of delivery is the expertise and authority centred in the physicians. The authors state that the hegemony of knowledge and power of obstetrical practice held by physicians leads to a unilateral decision which reinforces an interventionist and medicalized obstetric model, supporting the model defined by Davis-Floyd (2001).

## 4.2 ENGLAND

The maternity system in England works majority within a public domain. All the care is provided by the NHS – National Health Service – whose services are free of charge to patients in England. The NHS is funded by taxation with a fixed budget to spend on services. Most of these services belong to an NHS trust or NHS foundation trust. Each trust may vary in how many sites they have – e.g. hospitals and centre births. In total, there are 136 NHS trusts

in England that provide maternity services (NHS, 2016). Alternatively, women can go privately or yet combine NHS and private care, opting to hire a private midwife or obstetrician. However, in this case, all the services provided during birth, such as hospital expenses, midwives and remain health care assistants' care, are also charged, even if it is in a public hospital. Since the costs are highly expensive, it is not the most common chosen option.

Antenatally, the NHS offers ten appointments to women who are pregnant with their first baby and seven if they have had a child before, plus blood tests and at least two ultrasound scans. The first scan, the dating scan, is around 8-14 weeks, to estimate when the baby is due, to check its physical development, and to screen for possible conditions, and the second is around 18-20 weeks to check the physical development of the baby. If necessary, depending on the woman and/or baby's health, the NHS offer more appointments or scans. It is very common also that women during her antenatal attend parental classes. The main options are either from the NCT (Nation Childbirth Trust) - a parent charity group that support parents – which has a small tax or from the NHS which is expenses free. In these meetings, they discuss the stages of labour, pain relief options, how to identify labour, breastfeeding, first cares with the newborn baby, among others.

According to the categorization on the health care paradigms, Davis-Floyd (2001) characterize the maternity field in England as having a humanistic paradigm of childbirth. This model constitutes an effort driven by nurses and physicians to make care more partnership and individually oriented. The care provided balances between the needs of the institution and the individual, trying to establish a more relational and subject connection with the patients. As with the technocratic model, physicians also take science as standard and use similar tools and techniques, however, some differences distinguish both.

Firstly, in the humanistic model, science and technology are counterbalanced with humanism. Health professionals are inclined to use technology at their disposal but they also emphasize the relationship and caring with the patients along with it. The use of interventions should be evidence-based care and not base on medical tradition and all performed under the patients' request or desire (Davis-Floyd, 2001). As a result, all maternity care in England is driven by NICE guidelines. The NICE - National Institute for Health and Care Excellence - provides evidence-based information in the form of specific national guides for health practitioners and pregnant women. It aims to assist all the care offered during pregnancy with best practices for baseline clinical care, to ensure that all pregnant women receive the regular check-ups, support and information, and to support the decision making about the appropriate treatment in specific circumstances.

The main mode of birth is normal birth (73.8%), most of all happening spontaneously (61.8%). From the early stages of pregnancy, the woman is already prepared and instructed about labour and normal birth, as it is taken for granted condition. Caesarean sections are considered in case of a higher risk situation or when a woman has had a previous one. In this last case, despite health professionals primarily stimulate normal birth, given normal conditions, the woman has the right to opt for a planned caesarean section. Yet, in case of a maternal request for caesarean sections without clear medical indication, the normal procedure is to offer referral to a healthcare professional with expertise in mental health support. If after discussion and offer of support the woman still refuses a vaginal birth, the guideline is to offer a planned caesarean section (NICE, 2011).

In the early 1980s, the incidence of caesarean sections was 10%. In the 1990s rates began to gradually rise from 12% in 1990 to 21% in 2001 (Caesaren Section, 2002). From 24.1% in 2005-2006, it increased to 27.1% in 2015-2016, with current figures evidencing a 28% proportion of births happening surgically. Within this proportion, 12% are elective caesarean sections and 16% emergency ones (NHS, 2019). Antenatal care, labour and birth are considered less interventionist (HSCIC, 2015; Leal & Gama, 2012; Davis-Floyd, 2001), which can be seen, for example, by the performance of fewer ultrasound scans.

Secondly, there is a difference in timing and selection. In the humanistic model, health professionals are more open to mind-body approaches and more willing to wait. Usually, the primary care is conducted by general practitioners or family physicians, that first attempt to resolve the problem from more conservative methods and may delay referring to a specialist (Davis-Floyd, 2001). As a result, the main care provider in the maternity field is midwives. Midwifery is a separate profession from nursing, obtained through a degree-level programme approved by the Nursing & Midwifery Council (NMC) and constitute a larger body of maternity health care professionals. According to data from the Royal College of Obstetricians and Gynaecologists (RCOG) and the Health and Social Care Information Centre (HSCIC), there are approximately 1,970 consultants and 1,630 trainees working in the obstetrics and Gynaecology speciality and 21,517 full-time equivalent midwives (NHS, 2016).

Midwifery is recognized as the responsible profession to deal with pregnancy as it takes account of the whole context and not just the obstetric parts. Besides taking care of both the mother and the baby, its role also comprehends preparing women for the delivery, physically and psychologically. Most of the pregnancy appointments are performed by midwives. Depending on the woman and the baby's health and where they live, the woman may see a midwife for some appointments and a general practitioner (GP) for others. However, she only

sees an obstetrician in case of a complication or a higher risk. The same happens with birth. Usually, women are only assisted by obstetricians during birth if it is necessary to have an instrumental birth or a caesarean section, otherwise, the whole process is assisted by midwives.

As soon as the woman finds out she is pregnant, she must report to her midwife or if she has not been named one yet, to her GP who will address her one. They will book the first appointment, known as the booking appointment, which is longer and aims to evaluate and instruct the women to obtain her medical history and to give her the pregnancy book. The pregnancy book is a folder with all the information collected throughout pregnancy – personal data, fetal assessment, laboratory results, and the calendar with further appointments, tests and scans. The woman keeps it the whole pregnancy, so she has access to all information and her own progress. Once she is admitted for delivering, she handles it to the midwife which is then used to record her labour, birth progress and postnatal care. It has also a space for woman writes her birth plan, that will be read once she is admitted for giving birth.

Maternity system in England also focuses on allowing patients to lead and enhance their autonomy. Information, decision-making, and responsibility are shared between patient and practitioner (Davis-Floyd, 2001) and it is said to be women-centred care. From the rationale outlined in the Montgomery judgement in 2015, health care professionals are obliged to give women information about all the test and procedures performed and give her the opportunity to choose. They must talk in clear language the recommended treatment and procedures, explain the purpose/need of it and the risks and benefits involved, discuss the alternative options and the consequences of not performing the treatment or intervention, and then, give the woman adequate time to reflect and decide, finally documenting all the conversation in the maternity record or pregnancy book (NHS, 2017).

Most of the cases, such as performing tests and exams, do not require signing a formal consent, just explaining and asking if they agree with it – Or, as commonly identified on the interviews: “Are you happy with this?” -. Some procedures, on the other hand, require the mother’s signature for formal consent, such as caesarean section and induction. Independently of which, in all the cases, the process to obtain informed consent should involve the conversation with the mother, the opportunity for her to ask questions and to decide whether or not she agrees with it (NHS, 2017). Refusal of treatment has to be also one of the women’s options, she is entitled to decline a treatment even when it is for her or her baby’s health benefit (NICE,2011). So, for example, the options for pain relief are considered humanistic only if the mother asked for it and/or consent to have it from the practitioner recommendation.

This right of choice involves selecting the place of birth as well. There are four types of maternity settings that women can choose: freestanding midwifery unit, alongside midwifery unit, hospital obstetric unit and at home (Comptroller and Auditor General, 2013):

- Freestanding midwifery unit is an NHS clinical location that offers care to women with straightforward pregnancies during labour and birth in which midwives take the primary professional responsibility for care. All the assistance and assessments are performed by them and occasionally GP's may be involved. During labour and birth, medical services including obstetric, neonatal and anaesthetic care, such as epidural, instrumental birth (forceps/vacuum) and c-section, aren't immediately available but are located on a separate site which transfer by car or ambulance is required.
- Alongside midwifery unit is an NHS clinical location similar to the freestanding unit, the difference is that the range of diagnostic and treatment medical services are available in the same building or in a separate building on the same site. The transfer, then, is normally by trolley, bed or wheelchair.
- Obstetric unit is an NHS clinical location in which care is provided by a team, with obstetricians taking primary professional responsibility for women at high-risk complications during labour and birth. Independently whether or not women are considered at high or low risk, midwives offer care to all women and take primary responsibility for women with straightforward pregnancies during labour and birth. If necessary, diagnostic and treatment medical services are available on site.
- At home: if a woman opts for a home birth, two midwives will assist her at home providing the necessary equipment. If labour is not progressing as well as it should or any diagnostic and treatment medical services are requested, transfer by car or ambulance will be required.

These options depend also on where the woman lives and to which trust she belongs to. Nearly all trusts (96%) offer the option of giving birth at home, however, only 2.4% of births in 2012 were at home. Data from 2012 evidence that the majority of births (87%), took place in obstetric units, 9% in alongside midwifery units and 2% in freestanding midwifery units. The women preference, however, is slightly different: 25% of women prefer giving birth at the obstetric unit, 49% at alongside midwifery unit, 6% at freestanding midwifery unit and 10% at home. The proportion of births in midwifery-led units has increased from 4% in 2006-2007 to 11% in 2012 (NHS, 2016; Comptroller and Auditor General, 2013).

The decision for the maternity setting is also mediated by the health conditions, needs, risks and birth preferences. Women who develop higher risk pregnancies are recommended to give birth in an obstetric unit where obstetricians can also assess her if needed. The same option is advised for a woman who desires to have an epidural for pain relief, for example, since this procedure requires an anaesthetist to perform it. But in general, all sites are well structured in support for normal birth. The rooms have adequate birthing chairs (Figure 9), shower, balls, appropriate lights (Figure 10) and pain relief options, such as gas and air, tens machine (put at the back and it sends electrical messages), aromatherapy. Also, some rooms are equipped with a birthing pool if the woman desires to have a water birth (Figure 10, 11, 12).

*Figure 9.* Birthing chair.
Source: Data collection

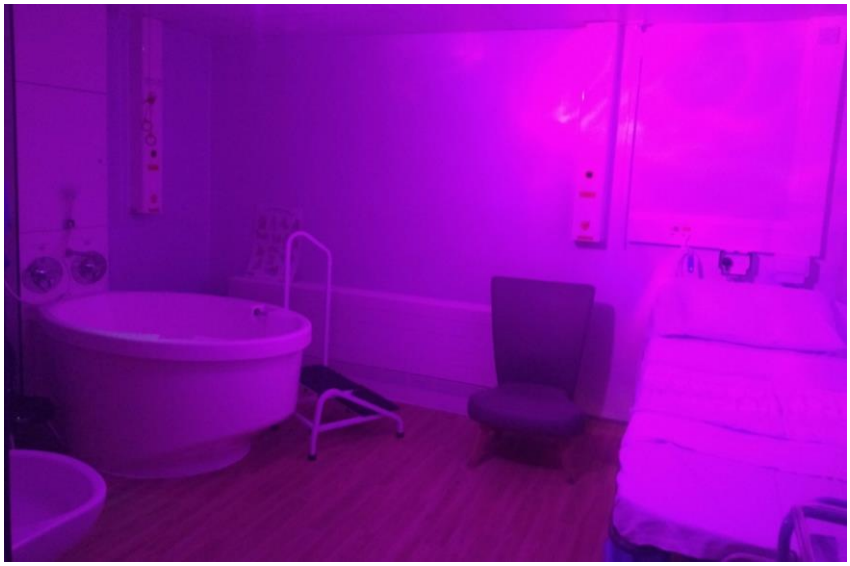

*Figure 10.* Birthing room in a Midwifery Unit with low lights.
Source: Data collection

*Figure 11.* Birthing room in a Midwifery Unit.
Source: Data collection

*Figure 12.* Birthing room in an Obstetric Unit.
Source: Data collection

No matter the choice of birthplace, all maternity care characterizes as one-to-one care. During all the stages of labour and birth, the woman is assisted by a midwife who stays with

her the whole time. She is responsible to periodically assess the woman, to provide the woman psychological and medical support and to offer options and strategies for pain relief if requested, such as trying different labour positions, aromatherapy, self-help, gas and air, injection, using water, tens machines and other medicines/injections. During the birth, a second midwife comes to assist together in case any extra care is needed or some emergency may happen. In case the midwife's shift ends before the woman has given birth, she is substituted by another midwife.

The NHS works on a cost-effective and safe base. Due to that, it is not possible to always have a personal health care provider. Usually, the antenatal is conducted with the same midwife as the appointments are scheduled in the GP' clinic. However, the labour and the birth are assisted by the team who are on call on the moment. The same happens when obstetrics appointments or procedures are necessary. There is no continuity of care. The woman is not designated to a specific professional but to a team. This is pointed sometimes as criticism by women who would prefer to know beforehand the professionals who will assist them.

Overall, women's experiences of maternity care in England are positive. In 2007, 75% of women classified the care received during labour and birth as excellent or very good, compared with 69% for the care received during pregnancy and 58% after birth. In 2010, these figures have improved to 84% during labour and birth, 76% for the care received during pregnancy and 67% after birth (Comptroller and Auditor General, 2013). Similar results were also obtained from the collected survey which will be described in the next section.

*Summary of similarities and differences*

*Table 7.* Comparison of maternity care in Brazil and England

| | **Brazil** | **England** |
|---|---|---|
| **Model of childbirth attention** | Technocratic model | Humanistic model |
| **The main provider of maternal care** | Obstetrician | Midwife |
| **The main source of care** | Hybrid system | Public |
| **Care centred on** | Medical authority | Women-focused |
| **The relation between practitioner and patient** | Authority and responsibility inherent in the practitioner, not patient | Information, decision-making, and responsibility shared between patient and practitioner - informed consent |
| **Other actors involved** | Health insurers, ANS, Ministry of Health, CFM, ONG's and Support Groups from the Humanization Movement | NHS, Nursing & Midwifery Council, Royal College of Obstetricians and Gynaecologists, NICE, NCT |

| | | |
|---|---|---|
| **Professional conduct structure** | Mostly individual work (Obstetrician) | Teamwork (Midwives, GP's, Obstetricians – varied from shifts) |
| **Technology role** | Supervaluation of science and technology | Science and technology counterbalanced with humanism |
| **Places of Birth** | Mostly hospitals<br>Fewer incidence of birth centres and home birth | Freestanding midwifery unit, alongside midwifery unit, obstetric unit and home birth |
| **Mode of birth preference** | Normal Birth | Normal Birth |
| **Main Mode of birth** | Caesarean section (55.5%) | Normal Birth (73.8%) |
| **Incidence of elective caesarean section** | 34.1% | 12% |
| **Incidence of normal birth with no interventions** | 5% | 40% |

# 5 FINDINGS

The main research question that guides this study asks how the relations of power shape maternity practices in the multi-logics field. Against the backdrop of this common aim, the findings have three key elements: (1) multi-logics field; (2) practices; (3) relations of power. Finally, I discuss how these three elements interact in each case, comparing and contrasting the empirical findings between the countries and with theoretical insights.

## 5.1 MATERNITY AS A MULTI-LOGICS FIELD

In order to address the first research question, I analyzed the maternity field in Brazil and England with respect to the multiple logics enacted in both sites. It was noticed that two institutional logics are at the core of the institutional multiplicity: medical and natural logic. Looking across the two sites and relating them to the Besharov and Smith (2014)'s model of logic multiplicity, I analyzed the relationship between the institutional logics and I identified two different types of multiplicity, configuring each one in a specific quadrant, see Figure 13. I present each case in the sequence.

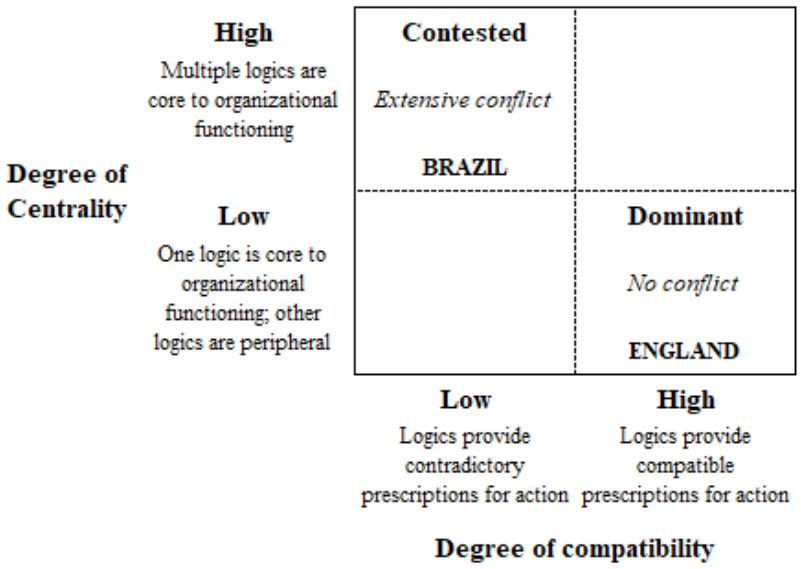


*Figure 13.* Types of Logic Multiplicity in the Maternity Fields.
Source: Based on data collection and on Besharov and Smith (2014:371).

*Brazil*

According to the data collected, Table 8 illustrated the two distinct maternity logics identified in Brazil, the medical and the natural logic. Analysing the relationship between them, I first identified that they present low compatibility with each other. As it could be seen on the

table, the maternity logics frequently imply contrasting values and goals, which in turn are reflected in the types of practices preferred and enacted.

The medical logic emphasizes the scientific specific knowledge and higher attention to risks and uncertainties involved. As can be seen from the quotes presented in table 8, in the second column, the birth is viewed more technically and as a medical event. More than a normal process in women's life, birth in this logic is conveyed as carrying many uncertainties, being a critical process that bears many risks and needs "*constantly monitoring*" (BPP1). Hence, births should happen inside hospitals, being surrounded by professionals who have adequate specific knowledge and at disposal of the proper equipment, otherwise, being considered an unsafe birth. The following quote from a physician illustrates that:

> *this knowledge, this security that we have to be always monitoring, right? And if you do not have an environment that provides this correct monitoring and also professional training, it is not only equipment to consider, we do have this risk of unsafe birth… So… home birth, small hospitals, in cities that have no conditions for it, all these [...] Where there is no preparation for the complications of childbirth (BPP1)*

Given the perception of birth embedded in uncertainties, it is valued, then, that physicians are in control of it, "*anticipating all possible complications*" (BPP2), "*already intervening beforehand*" (BPP2), and "*ultimately ensuring the safety of the mother-baby binomial*" (BPP1). Physicians are trained from their early formation how to "*do the birth*" and "*make the baby born*" (BPP4). Consequently, as an effect of managing all the process, medical logic embraces performing practices and interventions that accelerate and control the evolution of birth and labour. Instead of letting it follow its own flow, it was noticed many cases of intervening previously real need. The following quotes illustrate some of those:

> *Upon the arrival of the last obstetrician on duty, it turned out to be a caesarean section again, because I was already fully dilated, but it was a slightly longer expulsive (BM6)*

> *I started crying and asked: what did you do? She said: I broke your bag because now the baby will be born faster, and left the room (BM8)*

> *But the interventionist conduct is still very widespread, we [obstetricians], as I said, we want to make the baby born, and sometimes when I tell the students on training: no, leave her there, leave her alone, let's just listen to the baby. They say: Oh, but doctor, you don't want to examine? you don't have to…? […] We want all pregnant women to dilate their laps at the same pace, with a pattern of contractions in the same way. If we get this much dilation, we break the bag or I'll tell her to push because it is time for this baby to be born and if it's been so long since the baby's head is there but is not born yet, I will pull this baby, either with the forceps, or with the vacuum, or I will perform a c-section. (BPP4)*

> *He [obstetrician] does normal birth, but normal birth that does not take long. If it takes too long, he already forwards to c-section, which is what he did to me, right? He is not that person who will have a lot of patience. He went at 7 am, he came back at 10 am, and by noon he already said ... no, now it won't anymore... [then performed a caesarean section] (BM1).*

*Table 8.* Maternity logics in Brazil

| Medical Logic | Empirical Evidence |
|---|---|
| Birth as a medical event | "The passage of the baby in the delivery, of which we are talking about both c-section and normal birth, is the most critical moment of our life, if we think, what is the most critical moment of our life is when we are born, without doubt, birth is the moment that you are most at risk in life" (BPP1)<br>"What I think is important in the motherhood itself is what I said to you, knowing how to prevent some complications we have to have" (BPP2)<br>"Because until then, I've learned what all obstetricians learn, to *do* the birth, to do everything, to make the baby born [...] I had an interventionist model as the basis that is what we learn" (BPP4) |
| Control of time / Rush | "... when the baby's head went out, what I wanted to do? I wanted to pull the rest of the body. The first time I was assisting a birth, the nurse told the pregnant woman that was almost giving birth, look the baby's head is almost out, you will take a deep breath and in the next contraction it will come out. In my head, it was like: "next contraction? There will be no next, I'll pull! I want to get this baby out of here" because I have this anxiety of getting the baby out of there rsrs" (BPP4)<br>"Most mothers do not think that the baby will be born in its own time when they are at 39 weeks of gestation, they already want to schedule a c-section. Sometimes they entered into labour, but the baby is not born in five hours and then they think that it will not be born and that is it" (BM3)<br>"The obstetrician said: so, we will induce your delivery and you will have to have the baby. Until lunchtime, I want your baby here" (BM4)<br>"The obstetrician said: oh, I'll take these babies out before I travel, and then I travel tranquil with no baby waiting here" (BM6)<br>"The physician arrived in the room, I was in contraction, the nurse came, pushed my belly, the physician put the needle, broke the bag, and even laughed: all set, this boy will be born now" (BM8) |
| Centred in the medical conduct | "... always remembering that the conduct is medical" (BPP2)<br>"Once, there was a nurse who said: oh, but it's not time to push yet because the evidence shows to not push. Then, at that time I said, look I'm sorry, the conduct here is medical" (BPP2)<br>"And most of the women just rely on the doctor, who is usually a doctor who will do what is easier for him, which would be a caesarean section, and then she ends up having a caesarean section" (BM3)<br>"The physician came into the room and said: no, I will operate you. Then I said: no, but I don't want to be operated, I want a normal delivery. He said: No, I will operate you" (BM8)<br>"The use of oxytocin. I'm not in favour either, but if necessary, I'll put. If she finds it too abusive, she has the option of looking for another doctor" (BPP2)<br>"I told him about birth that I wouldn't want to have an episiotomy, he said: ---[woman's name], you don't have to want it, it's up to me, who is the doctor and if I have to do an episiotomy on you, I'll do it". (BM8)<br>"The obstetric field is very much centred in that doctor's self-centeredness, it is a medical centred, so the doctor as the main actor and… is still very instrumentalized" (BPN2)<br>"I respect each individual's desire as long as we have the safe binomial, this has to be thought of" (BPP1) |
| Women as patient | "I asked how is the delivery room? Is it prepared for it? The doctor said, no, it's a room, the normal operating room. So, I would be lying there, I wouldn't be able to choose the position I wanted to be" (BM9)<br>"We make the recommendations that the WHO makes that is leaving the woman upright, for example. A position they do not like to be is lying down. Then you get there on duty, she is 8cm and has to lie down" (BPD2)<br>"We see in the position of birth, which is convenient to the professional, it is obvious that it has nothing to do with women, so everything is focused on the professional" (BPN1)<br>"When I got there the patient was in the delivery room, positioned one leg to each side [gynaecological position]" (BPP4) |

| | |
|---|---|
| The predominance of technology and interventions | "In short, he [obstetrician] put me on that medication that induces labour, during all labour, they came to do the internal examination all the time, not only the doctor who was assisting me" (BM4)<br>"At the time that I had the -*baby*-, they used forceps in everybody that had normal birth there, you know, and there were people who they also made the little cut [episiotomy] too, but nothing was asked, nothing, nothing" (BM4)<br>"The matter of caesarean section in this safety issue is because nobody tolerates an unfavourable outcome, a not favourable outcome, so they end up preferring it" (BPP2)<br>"Their [obstetricians] goal was always to have surgery around everybody, right" (BPP4)<br>"Because it is better to do a caesarean section, for the doctor, for the doctor it is better, much easier, 20 to 30 minutes ends a caesarean section" (BPP4) |
| Focus on the risk, on the uncertainty avoidance | "I have a lot of patients who are physicians, maybe because of college, that we get to know, and most of them want a c-section because everyone had had a case of a baby who was born badly after a normal birth during the academic years and they say I don't even want to take that risk" (BPP2)<br>"Everyone has a fear of normal childbirth, so maybe, sometimes for backing, professionals prefer not to risk it" (BPP2)<br>"It was very straightforward, I don't do it, it's very risky, you can die, your baby can die too. It was just like that... two caesarean sections? No way, you cannot even go into labour, because it can break your uterus, you can die and your baby can too… so there was no talk" (BM7)<br>"There are many doctors who are "*cesarists*" [who perform only caesarean sections] in the hospital, so, we see a lot, even when sometimes the woman wants a normal delivery, he already puts a fear in her such as: 'well, let's see', 'until then we see how it goes'. So, you already realize that he will try to induce her to do a caesarean section" (BPN3)<br>"...people giving birth not in a hospital environment, as home birth, this is a big problem that we ... one of the great sequels we are having is in this area" (BPP1) |
| **Natural Logic** | **Empirical Evidence** |
| Birth as a natural/ physiological event | "I think because it's natural, for a matter of recovery, because it's better for the baby. So, at first, I always wished it had been normal delivery" (BM4)<br>"The normal birth is natural, so it's our nature, so it's the best, without intervention it's even better" (BM9)<br>"I think the first way of giving birth has to be the natural way, the way we were created to. The baby was created to be born naturally... Because it's better for the baby, it's better for the woman" (BPD1)<br>"I think we end up understanding more and more that the physiological is the best" (BPN1) |
| Lack of control | "Now the normal birth, which has more or less a whole physiological process, a beginning, middle and end, but that it is not always like that, things can take longer more or less, there are certain situations that are unpredictable" (BPP3) |
| The medical team in assistance | "The role of the team is always to respect the woman's choices" (BPD1)<br>"Then I had the baby vaginally, without any intervention, without anything, it was with a nurse, it wasn't with a doctor" (BM7)<br>"By the time the bag broke, she [the obstetrician] already knew she was not going to arrive on time. She just said: separate some cloths and wipe the baby's face when it is born. And she only arrived two hours later. And as it was everything ok, we were not scared and we were with her on the phone all the time" [home birth that the obstetrician did not arrive on time to assist it] (BM7)<br>"I didn't even go to the delivery room; he was born in the pre-delivery room. The obstetrician pulled the chair, sat down, crossed her leg and said: look, you are going to have a contraction and he will be born, the baby is being born" (BM8)<br>"The professionals are actually there to help to guide whatever is necessary. If nothing is needed... I say I love to watch, if nothing is needed, we will just watch. We even offer it to the father, if he wants to take it, so he does everything and we just watch, literally" (BPN1)<br>"The most important thing is this notion that who is important there is the couple, the woman, the baby. I'm just there to do it if necessary. I think this is the main look" (BPN1) |

| | |
|---|---|
| Women leading the parturition | "I went into labour a few days later, went to the hospital and had my baby naturally, without any intervention. I denied oxytocin when the doctor was prescribing. I said I didn't want to and I had a document saying that she said: no, that's fine, if you don't want it, I won't put it" (BM7)<br>"I think the most important is respect to the protagonism of women. Respect the physiology, her decisions, the position she wants to give birth. Look at that woman as a single individual and not standardize procedures for all women" (BPD1)<br>"I think natural birth gives back power to women, of women. And even the man, who is following the process, to understand that she is really capable, that her body is really capable and knows what to do, demystifying everything that has been built, that our body is imperfect, that we don't handle, that we can't handle the pain"(BPN1)<br>"I think that from the moment we understand this woman's autonomy, we understand that she can do whatever she wants" (BPN1)<br>"And of course, after informing her, it is the woman deciding how she feels safer and more comfortable" (BPN2) |
| Interventions only in needed cases supported by scientific evidence | "It is absurd to imagine that of all births, 90% will be non-physiological, 90% will have to have some intervention, even more than 90% in the private care ... that woman will have to need some help for the baby to be born, this is absurd, even from the point of view of nature. We wouldn't get where we are if we needed all this intervention for the child to be born. So, it's really an exaggeration, an exaggeration to put science where it doesn't need to, to impose resources where it doesn't have to" (BM4)<br>"We explain that interventions will be done when necessary" (BPD1)<br>"…the caesarean section was created to be a really necessary intervention" (BM1)<br>"And the antenatal so far is going really well, and she never even considered a caesarean section for any reason. Not even in face of nearly gestational diabetes that I am, she said never" (BM3)<br>"We know that the caesarean section is there for some complications, from the research they have, that about 15% of women need some help" (BPD1)<br>"I always say that when we talk about proper birth, humanized birth, we are not talking about not using technique under no circumstances, we are talking about using it only if necessary" (BPN1)<br>"The woman knows how to give birth; the baby knows how to be born and then the surgical intervention comes to cases in which normal birth is not possible" (BPN2)<br>"Surgery is and should be the last option in all cases of life. If you have something that will happen naturally without having to undergo surgery, why are you choosing surgery? you have to have a good reason for that" (BPP4) |
| Focus on the normal risk/low risk | "Even more than a normal birth, I wanted a home birth, so that was more, let's say, even harder. And he [physician within humanized movement] was always supportive, he said: no, it's okay to have a home birth, I support, if it's okay with you, all the exams are ok, there's no problem" (BM6)<br>"I believe that for birth it is the obstetric nurse who is more prepared than the doctor. The doctor is prepared for birth out of the usual risk. A usual risk birth does not have to have a doctor, I would opt for a doctor if I have any complications that really needed medical intervention or a medical choice, but if I had everything within the usual risk, I would continue with a nurse really" (BM7)<br>"The recommendation is always normal birth. Under normal conditions, with the mother well and the baby well, which is 99% of the time… a pregnant woman is not a time bomb, we want to treat a pregnant woman as a patient who anytime ... a time bomb that wants to explode" (BPP4) |
| Higher focus on evidence-based medicine | "The physician has to act based on scientific evidence, has to be a well-updated physician, right, who studies a lot about childbirth, this is fundamental, scientific evidence" (BPD1)<br>"We were deconstructing this idea because, in this way, it is showing scientific evidence that it does not have to do, that in more developed countries it is not done" (BM6)<br>"In the birth plan, I put the scientific pieces of evidence, for example, in the term of the episiotomy, I put the study, the law, you know, everything to support my request. In the term with the refusal of the eye drops in the baby, I put the reasons, I put the studies, I put everything" (BM8)<br>"To treat care in a way even based on scientific evidence" (BPP3) |

This pattern of conduct may be connected to professional education (Dunn & Jones, 2010). During their training, medical professionals are more exposed to critical and high-risk cases. So, there is a greater propensity for this experience to stand out and consequently prioritize prevention, even at the expense of performing unnecessary and invasive procedures in the short term. Medical discourses were centred on expressions as “safety”, “insecurities”, “risks” and “avoiding complications”, that ratifies birth as embedded in an increased risk that has to be constantly treated:

> *There was a possibility of fetal suffering in the medium and long term, so I had two options either I had a caesarean that night or I could continue monitoring every 12 hours ... I called dr.--, he also said, I indicate a caesarean section today (BM1)*

> *I have a lot of patients who are physicians and most of them want a caesarean section because everyone had had a case of a baby who was born badly after a normal birth during the academic years and they say I don't even want to take that risk (BPP2)*

Relating to this, the notorious preference for a caesarean section as the main mode of birth is also connected to these values. Since the surgery is more predictable, with all the process standardized and time-controlled, there was a higher preference of this mode among medical professionals, including for better convenience of time schedule, as can been seen from the following extracts:

> *Also, the matter of caesarean section in this safety issue is because nobody tolerates an unfavourable outcome, a not favourable outcome, so they end up preferring it (BPP2)*

> *Because it is better to do a caesarean section for the doctor. For the doctor it is better, much easier, 20 to 30 minutes ends a caesarean section” (BPP4)*

Therefore, birth happening in an appropriate place, with expertise people and with the predominance of technology are supported as a guarantee of safety and achievement of the desirable outcomes. Being surrounded by patterned procedures and technology at disposal provide higher security to physicians who feel in control of the situation, which is not always equally controlled and predictable in normal births. Consequently, the lower performance of normal births tends to increase the insecurity of its practice due to an ever-decreasing experience.

> *The most important thing that I consider in maternity care is safety. Today the great events that we have about losses, especially the loss of children and women, were related to unsafe birth (BPP1)*

> *Everyone has a fear of normal childbirth, so maybe, sometimes for backing, professionals prefer not to risk it (BPP2)*

On the other hand, the natural logic is configured around different symbolic constructions. It involves the conception of birth as a natural and physiological event. The focus

in this logic is on the benefits of delivering normally, such as healthier for both the mother and the baby, best recovery and the fact that is a process from the own body/women's nature, so provided by inner wisdom. The maternal and baby nature knows what and how to do in its right time. Hence, it is also a process without control or predictability but conducted by the own nature of the body. The following quotes exemplify this:

> *I preferred normal birth because I always believed that our body knows what it has to do, you know? [...] I always believed that the body, our body knows the best way (BM1)*

> *Normal birth is good, recovery is great, etc., and because it is something natural too, it's ours, of the woman, it is physiological, so I wanted to have the experience (BM8)*

> *Now the normal birth, which has more or less a whole physiological process, a beginning, middle and end, but that it is not always like that, things can take longer more or less, there are certain situations that are unpredictable (BPP3)*

Given that it is a normal process in women's life, a natural event, it presents a conventional or low risk in most of the time. The focus here it is not on the possible embedded risks and complications, as in the medical logic, but on the fact that primarily, it is a natural common event for most women, that is beyond a pathological state. Considering usual conditions, then, it should be treated as natural as possible, with no necessity to happen inside hospitals, surrounded by technique apparatus and medical team.

> *The recommendation is always normal birth, right? Under normal conditions, with the mother well and the baby well, which is 99% of the times, [...] the advisable is normal birth, it is better for mother and baby (BPP4)*

> *Everything was perfect, the pregnancy was quiet too, there was nothing, no risk of having to go to the hospital during pregnancy, so we could try at home. My thought throughout pregnancy was always that if at the time of delivery, I had any need of having to go to the hospital, then I would (BM3)*

Interventions, in turn, must only be considered and performed if and when necessary. And in order to legitimize this requirement, it should always be based on scientific evidence instead of medical convenience, customs or experiences. Regarding the mode of birth, caesarean sections here should not be the primary choice, but a resource to be selected in the face of increased risk, complication or lack of labour progress. The following quotes illustrate this view:

> *I think we end up understanding more and more that the physiological is the best, that if it is necessary… I always say that when we talk about proper birth, humanized birth, we are not talking about not using technique under no circumstances are we talking about using it only if necessary (BPN1)*

> *The woman knows how to give birth, the baby knows how to be born and then the surgical intervention comes to cases in which normal birth is not possible (BPN2)*

> *It is absurd to imagine that of all births, 90% will be non-physiological, 90% will have to have some intervention, even more than 90% in the private care… that woman will have to need some help for the baby to be born, this is absurd, even from the point of view of nature. We would not get where we are if we needed all this intervention for the child to be born. So, it's really an exaggeration, an exaggeration to put science where it doesn't need to, to impose resources where it doesn't have to (BM4)*

Consequently, since in this logic there is the belief in birth as a natural and physiological event of woman's body, the leading protagonist of birth here is the woman herself. She is the one who actually "does the birth". So, the woman is considered the best person to lead how the birth should occur, in which position she wants to deliver and with or without the help of other practices, because she is who knows best her own body. Health professionals are responsible for assisting and instructing her in case of a complication or the need to intervene at the time, but always letting her choose from the recommendations made:

> *My birth was 100% natural too, and I did my birth again, as it should be. My delivery was all accompanied, assisted by an obstetric nurse, who fully respected me, she was by my side (BM8)*
> *I went into labour a few days later, went to the hospital and had my baby naturally, without any intervention. I denied oxytocin when the doctor was prescribing. I said I didn't want to and I had a document saying that I showed her and she said: no, that's fine, if you don't want it, I won't put it (BM7)*

> *I think the most important is respect to the protagonism of women. Respect the physiology, her decisions, the position she wants to give birth. Look at that woman as a single individual and not standardize procedures for all women […] the role of the team is always to respect her choices (BPD1)*

> *The professionals are actually there to help to guide whatever is necessary. If nothing is needed... I say I love to watch, if nothing is needed, we will just watch. We even offer it to the father, if he wants to take it, so he does everything and we just watch, literally (BPN1)*

Such assistance, hence, can and frequently is encouraged to be made by obstetric nurses, exclusively, in the case of home birth or centre births, or by sharing the assistance with obstetricians in hospital births. In this case, obstetric nurses share the technical role to assess the woman and the baby during labour and birth with the physicians, being able to assist the whole process. In many cases, they convey the resumption of the midwife, common in birth practices in the past, but simultaneously representing the scientific role valued by the logic, provided by their training and obstetric knowledge, and the craft performed more naturally, given the ability to address uniquely normal birth, so less lean to intervene.

> *I believe that the obstetric nurse is more prepared than the doctor for normal birth. The doctor is prepared for normal birth out of the usual risk. A usual risk birth does not have to have a doctor, I would opt for a doctor if I have any complications that really needed medical intervention or a medical choice, but if I had everything within the usual risk, I would continue with a nurse (BM7)*

> *The nurse, besides being able to assist the delivery itself, helps a lot in the monitoring. So, as the labour is sometimes lengthy, it needs strict monitoring of both the woman and the baby, to check if the baby's vitality is fine, so you need someone to help you, help the doctor. The doctor can do this too, but if I have someone to help me, this work is divided because sometimes it's a long labour, and the doctor not only monitors and assists the delivery but also has a specific function that is unique to the doctor, for example, dealing with situations where the nurse cannot solve and should not, right? For example, caesarean section, this is exclusively a medical procedure (BPP3)*

This aspect, however, was observed as highly opposed in medical logic. In this, considering the sensing of pregnancy from a focus on risks, there is a strong centralization on the obstetricians. The combination of specific scientific knowledge and the application of science provides obstetricians with higher authority and legitimacy under the medical logic (Dunn & Jones, 2010; Cain, 2019). They are seen as prepared to "*not only know how to solve a problem, but how to prevent it from happening*" (BPP2), so their presence during all pregnancy, labour and birth is considered indispensable. Even though in many cases no practice is necessary, it is still considered better and safer to have them close. As a result, expertise and authority are centred on medical professionals. Since they have broader specific knowledge, they are seen as the main responsible for deciding which is the appropriate conduct and practices to perform, even if it is against women's will. The following quotes exemplify some cases of medical centrism:

> *Actually, the conduct is very medical, so you already instruct the patient since antenatal that this can happen [change of practice agreed] (BPP2)*

> *The use of oxytocin, I'm not in favour either, but if necessary, I'll put it, if she finds it too abusive, she has the option of looking for another doctor (BPP2)*

> *On my thirty-seventh week ultrasound, the doctor said, she suggested it was a caesarean section. So, until then I advocated normal birth, but still a little scared, you know? Great insecurity, so she decided (BM5)*

> *I told him [physician] that I wouldn't want an episiotomy, he said: you don't have to want it, it's up to me, who is the doctor and if I have to do an episiotomy on you, I'll do it (BM8)*

> *There is hardly any need to do any procedure when the baby is born well, but the paediatrician needs to be present because it is… well, it needs, I believe it is safer to be present (BPP3)*

The low compatibility between both institutional logics in this regard was also evident by the need to legitimize that obstetric nurses are capable to assist normal delivery. Although within natural logic their assistance is common and highly valued, along with this defence, it was identified a need to ratify that they can and are allowed to perform such practice. The low compatibility was also evident in an obstetrician speech in which even defending the

importance of obstetric nurses and stating that they can assist the birth, the better is still to have a physician together. The following examples illustrate this:

> *all the antenatal care was with her [obstetric nurse] ... She asks for all the normal exams, antenatal care, you have the pregnant woman's card, everything ... and she can assist normal birth, it's not just a job of the obstetrician (BM3)*
>
> *...the nursing part, since the nurse, she is able to assist the normal delivery without dystocia (BPN2)*
>
> *Because a low-risk birth, depending on the place, it can be assisted by either a nurse, specialized in obstetrics or the doctor, but I believe that the doctor, along with the nurse plus doula and a paediatrician, they are the four professionals, a team well suited for a humanized birth, a doula, a nurse, an obstetrician and a paediatrician (BPP3)*

Therefore, all the extracts and contrasting values show that both the maternity logics present conflictual instantiations, which allows framing their relationship as presenting a low degree of compatibility. The empirical data gathered illustrate differences in values, beliefs and conduct regards to same aspects present in the maternity field. In a way, it conveys differences perceptions as insiders versus outsiders of a logic. Table 9 presents this comparison.

*Table 9.* Comparison of maternity logics in Brazil

| | **Medical Logic** | **Natural Logic** |
|---|---|---|
| **Normal Birth - time length** | "The concern of normal birth itself was more of suffering for him because I've heard that besides the suffering of pregnant women, normal birth when is very forced, right, a forced normal birth, it can harm the baby […] If it passes the time in the mother's belly, being born purple practically, then it is not viable" (BM2) | "I wanted normal birth because I wanted that my son was born in the best way that was possible, in his own time, with love and respect." (BMS65)<br><br>"Be born vaginally so it was at the time of my baby" (BMS115) |
| **Normal birth – interventions** | Normal birth is badly seen by doctors also because here, it is very widespread, especially by nurses and doulas, natural birth without analgesia, 'Ah, analgesia cannot'. The woman has to feel pain, something very 'Riponga' [hippie]. And it's not like that, it can have a middle ground, it doesn't have to be that scheduled caesarean section, but it doesn't have to be this just natural delivery either (BPP2) | "I think that the normal birth being normal [natural], not those full of interventions. But what is physiological. We indicate the physiological, nothing that is induced, nothing that is..." (BPPD2) |
| **Homebirth** | "Unsafe birth would be a case of lack of experience, for example, of hospital learning, outside a safe environment and also in which people are giving birth not in the hospital, like home birth. This is a big problem that we ... one of the great sequels we are having is being in this area" (BPP1) | The environment [home birth] is totally different, the attitude of family members is completely different. The autonomy that we have in this birth is much greater and I think being at home makes us automatically think less about interventions because we do not have access. And this is very clear right, when we go to the hospital, automatically the interventions come in cascade […] So the home environment is chosen for that, so |

| | | |
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| | | that the woman, the couple, they have the freedom to do what they want" (BPN1) |
| **Delivery assisted by Nurse/Midwife** | And I still find the presence of the obstetrician an important thing, I do not think it is unnecessary, I know that some places, the role of midwives, in England, for example, is an important thing, that women are extremely trained for that, for low-risk cases, but … (BPP5) | "A low-risk birth, depending on the location, can be assisted by either a nurse who specializes in obstetrics or a doctor (BPP3) |
| **Assistance shared with nurses** | "I don't work with anyone in a team, when I work, is with the nurses from the hospital […] Since I haven't found anyone that I trust to this day, so I don't let anyone do .... because I don't trust anyone, they (nurses) rested and I did the work" (BPP5) | "I work in teams and we work in teams, with doula, nurse and the doctor […] I believe that the doctor, along with the nurse and the doula and a paediatrician is… a team well suited for a humanized birth" (BPP3) |
| **Doula** | "We do not have professional doulas in our network, we do not have them. They are completely… those who call themselves doulas, they are not doulas, within the concept they should be. So, I say that certain individual actions burn the profession [...] they play unskilled roles, they interfere with the antenatal condition, they interfere with the condition of childbirth [...] They have no training, they have no responsibility, they just generate conflict, because it's easy for me to become a mystic, our doulas here became a mystic"(BPP1)<br>"Some hospitals here do not accept nurses or doulas, because they try to induce this, this posture and interfere where is the medical conduct, so there are doctors, colleagues who say, 'ih don't come with these people here,' and they don't let them even enter" (BPP2) | "Another situation that helps and this is scientific, I at least do not work without it, is the support of a doula. So, women who have this person together, a doula, this is scientifically proven, they have a greater chance to be able to have a normal delivery and even more, to be satisfied with what happened, with the delivery, with the birth [...] so having the accompaniment of a doula, for example, helps a lot" (BPP3)<br><br>"it's teamwork, right? If I were to choose one to have by my side, I would choose doula, I wouldn't choose the doctor, which is much better, right? I, as a doctor, I have much better experiences of childbirth when there is a person who is holding hands with the pregnant woman [...] doula is the best painkiller that there is for childbirth, the thing that most takes pain is having someone with this function on your side" (BPP4) |
| **Medical Conduct** | "I've already had a problem with a patient yes. A patient came with a lot of demand - not to ask her to push, to let half-light, not to tell her to push the baby, under no circumstances put the hand on her belly… things that I'll do it, on the time, I'll tell her to push, I won't be quiet right" (BPP5) | "The professionals are actually there to help guide whatever is necessary if nothing is needed... I say that I love to watch, if nothing is needed, we will just watch [...] And sometimes I watch the videos of the births and I say: why I put my hand there, I had to let him go out alone, I didn't need to put my hand. But it's something that still needs to be deconstructed… I often end up helping there, which is unnecessary" (BPN1)<br>"There are some that I get more worried sometimes and at the time I want to give a little help? Yes, but most of them I wait to leave [...] before I wanted to do everything and now I don't want to do anything anymore rsrs, I say to the patients: if you don't need me it's better, I just want to be there to watch you deliver your baby" (BPP4) |

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| **Birth Plan** | "do a birth planning, I say that the dynamics of pregnancy, it is quite complex, it is not so simple that I will put in a... such that the birth plan for me is to sign a contract that you know you will not accomplish. Because it won't... how are you going to guarantee that? Something that has no way ... it has a whole dynamic. You can talk about good practice, not being an interventionist, following good practice training. Now, the birth plan is something that is not just about making a contract and registering it in a registry office" (BPP1) | "Usually the doulas make the birth plan right with the pregnant women and ... and what the birth plan is really not very different from what we develop here during prenatal, which is this professional bond patient, she is already telling us how she would like the process" (BPN2) |

Analyzing Table 9, it is possible to comprehend better the low compatible relationship between both institutional logics. It evidences some differences in perception between actors inside and outside each logic. The issue of centralization of medical conduct, for example, while viewed in medical logic as coherent, given that doctors hold the specific knowledge, is frequently portrayed with indignation by actors of natural logic. For those, especially women, the centralization of authority and conduct on medical professionals is often a trigger that legitimizes obstetric violence and the indiscriminate use of practices to accelerate labour and, therefore, for medical convenience, or yet, as a technique to deceive women of their own will, such as normal birth. It is conceived by an outsider as a line of production in which women are voiceless.

On the other hand, the greater naturalization of childbirth and encouragement of assistance by other professionals, such as doulas and obstetric nurses, also is percept as a contradiction by the defenders of the medical logic. While in the natural logic this is seen as an additional factor to reassure women give birth vaginally, for actors of the medical logic, it is often seen as the defence of a "*hippie birth*", a "*madness*" and "*Indian behaviour*", or even a "*disservice*". Consequently, within this logic, the presence of these professionals in some hospitals should be avoided or even prohibited.

In addition, looking across the second dimension of the relationship between the institutional logics, I identified that the medical and natural logics present a high centrality, that is, they are both in the core to the maternity field. The medical logic is dominant in maternity care. It is highly instantiated among health professionals, especially obstetricians, which are the main responsible for care. Antenatal and delivery are mostly assisted by physicians. Usually, in the public domain by general practitioners and obstetricians, and obstetricians in the private domain. From our survey, 95.5% of women were assisted by obstetricians. The high

rates of caesarean section (55.5%) and normal birth with interventions (95%) (Valadares, 2017; Leal & Gama, 2012) in the country also confirm the great instantiation of the medical logic as they are the ones responsible to conduct those practices.

On the other hand, natural logic is higher instantiated within pregnant women. According to our survey, 72,75% of women preferred normal birth against 21,41% who preferred the caesarean section and 5,84% without preference. The same was noticed within the interviews and by other researches (Potter et al., 2001; Faúndes et al., 2004; Domingues et al., 2014). Despite all these sources commonly evidence large differences in the incidences of caesarean sections between the sectors, public and private, in regards to the mode of birth preference, there are no differences between the groups. In large proportion, thus, natural logic is dominant within women independently of the type of care they receive. Also, this logic is gradually increasing within health professionals and the general public with the movement of humanization, especially obstetric nurses and doulas that already have their training aimed at normal deliveries. Projects such as the "*Hospital amigo da Criança"* (BPP3), "*Parto Adequado"* (BPN3), and national contest with the prize "*Galba de Araújo"* (BPP3) are results of the movement to motivate more humanized practices and natural deliveries in the field. Such initiatives, for example, are head by health care professionals and impact the whole team that also needs to adjust to it.

Shortly, pregnant women and physicians are both central in the maternity field, and they usually instantiated incompatible institutional logics. The differentiation between logics embraces professional education. The training of medical professionals is built on the application of science, with a focus on the knowledge and treatment of diseases (Dunn & Jones, 2010). As a result, they tend to act and intervene more easily even in cases such as birth that is not decisively related to the disease. Women, in turn, usually frame pregnancy as a natural process of their own body which should be carried as natural as possible.

Hence, looking across these dimensions, the multi-logics maternity field in Brazil can be characterized, according to Besharov and Smith (2014)'s typology, as a contested domain. The high centrality of both logics added to their low compatibility results in a conflict arena. The institutional logics compete to co-exist with constantly disagreement between their respective actions. For example, despite obstetricians hold higher authority under the medical logic, in the face of discordance with the women's preference, even with the justification of increased risk or uncertainty, they were not always interpreted as valid. Many times, the physicians' arguments were portrayed as not trustable or indeed medically justified, or one of

the "*caesarean tale*" from a "*cesaristic*" doctor to deceive the woman. Yet, some cases reported the sufferance of obstetric violence and terrible experiences:

> *I know a lot of women who ended up falling into the 'caesarean tale', who wouldn't need it and regret it, they think, 'oh gosh, why didn't I go to another doctor, why I didn't fight harder for my birth…. So, the caesarean tale is the various myths, right? So, cord around the baby's neck, low liquid, reaching 40 weeks and not having any dilation, wow this is something that makes me very nervous ... And worst of all, a friend of mine, recently, was going to have the baby in a hospital that is super busy and would be close to a holiday. Then the doctor told her that she could not have the baby in that hospital because she could go into labour on holiday and there would be no place in the hospital and she believed and gave birth a week or two before because of this (BM3)*
>
> *because there are a lot of doctors who are 'caesaristic', so he ... we see a lot even when sometimes the woman wants a normal delivery, he already puts fear in her (BPN3)*
>
> *I suffered a lot of obstetric violence […] I remember all these details that I'm telling you, it comes all like a movie, it was too much, too much (BM4)*
>
> *And it was a night, that I tell everybody like that, a night that was a show of horrors. I didn't have the knowledge, so I thought these practices were normal. But I suffered violence (BM8)*

The configuration of the Brazilian maternity field as a contested domain was also visible on the data gathered from the survey. Despite more than half of women (61.5%) had the birth they want, most of them (76,56%) expressed a negative perception of maternity care in Brazil. Assessing the reasons for the negative evaluation, many critics address directly to the medical logic, regarding elements as the predominance of technology and interventions aimed to rush (too focus on caesarean sections, violent and disrespectful, too interventionist), centred in the medical conduct (focused on ease of professionals, medical centred, lack of information to women) and women as patient (lack of respect for women's wishes, women deceiving), among others.

Consequently, the relationship between the two core maternity logics in Brazil is characterized by a competition between logics (Reay & Hinings, 2009; Goodrick & Reay, 2011). The instantiation of one logic undermines the other and allows for the simultaneous influence of the multi-logics on the actors and their practices. Actors' conduct and preferences were judged to be legitimate on the conformity with the elements of each logic. These aspects, presented in table 8 are influential motivators to understand why actors endorsed one logic over the other or why they avidly percept the other as incoherent, violent or unsafe, for example. This also works as an explanatory mechanism for understanding the growing emergence of natural logic within the country with the Humanization Movement.

*England*

As in Brazil, I identified in England two main maternity logics: a medical and a natural logic (Table 10). However, contrary to there, in this country, the institutional logics showed a different type of multiplicity, they present a high degree of compatibility and a low degree of centrality. When we analyse the relationship between the logics, different from the former case, both logics present a high degree of compatibility. Even if medical action is needed, all care in England both by obstetricians and midwives is oriented by patterned guidelines in which the core effort is to prioritize the naturalness of birth. The same belief is held by women. As a result, the main aspects of maternity were shared by the two institutional logics. Birth in England, for example, is conceived in the two maternity logics as a physiological event. It is the normal way that babies are born, which has always been practised around the world since ages to deliver the child. Therefore, is the primary mode of delivery:

> *I got myself into the mindset that my body can do this, I've made to do this. Women do it all over the world every day. It's a very normal thing. (EM3)*
>
> *I realized that in the UK, they are much more focused on... giving birth is something normal, it's natural, you can have… it is something pretty normal…there not much blood test and examinations, and so on. Here is more 'less' but at the same time, less scary. (EM10)*
>
> *I wanted to experience the most natural thing that my body was made to do, and have the empowered feeling of having achieved bringing my child into the world myself. (EMS91)*
> *Because it was my body doing as it knew how to (EMS86)*
>
> *I prefer the thought of natural labour and birth as it's what our bodies are designed to do. (EMS62)*

This normality is such that normal birth is constantly taken for granted. It is the natural path to be followed: get pregnant, enter into labour and deliver vaginally. Other options, such as caesarean sections would only be considered in case of complications that deviate from the usual risks. This point was particularly interesting during data collection because in many times some questions were not properly understood as were in Brazil due to this assumption. For example, when questioned about preference or recommendation of the type of birth, the answers were addressed to the place of birth instead of the mode itself, as to deliver vaginally was already the "norm". The following quotes illustrated this assumption:

> *S: how do you want your baby to be delivered?*
> *M: we wanted to have a home birth*
> *S: So, vaginal delivery?*
> *M: yes*
> *S: and why?*
> *M: well we thought it would be easier at home*
> *S: and why the normal birth?*
> *M: why?*

*Table 10.* Maternity logics in England

| Medical Logic | Natural Logic | Empirical Evidence |
|---|---|---|
| **Birth as a physiological/ normal event** | | "I realized that in the UK, they are much more focused on... giving birth is something normal, it's natural, you can have… it is something pretty normal…there not much blood test and examinations, and so on. Here is more less but at the same time, less scary". (EM10)<br>"And so, for me, the obvious choice was to try and make the birthing process as natural and as relaxing as it could be. Because I really believed in my body's ability to do or do naturally is able to do" (EM3)<br>"It is something very female and also arouses this strength that we have and know what our bodies are able to do" (EM5)<br>"So, they're [physicians] really focused and passionate about normal birth so they're very positive about it" (EPMW6)<br>"If you are a pregnant woman and in labour, there isn't anything wrong with you. It's a normal natural process. It's not that there's something wrong. So, we only want doctors to intervene if there is something wrong, and then they absolutely should" (EPMW4)<br>"Because here you're dealing with somebody who's relatively well, who is going through what is considered a physiological process, it's not a disease, it's not, she's just not sick in any way", (EPP4)<br>"I am probably more inclined to allow labour to proceed and to try to deliver vaginally," (EPP2)<br>"I think as far as possible, you know, a normal vaginal… because I think that it has the lowest rates of mobility for their mother, and you get good outcomes, it's cost-effective, obviously, you have monitoring, and there are some cases where you have to do a caesarean section and so on. But we do not particularly agree. But I think with well-managed care a high proportion of women should manage a normal vaginal delivery" (EPP3) |
| **Woman focused** | | "Don't assume that they know and always tell them these are the options, you decide when you like them and just let me know otherwise I'll keep helping you with whatever you're doing" (EPMW2)<br>"You'd talk very much with the mother. That's your first dialogue that you have with the mother, you talk about the progress how, what does she want?" (EPMW1)<br>"I mean if a woman feels empowered, and like, she is in control, and she is making choices or informed choices, so it's all about an informed choice. As long as she has all the information, she is free to make the choice that she would like to make... we can offer our opinion but we can't force her to do anything which she doesn't want to do". (EPMW4)<br>"So, I think it's really important that we take across women's thoughts and experiences of the delivery process… I also think of improving the experience, making sure they have a choice and what they want." (EPMW5)<br>"So, you need it there for the safety of mom and baby. But also, you obviously need to consider their choices in there, what they want out of it. We have our guidelines as to what we need to offer, but if they don't want that but that's their prerogative choice… depends on what the woman wants, how she wants to deliver" (EPMW6)<br>"So, it's really, I think, any plan that you make with women, it's about listening. That's where we get it wrong with women, you need to be able to communicate with them. Listening is such a crucial skill, find out what it is that they're worried about, trying thinking with all your experience what you could put in place to address some of those worries. And some people have such significant worries that it's impacting their mental health and we work very closely; we have a consultant psychiatrist here. So, if I think that they need more help in" (EPMW9) |

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| | "So, the philosophy here it's very much that women often choose a place in birth. Now, clearly, that choice has to be on an individual basis, discussed between, initially them and the midwife, who will be finding out you know, what are the health problems they have" (EPP1)<br>"So, obviously women are given the choice. If they are low risk, then they have a choice to obviously to deliver in a consultant-led unit, or to go to a midwifery-led unit or to have a home birth. If there are high-risk cases, then the recommendation to deliver on the labour ward, so in an obstetric unit, but as I said, is the patient that makes the decision" (EPP6)<br>"So, we try very much to make it a combined decision, trying to involve women in that decision" (EPP2)<br>"Whatever we are doing, we have to have the woman on board with it". (EPP4)<br>"I think here is very much about choice …we've got a lot of choices within, so if people want to go down that very sort of medicalized route, they've got the option or like as I'd say we're sort of halfway in between, and then you've got others that might want a home birth or purely freestanding midwifery unit, there are all of the options there" (EM1)<br>"I was given a leaflet about what the options are and told to me read that. And then later in the pregnancy, she brought up you know, have you had a chance to think about where you'd like to give birth? And I said, Yes, I want to go to the spires. And she said, fine, that's great. That was the end of that" (EM3)<br>"I was even surprised that they asked me because if you know that should be doing it, you should do it," (EM7) |
| **Lessen invasive conduct** | "they were going to have to do a caesarean if the forceps didn't work" (EM1)<br>"But also, it's how to make things safe, and to have no complications, if possible, or when you have them is to deal with them appropriately" (EPP6)<br>"Here it is the other way around…So, with my sister, she had an emergency caesarean the first time for her son and they've given her lots of appointments, discussing her options for the next time and, she said it is very much the other way that they want to encourage woman not to have a caesarean and try naturally and it seems like it's the pattern" (EM1)<br>"When we found out she was breech I knew that I had the right to request a caesarean if I wanted one, but I still didn't want a caesarean. So, I said, Look, we'll give the ECV a try and get her to turn. And if she turns then we'll go for a natural delivery as planned. And luckily, she did turn" (EM3)<br>"if is the first baby, you get booked and you just wait until labour happens and if labour doesn't start, they will start giving you information about the induction. That would be the first option. So, a caesarean is not something that is considered even as an option" (EPMW2)<br>"So, we had a lot of discussions, should be induction or should it be c-section and he said that because she was small and it was early, then it was a 40% chance that would be a C-section anyway, even if we tried to do a normal birth. And then I said, what do you think I should do? And he said, well, actually I'm quite an anti-c-section, so I think you should try a normal birth. And it was quite easy." (EM7)<br>"We certainly… you certainly would not be having an elective design section unless it was for a medical indication like a breech baby for example…before 41 and a bit but also women rather than… if they can't go into labour they would be in induced first rather than getting straight to a caesarean section unless there was some other reason why induction wasn't going to be safe." (EPP1)<br>"…it's to do things as naturally as possible" (EPMW6)<br>"And if you've had a previous section they can come and talk through and taking away any unnecessarily medicalization, so you wouldn't necessarily see an obstetrician if you had a previous c-section unless you got a complication around that section. |

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| | | So, you've normalized even that pathway. And have people around you, not just midwife, but people around you that believe in that process and support that process" (EPMW8)<br>"We do forceps and instrumental deliveries which obviously increases the chances of having a vaginal birth in future pregnancies and obviously avoids a certain number of caesarean sections. My personal view is that is safe as long as you are trained. And I think in the bigger picture it does reduces the risk of caesarean sections… because it's safe and because it's…, as I said, in the long run, it reduces the risk for future pregnancy and things like that. And it's safe". (EPP6) |
| **Time Control Concern - *"rush"*** | **Natural flow** | **Medical Logic:**<br>"then the second stage I think I pushed for two hours and then they can see the head but it just wouldn't come out. And I think they started to worry about, you know, all these other risks because it's been, I don't know, I think they've got a guideline…. I think I sort of reached that time frame so they just decide to accelerate the birth. So, at a point, I think the obstetric just rushed in […] So my son, my first son was delivered forceps. And then yeah, and also, I had an episiotomy," (EM4)<br>"So, then we decided to transfer me to the theatre, so I think from that moment onwards I was surrounded by quite a lot of medical staff, so not just me and my midwife. Yeah. And then I was rushed to the theatre" (EM4)<br>"even though I had a natural birth, they were quite pro-intervention, my doctor was quite pro forceps and... wanted to speed it up (EM7)<br>**Natural Logic:**<br>"think perhaps trying, having the opportunity to try a normal birth and also quite open with... I didn't have specific thoughts, I was very much open in the fact that I didn't mind if, obviously, clinically, there was a reason for whatever was going to happen. But I very much wanted to have a natural birth" (EM1)<br>"just go with the flow, because there are certain things that... mainly when is your first, when is the first pregnancy you don't know how it's going to go and it's better not to have a certain idea" (EPMW2)<br>"I actually think usually let nature take its course is the best intervention we can do and literally let nature take it ...if everything's going well you know it's going well, it's when you have these cases where perhaps...when things aren't normal that's when you need to intervene if things are going normally I don't see any reason to intervene." (EPMW5) |
| **Focus on possibilities of increased risk** | **Focus on the normality of risk** | **Medical Logic:**<br>"my blood pressure started to increase a little, little bit but she said that I had to be transferred to the delivery suite but she came with us," (EM10)<br>"they found out that there was meconium, so the baby pooped already so… from that point onwards I was not considered as a low risk so I was considered high risk because, I don't know if you know about me meconium but is a sign that the baby might need additional attention so they didn't allow me to go to the Spires, as I planned so" (EM4)<br>"there were more frequent appointments in the private [consultant], I had lots and lots of scans. Lots of long discussions from quite early how we might give birth" (EM7)<br>"I think it's a personal choice, we try and make every option as safe as possible. Okay. But obviously, personally, if you asked me, delivering either in the midwifery-led unit that is in the same building as the delivery suite or on the delivery suite is safer, just because if you... if there were problems, then you have... help is closer than delivering at home or in the standalone unit" (EPP4)<br>"I think it depends on each woman; each one has their own… I, as a doctor, wouldn't want to go to level seven [Alongside Midwifery Unit], because I'm the opposite, rsrs, I want to be around the doctors because if I have any complications I want to |

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| | | have the right people there, to deal with that … but there are lots of people who don't think, and I think level seven is safe too, so for those who want it" (EPP5)<br>**Natural Logic:**<br>"So, we have an induction midwife upstairs to starts the process and then came to us. So, we try to keep people who are not into labour away from here, because if they are here, you know things are going to be escalated into bigger problems or intervene… We are assuring monitoring constantly... but get into labour at home, they are in a more environment" (EPMW8)<br>"it's thinking about low risk, high-risk women, if you have a low-risk women, it should be midwifery-led care, you know, if you have the practitioner who's going to be looking after you in your pregnancy, your labour, your birth, pull safely, and they are with you, women are more likely to feel confident going forward and having a normal birth when you have low-risk women they shouldn't be booked under consultant care because the obstetrician should be looking after the high-risk women, who need their extra knowledge" (EPMW6)<br>"We know from research in if there is nothing wrong with the women and there's nothing wrong with a baby, the safest place for her to have her baby is at home or in a birthing unit. Because it lessens the chance of doctors getting involved. And then and then you know, maybe an epidural, maybe instrumental delivery like forceps or caesarean section. The doctors just stay out of it, then they tend to have a normal vaginal birth. And then we recommend vaginal birth because then you don't have a scar on your uterus." (EPMW4)<br>"low-risk experience, so trying to think about, do actually need to have childbirth within hospitals? if they're normal, healthy women why can they have a delivery at home? Why do we bring them into the hospital?" (EPMW5)<br>"the midwives do a lot of work on supporting women through pregnancy and delivery, and the sort of try to maximize oxytocin, so trying to keep things as non-clinical as possible, keeping lights down, been getting nice music, keeping doctors out of the room as much as possible, trying to keep things as know what to have to keep contractions going" (EPP2) |
| **Greater use of technology and intervention** | **Interventions in needed cases or women's demand** | "Well, obviously, the midwives are aiming and, we are also aiming to achieve a vaginal birth. But I think, and sometimes you might find that they are obviously very… very keen to avoid any intervention, which we are already so not very keen on doing" (EPP6)<br>"if you are in an obstetric unit, where we have obstetricians, we know from our research that it's much more likely that you are then going to be putting a monitor, have your baby monitors throughout the entire labour. Whereas if a woman is a low risk, normally, we would just listen every 15 minutes with a handheld. And then if you're monitored, then you're more likely to have medical intervention. So, we call it the cascade of intervention" (EPMW4)<br>"And if I was doing a normal delivery myself the only kind of medical intervention that I would probably do it, would be referred to a doctor or speak to a doctor or transfer to the delivery suite where there is a doctor anything that I need doctors in or anything that goes out of the normality, that's when an intervention is needed, or if the woman feels intervention is needed" (EPMW5)<br>"I think a lot of midwives here would go for normal delivery themselves and... but I think a lot of doctors would as well, as it happens, so...I think obviously …. I think doctors are more medicalized in birth, I think midwives are less, but then I think is ultimately down to a lot of training and things" (EPMW5)<br>"I pushed and push for more than two hours and after two hours I said that is it, they will have to help me with the ventouse, so the doctor came and... yes, they also did the episiotomy," (EM10) |

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| | | "when they midwife in the hospital reviewed the labour with them, she said okay it is 2 am, the doctor came and he suggested to do a c-section and" (EM6)<br>"And I remember I was like yeah, I think this baby is ready to come but he didn't come, don't you want to use the ventouse, she was laughing, no, I am not going… Or do something, maybe break my water, and she said no, some babies are born without… in the…" (EM10)<br>"But the alongside midwifery unit gives you the opportunity to have a safe delivery and a calming environment with minimal intervention and for me, that was just everything that I wanted." (EM3)<br>"if anything goes outside the normal trend, then that's when you start thinking about what it needs to be done, and if it is an option that cannot be changed and you need a caesarean. But otherwise, you will just follow the normal trend and if it comes out of that, that's when you start thinking, that's the decision process." (EPMW2)<br>"From the beginning, from the midwifery training, you are guided to all-natural kind of thing. So, midwifery go to the extreme of all-natural regardless of anything, any complications" (EPMW2) |
| **Specific view** | **Holistic view** | "And doctors have a different way of thinking to midwives, midwives balance up the risk of that, but they're…. well the safety of mother and baby is always first and foremost in our mind. But also, we, I think we have a slightly more holistic approach, doctors are always just looking at, they're looking at risk that they are, their mindset is to just to fix people and make people better" (EPMW4)<br>"Midwives and obstetricians are…we are often in conflict…. Well, I feel that midwives are often on the side of the women and we actually get to know the women and we can say well, okay, our guideline says this, however, this woman" (EPMW5)<br>"So, we tend to do shared care here. So, they will meet the obstetrician to make sure that the right path is happening. So, she might need extra blood tests or extra tests along the way. But the women also need that normal midwifery side of things. She needs to know what's normal in terms of their pregnancy, what's normal to happen in labour, what's normal afterwards and explore feeding her baby and you know, all those things, so you need to work... they both bring to the table skills that work alongside each other. And we have women that have quite high-risk pregnancies, or we think it would be high-risk pregnancies. But we can still make quite a… we can help facilitate quite a nice normal birth for them along the way". (EPMW9)<br>"I prefer working with the low-risk women because I find that this is more holistic, yeah I find that it's more holistic, you're really working with the women and feeding off her cues and how she's feeling and I think you need to be more intuitive to people's feeling and...sometimes when you are doing more high-risk care, it is more medicalized" (EPMW4)<br>"I think midwives are very, very important because we are the point of care between mothers in their pregnancy" (EPMW4)<br>"Usually midwife is like, we say advocate of woman who is… as if she were a companion who is with the woman there, the woman said she doesn't want this, she doesn't want that. Because sometimes, as a doctor, you're taking care of a lot of women and you haven't read her entire birth plan, you don't know exactly, and the midwife is the opposite, she's been following you from the beginning, she can give a better explanation of what the woman wants or doesn't want to" (EPP5) |

*S: why do you prefer having normal birth as well?*
*M: normal birth?*
*S: yeah, vaginal delivery*
*M: well that's the normal way we deliver babies, isn't it?!! yeah, no, I mean I never... usually here people go for a caesarean when there is an emergency, but you don't really want the caesarean cut. I don't know it's not something that would even look to have... if I think it's a caesarean cut, I think it's is something painful... I feel sorry for women who had a caesarean cut because they cannot usually feed their babies immediately or carry them because of the cut on the tummy, so it's not something actually I would want to have, so never... It was never on my mind as an interesting option rather something, you know,... an emergency thing but not something I would choose (EM5)*

*Here the assumption is that you get pregnant and then you wait until you get in labour and you have your baby (EPMW2)*

The belief of normality of birth was conveyed also in how they reported the process, gave recommendations and proceeded with the care. Quotes of encouragement in the early stages of labour to stay at home (EPMW2) and stories of babies that were often born outside the hospital or in the lift (EPMW4) were usual. In the case of multiparous, it was even common to give the women a home delivery pack just in case she could not arrive on time at the birthing unit (EM1), even though the woman wasn't planning a home birth or even want one. The compatibility of the normality of birth between the logics was also based on the issue of health and recovery. There was a constant argument among actors that normal delivery is healthier and less risky for mother and baby and it provides better and faster recovery for women. Due to that, it was the logical choice to follow. The following quotes exemplify this:

*Cause here I think, well I noticed between me and people who had a normal birth, for my body to get back to normal was longer because I think your body doesn't realize for a while you have the baby. So, I think that's why here people want to try and have a natural one…. But It's a real mindset (EM2)*

*it is the natural way to have babies, it has less complications, the risk with surgery is quite high, infections are higher and… the bonding, bacteria for the baby, and things with lactation are a lot better and a lot less dangerous with vaginal birth. Also, the recovery with surgery is more difficult and the body is capable to have babies normally (EPMW7)*

*I think as far as possible, you know, a normal vaginal… because I think that it has the lowest rates of mobility for their mother, and you get good outcomes, it's cost-effective, obviously, you have monitoring, and there are some cases where you have to do a caesarean section and so on. But we do not particularly agree. But I think with well-managed care a high proportion of women should manage a normal vaginal delivery (EPP3)*

In turn, this aspect also leads to a consensus among the place of birth and the perception of pregnancy. First, since giving birth is a natural thing, the ideal is to deliver in places that provide major naturalness to the process, as home birth or midwifery units. These places, for being run only by midwives in a proper environment are less prone to interventions during labour:

> *We know from research that if there is nothing wrong with the women and there's nothing wrong with a baby, the safest place for her to have her baby is at home or in a birthing unit. Because it lessens the chance of doctors getting involved. And then you know, maybe an epidural, maybe instrumental delivery like forceps or caesarean section. The doctors just stay out of it, then they tend to have a normal vaginal birth. And then we recommend vaginal birth because then you don't have a scar on your uterus. (EPMW4)*

> *Go back to your midwife carry on having care with her, as long as your blood pressure stays normal, then you can carry on and deliver with midwives, you don't need to see doctors (EPP2)*

Secondly, from this perception, pregnant women on those logics are not seen as patients or carriers of a special, pathological condition, they are just 'women', normal person, having a normal process:

> *That's quite a strong thing here, is that… so we never talked about a patient in obstetrics because it's not… that implies a pathological, a disease process, we have to be talking about women because it's a normal person. (EPP1)*

> *Because here you're dealing with somebody who's relatively well, who is going through what is considered a physiological process, it's not a disease, it's not, she's just not sick in any way. (EPP4)*

Other aspects of compatibility between the logics concern the centralization of care. In England, maternity care is focused on women. Along the whole pathway in pregnancy, it is aimed that health professionals discuss with women what are their preferences, what matters to them in regards to the birthing experience and, as long as possible, accommodate their wishes. Hence, it was highlighted the conduct of always given her the right of choice with respect to certain aspects of maternity care, such as the birth setting, pain reliefs and practices during labour and postnatally.

Woman, here, is responsible for decision making. Health professionals are not allowed to perform any conduct without her formal consent. Consequently, communication is well valued as a way to listen and explain to a woman why something is a benefit or why maybe there is the need to change conduct. When woman's preferences and professional's recommendations are in disagreement, the normal procedure is to give the adequate information to women so she is able to make an informed choice, but ultimately is always her choice. The health professionals are responsible to inform here, give their clinical judgement and, mostly, support her wishes.

> *So, it is all about managing expectations, really, and understanding their thoughts and feelings around it and not dismissing them and actually taking the time to understand (EPMW5)*

> *So, that women may make choices that are different to the ones we would recommend because everybody has a different perception of risk, and we have to respect their choices, because ultimately, they are well women, sane in mind, and may make a choice that we're not perhaps happy with but we have to support them with it. (EPMW9)*

> *I think women should be empowered to choose what's best for them. So, although as an obstetrician, you can make a recommendation and you can say, Well, I recommend that, I think that women should decide, and should be well informed. So, I think we shouldn't... we can only make recommendations, but the women should make the decision" (EPP6)*

> *So, as always, we have guidelines for everything, but it's still always a woman's choice, it's her choice…we cannot, we cannot make somebody do something against their will. And we have a duty of care to support them (EPMW4)*

Finally, the last aspect of logics compatibility is regarded the professional conduct. Maternity care in England is established as to lessen invasive conduct, that is, to always try, as much as possible, to lower the incidence of invasive interventions antenatally, during labour and postnatally. It is noticed, for example, the practice of fewer scans and examinations. Only if a problem is detected that the incidence of these exams is increased. Moreover, when it is noticed the need to intervene, the pattern conduct is always to prioritize softly interventions first and moving to more invasive ones as the former was not enough.

So, for example, in cases of long pregnancy (longer than 41 plus), the initial step is to induce labour, rather than moving directly to caesarean section. If the baby is breech, it is standard to first do the ECV manoeuvre to try to rotate the baby, and then if this fail, to offer women the options of try delivering in this way or do a caesarean section. Yet on complicated or longer labours, it is used to try instrumental births (forceps or vacuum/ventouse) first before moving to a caesarean section. These cases are illustrated below:

> *But again, if they want to delivery somebody early because of preeclampsia, blood pressure, then they would induce labour, they wouldn't necessarily do a caesarean section. So, because it's still better for mom and baby to have a normal vaginal birth (EPMW4)*

> *At 35 weeks, they said look she is breech. So, when you're 37 weeks, you need to go for the... basically going to have an ECV, you know, the turning procedure (EM9)*

> *they were going to have to do a caesarean if the forceps didn't work, so he was actually delivered in the theatre because they were pretty much all ready to go for an emergency c-section at that point (EM1)*

The lessen invasive approach relates also about "*balancing the risks"* (EPP3), but not only at the moment, in the short term, but considering the long term as well. Stated differently, when to decide which conduct to go, health professionals focus on the implications of the practices at the actual time, for example, to deliver the baby faster, and analyse what would be the implications of those practices for the mother and the baby in the future. So, for example, caesarean section in England is avoided as much as possible because, according to the health professionals, researches show that not only caesarean section presents greater risks at the moment of performing it, such as infection, haemorrhage and delay in the production of breast

milk, but also in the long term, as increased risk of future pregnancy complications and pregnancy loss, and higher chance of respiratory problems in infants, among others. Therefore, it is aimed to reduce harmer results in that and next pregnancies. The following statements ratify this:

> *So, somebody has a vaginal birth for their first baby which is the most common even if it's a forceps, then other children, hopefully, are much more likely to be vaginal birth. You will always have to bear that in mind when you do your first section. It's not just about it, if there's a good indication to do it, that's fine. But that has implications on the rest of the pregnancies (EPMW8)*

> *And what I'm very much been trained to do is to only intervene if I really think it's necessary, and not to intervene if it's not, in order to avoid causing more harm further down the road. (EPP2)*

Finally, lessen invasive conduct means as well as trying to make the birthing process as normal as possible for the better experience of women. Even when there are complications or higher risks, health professionals support to normalize what is possible so the woman can have a more natural experience and be less affected by the abnormalities that would come out. This embraces, as the second example below, maintaining midwives looking after the pregnant woman even when she is under consultant care:

> *If somebody can't have a vaginal birth, what can we do to make her feel that it's as normal as possible?...so despite the fact that it's a delivery suite and a lot of most of the women here are at high risk we would still want to normalize the birth process after we discuss why she wants to do that and what she wants (EPMW8)*

> *So, we tend to do shared care here. So, they will meet the obstetrician to make sure that the right path is happening. But the women also need that normal midwifery side of things. She needs to know what's normal in terms of their pregnancy, what's normal to happen in labour, what's normal afterwards and explore feeding her baby and you know, all those things, so you need to work... they both bring to the table skills that work alongside each other. And we have women that have quite high-risk pregnancies, or we think it would be high-risk pregnancies. But we can still make quite a… we can help facilitate quite a nice normal birth for them along the way. (EPMW9)*

Therefore, as could be seen from the exposed quotes and Table 10, the maternity aspects discussed so far, related to most of the maternity care, are very much aligned between both the professionals - obstetricians and midwives -, and ratified with the experiences reported of the mothers. The following aspects, discussing in the sequence, presented lower compatibility, on the other hand, although they are seen as still aligned around consistent beliefs.

Firstly, it was observed a slight variance regarding security versus risk perception, again intimately linked to a difference in professional training (Dunn & Jones, 2010). Obstetric training is built on knowledge and treatment of diseases. Particularly, in the English maternity field, obstetricians are responsible to treat only high-risk cases, so they are in contact

exclusively with complicated pregnancies and labours. Midwifery, on the other hand, is established to assist low-risk and straightforward pregnancies. As a result, medical logic is more concerned about the possible complications and risks that labour may unfold, whereas midwives direct the perception of the security of a normal physiological process:

> *it's different because they only see women who got problems… they would see women antenatally, but they usually see women with medical problems obstetric problems, they are not seeing the normal woman, you know, they will always see the women that have problems (EPMW3)*

> *as midwives, that's what we do, we deliver normal deliveries, and so that's what we do, we take women through the normal physiological process of labour and delivery. So that's our experience…we don't do forceps or sections, so the obstetrician does that, so if labour is deviating and or not progressing then obviously the obstetricians are asked to review (EPMW3)*

As much as medical logic shares the perception of normal birth as a physiologist and primary choice, again, the different experiences with varying levels of risks direct the focus to the possible complications and abnormalities. That is, carriers of medical logic concentrate more on the possible "what if's". Thus, they are more eager to intervene and to monitor more closely with extra care, as well as to be surrounded by more technical assistance, technology and inside a supposedly safer environment. It was noticed that, even though as professional assistance they advise midwifery units and home birth as safe places to deliver when it was a personal choice of their own pregnancy, the majority choice was to give birth in a delivery suite in which doctors are closer in case extra help was needed.

> *I think it's all the complication that you've seen, we see more complex cases compared to a midwife. They see lots of normal deliveries and nice and low-risk patients and we see all the horrific cases so we feel safer in labour ward yeah that's the thing. (EPP6)*

> *you wouldn't find very many obstetricians that would give birth at home, I mean by choice, because we see all the bad stuff happened so we wouldn't, I don't think there's... there won't be very many who will decide to be at home for their labour, so it depends on what the experience you have, for the choices you make. (EPP4)*

> *Now from an entirely personal perspective, for me, that's the natural choice [Alongside Midwifery Unit] because we know that there's, particularly if it's your first birth, your chances of needing transfer are relatively high…and if you're in the same building you know it's either along the corridor or even gets the doctor into your room so it's much easier (EPP1)*

> *I knew I wanted the John Radcliffe hospital, I knew that I wanted that because she's my first and if anything went wrong I would never forgive myself if I wasn't in a safe environment, so I knew I did not want to a home delivery or delivery where it was just the midwives only, I knew that much, so I definitely knew I wanted the hospital (EM9)*

Inversely, in the natural logic, the focus was directly on the natural process, so in the usual risk. Complications are seen as a possibility but do not have a central role since in a straightforward pregnancy, the chances of complication are low. The majority of births happen

smoothly. Therefore, the recommendation for the place of birth and the midwives' own experience of births also changed. Here the main suggestions were for home birth or midwifery unit, which provides a more adequate environment for the normality of birth:

> *I would always say if you're a low-risk woman, so the first baby, I always say go have a normal delivery at a birth centre…And then if she was still low risk and would have a second baby, no problems, I'd say go for a home birth. Why not? You're normal, it's a normal process. Go for it (EPMW5)*

> *So if you have low-risk women who are, you know, predominantly, they're very healthy, they should be in a home environment for them or a midwifery-led and encouraged to have a normal birth and you do observations along the way to make sure mom and baby are healthy, all of what you're doing is making sure that you have a healthy mom and baby on board. And if you make an observation and assessment and the things aren't happening naturally, then you should refer them on to the high-risk side of things. So, you need to understand what is normal. And even when women are high risk, there are aspects of normality you can bring into their birth and (EPMW9)*

Implicitly related to that, are the matters of time tolerance and inclination to intervene. The constant contact with risky cases leads medical logic to a greater concern about controlling the time to obtain favourable outcomes faster. Midwives, on the other hand, defend a more "follow the flow" approach, which was also observed as dominant among women. Women often state to have an open mind to let nature take its course without a specific idealization of how they want the birth, but open to letting it flow naturally:

> *I am of the opinion that you know, I wouldn't be so rigid, it would depend on clinical need. So, there are some things about pain relief, sort of opios so I perhaps wouldn't want to use and bits and pieces like that (EM1)*

> *the best plan, we say, is to let things to go… it's better to just relax because for the labour to work you've got to be relaxed, you can't be uptight thinking (EPMW2)*

> *If everything is fine, you just keep going, going, going until the baby's born. (EPMW2)*

Consequently, these differences in perception also were implicated on professional conduct. Medical logics have a higher propensity to intervene and use technology in assistance in comparison to midwives that tend to try normal techniques to help women first. Which was identified as their own preference as well:

> *Even though I had a natural birth, they were quite pro-intervention, my doctor was quite pro forceps and... wanted to speed it up with drip and things like that so it wasn't you know, wasn't very natural, I think as soon as you have a doctor rather than a midwife involved then it becomes more interventions definitely (EM7)*

> *We know from research in if there is nothing wrong with the women and there's nothing wrong with a baby, the safest place for her to have her baby is at home or in a birthing unit. Because it lessens the chance of doctors getting involved. And then and then you know, maybe an epidural, maybe instrumental delivery like forceps or caesarean section. The doctors just stay out of it, then they tend to have a normal vaginal birth. (EPMW4)*

> *The key, the key difference is that you don't have that pivotal role of the midwife in the middle, advocating normality where it's appropriate. (EPMW1)*

> *And when they are obstetricians they do all the abnormal to us so all the forceps, sections and ventouse, so in a way, they are skilled to abnormal and we do the normal, so they don't always so even when they do a forceps, for example, they don't... once they've got the head out, you could then just do a nice gentle delivery, but you know they don't do normal deliveries as we do so... so they are biased towards high risk and intervention because that's all they deliver (EPMW3)*

Finally, a last difference, also connected to these aspects relates to the professional view on pregnancy and birth. The midwife was frequently portrayed as the woman's advocate. She was involved with the pregnant woman from the beginning, being aware of their preferences and wishes. Thus, she did not only take care of the safety of delivery itself but also the woman's physically, emotionally and psychologically well-being. Consequently, natural logic is conveyed as having a more holistic view. It takes into consideration all aspects related to maternity. Medical logic, in turn, is more active in specific moments of more complicated cases. Its view, then, is more specifically on the issue highlighted, for example, a complication at the time, and not on the whole picture:

> *Usually, the midwife is like, we say advocate of woman who is… as if she were a companion who is with the woman there, the woman said she doesn't want this, she doesn't want that. Because sometimes, as a doctor, you're taking care of a lot of women and you haven't read her entire birth plan, you don't know exactly, and the midwife is the opposite, she's been following you from the beginning, she can give a better explanation of what the woman wants or doesn't want to (EPP5)*

> *…so, it's time to let the doctors to understand the woman's decisions as well because we spend the time with the women and get to know them and their decision making and the doctor sees it very black and white. They don't actually get to know the women and understand her and what she's about. I think that's why we often run into conflict Yeah, we do have conflict Don't get me wrong (EPMW5)*

> *And doctors have a different way of thinking to midwives, midwives balance up the risk of that, but they're…. well the safety of mother and baby is always first and foremost in our mind. But also, we, I think we have a slightly more holistic approach, doctors are always just looking at, they're looking at risk that they are, their mindset is to just to fix people and make people better (EPMW4)*

To sum up, the similarities related to the two maternity logics evidence high compatibility between them. Although there were some differences of perception and view, at the core the main aspects involving the maternity care were shared within both logics. The instantiation of the logics, thus, generates aligned professional conduct and coherent discourses and practices. Also, when medical intervention was needed but it was in dissonance with the mother's preferences, again, differently from Brazil, in England, the justification of increased

risk was accepted, and women tended to follow the health care professionals' guidelines without resentment.

In turn, when looking at the extent to which those logics were at the core, the data gathered showed a low centrality in the field. That is, one logic exerted primary function on the maternity field over the other, in the case, the natural logic. The natural logic was mostly instantiated among midwives and women whereas the medical logic was more dominant among obstetricians. However, as presented in the empirical context section, maternity care in England is assisted mainly by midwives. If everything is straightforward, with no prior medical difficulties and things progressing normally, pregnant women would not necessarily have to see an obstetrician, they would just see the midwife and maybe the general practitioner. Obstetricians only get involved if either there are pre-existing medical conditions, i.e. previous pregnancies that had complications, caesarean sections, or yet if complications arise during pregnancy. And in all of those cases, midwives usually still continue to assist the pregnant woman with shared care. The following quotes corroborate this:

> *The midwife usually knows the patient well, because she stays from the beginning and she does normal birth care, she doesn't intervene. What we do is a workaround. Three, four times a day, we do a workaround, we talk about each case, but not necessarily enter the room and talk to the woman. We talk to the midwife. The midwife leaves the room and tells her case. If it's okay, if it doesn't need intervention, we don't do anything, just know the story, right. Then when it becomes abnormal and needs medical intervention, then the obstetrician would talk to midwife and go into the childbirth, talk to the woman also about what is needed (EPP5)*

> *When the midwife or obstetric nurse look after pregnant women for a period of time and then the obstetrician comes in to deliver the baby, that's really when it goes wrong actually, cause the midwife is perfectly capable, you know, she's had the training to deliver that baby, in fact, the mother delivers the baby, the midwife just facilitate that. But you know…I think that makes a difference. I think you have to separate and have obstetricians look after high-risk women and midwives the low-risk women. And they have to have a very good relationship, the midwives and obstetricians. Because that works really well. For the obstetrician say, No, this is normal, this stays with you. And when it's not normal, I'm going to help you, because things do start off normal and then end up having complications, so you need a great working relationships but you should have two pathways running alongside each other that may crossover from time to time but um, that that will make women much more confident about having a vaginal birth (EPMW9)*

> *I don't do normal deliveries. I mean, I occasionally watch one just because they say oh, can you come in and do something if that actually will happen or it's a very premature baby. But yes, otherwise, I might be involved if it's instrumental or caesarean. (EPP2)*

> *It is funny because the second time I didn't see any doctor. I was in the delivery suite but there was always the midwife. (EM10)*

> *It went well, it is just interesting in England that the midwife is in charge of most things…. in this country most things are delegated to midwife and they are in charge of most things. The only moment when the gynaecologist comes into the whole thing is when there is a problem,*

> *like in my case, only when I needed the forceps delivery they called for a doctor. But otherwise in England, you just see the midwife and the GP (EM5)*

> *So, what shapes that is the fact that the midwife is an important part of that package, the doctors are only drawn in when there are problems (ER1)*

The results of our survey also corroborate this. Of the sample we collected, 96.4% of women received midwifery care, and of these, 38.27% of women were assisted exclusively by midwives. The remaining sample received at some point shared care, but in some cases, the medical care was conducted by general practitioners only. Moreover, as presented in Table 10, maternity care is woman-focused. Pregnant women should be involved in the whole process and should give consent to all procedures and practices performed. Data collected evidenced that woman predominantly endorse the natural logic too. According to the survey, 89.29% of women showed a preference for normal birth against 7,14% preference for caesarean section and 3,57% with no preference. The same incidence was obtained from the interviews, in which 90% stated preference for vaginal delivery.

Accordingly, considering that the maternity assistance centres in midwifery care and it is woman-focused and that both mothers and midwives higher instantiate natural logic, we can state that natural logic is at the core of the functioning of the maternity field in England. Medical logic is peripheral, with a lack of dispute for dominance. Added to this, the high compatibility between logics leads to consistent values and practices for field operation, as if it would reflect a single logic. Together, then, and based on Besahrov & Smith (2014), I configure the maternity field in England as dominant, with apparent lack of conflict. This configuration, besides evident in the aligned quotes from all the different groups of actors, was also ratified on the positive assessment of the maternity care in the country. Data from the survey revealed that the majority of women, 76,71%, was satisfied with the care. Most of the reasons presented by the negative evaluations (23,29%) addressed limitations of resources of the public domain, as care being understaffed, underfunded and discontinuity of care.

Looking across these dimensions, differences as the ones found in Brazil, regarding contrasting perspectives of each logic from insiders and outsiders were not observed in the same intensity in England. Some minor cases were mentioned, as lack of choice, too interventionist, intervene too early, anti-caesarean sections, which are better described in the following sections, nevertheless, most of these cases were not presented in a conflictual or contested behaviour, as identified in Brazil. Thus, this lack of opposing view reinforces how the multiplicity of logics configures the field as dominant.

Consequently, the relationship between the two maternity logics in England is configurated as a collaboration between logics (Reay & Hinings, 2009; Goodrick & Reay, 2011). The instantiation of maternity logics in this field complement each other in a collaborative relationship, so the prevailing logic is reinforced by the peripheral one. When different logics worked together, they were determined on an individual basis. The rationale behind it was established on the shared core elements that facilitated the collaborative relationship. Thus, this relationship allows each group to follow different logics (Reay & Hinings, 2009), as two paths that run alongside and when crossover each other, do it in a reinforcing way supported by consistent share goals.

*Comparing the countries*

Looking across both maternity fields, there are striking differences between them, especially between medical logics. Although some aspects were similar in both, for example, a greater focus on risks and uncertainty avoidance, on the other hand, some core aspects were very distinct between both medical logics and between their relationship to the natural logic. In England, for example, in consonance with natural logic, vaginal delivery is still the dominant mode of birth among all health professionals (physicians and midwives), conveying the idea of the safest and healthiest mode of birth given normal conditions. In Brazil, conversely, caesarean section conveys higher security and a less risky alternative as it, in this logic, supposedly avoids the possible complications and unpredictability that normal birth may unfold. Thus, contrary to natural logic, it was pointed out as the personal choice of most physicians.

The speeches of health professionals in England were also found more united. There was the cohesion of the lines, focus on the same points and defence of similar arguments. Still, most of those have been confirmed in women's experiences. Even when obstetricians, for example, showed a preference for having a birth at the delivery suites, none of them stated that having at home or in the freestanding midwifery let was unsafe. They mentioned it as a personal precautionary choice in case some complication might emerge, as they usually dealt with those cases only. In Brazil, by contrast, there were many disintegrated lines, distinct focuses and even contradictory arguments. In the same example, while some doctors and nurses talked about home birth as a safe option, others pointed it as an unsafe birth and responsible for current sequelae in the field of obstetrics. Even one of the nurses who assist home birth reported that, at first, when she was invited to start this home care, her first reaction was contrary, showing how normal birth in Brazil is not seen as strongly safe and natural as it is in England, it follows:

> *The doula was talking to me about home birth, and at first, I: imagine! What for? How? No, the hospital is much safer right, so what for will I risk myself, will risk the woman's life? Why will I risk my professional licence, if something happens… no, no, no, no, no. Then, a year later, a patient came up, who had support, a friend who was an obstetrician and ...then I said so since there is this direct medical reference for us if it is needed to, so let's go. (BPN1)*

The higher cohesion identified in England also addresses the type of care women receive – midwifery care or consultant care. Even when there was a change in the care, which consequently could also imply a change of the place of birth (home birth, midwifery let unit or delivery suite), and the caregiving authority (midwife or obstetrician) there was still consistency in practices, values and structure of the actors involved. Births continued to have a midwife assisting the woman, even when obstetrician assume primary care, and there was still the goal to always prioritize first the less invasive approaches. The practices performed after birth, such as breastfeeding, skin-to-skin contact, vitamin K, cord cut were also very much alike in all cases observed.

In Brazil, on the other hand, I found very different experiences depending on the caregiving in charge. If it was an obstetrician or an obstetric nurse linked to the humanization movement, the way that labour and birth were conducted was highly different from a health professional not linked to it, or yet, the ones considered '*cesaristic'*. In births considered '*humanized'*, usually, labour and birth took place either at home or in a private hospital room and assisted by a team, generally composed of the obstetrician, obstetric nurse and doula. In medical logic, in turn, the majority of labours and births took place in the operating room, regardless of whether it was a normal delivery or a caesarean section, and were usually assisted only by the obstetrician with the backup support of the nurses from the own hospital. The practices performed after birth showed no similar pattern between cases as well.

Other cases, such as the presence of doulas or reasons for recommending a mode of delivery in some specific conditions (breech baby, VBAC – vaginal delivery after caesarean section) have also been found in disagreement many times among the health professionals' statements and the birth experiences reported by women. Consequently, in Brazil, I found a greater incompatibility even among the group of health professionals. Among those recognized as belonging to the Humanization Movement, it was found a higher identification, thus, higher compatibility with the medical logic in England, that is, showing higher compatibility between the maternity logics.

All these different scenarios and aspects of institutional logics, added to different levels of centrality between the logics, corroborate to show that Brazil and England have different types of multi-logics fields. Although they both present two main logics, the relationship

between these maternity logics is configurated differently in each field. Additionally, considering the goals of this thesis, in the next section, I look at how these institutional logics were enacted in the fields, analysing the maternity practices promulgated in each country.

## 5.2 MATERNITY PRACTICES

The second research question focused on what variation exists among maternity practices stemming from multi-logics in Brazil and England. To answer this question, I first identified the practices undertook by the actors involved in the field, both quantitatively through the online survey and qualitatively through the interviews and documentary research and then I analyzed the perceptions and symbolic values underlying them. Table 11 presents the incidence of some practices performed during labour in each site obtained from the survey.

*Table 11.* Maternity Practices in Brazil and England

| Practices | Brazil | England |
|---|---|---|
| Vaginal delivery | 41.8% | 71.4% |
| Caesarean section | 58.1% | 28.6% |
| Epidural | 42.8% | 41.3% |
| Episiotomy* | 36.0% | 40.7% |
| Fasting | 38% | 10.2% |
| Synthetic oxytocin | 26.2% | 36.2% |
| Amniotomy | 18.4% | 24% |
| Lithotomy | 14.5% | 0% |
| Continuous fetal monitoring | 30% | 57.7% |
| Enema | 1,7% | 1% |
| Trichotomy | 13.6% | 5.1% |
| Kristeller's manoeuvre | 12.1% | 2.6% |
| Early or directing pushing* | 11.6% | 5.0% |
| Forceps or Vacuum* | 5.8% | 30.7% |
| Acceleration of the process of placenta delivery* | 17.4% | 44.3% |
| Continuous vaginal examinations without a clear indication | 9% | 2% |
| Restriction to walking/freedom of movement | 6.5% | 33.7% |

*Note:* The incidences of the practices with * were calculated only in relation to the respondents who had vaginal deliveries given that such practices are usually performed only in this mode of delivery.

Depicted in Table 11, although Brazilian and England's maternity fields presented similar practices, in some cases, they were connected to distinct meanings (Zilber, 2002), table 12 illustrates these differences better. I found that some practices differentiated in terms of how they were perceived by the women, reinforcing the configuration of the distinct types of multiplicity between them. I present each site separately in the sequence.

*Table 12.* Comparison of maternity practices in Brazil and England

| Practice | Brazil | England |
|---|---|---|
| **Vaginal Delivery** | - A delivery alternative / a choice to consider<br>- A way to give power back to woman/ empower her<br>- Transformation of the woman into mother - a transition phase<br>- Natural process, healthier and best recovery<br>- Something fearful, unsure that may "pass the time to be born"<br>- Myths x fear of pain<br>- A search/fight/ needs to prepare for it<br>- A possibility/ An attempt | - An assumption / taken for granted<br>- Healthier way<br>- Best recovery<br>- The normal way to delivery |
| **Caesarean section** | - Another birth choice<br>- Safe option to deliver<br>- Ease of planning<br>- Convenience of doctors | - Riskier and higher chance of complications<br>- Mode of delivery when something went wrong / more complicated<br>- Need to justify why had it<br>- Emergency or medical need |
| **Birth plan** | - Really important and valued to have in the normal birth<br>- A way of assurance the respect to women's choices<br>- A formal instrument to avoid obstetric violence<br>- A way of being aware of the doctor's position of each choice and through that identify if he has a more "interventionist" or "humanized" approach | - Not always necessary and given importance to<br>- Birth preferences<br>- Way to think about birth |
| **Episiotomy** | - Obstetric violence<br>- Unnecessary practice for medical convenience | - Not pleasant but medically justified for being necessary during labour |
| **Intervention** | - Violence<br>- Doctor's convenience<br>- To rush labour<br>- Only justified when supported by scientific evidence | - Actions needed to allow labour to flow<br>- Help to the woman when labour is not progressing |

*Brazil*

According to both the quantitative and qualitative data, women expressed a preference for vaginal delivery. Our survey showed that 72,75% of women would rather have their babies' delivery vaginally. However, the incidence found was only 41%. Figure 14 shows the incidence of the main modes of delivery in Brazil. Figures obtained showed consistency with the national record (Valadares, 2017).

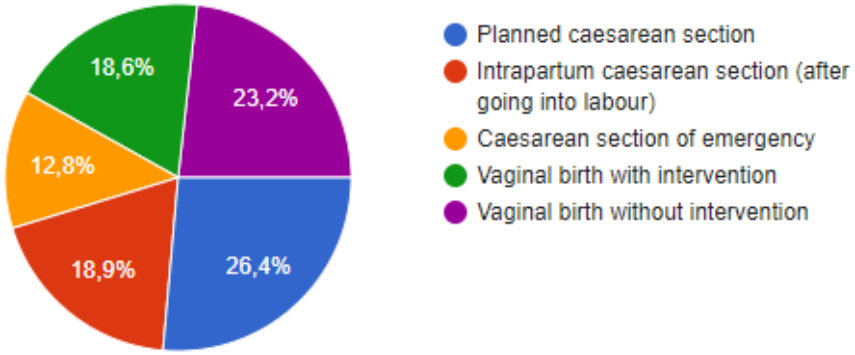


*Figure 14.* Modes of delivery in Brazil

As illustrated in figure 14, Brazil evidences a low incidence of vaginal delivery and among this a high incidence of interventions. As a result, according to table 12, normal birth in the country carries different and sometimes contrasting meanings. Initially, differently from England, normal birth in Brazil is not seen as the norm, especially in the private domain, where it is considered an option to delivery that should be discussed and decided with the physician. In addition, in line with the technocratic model of childbirth attention (Davis-Floyd, 2001; Rattner, 2009a), which overemphasizes technology and knowledge is centred on physicians, normal birth carries a lot of unfamiliarity and myths, especially among women and the lay population. Although most of the women have a preference for it, as it is considered healthier and provide better recovery, in some cases, normal birth also conveys the idea of something unsafe that due to its unpredictability and lack of control may lead to negative outcomes, such as, "passing time to be born", generating a lot of insecurity about it. The excerpts in the sequence evidence these meanings:

> *The concern of delivery itself was more of suffering for him because I've heard that besides the suffering of pregnant women, normal birth when it is very forced, a forced normal birth, it can harm the baby. Even spiritually, traumatized (BM2)*

> *I think sometimes, I was very afraid of ... like this, I have a cousin, her baby is one year old and ... they forced her to deliver her normally and the child was going over of the time to be born. And ... she even swallowed faeces inside the belly. (BM2)*

> *I thought about the baby, so to deliver normally. However, the months went by and I was realizing that my fear, although I was thinking about the baby, it was very me (BM5)*

> *I think the encouragement that has been given to normal birth is great. But I have seen that in most cases, this insistence has endangered the life of mother and baby. Maybe that's what fuelled my fear of normal birth (BMS281)*

However, its low incidence was mostly portrayed as due to an unbalanced system in which physicians take all the authority and decide for their own convenience. According to one survey' response, *"it is a system that does not let women be protagonists of their own body/childbirth. In general, male doctors decide for women. It is a very violent system"* (BMS381). Other researches corroborate this by showing that antenatal care may be inducing more acceptance of caesarean delivery (Leal & Gama, 2012) and that the frequent misinformation and lack of knowledge regarding normal birth among women, allied to the hegemonic position doctors traditionally occupy in the maternity care leads to a unilateral decision (Pereira, 2006; Freire et al., 2011).

Accordingly, practices such as dissuading women were also observed in regards to normal birth in the relationship between the woman and her doctor. Many women reported

that, during pregnancy and childbirth, they ended up having a caesarean section or even not having their preferences respected by medical conduct. Physicians were pointed to kept stalling women and subtly putting obstacles to undermine normal birth, which let women very insecure and ratifies the aforementioned researches. This, in turn, contributed to the myths and misunderstandings related to normal birth. The following extracts evidence this:

> *So when I was 7 months old, I was already putting pressure on the doctor, because I said that I wanted to be normal birth, he said: "ok, we will decide this in the moment, we will decide this in a little bit later, more forward ", at 7 months I said: look, it's ok, my pregnancy was super good, I had no problem, I want normal delivery, then he started to put several obstacles (BM1)*

> *I wanted to do some tests to see if it was okay because I wanted normal delivery. She has already widened her eye and said: no, normal delivery after caesarean section is impossible, you can only be in labour 8 hours, if the baby is being born, I will have to have a caesarean section if it arrives within 8 hours of labour. She filled me with fear, that's when I started to get informed and saw that she was crazy (BM7)*

> *I had even asked if we could wait next week to do the c-section. But he said, no, no, no, if you are going to do a c-section then you can't take the risk of not having time to do a c-section. Because I wanted to complete the 40 weeks, but then he said that there was no way ... what I understood was that, I did not go deep into the subject, but I understood that then I would go into labour and then I couldn't do caesarean section (BM2)*

> *we see a lot of things happening there, oh your baby is big, your basin is small, and the doctor really induces the woman to want to anticipate the birth for whatever reason, I've heard a doctor saying to the patient that during labour, she cannot have a caesarean section, then have to wait to be born vaginally, the baby goes into suffering. So, absurd things that we listen to induce the patient to choose something that is not her initial wish […] there are a lot of pregnant women coming to me in late pregnancy when their doctors start discouraging them because in early pregnancy no one discourages them, they go around, surrounding until she has had the courage to change or she is convinced (BPP4)*

> *It was subtle things, but that moves us. Just like he[physician] always talked to the nurse like that, ah see how the others are there since I'm still stuck here, I can only leave here when this baby is born. We feel bad for the others who are there, you are like, OMG this child has to be born soon, the other women are there alone, he's here with me, I'm taking all his time, there's only him here, there's no other person. Another thing he said like that, my husband asked if he could come in, and then he said to the nurse: No, no, now you cannot enter, there is no way he can enter, if it was a caesarean then he can enter. It is subtle things like those, but they are marking (BM6)*

In turn, within women who was able to deliver vaginally, there was a high incidence of interventions, as depicted in table 11 and showed by Leal and Gama (2012). Analyzing the data gathered, mothers and other professionals connected to the Humanization Movement, tend to undermine the excess incidence of interventions, usually portraying them as medically unjustified and tied to the doctor's convenience and to accelerate labour, being, as a result, really criticized. Added the fact that some of them are reckoned by the World Health Organization -WHO - (OMS, 1996) as clearly harmful or ineffective practices and that must

be eliminated, such as lithotomy; enema; trichotomy and early or directing pushing, the incidence of these practices are conceived as obstetric violence. Obstetric violence embraces both physical violence, through the enactment of material practices and symbolic violence mostly represented by discursive practices, such as common sayings spoken to the woman during labour. Some examples are illustrated in the sequence:

> *I asked the nurse who assisted me if my husband could accompany me, she said something horrible, want to hear? She asked me why I wanted my husband to come in so he could see me all stretched like that and never desire me again, that's what she asked me ... It was horrible, my experience there was terrible […] the nurses said to me, oh now you cry, latter you forget it, three years from now you're here again (BM4)*
>
> *Then I was crying, another nurse came in and said to me that I was not supposed to be crying, that I was supposed to be silent, not to disturb other women and that doctors also did not like to see women crying […] another nurse came and said to me: look don't scream and don't cry because at the time to do it was good, you didn't cry (BM8)*
>
> *I suffered a lot of obstetric violence. From various doctors on duty (BMS356)*
> *On the day of delivery, the doctor looked like someone else. It was early in the morning and it seemed like he wanted to do the job quickly so he could go home and rest. I felt helpless, unhappy. If it wasn't for my son, it would be the worst day of my life. Feeling a lot of pain, and zero empathy on the part of the doctor (BMS384)*
>
> *There are also the internal examinations, which they make a lot of examinations, each of them who arrives makes two, three examinations (BM6).*
> *The health system is not good, there are many professionals who have no dialogue with patients. The lack of information culminates in the imposition of practices of obstetric violence. (BMS299)*
>
> *I had the type of delivery I wanted, normal without analgesia. But not in the way I would like. The worst for me was the gynaecological position [lithotomy]. It wasn't what my body asked for and I had a lot of tears, I think because of that. I also prefer not to have an episiotomy. (BMS165)*

The episiotomy, for instance, mentioned in the last excerpt, was one practice noticeably reported as obstetric violence. Usually, it is seen as a means of ease for physicians when suturing later, as it is a straight cut. Women and practitioners linked to the Humanization movement claim that a natural tear is better because it leads to better recovery for women, but as it is an irregular cut, which makes more difficult to suture later. Another point highlighted in relation to the enactment of those practices was that most of them were performed without being asked for consent or even informing women of their need or performance. Often women were not involved in the decision of those practices and could not properly explain why they received it.

> *She went to the hospital with 7cm of dilation and then she stayed there the rest of the labour, at the end, the obstetrician did an episiotomy without need [...] she is still a little upset.... is that, in the end, in the expulsive phase, the baby had pooped, so the obstetrician freaked out*

> *and wanted to do the episiotomy, but she was already in the birth canal, already crowning, so there was no need for episiotomy or even less to pull the baby at any cost (BPD2)*

> *Suddenly they came and gave me a serum. I said, what? but for what? They said: It's just medicine to help you. All right. My contractions are over immediately. It interrupted my labour [...] It was all without even explaining. Later that I found out that what they gave me was buscopan (BM4)*

Connected to that, alternatives of pain reliefs were not only not found as recurrent but also identified in many cases as a denied right to women. Maternity service in Brazil has fewer options available than England, the main option is the use of epidural, which was not found to be really practised. Two different scenarios were noticed. First, its low use was often linked to low resources and obstetric violence, especially within the public domain, when it is not regularly offered to women and yet frequently denied when women ask for it. Second, it was not so well advised within defenders of the humanized birth because it can unfold a cascade of interventions and make normal birth more difficult to happen. This can also be attached to the lower incidence of vaginal delivery in the country, which in turn, decreases the expertise knowledge and practice among practitioners to perform this practice effectively. The following quotes illustrate some cases of denial to women:

> *when I went to caesarean section the baby was so low that it was difficult to get her out, by the cut. Even when the anaesthetist applied the medication he said: "Why didn't you called me? I could have done analgesia for you to have a normal birth." And I said, but is not noted on my chart? but I asked for analgesia three times, for three different people I asked for analgesia and none registered there that I had requested. They said, oh well I'll put it here, soon the anaesthetist comes and makes analgesia on you. They didn't put it like they don't ask for anaesthesia, they leave you there, they leave you in pain (BM6)*

> *I had already paid for analgesia, but the physician on duty did not perform this type of analgesia, only for caesarean section (BMS60).*

> *I will only choose the particular if I have conditions to have better comfort in the accommodation for the companion and eventually analgesia in the final part of the birth that for me, although it was very fast, it was very exhausting. (BMS270)*

> *Then another 40 minutes passed I complained of pain and asked for anaesthesia. I asked if he could give me anaesthesia for the pain to calm down, to get some rest, for me to reach the final stage right of labour. Then he came into the room and said: no, I'll operate you (BM8)*

Moreover, in the face of an uncertainty scenario or increased risk, such as baby breech, bigger baby, previous caesarean section, among others, the conduct tends to favour the caesarean section. Among women frequently, the choice of caesarean was also linked to the "fear of suffering violence" (BM2), "fear of the pain" (BM5), or "traumatic previous experience" (BM6). Table 13 also corroborates this. It shows the reasons why women expressed a preference for caesarean section. Accordingly, more than half of women who

preferred the caesarean section was due to the aforementioned fears or by myths linked to normal childbirth, often due to the dissuasion practices. However, some cases also pointed out violent conduct during the operation such as to tie the arms as in a crucifix. In those cases, women reported not having been told why or asked permission too.

> *Because of all the reports of poor childbirth care to the women around me, I created such a fear that I would end up in the hands of a doctor I didn't know, who didn't respect me. That is why my decision to have a caesarean section. (BMS23)*

*Table 13.* Preference reasons for caesarean section in Brazil

| **Preference reasons for caesarean section** | |
|---|---|
| Fear of the pain / Normal birth / obstetric violence | 39,58% |
| Better/ Safer | 16,67% |
| Risks of waiting for normal birth/complications | 10,42% |
| Calmer / easier | 8,33% |
| Medical reasons | 7,29% |
| To have control | 5,21% |
| Family tradition | 3,13% |
| Did not want to wait long | 2,08% |
| Would not like a normal birth | 2,08% |
| Best recovery | 2,08% |
| Health insurance did not pay | 1,04% |
| Tubal ligation | 1,04% |
| Fear of not have her own doctor assisting at the time | 1,04% |

As a result, there were also contrasting perceptions about caesarean section. For many, especially women and professionals linked to the Humanization Movement, it is a recurring practice for the convenience of doctors and higher profits, who are often approached as "*cesaristic*" doctors. Because it is faster and more predictable, obstetricians tend to set aside a specific day to perform several scheduled caesarean sections. Consequently, they are able to plan their daily routine more easily without the unpredictability of having to assist labours.

> *Normal birth is only worse for the doctor, who does not know when it will happen, how long it will last, who cannot turn off the phone [...]Brazil is the champion country in number of caesarean sections, because it is better to have a caesarean section for the doctor, for the doctor is better, much easier, 20 to 30 minutes ends a caesarean section, no matter if it is bad for someone, for me it's good, for me it's better, so yeah, our system is this one and nobody wants to follow any recommendation because the recommendation says that you have more work, so I won't follow any recommendations (BPP4)*

> *A great pro-caesarean conspiracy that builds on insecurities fuelled throughout society. (BMS365)*

On the other hand, as this movement intensified in support of normal delivery and humanized care, I also identified some retaliation against it and in favour of caesarean section.

Consistent with the technocratic model, since it is something more planned, caesarean was also seen as a safe option, especially by doctors who have greater control of the process. Table 13 also evidences other ideas linked to caesarean section, such as to have control, easier and safer. However, I must state that, especially among women, this was the minority:

> *I have nothing to complain about, but it bothers me this wave of deifying normal birth as if it has no risk and crucifying the caesarean section as if there were only harm and not benefits (BMS80)*

> *I would just like to emphasize my preference for caesarean section, not for influence, quite the contrary, because of my own opinion. My choice even made me unsure given the current trend of normal/humanized childbirth, which made me feel less mother. But due to my opinion, I faced the opposite looks, trusted God and had a great caesarean section!!! (BMS12)*

> *I had caesarean section by choice. Honestly, this massacre at this option is something that bothers me. I am no less or more of a mother because I did not feel the pain of normal birth. I didn't feel because I didn't want to and not because I'm a coward and I'm afraid of pain, I just didn't want to (BMS58)*

> *Caesarean section has been gaining more prominence among colleagues because in normal birth you have to be on duty all year round. Since the baby can be born from 37 to 42 weeks, and as women pay the availability tax, they expect the doctor would be available 24 hours until the end. So, they cannot travel, they can do nothing. That is why is much easier do the elective caesarean, the scheduled caesarean. It is easier for me if everyone were an elective caesarean section. Also, the caesarean section on this safety issue, because nobody tolerates an unfavourable outcome, an unfavourable outcome, so it ends up preferring and ... especially this media issue and exposure and such. (BPP2)*

Therefore, due to this difficult and contrasting scenario, some new practices had become more frequent especially as a way to guarantee the women's choice. First, I noticed another type of practice related to normal birth, a reframing of it. That is, in Brazil in addition to encouraging vaginal delivery for its healthier benefits, I also identified the concept of normal birth based on a symbolic construction centred on women's empowerment and transformation. Normal birth was also transmitted as a way of giving power back to women, a power that had been taken when childbirth became the primary territory of physicians. It was seen as a transitional phase, a rupture moment when a woman became a mother, thus, a very important phase for her to experience. Thus, more than the healthier mode to deliver their baby, women valorise the experience of delivery itself. In addition, given the high incidence of interventions, mostly seen as violence, there was also an appreciation of natural birth. That is, if possible, a vaginal delivery without any interventions, which contributed to this feeling of overcoming and empowering. A nostalgic feeling, then, was found when talking about their own childbirths, and even a feeling of wanting to relive it, to feel again the sense of overcoming.

> *I won't pass through this life without having a normal birth (BMG2)*

> *I think that natural birth gives back the power to the woman, from the woman [...] It makes possible to understand that she really is capable, that her body is really capable and knows what to do, demystifying everything that has been built, that our body is imperfect, that we do not care, that we cannot stand the pain ... why feel pain? So, demystifying all that (BPN1)*

> *It is very funny the whole story, when you hear women talking about normal birth, and I can also say after my delivery, that we miss it, is very crazy that you miss the pain right ... because what is left is not the pain, when you embrace the process, when you are prepared for this physiological process, what is left, I think, it is the overcoming of every minute, every hour that goes by, the feeling that it was getting closer and closer and that you were feeling everything and that could handle to feel all that, so I think that's what you miss, it's very strong (BPN1)*

This reformulation also encompasses a resignification of pain. Pain, seen as inherent in this process of transformation, was constructed under a rite of passage aspect inherent in this rupture. In addition, it was considered a bearable pain, a pain that the body itself sends aware of what it can handle. But its relationship was detached from suffering, that is, the pain was present because it was a moment of transformation, but in the case of 'humanized' birth, there was not or should not be any suffering linked to it. Suffering, on the contrary, was linked to violent birth, feelings of abandonment, loneliness and obstetric violence. When a woman received proper care, the pain was not something that would impact on her or be remembered by her.

> *The matter of pain is a cultural issue too, because our grandmothers, our mothers, had more violent births, let's say, it was a bad care, where the woman had to give birth lying down, getting labour lying down, oxytocin on everybody, so it is a more painful normal birth, it is a more suffering normal birth and it goes from generation to generation, so it is about changing the view itself. Women who are well assisted, the pain stays in the corner, it is a detail, they will remember the moment they took the baby in their lap, will remember that as a moment, as a very special day, as a unique moment, the pain ends not being a villain in the history, so it depends a lot on the care model, when the care model changes, the perception of delivery changes as well. (BPD1)*

> *The pain of giving birth to a child is special, it is breaking boundaries and finding yourself stronger than you thought (BM - Quote extracted from a social group on Facebook).*

Second, I identified that due to the difficulty of achieving a normal birth, it was also linked to the idea of a search, a fight, something women needed to prepare for it. Thus, practices such as educating, making a birth plan, hiring a private doula and an obstetric nurse, attending support groups, doing yoga or Pilates were common. Educating practices consisted of women getting informed about normal birth. They seek to acquire proper knowledge so that they can interact with their physician about their preferences and rights and be aware of the medically justified reasons for a caesarean section, so that they would not fall into medical deception, and would be able to contest medical procedures linked to the technical model of childbirth.

> *the sooner the woman seeks information, prepare herself, find the right doctor who can handle this kind of delivery she wants, it is better. Because there is a lot to study, right? (BPD1)*

> *…I made this search for a home birth, so… it was my husband's and my empowerment, we went headfirst into this area, childbirth, humanization and everything, and then when he was born, I said: people need to know that… I say it is more ... empowerment, knowledge of knowing that it is possible (BPD2)*

> *There is a lot to improve, starting with women themselves seeking more knowledge and not accepting more backward doctors living on a pedestal completely ignoring the respect for birth. Women can no longer accept certain routine procedures done in many places. They need to report whenever they suffer any violence, but for this, they first need to acknowledge these violations and not believe the doctor's talk that normal birth is like that, with episiotomy, kristeller, synthetic oxytocin, among many other things. (BMS270)*

> *I think that for our condition here, she should be prepared and informed because the physiological conditions of childbirth, these things already exist in the person right, but for her to face this whole society, which is very medicalized and pro-caesarean, practically against normal childbirth ... I think one of the main things for women is to use this period during pregnancy mainly to get information… the woman who wants normal birth, humanized birth to see that is really a good thing, it is not crazy as they talk around or a trend. So, I think the information, information, research, participate in good quality courses, which are offered by teams… I think it's fundamental (BPP3)*

In relation to this idea of something to prepare, normal birth was also connected to a conception of a possibility, an attempt. Differently than in England, which is better explained in the next topic, where normal birth was attached to a certain thing, an assumption, in Brazil, it was usually connected to an attempt, a trial, always embracing an uncertainty, "*We can never say that it will be a normal birth, we will decide to try a normal birth"* (BPP3). Besides I do acknowledge the medical conditions that actually imply this uncertainty, my point here is to highlight that in Brazil normal birth was more frequently tied to unsureness, even among the actors who defend it, while in England, where normal birth was more common, I did not find this idea, even though medical conditions also applied there. As a result, when a woman could not manage to have a normal birth, usually she had feelings of failure and sadness as if her own body was weak or she couldn't manage the pain, "*I was sad with myself because I couldn't do it, understand? I think that was because I had failed, I could not get what I wanted most and I had to do something I did not want, so it was difficult*" (BM9). While, when she did manage it, she presented the nostalgic feelings mentioned before of overcoming and succeeding.

The birth plan was another practice well recommended and carried out as a way to assure respect to woman's preference. It is a formal instrument that the woman used to avoid suffering obstetric violence through undesirable practices. In it, women put their preferences for childbirth and practices they do not accept, such as episiotomy, for example. Thus, when their wishes were not respected, they commonly address it as the lack of a birth plan that would have enforced them. In addition, women were also advised to talk with their obstetrician about

the birth plan as a tactic to find out if he was the so-called “cesaristic”. Since it was seen as a formal expression of their preferences, it was believed that if the obstetrician was a “cesaristic”, he would strongly warn them not to do it or show opposition to it, while he was not, he would encourage its elaboration and discuss it with the woman.

> *As for the silver eye drops, she said it is also usual to do in the hospital if the parents don’t object, but if you write and the father tells the paediatrician on time, then they respect the birth plan. But of course, the father will have to be alert, because if he doesn’t give the paper to the paediatrician, you run the risk of doing it (BM3)*

> *At her birth, I really wanted him [husband] to be with her, but they already bathed her without even asking what we wanted. In fact, after I gave birth, I learned about the birth plan option. I didn't know that, so they didn't ask me anything. (BM4)*

> *I asked my husband to go with her [baby] and ask not to bathe, but only then the nurse said: no, no, but we always give bath here, we give to all the babies. But there was nothing written because I didn't imagine that I was going to have to go to the hospital, so I didn't make a birth plan, so I didn't have any documents, anything like that, that I asked not to make certain interventions, so they ended up doing everything (BM6)*

> *I arrived at the hospital; I had made a registered birth plan. The team was very surprised by the birth plan. They had never seen it. I remember a nurse asked me, who taught you how to make a birth plan? I said no one, I studied and found out that I have this right. Then she said: but this is not worth anything. Then I said to her: if you think I had the courage to set up a birth plan if anything comes out of it, do you think that I will not take it ahead? And then they didn't say anything else, they treated me very well, they respected me a lot. I gave birth in the position I wanted, the way I wanted, with my companion taking the baby, with the baby being respected, they did not do any intervention on my child, exactly as it was in the birth plan (BM8)*

Finally, other practices such as hiring a doula and an obstetric nurse and participating in support groups were also highly recommended and common. Involving others in the process was a way to construct a network to obtain reliable and technical information based on the precepts of humanization and to have the support that was often not received in society. Participation in networks and NGOs has become widespread in the country both in person and virtually. Many women had established contact with other women and professionals from different states, sometimes not even meeting in person. Therefore, relying on the assistance of other professionals helped women in decision-making, in referring professionals who worked on a humanization approach, in identifying if the physician was taking unjustifiable conduct, and providing support during labour for the succeed of normal childbirth through techniques and exercises that would ease it. Still, other cases such as going to the hospital in advanced labour, lying to their own family about their choices, lying to the doctors about the medical history, and going to public hospitals even when having health insurance were also noticed as practices performed aimed to achieve a normal birth.

> *…and the plan C was to go to the doctor on duty but with the obstetric nurse together, because then she wouldn't let, not that she wouldn't let, but she would be there supporting me to help with the decisions, say: look –[mother's name] what he wants to do will generate this, that, that and that, you have another option, negotiate with him. Because they do not interfere in your relationship with the doctor, but then can give you greater support. (BM6)*

> *Doula and a humanized doctor are indispensable to increase the chances of getting what you want in terms of delivery. Hospitals do not want, the system does not want, so if the mother is not empowered and have professionals on her side, in the first excuse, they already push you to caesarean section (BMS25)*

> *In the fourth pregnancy, I did a madness, I tell you, my story is a little crazy because in the fourth child I said he will be born of normal birth. Then I had health insurance, but I went to SUS. Before I looked for two doctors and it was the same story, one of them even said: you are crazy to get pregnant after three caesarean sections. Then I said, you know what, near my house, there was a public health clinic, so I went to SUS. I said I don't want to hear any more bullshit, then I said I have one caesarean section and two normal deliveries, she gave me a card and then nobody bothered my patience [...] And then I had a normal baby, without any intervention, without anything, it was with a nurse, it wasn't with a doctor, the only doctor was the paediatrician and everything was wonderful. But I say, everyone thought I only had only one c-section (BM7)*

In closing, considering all the aforementioned practices, maternity field in Brazil was not configured as having embedded and routinized practices. Different medical conducts were noted throughout the country, both in the public and in the private domains, although higher in the private. Health professionals stated that there is a lot of discrepancy between the shifts and a lack of protocols and updating by some doctors (EPP3; EPN1). According to EPN1, "e*ach shift is carried according to the physicians' personal approach. If he is adept to proper routines, okay, if he isn't, you're at great risk of either going straight to a caesarean section or to suffer a lot of unnecessary interventions*". Differences were also found in women's experiences. By the same time some women reported good care, others expressed terrible and traumatic experiences, considering, for purposes of comparison, the same mode of birth and type of care (public vs. private).

*England*

Most women in England also expressed a preference for vaginal delivery – 89,29% of women from the online survey and 90% of the interviewed women. However, here the disparity between preference and incidence was lower in comparison to Brazil. 71.4% of births happened vaginally. Figure 15 shows the rates of the main practices related to the modes of delivery in the country collected through the survey. Figures obtained showed consistency with the national record (HSCIC, 2015) as well.

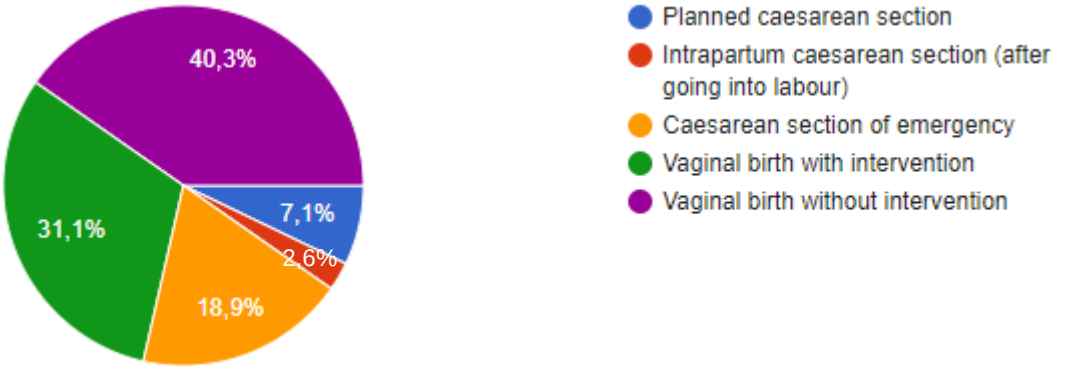


*Figure 15.* Modes of delivery in England

Despite there is the same preference for mode of delivery in England, a completely different mindset was found in regards to childbirth. Normal birth in this field was kind of an implicit assumption, the natural way to delivery. Thus, women and health professionals already took for granted that this was the established type of delivery when talking about maternity. Once the woman was pregnant, she was supposed to vaginally. Because of this, it was very common during the data collection that the interviewees started talking about the place of birth instead of the types of birth when questioned about modes of delivery. Expressions such as *default, assumption, assume, expect, norm,* were usually expressed when talking about the choice of delivery, as can be seen on the excerpts below:

> *I hadn't really thought about it. I assumed it would be a natural delivering, just because my mom had four children, and they were all-natural. So, I just assumed it would be (EM2)*

> *I was low risk, so I think… yeah, sort of the default option is just to give birth, not definitely a caesarean section, but just to give birth normally. Yeah. (EM4)*

> *I didn't really discuss that in-depth I think it was something like take it for granted, probably… I thought it was... take it for granted, that would be a natural delivery (EM6)*

> *So, the default is vaginal birth. So, it is vaginal birth unless there's a medical reason not to. (EPMW8)*

> *I think most women expect to have a normal delivery. That's the norm (EPP3)*

> *So, for the straightforward, woman who has no complications, then the assumption would be that she would aim for normal delivery and... would only have a caesarean or an instrumental if, as doctors, we felt it was indicated (EPP2)*

Consequently, the caesarean section here had also a different perception. It was connected to the idea of a problem. In general, other options of delivery, such as instrumental deliveries or caesarean sections were only considered when there was any issue involved, a complication on labour or increased risk. So, it was not something well seen or desired by women because it implied a possible emergency or difficult. Even the presence of obstetricians

around was pointed as uncomfortable for women because it automatically meant that something was wrong or bad, as they only got involved in cases of increased risk or complication. Normally, the woman would only discuss having caesarean section as an option for delivery if she has already had a caesarean section before, in which case she would be eligible to have again if it was her preference.

> *[…] because I associated c-sections to complications delivery and I didn't want this (EM10)*
> *I never thought I would have a c-section... c-section would be in case I had any type of problem in delivery so, like to save her or my life or so, that's the only way I ambition about c-section (EM6)*
>
> *I would have minded having a c-section, but I would have understood if it was required for emergency, then I would be okay with that (EM3)*
>
> *they wouldn't have met me, so, me wandering in and saying Hi isn't necessarily a relaxing thing for them. It makes them think, oh, what's going wrong, which then it has the potential to put up the adrenaline levels and reduce the effectiveness of their labour (EPP2)*

Our survey also evidenced this. Only 7,14% expressed a preference for caesarean section. Table 14 shows the reasons for that. Among the explanations, most women (71.43%) justified their preference based on a medical need. Instead of showing a personal preference that supports this, as was seen in Brazil, the reason was based on a health condition that indicated that caesarean section was the best option for them. When woman, however, express a strong preference for caesarean section during antenatal care and has no medical reasons for it, the usual practice was to refer her to a healthcare professional with expertise in mental health support. Typically, they first met a consultant midwife and depending on each case, they could also forward the woman to meet senior physician and psychiatrists who would address the mother's anxiety and fears in a supportive manner. Psychological interventions in these cases involved: support from a named member of the maternity team, continuity of care, formal counselling, and cognitive behavioural therapy.

*Table 14.* Preference reasons for caesarean section in England

| **Preference reasons for caesarean section** | |
|---|---|
| Medical reasons | 71.43% |
| Did not want to be induced | 7,14% |
| More controlled and planned | 7,14% |
| Wanted the birth that society and professionals managed to convince me was the 'norm' | 7,14% |
| Safer for baby | 7,14% |

The caesarean association with some complication was such that one mother reported that when she said to other people that she had caesarean, she often felts she had to justify why

she had it, "*Oh she was breech, do you see?*" (EM9). The connection was also ratified among health professionals. In general, they commented on the risks that having the surgery might cause, such as having a scar in the uterus, decreased female fertility, infections, more difficult recovery, and increased risks to the baby too as it would be the doctor who would initiate the birth and not the baby itself as in vaginal delivery. Therefore, most of them portrayed not as "*something that is safe, but as an operation that will end up damaging the woman's health"* (EPMW2), so that should be performed only under medical need, which was mostly the cases found. Elective caesarean sections represented only 2.6% of births.

Among the vaginal births, there was also a considerable incidence of interventions, in some cases even higher than in Brazil (Table 11). Nevertheless, unlike there, in England interventions were seen as a way to help labour progress. Because the focus was on prioritizing normal birth, when labour presented complications or did not progress as established in the guidelines, midwives usually tended to adopt some practices to easy labour to continue or accelerate the birth process. Depending on these practices, physicians were also involved. The use of epidural, instrumental deliveries (forceps or vacuum/ventouse), and caesarean sections, for example, were only performed by physicians.

Practices advised against by the WHO (OMS, 1996), such as lithotomy; enema; trichotomy; Kristeller's manoeuvre and early or directing pushing presented the lowest rates as illustrated in Table 11. In turn, practices commonly used for induction, such as amniotomy, synthetic oxytocin or for instrumental deliveries, such as forceps, vacuum and episiotomy, in contrast, were found higher in England. The same pattern was noticed in the cases reported in the interviews. Around 40% of the births received some intervention, mostly forceps/vacuum and episiotomy. However, as they were usually reported as necessary to enable normal birth to flow when it was progressing enough or due to some complication at the time, as fetal distress, in most of the cases, these practices were seen as medically justified. Even in the cases where women weren't happy and/or hadn't a pleasant experience with them.

The practice of episiotomy, for instance, despite presenting rates higher than in Brazil (40,7% x 36%), it was not pointed with the same outrage and anger as it was found there. Often women that received also expressed dislike about it, difficult recovery and preference by a tear instead. On the other hand, the same intense negative reaction and disbelief of its real necessity were not identified here. The episiotomy was not seen as violence, but as an unfortunately necessary practice for the birth of their child. Hence, for the next pregnancies (real or prospective), they had in mind that it was a specific case, not medical misconduct. In only one case, one mother reported that she chose to have a caesarean section in the second pregnancy.

She developed gestational diabetes, which made her a high risk, so, in addition to her previous unpleasant experience, she thought it was best to go straight to caesarean section.

> *The first time I hadn't a tear at on one side but I had the episiotomy at the other, I don't know which one I prefer, I think I prefer the tear" (EM10)*

> *[…] It was not a very straightforward birth experience. And, you know, that actually made change my choice of delivery mode for my second birth because… well, that was only part of the reason and the other reason was I had gestational diabetes. […] So, we just thought it might be better for me to just go for c-section, given me my previous birth experience and giving the size of the baby, so that's how I ended up with a C section for my second one (EM4).*

Accordingly, I noticed that, in general, interventions were not seen as heavily as in Brazil. In most of the cases, women did not show such aversion on having them. Even when they had displeasure experience, it was not given many reactions to it. In line with that, from the professional side, usually, it was not put such an emphasis on it, so the woman would not see as a big deal, but as a little help to her achieve normal delivery. So, for example, according to one midwife' explanation, a normal birth would count anything that didn't need forceps or vacuum because eventually any intervention often was needed.

> *I had a high-risk delivery following a low-risk pregnancy and was induced due to reduced movements. The baby became stuck during delivery hence need for forceps. Also, the baby born very ill and that is the reason baby not able to be placed on me and breastfed, delayed clamping etc as needed urgent medical care. My views were taken into consideration at every opportunity but unfortunately due to the risk things did not go as I originally wanted (EMS120)*

> *we wouldn't call that as an intervention as such I think is to kind of minimize the impact of those things so they don't think that they have something too horrible to them […] this country is proud of the general birth rate, even if they may have some interventions in the way because anything that can happen even anaesthetics or anything like that, they will always need, often they need something (EMPW2)*

Another recurrent practice that may be linked to this difference meanings was the informed consent. As in England, maternity care is women-focused, the woman was supposed to be active in all the decisions. Thus, during the care received in pregnancy, labour, birth and after birth, women were supposed to be informed of all her options so she could make the decision with the health professionals. Thus, practices as discussing, asking for consent - both formally, as a signed form, and informal through verbal questions ("are you happy with…?) -, and educating were also common.

Regarding the last practice, educating, I noticed a slightly different perception of Brazil as well. In England, there was also a high incentive to women educating, but the focus was to make women aware of the birth process so she knew what was happening to her body, coped to it secure that it was normal, and facilitated the interaction with the team during the process. Health professionals reported that in order to woman be able to make a proper choice, it was

important that she was informed about the stages of labour, what options she had for pain relief and what other practices (interventions) might be needed during labour and birth.

> *we generally recommend that women have some education beforehand and antenatal classes to understand what's in the group and learning about what's going to happen so that you reduce that surprise […] they get given standard information from the NHS (EPP3)*

Among the educating practices, the attendance to parental groups was central. All women interviewed reported having attending parental classes either provided by the NCT (Nation Childbirth Trust) or the NHS. These groups were usually attended by the couple. In addition, it was highly pointed out the practice of receiving leaflets from the midwives on different topics, such as place of birth, pain relief options, and more specific cases as ECV manoeuvre, caesarean section and induction when these practices were needed to consider. Access to NHS website and attendance to other groups such as hypnobirthing were also pointed. Finally, one mother also mentioned the practice of scheduling an appointment with a midwife to discuss how was her previous birth, particularly when it had complications. This was an opportunity for the woman to clarify any doubts about the previous experience and to be more confident for the next pregnancy without fear of happening again.

> *they give you a lot of leaflets so it's lots to sort of taking away and read and bits and pieces (EM1)*

> *So, I read, NHS has lots of things on their website, I read on the internet (EM2)*

> *I've gone on the NCT course. And they were quite informative about the different interventions that you could have (EM3)*

> *So, you have an appointment with one midwife for one hour and you discuss how your previous birth was. So she could answer all my questions because I didn't know why I had to push for two hours and then they decide to ventouse and they didn't explain me after the birth when the baby was there and I didn't think of asking questions but I must be curious and then a bit anxious that it would happen again with this baby so she explained. I learned many things (EM10)*

In regards to pain relief, its incidence was also higher. 58.7% of women used some kind of method. The higher rate compared to Brazil was connected to the fact that England had more options for it. There was an escalating series of choices of pain relief which were discussed with women in their antenatal care by the midwife on the appointments and on the parental classes. Also, it was at the disposal of women during labour. The lower options were aromatherapy, tens machine and wheat bags. Then, the bigger ones were the proper medication: gas and air (a mixture of oxygen and nitrous oxide gas), pethidine injections, and epidural. Epidural was the highest option for pain relief as it was the only one that stops the urge to push. Still, women had the option to use water in labour, having a water birth or the shower in the

room. Alternative methods such as homoeopathy, hypnosis, massage and reflexology were also mentioned. But those usually were looked for the women themselves.

All these options could be asked for the mother during labour or already be detailed on her birth plan, which again, was another contrasting point in comparison to Brazil. Birth plan in England was a recurrent practice as well but enacted with different meanings, especially from the point of view of women. Here, it was not given the same importance and insistence as it was in Brazil. Normally woman had in mind, and health professionals encourage it also, that it was better to be open to how labour was going to happen and, considering it was difficult to predict, it would be probably different at the time. Many mothers pointed out that did not have specific thoughts, especially after a first pregnancy, because they already knew that it might not be followed. Therefore, the birth plan usually was portrayed as birth preferences and encouraged as a way for women to get informed and think about birth and how they would like it to be, but flexible to change if needed to.

> *there's no point having a birth plan because nothing will go to plan if you'd for the natural delivery. The only thing that will go to plan is a planned c-section and I just figured for natural I just knew roughly a few little things, in my opinion, I just had to go with the flow if she came naturally. (EM9)*

> *We call them here more birth preferences rather than a birth plan because when you have a plan and things don't go to plan, you get very disheartened by it. But if you have preferences in terms of what it is a good idea to think in an ideal world if everything's going well would you like this to happen because it's just presenting... you don't want to be doom and gloom but you know things don't always go according to plan and what we've tried to do is if you have specific preferences we can try and influence what happens along the way to meet them (EPMW9)*

> *And usually, women write a birth plan about what they want and don't want in labour. We always tell them that you can't...you may not be able to stick with a birth plan because, you know, women can have multiple ideas but things may not always go that way, things went out differently so we just have to keep that flexible. (EPP4)*

Finally, looking at all the aforementioned practices and data collected, the maternity field in England was configurated as having highly embedded and routine practices. A very coherent discourse and united professional conduct were found among health professionals that were corroborated by the mothers' birth experiences. Regardless of the place of birth or type of care (midwife or consultant care), patterned action was followed according to established guidelines. Maternity practices in England were mostly enacted based on guidelines designed by specific institutions, such as NICE - the National Institute for Health and Care Excellence - and the Royal College of Obstetricians and Gynaecologists (RCOG). These are expert panels who produce national expert guidelines for antenatal intrapartum and postnatal care for the whole United Kingdom. Most of these guides were elaborated based on researches which are

widespread along with them. So, it was very frequently when talking about the maternity practices the use of expressions as "*we know that*", "*we know from research*" "*we have statistics" "because the evidence shows", "our guidelines say"* as a way to indicate that the statement made was based on a previous research.

> *So over here, it is very guideline-based, driven. So, for each condition, you already have an approved way of managing things. (EPP4)*
>
> *they published a report every five years, and from that, we've known that when you have continued of care is safer for the women. (EPP4)*
>
> *So, we know, we know already that women who have one to one care in labour, for example, and have the support and have a birth partner are more likely to achieve a vaginal birth, (EPP6)*
>
> *All the women are being offered induction sooner than that because of the evidence of increased risk of stillbirth later on in pregnancy (EPP2)*
>
> *they did a big study, I think, in 2011, called Birth Choices. It's about the place of birth and that showed that (EPMW4)*
>
> *if you are in an obstetric unit, where we have obstetricians, we know from our research that it's much more likely that you are then going to be putting a monitor, (EPMW4)*
>
> *If they go into labour our guidelines say we should give antibiotics after 18 hours (EPMW4)*

Many examples/situations were mentioned in most of the interviews and ratified by women when telling about their labour, corroborating the standard care. Women used to explain that practice was performed that way because they had a guideline or criteria for that. For example, the practice of internal examination was established in the guideline to be performed every four hours, the frequency also in line with the recommendation made by the WHO (OMS, 1996) and the heart monitoring every fifteen minutes. The following examples illustrated this alignment:

> *the vaginal examination we try not to, so we have guidelines every four hours. The CTG, the heart depending on if it is established labour or if it is the end, we would do every 15 minutes in the first stage, and every five minutes on the last stage (EPMW7)*
>
> *But I know they were monitoring me every 15 minutes or so or monitor the baby for the heart rate. And then me a couple of times to see how dilated I was. (EM3)*
>
> *I think they've got a guideline. So, after this many hours after your water broke, or this many hours after you've got meconium, I can't quite remember which is which. But I think I sort of reached that time frame (EM4)*
>
> *[…] according to their criteria you need to be in four centimetres dilated (EM4)*

Considering the establishment of all the guidelines and that the dominant care is provided by the NHS - public domain-, so cost-driven, there was a lot of policing on maternity

care as well. Health professionals had to document all the care provided, describing which practices were promulgated and, if there was a change of conduct from the guide or any intervention, to justify and prove the reason for that, for example, the incidence of caesarean section. These documentations were also used by the NHS and the Universities to carry out the researches that make part of the routine care. The main aim of the trials conducted was to make an impact on patient care in the short term, which was around five years. Therefore, they kept control over the care.

> *So, with us, it's about documenting, making sure that everything is written down. So, we have to document that we, this is what we recommend and this (EPMW4)*

> *But you should always in your documentation, and we haven't talked much about that, your documentation is very important that you at each assessing points, you make a plan of what you're thinking is, so you put your thinking and your discussions with the mother into your documentation. And then you say, when you're going to reassess that plan B (EPMW1)*

> *the NHS is the manager, so business, everything has to be... any intervention will have to be proven that he adds benefit as opposed to ... to be cost-effective, (EPMW2)*

> *the standards are more consistent with how people are expected to practice. Yeah, and there's more guidelines and more support for that. (EPMW8)*

*Variation in the maternity practices*

From the identification of the practices that actors undertook in the maternity fields, it was found distinct patterns and embedded meanings that differentiated the maternity fields in Brazil and in England. Hence, comparing it with the theoretical background, I then grouped these practices into seven categories, based on previous researches (Lawrence & Suddaby, 2006; Reay et al., 2013a). Depicted in Table 15, I present these seven types of practice along which the former maternity practices in both sites varied and some empirical evidence that illustrates each category. They are broader discussed in the discussion section.

*Table 15.* Variation in the maternity practices

| Practice | Maternity Field | Forms of enactment | Empirical Evidence |
|---|---|---|---|
| **Embedding and routinizing**: Embedded routines and repetitive practices | England | Guidelines<br>Established practices in the aftercare and questioning the mother of their preference/acceptance<br>Informed consent<br>Routinely actions | • [...] sort of the default option is just to give birth, not definitely a caesarean section, but just to give birth normally. Yeah (EM4)<br>• we know already that women who have one to one care in labour, for example, and have support and have a birth partner are more likely to achieve a vaginal birth (EPP6)<br>• So over here, it is very guideline-based, driven. So, for each condition, you already have an approved way of managing things. (EPP4) |
| **Enabling work**: Practices that facilitate, supplement and provide support | England | Interventions<br>Instrumental deliveries<br>Several options of pain reliefs<br>Consultant midwife appointment | • this country is proud of the general birth rate, even if they may have some interventions in the way because anything that can happen even anaesthetics or anything like that, they will always need, often they need something (EMPW2)<br>• […] there's a whole escalating series of choices of pain relief that women will be talked about, in their antenatal classes (EPP1)<br>• And we also have a consultant midwife, her speciality is talking to people and coming to an arrangement so they can find the safest path for both moms and their babies (EPMW4) |
| **Reframing** Re-making connections between practices and their meaningful foundations | Brazil | Re-significance of normal birth<br>Re-significance of the pain<br>Connecting interventions as medical misfeasance | • I think that natural birth gives back the power to the woman, from the woman [...] It makes possible to understand that she really is capable, that her body is really capable and knows what to do, demystifying everything that has been built, that our body is imperfect, that we do not care, that we cannot stand the pain (BPN1)<br>• The matter of pain is a cultural issue too, because our grandmothers, our mothers, had more violent births, let's say, it was bad care […] so it is about changing the view itself. Women who are well assisted, the pain stays in the corner, it is a detail, they will remember the moment they took the baby in their lap (BPD1) |
| **Constructing networks** Constructing inter-organizational connections with other actors/groups | Brazil | Attending/joining support groups<br>Hiring private doulas and an obstetric nurse<br>Participating on social media groups of the Humanization Movement | • Doula and a humanized doctor are indispensable to increase the chances of getting what you want in terms of delivery (BMS25)<br>• I already sought a differentiated support network. I first got in touch with the doula, of the -- [support group], and then through her, I got to know professionals who accepted and were really favourable to normal birth (BM6).<br>• I think this is the path we are tracing, which comes from women, that started from women this desire to change, this desire to do differently and, like all the changes that happen […] What we had of changes until now have started from women, from the population, but from the government, there were no major changes, (BPN1) |
| **Educating** Infusion of skills and knowledge | Brazil | Search for information/Studying about birth<br>Talking with a doula and other mothers | • the sooner the woman seeks information, prepare herself, find the right doctor who can handle this kind of delivery she wants, it is better. Because there is a lot to study, right? (BPD1) |

| | | | |
|---|---|---|---|
| | | Reading about other mothers' birth experiences<br>Pregnant groups | • I think one of the main things for women is to use this period during pregnancy mainly to get information […] So, I think the information, information, research, participate in good quality courses, which are offered by teams… I think it's fundamental (BPP3) |
| | England | Leaflets<br>Parental classes<br>Discussing with midwives | • we generally recommend that women have some education beforehand and antenatal classes to understand what's in the group and learning about what's going to happen so that you reduce that surprise<br>• they give you a lot of leaflets so it's lots to sort of taking away and read and bits and pieces (EM1)<br>• I've gone on the NCT course. And they were quite informative about the different interventions that you could have (EM3) |
| **Valorising and dissuasion**<br>Discourse practices that provide positive and negative assumptions to maintain the power of the beliefs | Brazil | Dissuade vaginal delivery from uncertainty situations<br>Dissuade humanized birth/birth plan/doulas<br>Valorising the easiness of planning and controlling the time of birth in elective caesarean section<br>Valorising of technology and the caesarean section as easier to plan and control, hence safer | • She has already widened her eye and said: no, normal delivery after caesarean section is impossible, you can only be in labour 8 hours, if the baby is being born, I will have to have a caesarean section if it arrives within 8 hours of labour. She filled me with fear, that's when I started to get informed and saw that she was crazy (BM7)<br>• we see a lot of things happening there, oh your baby is big, your basin is small, and the doctor really induces the woman to want to anticipate the birth for whatever reason, I've heard a doctor saying to the patient that during labour, she cannot have a caesarean section, then have to wait to be born vaginally, the baby goes into suffering. So, absurd things that we listen to induce the patient to choose something that is not her initial wish (BPP4) |
| | England | Valorising the vaginal delivery as the best and healthier mode of delivery<br>Conveying interventions as a help to women achieve vaginal delivery<br>Connecting the caesarean section to the idea of a problem<br>Dissuade c-section from the risks involved of an unnecessary surgery | • I think as far as possible, you know, a normal vaginal… because I think that it has the lowest rates of mobility for their mother, and you get good outcomes, it's cost-effective (EPP3)<br>• So, a caesarean is not seen as something that is safe. It's an operation, it will decrease your fertility in the future, it will increase your complications say in the long term and for future pregnancies, so it's not seen as something... is something that will end up damaging the woman's health (EPMW2) |
| **Policing**<br>Practices that ensure compliance through enforcement and monitoring | Brazil | Birth plan<br>Hire a humanized team | • Then I said to her: if you think I had the courage to set up a birth plan if anything comes out of it, do you think that I will not take it ahead? And then they didn't say anything else, they respected me a lot […] exactly as it was in the birth plan (BM8)<br>• and the plan C was to go to the doctor on duty but with the obstetric nurse together, because then she wouldn't let, not that she wouldn't let, but she would be there supporting me to help with the decisions, (BM6) |
| | England | Documenting all maternity care<br>Justify to NHS difference of conduct<br>Consenting law<br>Learning sessions, M&M meetings | • It's about documenting, making sure that everything is written down (EPMW4)<br>• the NHS is the manager, so business, everything has to be... any intervention will have to be proven that he adds benefit as opposed to being cost-effective, (EPMW2)<br>• the standards are more consistent to how people are expected to practice (EPMW8) |

## 5.3 RELATIONS OF POWER

As an intermediate step in explaining the variation in maternity practices between the countries, I aimed to comprehend first how the field was configurated in both sites, how the relations of power were established among the actors involved in each of them. Across the two cases, I identified three instances along which the relations of power were operating. Depicted in Table 16, the first source was relational, which included the balance or imbalance relationship between the actors in relation to the position in the field, knowledge and authority. It involved understanding how was the relationship established between actors? Was there any interaction between them? How were the decisions made? Were actors aware of those decisions and did they have a voice to opine? The second source was resource control and included both the ownership of important relationship resources and finding the means and resources to enforce the outcomes and social relations between the different actors. And finally, the institutional dimension involved the norms and rules fixing relations of meaning and memberships, integrating as well the external contingencies and other social actors such as organs, regulations and social movements.

*Table 16.* Sources of Power in Brazil and England

| Sources of Power | | Brazil | England |
|---|---|---|---|
| **Relational** | balance or imbalance relationship between actors in relation to the position in the field, knowledge and authority | Imbalanced relation; asymmetry of authority and information; decision making centred on physician | Balanced relation; symmetry of authority and information; decision centred on the woman. |
| **Resources** | control of resources and mobilization for means and resources to enforce the outcomes and social relations between different actors | Dependence of information and expertise by the woman; high mobilization of different resources; high level of acts of power. | Low effort to mobilize resources; little expression of the act of power |
| **Institutional** | norms and rules fixing relations of meaning and memberships, integrating the external contingencies and other social actors | Loose enforcement system on daily practices; a high influence of the Humanization Movement. | Strong enforcement system on daily practices; legal support for women-focused care (Montgomery Case); autonomy inside a continuum |

*Brazil*

In Brazil, the main actors of the maternity field were mothers and physicians. Others actors as the family, obstetric nurses, doulas, hospital (the institution with their own rules, staff and infrastructure) and regulatory organs were more peripherical. The field was mainly centred

in the physician. Legitimized by institutional control, physicians already had more authority and prominence for the professional role they play in health care. The role they occupy in the maternity field entitled them to be responsible for enacting most routines and ongoing practices (Lawrence, 2008) of maternity. Given this configuration of the maternity field, naturally, there was already an established imbalanced relationship between mothers and physicians in which the latter detained more specific scientific knowledge and authority to apply science (Dunn & Jones, 2010; Cain, 2019), hence to make decisions. In addition to that, the structure of professional conduct in the country was based on a very individual work basis. Even when other actors were involved, the physician was seen as the main responsible for the care. There was a hierarchy of authority in which physicians were at the top. So, their opinion was more considered and trustable. The recently regulation disclosed by the CFM, assigning physicians to define the best care and treatment for the mother and baby (CFM, 2019) also formally reinforced what was institutionalized in practice.

This inherent authority contributed to establishing an imbalanced power relationship. The excerpts that follow illustrate this. The first excerpt is from an obstetrician perspective who ratifies that the primary authority is the physician and other professionals were welcome to help but should not interfere on the main conduct that is a medical decision. Other similar reports were also found from obstetricians not linked to the humanization movement. This helps understand why doulas were not welcome by many obstetricians and hospitals, as previously mentioned. The main role of a doula is to support the mother, so they may be seen as conflicting when supporting the mother's preferences that were not in accordance with the medical recommendation. The other quotes show the perspective that outsiders, an obstetric nurse, a doula and a mother often have about this medical centralization.

> *great, the more people helping, always remembering that the conduct is medical, one thing that I don't think is nice it to poke the nose in between (BPP2)*
>
> *Ah so the doctor said, it is ok, if he had not done anything, she would have died (BPN1)*
>
> *he says that doula only hinders childbirth […] because for them [obstetricians], we are nothing right, they are God, we are nothing .... (BPD2)*
>
> *but it was like that, so, "okay, but if the doctor says ..." Because what the doctor says is just like God speaking, right? So, ok, but if the doctor ... (BM1)*

The imbalanced power relation between mother and physicians was corroborated in other findings. First, most mothers found very difficult to be able to interact and negotiate their wishes and preferences with physicians. Besides not having the proper expertise and specific knowledge that physicians had to discuss with them and opt for something different than what

was said, it was found the imposition of risk and danger as a strong convincement argument. Many women reported that their attempt to get their preference met was often followed by a subtle threat of risk from the physicians. To advise against, they infused the fear of higher risk and chance of putting their lives and especially their babies' lives at risk. This greatly led woman to give up choice and argument to the physician, who became the holder of reason and the best knowledge, ergo, the conduct to be followed

> *What I found most difficult is this conflict with authority, because you are negotiating, you are talking, I don't know, exchanging, with a person who is authoritative on that subject, which is health, it is a doctor who studied, only in college six years, made three years of specialization, and I do not know what else. So, he comes with too much authority for you. And the fear too because you're dealing with your life and your child's life and they throw you that responsibility, like oh you know, if you want to do it, it's for your account, but I'm telling you this is dangerous when you say this: you can put your child at risk (BM6)*

> *There was no option, the option was hers, put it in a very, very vertical way right, look this is the best to do otherwise such thing will happen, such thing, that terrorism right, there was no option, look you can do this or you can do that, no there wasn't (BM6)*

Second, regarding the choices, women were often not involved in the decision making or aware of the practices enacted, particularly during labour, when they were more vulnerable. Especially when women were assisted by the doctor on duty, either in private or public domain, frequently they were not questioned about their preferences, if they want or do not want some intervention, nor consulted about performing it or in case of a change of conduct. Similar cases were also found with personal care. During prenatal, little interaction was found in regards as to discuss the birth, its stages and the practices involved, again, especially with obstetricians not linked to the humanization movement. Women stated that the appointments were usually more practical, to assess and give exams. As illustrated on the following quotes, on the cases of mothers BM4 and BM8, not only were their preferences not met, but they were imposed. The physician decided how it would be done and just performed it. No option was given to women:

> *In fact, they didn't even ask, the SUS doesn't even give you the option. In my time, nine years ago, they didn't even question how I wish it was, nothing. Nothing has been said about childbirth with me ... Never, on the contrary. It was all without even explaining (BM4)*

> *I came in at 7 am, at noon the doctor came back and said that he was going to indicate a caesarean section, then at 1 p.m. I went to caesarean section, crying, I went to caesarean section (BM1)*

> *The physician arrived in the room, I was in contraction, the nurse came, pushed my belly, the physician put the needle, broke the bag, and even laughed: all set, this boy will be born now (BM8)*

Consequently, besides the asymmetry of authority, I also identified asymmetry of information in the relation, which was again centred on physicians. In addition to not being consulted, women were often not informed or aware of what was happening or yet why was happening in that way. The conduction of labour, birth and postnatal care was frequently carried out without given explanation to women about the enacted practices. Even in the face of conduct different than their desire, they frequently did not know why. The asymmetry of information was such that, in many cases during the interviews, the woman could not explain the reasons why some practice had been enacted, as the case of tying the hands (BM6), or why it had not happened as she wished, as the example of not waiting the forty weeks for caesarean section (BM2), detailed in the sequence. Two other cases also reported hearing something from the physicians in the operating room during caesarean sections, but as they were not directly speaking to them, they were also not able to fully explain (BM5, BM9). Expressions as "*no idea*", "*I don't know*", "*I guess it was a hospital norm*", "*maybe*" were common in those cases.

> *Actually, we never talked about childbirth as, in great detail, she talked a little over the top. I didn't ask too much, I didn't ask how it will be (BM6)*

> *I have no idea, but it happens a lot of women get their hands tied in as crucifix like that, so you can't hold your baby when he is born .... it was like that: they took your arm and ties here. No question, 'do you want it?', 'do you care about us tying it?', not even a 'look, we have to tie it'. No, they don't, they just tie it and that's it (BM6)*

> *The last thing I heard was from the anaesthesiologist to the doctor, 'yeah, it is going to have to apply the medication'. So, when he said that, they applied it as if it were a calmly, yeah, a calmly, a sedative, I don't know, I don't know why. Then I slept, I woke up six o'clock in the afternoon (BM5)*

> *So, he said, 'no, no, no. If you are going to do a c-section then you can take the risk of not having time to do a c-section'. Because I wanted to complete the 40 weeks, but then he said that there was no way [...] what I understood would be that, I did not go deep on the subject, but then he hinted that then I would go into labour and then I could not have a caesarean section. (BM2)*

This last excerpt, reported by mother BM2, ratifies some statements about the alleged *caesarean tale,* mentioned before, a result of the asymmetry of information. In this case, the mother wished she had waited 40 weeks, the due period, to have the caesarean section and the doctor said it was not possible. What she understood as the reason was that the impossibility of waiting was because if she went into labour, she could not have a caesarean section later, so she gave in. But she said that without being sure because they did not talk further or explained the matter. Coincidentally, this justification was pointed out in other interviews by an obstetrician – who was connected to the humanization - and a mother - who said she almost graduated in obstetrics during pregnancy-, as excuses doctors give to deceive the woman into

having a caesarean section as they want. According to this obstetrician, "*I've heard a doctor saying to the patient that during labour, she cannot have a caesarean section, then have to wait to be born vaginally, the baby goes into suffering. So, absurd things that we listen to induce the patient to choose something that is not her initial wish" (BPP4).*

The matter of information was evident when comparing the relations established between mother and obstetricians who were connected and not connected to the humanization line. Within the obstetricians not connected to it, no effort nor incentive to information was found. They did not point out in their speeches the need or importance of women seeking information, and preparing themselves. The focus of their statements was on safety, risk and transmitting trust so women can rely on them. When directly asked about information, they usually talked of information about general doubts pregnant women have during pregnancy on general topics, such as food habits and hair colouring. It was also unanimously among them that the source of information had to come from them.

On the other hand, among physicians linked to the humanization movement, the posture was totally opposite. The information issue came from them right at the beginning of the interviews when they were talking about the main issues in maternity care. According to them, the most important thing was that woman get informed and prepared and aimed to understand the birth and its process. This posture was more in alignment with the one found in England. And as for the sources of information, they indicated looking for information from the WHO, doulas, nurses and courses provided by these professionals and discussing any doubts with them.

Thus, in the cases where information was more symmetric within the physicians-mother relation, it was found a higher level of interaction between them. Women used to question more and be more aware of the situation. As a result, it was noticed a more balanced relationship between health professionals connected to the Humanization line and mothers. Women reported they felt more involved in the labour progress and the care received during birth and after birth. They were consulted when any practice needed to be done and they were able to opine more easily. The following example is from a birth experience at Sofia Feldman Hospital, a public hospital in Brazil recognized as a reference for humanization:

> *All the time too, all they had to do with the baby, the evaluation, the usual procedures, audiometry, heart exam, tongue exam, vision, were like this: we need to evaluate the baby, do you authorize? Are you coming along with us? Everything in front of me, and of my companion, everything in our presence, with our acceptance (BM8)*

Considering the relations of power within the dimension of institutional power, it was identified that there were different external contingencies impacting. First, there were other

organs and institutions that establish rules and regulations of how the system should work, both nationally (Ministry of Health, Federal Council of Medicine, ANS), and universally such as WHO, who among several documents, has issued a specific guide of practices for birth (OMS, 1996). Although some rules and regulations have been promulgated by these institutions to incentive normal birth and a more humanized care, especially in recent years (Brasil, 2005a; ANS, 2007; MPF, 2010; Brasil, 2015; Brasil, 2016; CFM, 2016), in many cases it was noticed a lack of compliance, which indicates a loose enforcement system on daily practices.

For instance, normal birth was encouraged through the payment of anaesthesia by the services of the Unified Health System (SUS) (Leal, Gama, 2012) and the assistance of birth care by obstetric nurses. Later, in February 2016, the ANS promulgated the normative resolution n.398 which provided the mandatory accreditation of obstetric nurses by operators of private health care plans and hospitals that make up their networks. It also reinforced the obligation of physicians to deliver documents and guidelines to parturient, in order to clarify the risks and benefits of caesarean section and normal delivery, already established in previous resolution (Brasil, 2016). However, all these topics were found with low incidence despite having a legal basis. The matter of anaesthesia, as previously mentioned, was pointed by some mothers as not being offered and yet being denied when asked for it. According to a respondent from the survey: "*At the maternity door, it said that the mother had the option and could choose the way of delivery, a lie, I had no right nor analgesia" (BMS338).* Moreover, only 43.8% and 52.8% reported had been instructed about both the benefits and the risks of caesarean section and normal birth respectively.

Another measure taken by the Ministry of Health was the definition of a decreasing percentage ceiling for the payment of caesarean sections to hospitals. In 1998, they limited the payment of caesarean sections to 40%, decreasing to 35% in 1999, and reaching 30% in 2000. More recently, the Ministry of Health, together with the ANS, began to intervene in the private sphere too. Nevertheless, the incidence of caesarean section has been rising steadily in the country since the 1970s, even with this limitation. About this payment restriction, one obstetrician stated that:

> *I think it was when Minister Serra was Minister of Health, Serra established that he would pay in the public system, only 30% of caesarean sections, what did it open? It opened more space for the market, look at the public system you can do 30%, look I already have 100 birth here, I've done 30, if you want to do the thirty-first you have to pay for it, that's what happened, no change of behaviour. (BPP1)*

Additionally, in 2016, the CFM has enacted the resolution n.2.144 which states that caesarean section at the patient request could only be performed from the 39$^{th}$ week of gestation

(CFM, 2016). Although some obstetricians mentioned the importance of waiting for this period, the findings showed that around 30% of women who had elective caesarean section had it before 39 weeks. In 2005, it was established the right of having the company of your desire through the law nº. 11.108, known as Companion Law (Brasil, 2005a). With this law, the Ministry of Health issued an ordinance in the same year (Brasil, 2005b), and the ANS in 2007 (ANS, 2007), authorizing hospitals and health plans to extend accommodation and meals coverage to the companion. Similarly, several municipal laws have approved the presence of doulas in municipal maternity hospitals and private hospitals. Yet, again I found some conflicting data. 9,9% of the women related that were left alone or denied the right to have some person with them. Some interviews also evidenced this, including a difference in relations to the type of birth. One mother (BM6) reported that the obstetrician did not allow her husband to come in during labour, but if she decided to have a caesarean section instead, then he could accompany her. The doula BPD2 and the obstetrician BPP2 also reported that some public hospitals and physicians do not allow the entrance of doulas. Some of these examples and others are illustrated by the following quotes:

> *The obstetrician in chief at – [hospital] you just cry, he's the one who doesn't accept doula, speaks badly about doula. It was he who deprived the entrance of doulas in – [hospital] (BD2)*
>
> *there are nursing teams here who are sometimes banned from entering certain hospitals or even doula (BPP2)*
>
> *Once there, they wouldn't let me have a companion there, I went to – [public hospital] here in Maringa, I didn't have the option of the companion (BM4)*
>
> *when he [husband] entered in the operating room, she [baby] was almost out, they had already taken, so he followed very little. So, I thought he was going to follow more her birth, but I don't know if it was the hospital rule (BM9)*

All these examples show that while there were norms and regulations that acted in favour of the woman and normal birth in the maternity field, institutional power was characterized by a loose enforcement system. On the daily routine, the authority of the physicians in charge was higher in deciding how to conduct the maternity practices, even if, as some cases exposed, they did not work aligned with established regulations or institutional recommendations for good practices, such as WHO (OMS, 1996). Thus, an effective policing on daily practices it was not identified.

> *I think all these ordinances and federal laws, they have to exist, it is on the right track, because it is only in Brazil that happens this way, that the caesarean section has exacerbating rates, right? And it is Brazil that is different, outside works normally. So, I believe it is very valid here. But it still blocks a lot in relation to institutions. So, we who follow more closely, institutions aim to profit, so they want something that gives a financial return. We also depend a lot on the medical practice, on the doctors being able to and want to follow, right (BPN2)*

> *If you do not change the concept, it will not be by law that the birth rate will be changed, this only creates metric variables. (BPP1)*

In addition, a large influence of hospitals as an important source of institutional power was identified as well. Hospitals have their own structure and standardization of care that often stifles and institutionalizes this noncompliance to the mentioned law, regulations and the WHO recommendations of good conduct. As many hospitals are private, it was also realized that, despite the laws and regulations mentioned above, there was still a lack of incentive from the hospital itself to charge and demand a change of posture, or a responsible regulatory body, as pointed out by the obstetrician BPP1, to ensure the compliance of those regulations. The physical structure and facilities of most hospitals were mostly not suitable for labour and normal delivery, which again, reinforced normal birth as a minority option.

> *There is always some difficulty in giving transparency. This is a difficulty, and we would have to have a regulatory body ... rescuing this information issue a bit, we had to have a health regulatory agency, where it would begin to make your act transparent, the way you search, this is very difficult right. (BPP1)*

The importance of the greater performance of these institutions could also be perceived by the impact they had on successful cases. Where hospitals have had this role in enforcing WHO guidelines, there has been a subsequent change in behaviour. For example, the mother BM8 reported a highly satisfactory and humanized birth experience in the Sofia Feldman hospital, a public hospital in the state of Minas Gerais, already a reference in humanization. A second example was given by the obstetrician BPP3, from a private hospital in Santa Catarina that participate in the Child-Friendly Hospital project and competed for the Galba de Araujo Award, both of which are guided by the WHO guidelines. Hence, it needed to adjust the professional conduct according to these recommendations. Finally, the obstetric nurse BPN3 talked about a private hospital in Paraná that recently implemented the Adequate Childbirth project and has been directing both the physical structure and staff for this change. According to her, the results were already being seen by the increased incidence of normal births, which was practically nil in the hospital before the project.

> *And that's how we started, so it was kind of ... I'm not going to talk imposed, but something like that. The purpose of that hospital was to be a reference in humanization. We participated in a National Contest called Galba de Araújo and we were able to do humanized care and had a normal delivery rate within the precepts of the World Health Organization (BPP3).*

> *We started doing a little while ago when the hospital entered the proper birth project. So now it's also changing some things [...] it's a private hospital, so now that it's starting, after the hospital has entered this project, so now that they are starting to increase normal childbirth, which used to be something like 1 per month, or none [...] the professionals too, because there are a lot of 'caesaristic' physicians, so now this issue is also changing ... because as the hospital*

> *is fitting into the project, they have to fit in too, right, even though they were used to indicate only caesarean section, they are having to stimulate normal delivery too (BPN3)*

In a second moment, still within the institutional dimension, it was also identified a large impact from social movements and media in support of women, all considered part of the Humanization Movement of Childbirth. In different degrees of actuation, from national social media groups to the establishment of local spaces for presential meetings, this movement has among its core aim to inform and empower women in her choices. These groups acted mainly in the dissemination of information that instructed and demystified the normal delivery. Women also used to clarify their doubts and check whether the doctors' recommendations or justifications were consistent among the participants. Topics related to childbirth, the maternity system in Brazil, the stages and myths of normal birth, real indications for caesarean section, obstetric violence, good conduct practices during labour, birth and first care with the baby, among others were frequently discussed. In the presential groups, there were often antenatal courses focused on normal birth and physical activity classes to help to prepare for labour and birth, such as yoga. During some events, it was also common the *blessing of the belly* or *blessing shower,* in which the pregnant women who were close to giving birth had their bellies painted and the participants wished words of support and a "*good time"* to them (Figure 16).

*Figure 16. Blessing shower with belly painting*
Source: Data collection

Within those groups, there was a strong network of considered humanization professionals. So, it was very common to indicate services of other health professionals linked to the movement that worked as a team in the birth care. The following excerpt reported by one of the interviewed nurses shows both the importance of the humanization movement in the maternity field and ratify that this importance also comes from the loose enforcement system. That is, given the lack of enforcement by regulatory bodies, the movement acts in their place

in demand for change. The other quotes evidence the network formed by the indication of services and joint work between different health professionals:

> *I think this is the path we are tracing, which comes from women, that started from women this desire to change, this desire to do differently and, like all the changes that happen, come from the population and little by little it's gaining strength. Perhaps, let's hope that we get to the government level, for them to buy the real fight. We see small actions that the government institutes […] but so far, we saw little real change starting from the government. What we had of changes until now have started from women, from the population, but from the government, there were no major changes, (BPN1)*

> *Sometimes she looks for the service of our colleagues, doulas or nurses, or come straight to me [...] from it, I already provide more or less the way she should go. If she has not a team to help yet, I indicate who are the people who work within humanization, at least here in our work, I offer the help of other professionals because I work in teams and we work as a team, with doula, nurse and doctor. I offer and indicate who these people are and she leaves here already with the indications and until the next appointment, she has already made this contact with the other professionals (BPP3)*

> *Most of the time they indicate me, not the other way around, so here in the city there are strong childbirth care groups and the patients look for these people and they end up referring the doctors right, in a way this is good because if the group that provides birth care is indicating this doctor is because he really does a proper care right? And not the opposite, the patient is not believing only in the doctor, an individual person (BPP4)*

> *I already sought a differentiated support network. I first got in touch with the doula, who was the -, of the -- [support group] and then through her, I got to know professionals who accepted and were really favourable to normal birth (BM6).*

Finally, according to the empirical findings, women reported that once they started participating or becoming involved in this movement, they become more aware of the difficult to delivery naturally in Brazil, for being embedded in what they call a "*caesarean section epidemic*" culture. As a result, once this contextual situation was noted, the influence of the resource dimension of power became more recurrent. That is, it was identified a high level of resource mobilization (Avelino & Rotmans, 2009). In order to reduce the imbalance relation of power, women searched for different means and resources to ease dependence. Three types of resources were more recurrent: mental resources, human resources and monetary resources (Wry, Cobb, & Aldrich, 2013; Avelino & Rotmans, 2009).

The starting point for resource mobilization worked around information, a mental resource. The most valuable resource mentioned by health professionals connected to the humanization movement and women was information. Information and expertise were mostly centred on physicians, which led to a natural dependence on women. When women started to educate themselves and look for information, they reported that it was when they had different experiences and understood better what happened to them. Thus, information was seen as the main responsible for women to become aware that they fell into the "*caesarean tale*", suffered

obstetric violence, or yet was deprived of their wish for a deceiving excuse. The following quotes illustrate these perceptions:

> *because I had read a lot and understood that what happened to me, my doctor talk, okay let's do the normal and come on time and end up doing a caesarean was more because of the interventions she caused and was something very common, which happened a lot, very often, and it was kind of like that, women were tricked into this scheme. (BM6)*

> *I was unaware, so I thought these practices were normal. But I suffered violence. (BM8)*

Consequently, information was responsible for them looking for other means to change their experience in further pregnancies. Many women reported that the information was a critical factor for change, it was the key issue to establish the difference between births in the case of multiparous women who had a poor prior experience. Here, information and support network, mentioned earlier, were also very much involved. In most cases, the information led the woman to the support network or the participation in the support network led her to search for more information. Regardless of the order, both things were defined as milestones for changing experiences.

> *The labour I had in the first child to the second, was a change… from 0 to 100, it was 100, completely, because it was labour where I was respected […] I was the protagonist of everything, totally different from the first (EM8)*

> *Information and support network were the two key points so that I was able to change my story with birth. Because what would be the logic for me at the time, I had a caesarean, right, so if I had four children, I would have four caesarean sections, because that's what people said (BM6)*

> *Already with the second son was different, because I had already started to go after groups on Orkut, the former GPM, I think it was something like that, that talked about normal birth. There were already some reports of normal birth after caesarean, very few, but there were already, and I had one caesarean section, so hey, if there were women who had a normal delivery after two caesareans, I could have with one. And then I started to inform myself (BM7)*

Given the contextual boundary conditions (Avelino & Rotmans, 2009), the information was seen, thus, as the most relevant resource because it changed the posture and the care received, consequently the desired outcomes, and enabled the mobilization of other resources, treated sequentially. Regarding the change of posture, the data collected showed that from less dependence on information, the relation of power between the actors became more balanced and women were better able to interact and question physicians. Holding information, women stated they felt more prepared to question their acts and other possibilities of conduct, therefore to avoid being deceived again and enforce their preferences.

> *The information helped me because then I started to question him more, and if it happens ... because then I started with the "what ifs". In the first pregnancy, I didn't have this "what if" it happens, because I didn't even know what could happen, so in the second I already spoke, dr.*

> *-- but what if ...? When do you think? Do you an episiotomy? In which situations? Ah and about the proper medicine to induce [oxytocin]? (BM1)*

> *The second prenatal was already different. As I was seeking information, I questioned, and as he noticed that I had knowledge and information, he explained, because then I debated. So, it was very different. I questioned, what is that for? He ah for that. What is this exam for? Ah, it is necessary to know if there is a bacterium. Okay, but I read an article that this examination is old or that if I have the bacterium, the conduct with the antibiotic will not solve and etc. etc. […] And then we would talk and debate, you know. But it is because the doctor also accompanied me and he noticed that I sought knowledge and information. (BM8)*

> *…especially now in the second one, getting to a new doctor, having the information I had, was much easier, cause then she could not even try to sell me down the river, even the exams ... it sure helped a lot (BM3)*

The search for information also led to another important resource. In order to balance authority on decision-making and enforce their wishes, the woman typically adopted the birth plan. As discussed in the previous section, the birth plan was designed primarily as a resource to ensure compliance and guarantee preferences would be respected. Considering it was a formal document, women described in it the practices they would like and the ones they refused to receive. The preferences encompassed from simple things, like how they would like to be addressed, for example by their names e not ‘mommy’, to major interventions like episiotomy. It also embraced practices related to after birth and the first care to baby, such as to have skin-to-skin contact, breastfeed immediately, having their husband to cut the cord, among others. Thus, the birth plan was a resource derived from the information because woman usually found out about it after getting informed about normal birth and the maternity care in Brazil and information was needed to set up the birth plan and to put the scientific pieces of evidence and respective laws/ regulations/ guidelines that support their choices.

> *if I had not sought information I would have no arguments for setting up a birth plan, for example, and being able to discuss with the doctor to deny what I was denying, to speak with him properly because I was denying that, right, it's a challenge, but it's very valid, (EM8)*

Second, women used to mobilize human resources as well that acted mainly as supporters (Avelino & Rotmans, 2009). Besides attending to support groups, it was also common to hire a doula and an obstetric nurse. These professionals helped antenatally through the indication of obstetricians considered humanized and educating women. During labour and birth, they provide emotional and psychological support for women and, given their technical knowledge, they also help the woman to manage labour and identify if the physician was having deceiving conduct. As their role was toward normal birth, they were considerable trustable sources for women to check whether medical conduct was coherent and scientifically justifiable. Additionally, they were also of great help to assist women during labour at home.

Another strategy women used to do to decrease the risk of end up in a caesarean section against their will or suffer excessive interventions was to arrive late on the hospital, in an advanced staged of labour. These health professionals, thus, were also worthy to access the woman and the baby at home to guarantee everything was fine, given that woman did not have this technical knowledge nor the proper equipment to do the monitoring.

> *I hired a doula to trust her. Today I trust doula and not the doctor. I'll only go to caesarean section if she says it needs to, because the first child, the doctor sent me to caesarean section, so now I'll get someone else to trust (BMG1)*

> *Then I found the support group that was wonderful. I was still with that old doctor of mine, but then the girls [doulas], talking to me they said, --[mother's name] maybe he is not a "normal birth doctor", you know, for not conducting labour as he should, you know, because I was so good, I was halfway, but he didn't know much what to do and neither did I. And then I changed to Dr. --, he told me he did, that he assisted normal birth, even I have already had a caesarean section (BM1)*

> *The doula helped me a lot in this matter, with this whirlwind of information I was having, with the feelings I was having, if I was making the right decision, just to calm down (BM9)*

> *Some women who seek us to assist in the SUS, what we advise? Hire an obstetric nurse because she does fetal auscultation and then we will try to get in the hospital in an active phase of labour so the birth can happen [...] in order to get to the hospital in a more active phase, you have to know more or less the dilatation at least right, and also to stay home safely right, knowing that there will be a nurse there who will see if the heartbeat is ok (BD2)*

> *We try to whisper to her or to her husband for them to deny it, they say no, they don't want it, I won't (BD2)*

Human resources also involved changing obstetricians during pregnancy. Often, when women realized the imbalance relation with their obstetricians, in which they were deterring and putting obstacles to normal birth, it was common they changed to other obstetrician known for assisting normal deliveries. Also, in some cases that women lived in cities where there wasn't the considered humanized team, mainly small cities, it was common they would have their babies in other cities. The following excerpt evidences the joint relation of mental resource (acquiring information), human resource (changing doctor and hiring a doula), and the institutional dimension of power through the influence of social groups and other actors legitimized by being connected to the Humanized Movement.

> *Having information changed so much that then I changed my doctor again, I went to the third obstetrician. It has changed so much that in my head there was no reason why I should change because my doctor always said that he does normal birth. But then, I was talking to the girls [doulas], and one day – [doula] had a closer conversation with me and said, 'hey, is it worth to carry on with him? You already had a birth with him that he eventually directed to an unnecessary caesarean section'. Because in my mind it had been all right. In my mind, I didn't have a normal birth because it really couldn't, but then I started to see that I could have. It was only later with the group, with the conversations, with the doulas, with the conversation with dr. – that I saw that at first, I could have had alternatives, but it was only later. (BM1)*

All these last resources also involved monetary resources. Attending specific parental groups and physical classes, hiring a humanized team (doula, obstetric nurse and obstetrician), having birth in other cities, all involved higher expenses that woman had to disburse. For example, mother BM1 reported that her sister had recently hired a humanized team and had to pay five thousand reais to endure she would have a humanized birth. Thus, monetary resources worked as a way to lead the outcomes desired and enable the mothers to become more aligned with the realities they face (Salancik & Pfeffer, 1977).

Finally, other actions such as opting to be assisted in the public domain (SUS care) even having an health insurance; lie to their family and friends about their choices to not be undermined by them, especially when they chose home birth; lie to the physicians about their medical history (for example, in the case of previous caesarean section), use of threat to enforce their rights, were also other means women mobilized to achieve the aimed outcomes. Table 17 illustrates other cases reported by women on the survey, comparing both sites.

*Table 17.* Acts of mobilization in Brazil and England

| **To have the type of delivery you wanted, did you have to adopt any of the options below?** | | |
|---|---|---|
| | **Brazil** | **England** |
| Change doctor/midwife | 11.6% | 0.5% |
| Hire a private obstetric nurse | 3.4% | 0.0% |
| Hire a doula | 9.2% | 0.0% |
| Have the childbirth in another city | 6.3% | 0.0% |
| Participate in support groups | 10.9% | 4.1% |
| Induce labour | 12.1% | 18.9% |
| Accept some intervention you would not like | 12.8% | 11.7% |
| Accept caesarean as the safe option | 0.2% | 0.0% |
| No | 36.3% | 43.4% |

For example, the mother BM7 reported that she did "*something crazy"* in her fourth pregnancy. She had already had three previous caesarean sections and could not find an obstetrician that support normal birth for the fourth pregnancy. She looked for assistance at SUS, then, even though she had health insurance. At SUS she then lied about her previous medical history, she told that she had one child delivery by caesarean section and two by normal deliveries. According to her: "*It was the information that gave the courage to go to have the birth the way I wanted, so it was ... I'll do it this way because I know the risks, I know the benefits, I know ... made a big difference in the fourth pregnancy, in the normal delivery, that's where it made a big difference"* (BM7).

The exposed excerpts and Table 17 evidenced that in most of the cases, in order women had their preferences met, they usually had to take some action to make it happen. This search

for means and resources indicate, on the one hand, the asymmetric relation established between actors, but on the other hand, a strong act of power from women to make their will to be achieved. Faced with an imbalanced relationship, actors exerted strategic acts of mobilizing (Lawrence, 2008), through individual and collective actions - involving support groups, and other actors, such as doulas, obstetric nurse and groups of mothers-, as a means to change the established relation in which they were in disadvantaged dependence.

In closing, given that the relation of power between actors was imbalanced and institutional power has loose enforcement, with lack of compliance of norms and resolutions in support for women, relations of power in the Brazilian maternity field was configured by higher asymmetry. Women, then, manage to balance more by looking and obtaining resources that ease this asymmetry, exercising a high agency role (Lawrence, 2008). Considering the contextual boundaries, information appeared as the most valued since it presented greater effect in the relationship (Gulati, & Sytch, 2007), leading to the mobilization of other resources as well.

*England*

The English maternity field is differently structured. The main actors involved were mothers, midwives and the NHS, responsible to provide and establish how the care should be. Others actors as the physicians, the family, and the maternity units (both obstetric and midwifery-led units with their own staff and infrastructure) and other organs were more peripherical. The maternity field was presented as woman-centred, with a high focus on women's choices. As a result, looking at the first dimension of power, the relation between women and health professionals was more balanced with symmetry of authority and information.

Since antenatal, the care in England was configurated around the process of informed consenting. Health professionals were supposed to exchange lots of information with the woman so she was aware of her options and appropriately informed to make the decisions. The normal conduct was to always ask the mother which were her preferences and, in case of the necessity to perform a practice, to ask for her consent first. Therefore, it was found a balanced relation of power between mothers and health professionals (either midwives or physicians), in which despite the latter detained more specific scientific knowledge to apply science (Dunn & Jones, 2010; Cain, 2019), as they had to share information and women were entitled to decision making, information and authority between actors were symmetric.

This balanced relational power was also institutionally sustained by the Montgomery case, as an institutional dimension of power. In this legal lawsuit in Scotland, the NHS was sued for medical negligence for not giving proper advice and discussing all the risks and alternatives involved with a mother. From this, a new rationale was outlined, which affected the professional-patient relationship throughout the UK. The law relating to consent was reinforced so health professionals were obliged to discuss with the women the existent options in their treatment and advised about the alternatives and any associated risks, leading to her the decision (NHS, 2017). The following excerpts from professionals evidence this:

> *So, we try very much to make it a combined decision, trying to involve women in that decision and certainly... and there's been a recent, I don't know if you heard about the Montgomery case in Scotland (EPP3)*

> *So now, there was a recent, not recent, well, a couple of years ago, there was a problem with a lady called Montgomery, suing the NHS. So this has changed our consenting process […] And the ruling now is that we have to offer all women all the options and you have to explain all the risks that a reasonable person would consider, not what the doctor thinks is correct, but what a reasonable person would consider as important and then you have to let them make the decision. So even if it's not something that you would think as a license issued, they still have...they still make the decision so that's how they're consenting processes (EPP4)*

The data collected corroborated these findings. When telling about their experiences of birth, usually, women reported that they were involved in the whole process. Since antenatal care, the woman received leaflets to instruct and discuss their options of giving birth, such as place of birth and pain reliefs, and they were questioned about their preferences and choices. During labour and birth, they stated also being informed of the process. If there was a need to perform any intervention, from the basic routine practices (i.e. monitoring the baby's heartbeat) to more invasive practices (i.e. forceps delivery and episiotomy), or change the planned conduct, women were asked before if they authorized the procedure and they knew to explain why those practices were needed.

Additionally, practices performed after birth, to both the mother and the first care to the baby, such as skin-to-skin, breastfeed immediately, cut the cord, eye drops, vitamin K, were always questioned if the mothers and their partners would like them. Hence, generally, women felt that they had choices and it was their decision. Table 17, presented earlier, also corroborated this by evidencing that little action was required by women to have their preferences met. Contrary to Brazil, most of the actions show 0% of incidence, showing lack of need to interpose. In the sequence, some quotes from the interviewed mothers also ratify these issues:

*So, they asked all of that. I mean, they give you a lot of leaflets so it's lots to sort of taking away and read and bits and pieces […] I think it was very much, you know, this is an option, and then you would decide then, from my experience, (EM1)*

*I felt hugely involved with the process, everything was a discussion, I wasn't told, although he said always, like, I think that it's better to try a natural birth, if I said no, I don't want to, he would accept I think….I always felt that the doctor was a very... much a relationship and everything was a discussion, I never felt I was told to do anything… (EM7)*

*In the process they explained that I needed the forceps because otherwise, this was just taking too long for me to come out and…. so yeah, they said it was necessary and, at the moment, you agree (EM5)*

*So, it was basically more my decision, but I did discuss this with the midwife and also, I think it's generally with a care team in the JR […] they tell me before they do anything (EM4)*

*The midwife was really nice, she explained to me everything, I asked lots of questions during labour and she explained to me […] So I had skin-to-skin and then she asked me I could choose actually, she told me Do you prefer me to do everything... do you take the baby now or do you want to do it later? (EM10)*

*they asked me for vitamin k for example, if I want to give her by injection or oral, so yeah, I could choose some things (EM8)*

*They asked if I want to have delivered on to my stomach so she was immediately put there as soon as she was born. And I said yes. And I am glad that happen. And they asked in the first hour, do I want to have some help breastfeeding and I said, yes, and I am glad that too, yeah. Hum... they asked -- [husband] if he wants to cut the cord. I read something about delaying the cord cut, but we never really discussed that. But I think probably it was a bit delayed, maybe a few minutes, and then they asked if she wanted the vitamin K injection and also the injection for the placenta delivery, they asked if I wanted to (EM7)*

The last quotes about the after-birth practices (EM10, EM8, EM7) evidence a highly contrasting situation to Brazil. In both sites, the same practices were involved. However, there, in order to ensure the enactment of some of those practices or that they would be performed as women would like, for example, the cord cut be delayed instead of cut immediately, women had to write it in a birth plan or hire a humanized team. In England, on the other hand, it was routinely to always ask women. So, the use of the birth plan as a resource power in Brazil was not seen as a need here, because it was already proper to the balanced relation of power between actors.

In the pregnant women's file, there was already a separate space for the woman to write her birth plan, or commonly spoken, birth preferences. So, when the woman was admitted to give birth, the team that would assist her on time would have access to it. The discrepancy between the sites was such that, again, the birth plan was not really overvalued by women. Because there were this information exchange and informed consent process, women felt confident about the professionals and that could trust them; therefore, they were more inclined

to just follow them and their recommendations without needing to enforce their preferences. Also, they sense that regardless of having a wish or not in the birth plan, it was already a standard procedure of maternity care to question first. The following quotes illustrated this:

> *The consultant asked if I wanted to write a birth plan, but I said actually, because of the way the pregnancy was getting a bit unpredictable, I said, do you know what? You are the boss; you can choose from…. yeah, and I trust you, I think that we've known each other well enough that we can talk about it at the moment, that was fine. So, no, I didn't write one (EM7)*

> *I did put that in the birth plan. I think it went well, but in my opinion, it was not because I put that in the birth plan but because that's the normal practising in the hospital in those suits (EM4)*

> *You really have to just follow the doctor; I think and think that they will make the best decision for you at that point because it's already got quite complicated. So, I sort of just trust them, and then just follow what they say (EM4)*

On the other hand, some exceptions were found in regards to the relational power between actors, leading to a change of perception after the birth experience. The exceptions were found in regards to failed induction in which women shared that they were not properly informed and felt powerless. One case was reported on the survey, according to the mother: "*The pros and Cons of induction due to small (9th percentile) child were not discussed in detail, I do not feel I was informed well enough to make a choice, just agreed to consultant's recommendation" (EMS139)*. Two other women reported regret agreeing to the professional recommendation to do it, as it ended up in a caesarean section. In the first case, the mother EM2 stated that she was diagnosed with gestational diabetes, which she was not convinced, and due to that, the baby was considered bigger than average. So, as standard care, health professionals recommended inducing labour for being less risky. The labour took long, around seventeen hours, but she did not dilatated enough and had to do a caesarean section instead. Despite she had to consent with that, the mother told she felt she had no other choice and that she was not fully explained of the whole process and stages so she could assess the situation and choose properly. Yet, she believed that if she had not been induced, it would be totally different. The following quote evidences this:

> *[…] So, I was induced and that didn't work. And then they said, we're gonna have to do an emergency c-section. So yeah, it wasn't a choice […] they have to ask me permission, but I don't think... like when it happened … I don't think was clear what the options are, it was just kind of like they examine you and say this is what is going to happen now, but it wasn't like… It was telling one step at time as it happens, so I didn't really know what's going to happen until they gave me the option or told me what's going to happen you know, it wasn't like a birth plan […] I don't feel like I really have much saying in anything. That's the thing. I think like... they basically... the moment they decided I had gestational diabetes, which I'm still not convinced I had because I didn't even have to take any medication, I have to check my blood pressure, blood sugar, and it was always normal. So, I think it's a mix-up. And then after that point, they were*

> *like, well, because you've had this, you have to do this and this, and it was all dictated to me, so I didn't really have any option (EM2)*

In the second case, the mother EM6 reported that in the twelve weeks ultrasound, the midwife changed her due date. According to her, "*she took away six days from me"*, even she saying that it was not right because she knew when she had her last period. Then, when she was close to 42 weeks and still hadn't delivered - usually the longer they wait to deliver-, the midwife recommended inducing. The mother agreed, but she said she did not understand properly the implications of that, that it could fail and end up having to do a caesarean section, which was what happened. She expressed intense regret for agreeing, especially because, since she was not convinced about the due date change, for her, she was still on time to wait to deliver vaginally, and then could have had a different outcome. The following quotes evidence this:

> *I was feeling like, I don't know...I cannot do anything or I felt really powerless. And… and then she said like, well, should we then book an induction? I said, Okay. Is it safe? But my safe was like, okay is it safe for vaginal delivery, so I am not gonna... And she said, Yes, yes, it is safe. So, I said, Okay. And they went ahead booking the induction, I think she, I don't know if she misunderstood me at some point […] But I don't, I think they didn't explain to me, okay you're gonna be monitor, it's safe to wait, they were telling me that I was 42 weeks so I was really nervous, I don't know I really trust them and I think I shouldn't. […] And I felt really powerless […] I had the power to say no, but you know in a way, I was going to be protected, they were going to monitor my baby […] they asked for consent but they were like... it was like I didn't have any other option, I didn't feel I have any other option […] for me was really violent like I don't know […] I didn't feel I was asked about it. I had the feeling during the whole process that I didn't have any other option, just like that (EM6)*

Analysing all the data gathered, these two examples were the only cases identified where a different outcome in relation to birth preferences was noticed as an asymmetric relation of power. Other cases where preferences were not met, were mostly reported by women as given to the situation at the time that did not enable birth as they wanted, as can be seen in the following quote. Nevertheless, it was noticed in both the situations, resulting from or not in a preference met, that the balanced relation of power was also due to a greater influence of the institutional dimension of power. Firstly, the structure of work in England was configurated on a collective basis. Physicians and midwives did not have their own patients, there was no continuity of care by the same professionals. Thus, as more people were involved and there was a combination of midwifery and obstetrics, the relationship eased to be more balanced than it was noticed in Brazil, where it was centred on the obstetrician. This allowed more information exchanged and conjoint decision making.

> *It was the complete opposite of what I had planned antenatally (I was intending to have a water birth at home) but since I developed complications towards the end of pregnancy (pre-eclampsia), labour had to be induced at 38 weeks and I ended up with a c-section due to failure*

> *to progress in 1st stage. My care, however, was excellent throughout and each aspect of the care I had received had been discussed in detail. (EMS73)*

According to the coordinator midwife of an obstetric unit, in addition to performing joint work, health professionals also had some training together. For instance, the course *prompt course* was mandatory training for emergencies and was directed to a multidisciplinary team, so everybody was updated of the same conduct. Other midwives and obstetricians also reported that professional rotation within different birthing centres it was used so the knowledge and experience could be shared. Moreover, the midwife EPMW4 told that quite often they have learning sessions, named M&M, mortality and morbidity. M&M's were reviews of complicated cases or cases that had unexpected outcomes. So, they gathered consultants, obstetricians, midwives and paediatricians to go through it and discuss what could have been done better. All these examples contributed to reinforce aligned conduct.

Second, as previously discussed, the maternity care was highly standardized. This standardization was institutionalized by several guides that structured the entire conduct of maternity care. Health professional conduct was limited to the established guidelines. Each different situation had a specific guide through which midwives and obstetricians should act accordingly. Different approaches, especially when involved higher expenses, must be justified to the NHS, so it had to have a clear medical reason. The informed consent regulation was another example of the institutional power dimension, in which the change on the consenting process was outlined by the Montgomery case. Therefore, the balanced relation between actors was supported by a strong enforcement system. Women were backed by pre-established conducts determined by the NICE and other institutions that verified the benefits/ harms of practices that should, therefore, be encouraged/avoided respectively.

> *the NHS is about efficiency and is most cost-effective and safe […] how we work in the NHS is this NICE sort of mix (EPMW1)*

> *the NHS is the manager, so business, everything has to be... any intervention will have to be proven that he adds benefit as opposed to ... to be cost-effective, everything must be cost-effective before it's approved. So, it is a business, they've got to make it sustainable (EPMW2)*

> *because we're in a public system, we tend to practice more similar to each other. But we have an organization called the National Institute for Healthcare Excellence, known as NICE, that produce guidelines for how we should practice (EPP1)*

> *we have some fairly... the Royal College sets out a lot of guidelines (EPP3)*

> *well, we have strict guidelines for that. So NICE guidance, NICE is the National Institute of Clinical Excellence, they've got guidance for managing women in labour. So... and WHO has also a data on that (EPP4)*

On the other hand, it was also identified that the autonomy grant to women existed inside a continuum. As discusses previously, in the maternity field in England it was usual that women could choose, however it was found that this choice was located within a range of alternatives preestablished. For instance, the choice of birth was only addressed to the place of birth, whereby women would have four alternatives of choice (home birth, obstetric led unit and two midwifery units). But as the mode of delivery itself, the established assumption would be a normal delivery, given the usual risks. Hence, maternal request for caesarean section, for example, was not found as an option offered by all trusts, even though it was the national recommendation (NICE, 2011).

> *So as always, we have guidelines for everything, but it's still always a woman's choice, it's her choice. However I know that our consultants here, will not do a caesarean section on a woman if she has no risk factors, if she is well and her baby is well, they will not do a caesarean section on that women even if she wants one, unless, the consultant, the obstetrician thinks that it would be really (EPMW4)*

> *So, we like to think that the patient makes a decision. And we like to think that we give them all the information that they need to make the decision and decide what's best for them. And then we support their decision. However, I'm not quite sure about the… whether that care is the same all across the country. So obviously, the Royal College, they say that we should do maternal request caesarean sections as long as they go through a certain pathway, and they understand the risks and the benefits. But I'm not quite sure whether all hospitals provide that facility or not. That's something that probably is not fully implemented across the country (EPP6)*

> *I think the assumption here is that the women cannot choose, so when they get pregnant they assume that they're going to go through labour, they don't have in their mind the option of being able to choose which way I would like to have the baby […] So, they don't have to mention that the type of birth is an option, that's not an option, what is an option is planning your place of birth, you've got three options homebirth, midwifery-led unit and hospital, the delivery suite. So is focused on those options […] they can never choose those things. Yeah, this could never be an option, because also, they've got fit in the system. So, this will never be...This is very different. Nobody would even be considering these things (EPMW2)*

The women's report also corroborated this in both sectors of care, NHS and private. The mother EM7 said that when she looked for a private consultant, he told her that he could not assist her privately for the only reason of having an elective caesarean section, only if after already being a patient she had a dubious medical picture that a planned caesarean section would be considered as an option. In turn, the mother EM9 told that she was only able to have a caesarean section, as it was her preference because her baby was breech and the consultants could not manage to turn her with the ECV manoeuvre. She also confessed that the caesarean section was what she *secretly* wanted, but she had never told that to her midwife nor the obstetrician since she already knew that in the country vaginal delivery is the norm. The following quote illustrated her saying:

> *but because she was breech, I had a planned c-section in the end. And so, sort of what I secretly wanted which I shouldn't really say out loud, but I did […] But if she wasn't breech and I had to have a natural, I would have obviously just had a natural or what seems what happened really […] I didn't say I wanted a c-section, no. Because in this country, certainly in Oxford you can't elect to have a c-section and to be honest, everything promotes a sort of natural delivery, sort of about natural delivery. So, I think you might be seen as a bit strange if you talk about a c-section actually, […] here it's very much natural delivery and you can't elect to have a c-section (EM9)*

This institutional limitation to choose was also identified in regards to other issues. First, it was pointed out that women usually would rather have continuity of care, that is, to have the same person to assisted her antenatally and during birth, or at least to know beforehand who would assist her at the time. This was not considered possible due to the system configuration, in which health professionals worked in shifts and it was highly unpredictable to know when the woman would give birth. Second, about the choice of place of birth, it was identified that women were assigned to a hospital-based on their postcode. So, depending on the area they lived, they would have fewer options available or would have to travel to delivery in the place they want. Last, it was found difficult to get an appointment with obstetricians or extra appointments if women were claimed with no medical need. All these cases were considered not possible due to external contingencies of funds limitation.

> *Here is by your postcode, so you're assigned to a hospital-based on your postcode. So, you don't really have a choice […] I think the thing is that you don't really get much choice cause it is free stuff, so you can't, I mean, obviously, you pay tax for it, but I mean I don't think in the NHS you can really say much (EM2)*

> *it is really tricky here to get an extra appointment unless you book private, (EM5)*

> *I only met the same midwife. I couldn't choose a midwife; it was assigned to me because I was at this medical practice (EM8)*

> *They didn't really say, ECV or natural breech or wait, or c-section, it was mainly only ECV so sort of this is what you're hearing pretty much (EM9)*

Finally, while cases of asymmetry of power and limited choices by institutional control were identified, resource mobilization, on the other hand, was not prominently identified in England, especially when comparing to Brazil. Although women's dependence on the type of care provided was expressed with discontent by some, the act of power, in return, to try to reduce this established dependency was little expressed. Table 17 corroborates this by showing a few incidences of actions needed to have their preferences met. The few actions that presented higher rates comprised accepting some intervention that would not like (11.7%) and induce labour (18.9%). Both of which encompass actions of compliance, that is passive actions of adherence to medical conduct (Lukes, 1974). In overall, it was not noticed a great effort to

search for changing the next scenarios. The cases observed involved mental resources, human resources and monetary resources.

Similar to Brazil, mental resources and human resources were connected. While the former involved the search for more specific information about the personal situation, the latter corresponds to start attending to support group, in the case, a support group for caesarean section. Both were connected because the group was found by searching for information, which in turn provided more information, especially knowledge of similar reports from other mothers. For instance, the mother EM6 stated that she decided to look for information and attend this group because she felt that her experience should not have happened as it was, so she felt the need to try to understand what was behind it if it was her body that didn't work. Finally, monetary resources englobed hiring a private consultant and go privately in an NHS hospital. In this case, the mother EM7 stated that decided to have a private birth so she could have more personalized care and if a caesarean section was needed, she could have the option right to the last minute. The following quote illustrated the resource mobilization of mother EM6

> *I've been reading, now I am in a support group for c-section and the other day I read a history about a woman back in Spain, that was induced after having a previous c-section and she was induced with prostaglandins to start with […] I wish I had seen something in the internet because I've read so much stuff now, like …. that it's only 40% of the babies that don't come naturally into labour and also that many of the times inductions happen because the day it is not right, and... it's yeah... induction should not happen so likely … Now I am in this list that it's called, c-section support, we are different women's experiences and I'm just thinking that if I had asked them just that week, I would have more, I'd felt much more reassured and I would have waited, because when the doctor said I could wait, I never register that, because I thought it was risky (EM6)*

To end with, in the English maternity field, relations of power between actors was configurated by a greater symmetry of information and authority. This symmetry was also conceded by the insured regulations (for example, the Montgomery case) and the structuring of the maternity care as woman-focused, which entitled women to receive information and the right to choose. Additionally, no greater dependence on mental resources – information- by women was identified, as it was in Brazil. The statements of professionals and mothers also validated the sharing of authority and information. All of this has contributed to reinforcing a balanced relation of power. On the other hand, the capacity of choice was mediated by a limited autonomy. The institutional control, set as a tight enforcement system, was designed as giving women the right to choose but to choose from a pre-established range of choices. Hence, some cases were identified in which the woman felt powerless or that her primary preferences were not contemplated by the possible options. Nevertheless, in overall, the majority of them did not

attribute this to an unbalanced relation of power, consequently, little effort to mobilize resources in response to it was identified, setting a low agency role.

*Additional analysis: quantitative findings comparing the countries*

Complementary to the findings mentioned above, I further conducted some additional quantitative analysis with the data gathered from the survey. Considering the definition of power as the capacity of actors to determine the outcomes they desire and intent (Salancik & Pfeffer, 1978; Ranson, Hinings, & Greenwood, 1980; Giddens, 1984; Hinings & Greenwood, 1988; Kashwan, 2016), the online questionnaire comprised a range of common situations related to birth and maternity care in which I could measure how was the level of power of the mothers in relation to enforcing their preferences. The questions examined whether women's preferences were met and whether they needed to take any steps in order to achieve them, i.e. to enact any strategic acts of mobilization (Lawrence, Winn, & Jennings, 2001).

I then conducted the analysis of variance ANOVA to identify if there was any difference between the means of power from the two sites - mothers in Brazil and mothers in England. According to Field (2005), ANOVA compares some means when those have come from different groups of people. If the group averages are the same, then our ability to predict observed data will be poor (F will be small), but if the averages differ, we will be able to better discriminate between cases of different groups (F will be large). So, in this context F basically tells us if the group averages are different.

As can be seen in Table 18, there was a significant difference between the means of power between the sites, $F(1, 605) = 24.01$, $p<.001$. This indicates that the level of power between mothers in Brazil and mothers in England is indeed different. Also, depicted in Table 19, and in accordance with the findings previously mentioned, the mothers in England presented a higher level of power, corroborating the more symmetric relation of power when compared to mothers in Brazil.

*Table 18.* ANOVA Analysis

| Cases | Sum of Squares | df | Mean Square | F | p |
|---|---|---|---|---|---|
| SITE | 47.94 | 1 | 47.939 | 24.01 | < .001 |
| Residual | 1208.14 | 605 | 1.997 | | |

*Note.* Type III Sum of Squares

Table 19. *Descriptives - Power*

| SITE | Mean | SD | N |
|---|---|---|---|
| ENG | 3.633 | 1.276 | 196 |
| BR | 3.032 | 1.474 | 411 |

So, Table 19 indicates that the level of power of mothers in England is higher (Eng. Mean = 3.633) than the mean of power of mothers in Brazil (BR Mean= 3.032). This difference is significant with a p-value <.001. Figure 17 better illustrates this difference.

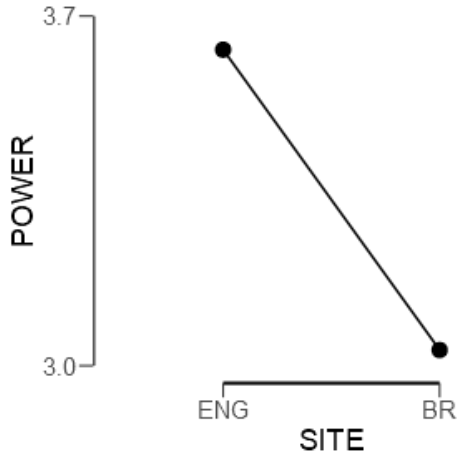


*Figure 17.* Means of power between mothers in Brazil and England.

In a second moment, I used ANCOVA to remove variation due to the influence of acts of mobilization prior to testing the difference between the power averages between both sites. As I identified that in Brazil women usually adopt acts of mobilization to enforce their preferences, given the asymmetric relation of power, I further conducted an ANCOVA analysis to investigate whether this had an effect on the women's level of power. ANCOVA extends the basic idea of ANOVA. It is a covariance analysis that compares the means adjusted for the effect of other variables, the covariates. In this sense, ANCOVA is used to test for differences between groups of means when we know that an extraneous variable may affect the outcome variable and thus control these known variables (Field, 2005).

In this case, I looked for the interaction between the sites and the acts of mobilization that women engaged with. I looked not only if women had their preference met, but also if they had to do something in order to achieve it and if these acts had any effect in enhancing their level of power. As a result, depicted in Tables 20 and 21, the covariate, acts of mobilization, was significantly related to the level of power of mothers, $F(2,601) = 40.906$, $p<.001$. On the other hand, when we look at the interaction of the variables, site* acts of mobilization, the difference was not significative anymore. Therefore, in line with the findings previously

presented, as woman start to engage with acts of mobilization, the level of power between mothers in Brazil and in England was no longer different. This evidence corroborates to show that the agency role that mothers engage in Brazil made a difference in softening the asymmetry of power. As women in Brazil sought for resources and other forms of power, they were able to level power with women in England, which was previously- without considering this mobilization-, superior.

*Table 20.* ANCOVA analysis - Power

| Cases | Sum of Squares | df | Mean Square | F | p |
|---|---|---|---|---|---|
| SITE | 12.532 | 1 | 12.532 | 7.354 | 0.007 |
| ACT_MOBIL | 139.410 | 2 | 69.705 | 40.906 | < .001 |
| SITE ✻ ACT_MOBIL | 6.163 | 2 | 3.082 | 1.808 | 0.165 |
| Residual | 1024.121 | 601 | 1.704 | | |

*Note.* Type III Sum of Squares

Table 21. *Post Hoc Comparisons – SITE*

| | | Mean Difference | SE | t | $p_{tukey}$ | $p_{scheffe}$ | $p_{bonf}$ | $p_{holm}$ |
|---|---|---|---|---|---|---|---|---|
| ENG | BR | 0.411 | 0.152 | 2.712 | 0.007 | 0.197 | 0.007 | 0.007 |

Moreover, despite not having a difference between the sites, I carried out some further analysis to check if there was a difference within the acts of mobilization. In order to do that, I separated between no acts of mobilization; one act of mobilization; and two or more acts of mobilization. The reason to group in this way was to have better representativeness of the samples given that in England we found very few cases of women who engaged in more than three acts of mobilization, whereas in Brazil it was significant until six acts, the maximum.

I then conducted some post hoc tests to check this. The post hoc tests consist of "pairwise comparisons that are designed to compare all different combinations of the treatment groups" (Field, 2005:339). According to the author, it is a way to control familywise error by correcting the level of significance for each test such that the overall Type I error rate across all comparisons remains at .05, and by doing this, to assure the statistical power of the tests. So, I conducted four types of post hoc tests, which, as depicted in table 22, all evidenced significance. These findings mean that, within the acts of mobilization, all the groups' means of power were significant.

Table 22. *Post Hoc Comparisons - ACT_MOBIL*

| | | Mean Difference | SE | t | $p_{tukey}$ | $p_{scheffe}$ | $p_{bonf}$ | $p_{holm}$ |
|---|---|---|---|---|---|---|---|---|
| 0 Act_Mob | 1 Act_Mob | -0.777 | 0.129 | -6.006 | < .001 | < .001 | < .001 | < .001 |
| | 2+Act_Mob | -1.562 | 0.200 | -7.809 | < .001 | < .001 | < .001 | < .001 |
| 1 Act_Mob | 2+Act_Mob | -0.785 | 0.216 | -3.635 | < .001 | 0.022 | < .001 | < .001 |

Finally, from these analyses, Table 23 presents the means of power I found in each site considering the covariate. As we can see, when women engage with some actions, their level of power increase in both sites. On the other hand, the covariance intervals (CI), showed in the last two columns (Lower CI and Upper CI), help to understand why the difference of the means between the sites was not significant despite I have found different values. The confidence intervals show the standard deviation of the sampling distributions of the data. It evidences that the true value of the mean is likely to be between the lower and upper confidence intervals. As a result, when confidence intervals overlap, the means are statistically equal, while when there is no overlap of confidence intervals, there is a difference between the group means (Field, 2005).

Table 23. *Marginal Means - SITE ✲ ACT_MOBIL*

| SITE | ACT_MOBIL | Marginal Mean | SE | Lower CI | Upper CI |
|---|---|---|---|---|---|
| ENG | 0 Act_Mob | 3.347 | 0.117 | 3.117 | 3.577 |
| | 1 Act_Mob | 3.962 | 0.179 | 3.610 | 4.314 |
| | 2+Act_Mob | 4.579 | 0.299 | 3.991 | 5.167 |
| BR | 0 Act_Mob | 2.608 | 0.081 | 2.449 | 2.767 |
| | 1 Act_Mob | 3.547 | 0.121 | 3.310 | 3.784 |
| | 2+Act_Mob | 4.500 | 0.224 | 4.060 | 4.940 |

These findings are better noticeable in Figure 18, which illustrates the comparison of power between the sites and within acts of mobilization highlighted through error bars. The error bars illustrate the variance of interval (Lower CI and Upper CI), with and without overlapping. If we compare the level of power between mothers with no acts of power, we can say that there is a statistical difference because the error bars – the CIs -, do not cross between the sites. This means that indeed mothers in England have more power than mothers in Brazil because the intervals of means do not overlap between each other, so encompass different figures. On the other hand, when we look at the interactions of mobilizations of means and resources, the means of power between the sites do cross between each other, meaning that they are not statically different, but may have similar figures.

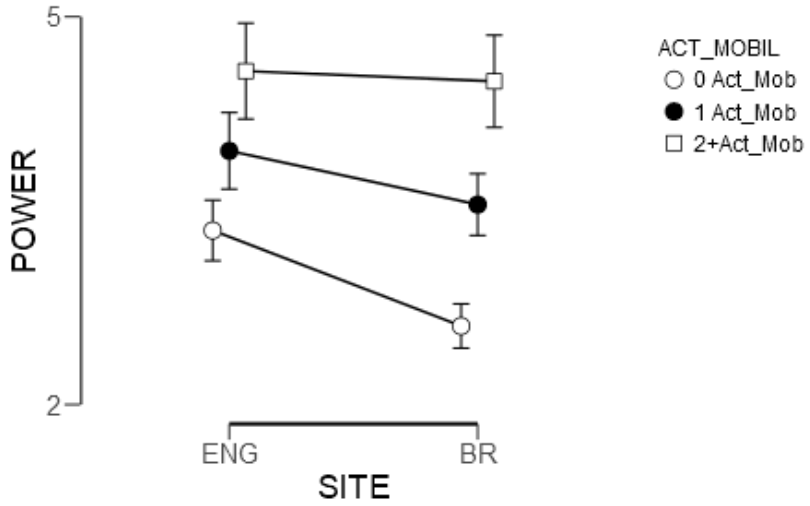


*Figure 18.* Descriptives Plot

In closing, despite the lack of significance between the groups, this actually contributes to the previous findings. From these analyses, and in consonance with the previous, we can state that women in Brazil when engaging their agency role through the mobilization of means and resources were able to soften the differences in power relation and enforce better the achievement of their preferences, both in related to its own context and when compared to England, as the level of power was not statically different anymore.

## 5.4 THE ROLE OF RELATIONS OF POWER IN THE ADOPTION OF MATERNITY PRACTICES

Finally, I now turn to the main research question to comprehend how relations of power shaped the variation in maternity practices stemming from the multi-logics field in Brazil and England. In exploring the dimensions of power, discussed in the previous section, I found that the effect of relations of power in practices of the multi-logics field headed a corresponding effect on the multiplicity of logics, which suggests a recursive relationship. Power occurred through subjective relations which implied different levels of imbalance dependence between the actors involved in the maternity field. Over time, these relations constrained and enabled action (Feldman & Orlikowski, 2011; Giddens, 1984) and in so doing, geared corresponding reinforcing and disruptive effects in turn.

I describe these findings in detail in the sequence, addressed to each case. But, in brief, I found that higher asymmetry of power surfaced incompatibilities between logics multiplicity that motivated agency that were more likely to enact disruptive practices, engendering change effects on the typology of the multi-logics maternity field in contrast to lower asymmetry of

power that made inconsistencies between logics multiplicity less visible, demotivating agency toward reinforcing practices that led to the maintenance of the dominant multi-logics field. These findings suggest that the multi-logics field opens space for heterogeneous practices whose enactment undergoes an internal process mediated by the relations of power established between the actors that influence the negotiation and access to incorporate the institutional logics in return.

*Brazil*

As discussed before, Brazil presented an imbalanced relation of power between actors. Physicians held more specific information and authority than mothers, being the primarily responsible for decision making. The lack of involvement, consultation and communication of women regarding the promulgation of the practices made it evident the unbalanced dependence in which the relationship between actors was configured. Hence, at a first moment, especially among health professionals not linked to the humanized movement or pointed as more favourable to caesarean section, the practices that reinforced this asymmetry were more likely to be enacted, such as the valorising and dissuasion. This practice was discursive in nature, by which it strengthened the preconceptions of normal birth as something unsafe that posed a lot of risks, in contrast to an implicit valorising of caesarean section, the solution, as a birth that could be controlled, planned and with all the stages known.

Valorising and dissuasion practices were recurrent when women told their physicians their preference for the mode of delivery. Among their reactions, it was commonly pointed: trying to convince women that the preferred type of delivery was risky or that another type of delivery was better; saying that it depended on too many factors or that it was too early to define; saying that he would do it if everything went well, but that he would not take any risks – hence implicitly reinforcing the idea of normal birth as a risky birth; placing obstacles during pregnancy that undermined the choice of women and portraying it as unsafe; charging higher amounts for normal childbirth or an extra fee beyond health insurance. The following quotes illustrate this:

> *My doctor said: no, you don't even think about normal birth, you think about a caesarean section because there are so many risks involved ... He said there are no twin births anymore. (BMG3)*
>
> *My baby had already completed 40 weeks and it was that story, it would put the baby at risk. (BM7)*
>
> *We have women who were convinced that if she had not had a caesarean section, her baby would have died. And that often leads this woman in early pregnancy, listening to all the lurid*

> *stories, because there is always someone to tell… listening to all the stories leads this woman to decide: 'no, but I do not want to take, I do not want my son to take any risk. No, I will do the caesarean because it is faster, I will not feel pain and yet my son will not have a risk.' Because there is this culture that the caesarean does not put the baby at risk ... while normal birth it will pass the time, all these things, the cord will hang him, so ... there's everything (BPN1)*

The enactment of reinforcing practices, then, strengthened the medical logic by disseminating the symbolic constructions around the valorising of technology and risk avoidance. It implicitly provides the security of a favourable and known outcome, free from any unpredictability or unexpected risk that was involved in a normal delivery. In the quotes from the health professionals BPN1 and BPP2 in the sequence, we can see this. They show the association of caesarean section with higher security to health professionals, which is already moulded from their education. On the other hand, by imposing those practices, the asymmetries of power unravel more easily the inconsistencies between logics, surfacing the highly contrasting views between them and the consequent material efforts from that. The quote from the mother BM4, illustrated in the sequence, evidence how these inconsistencies are naturalized by the lack of information and decision share between actors, leading to a unilateral decision:

> *I still very loaded with the professional formation, all the technique, all the fear right, because the formation, it forms us into the fear right, you have to do because otherwise, it will happen, this and this, and will die, and will roll, so it's ... the technique is that you are formed, we are formed to help, right? (BPN1)*

> *Nowadays many physicians end up preferring caesarean because it is linked to safety, so it is much easier to take a baby at 37 weeks and 5 days from a patient who has diabetes than to take at 38 weeks and 2 days and have fetal death, so that's why they end up in the caesarean section, for safety's sake, so today, there are so many resources and with normal birth, you have to wait, you cannot control, it's harder and so (BPP2)*

> *I say like this, Brazil, they complain a lot about the number of caesarean sections, but as I told you, there is nothing that helps you, that guides you, that makes childbirth be a normal, natural thing, you just know that you are obligated if you go to the SUS, you are obligated and ... but you have no information on how it will be, nothing (BM4)*

On the other hand, the perception of these asymmetries and consequent contradictions opened space for agency. As women realized that they did not have the ability to defend their institutional logics within the field over the remain (Greenwood et al., 2011) and to enforce their demands due to their unbalanced capacity to impose (Pache & Santos, 2010; Greenwood et al., 2011; Bjerregaard & Jonasson, 2014), it was noticed an extensive effort toward balancing the asymmetric relation of power established. Women started to exercise their act of power (Avelino & Rotmans, 2009), through the search for new resources and means to enforce her preferences. Consequently, women engaged a more extensive set of disruptive practices, that

is, practices that had disturbing effects on the dominant maternity system and led to different outcomes from those of the mainstream.

Firstly, educating practices were seen as a touchstone for behavioural change. Seeking information was often the initial step for women to be aware of the asymmetrical power relationship and that their preferences were indeed possible to be met. This required, then, getting instructed about normal birth and its stages to lessen the doctors' reliance on information and to be able to reason with him and identify when he wanted to induce unnecessary caesarean section. The infusion of skills and knowledge acted like a mean of liberating women from the imbalanced dependence toward the achievement of their practices and setting of a different relation with their physicians. The following statement evidence the extensive effort the mother had to make to be able to achieve, in the second pregnancy, the birth she could not have in the first, caused by the dependence on technical information from the physician and consequent reliance on him:

> *I think the hardest thing is to have access to a quality antenatal care, an antenatal with the right information, with information, it already starts there, you know ... to be attended and the doctor fill you in of everything that is going on, ask if you have doubts, clarify your doubts, I think that makes a lot of difference and ... yeah ... I don't think I should have searched that way, of course, information is needed for everything, but I don't think I need to have done a saga the way I did, having to almost study obstetrics to give birth with respect. I feel that it had to come from the professional that assists me, he had to bring me this information, make me aware of it (BM8)*

> *Because I think this impotence issue is sometimes veiled impotence, let's talk like this, we think we are deciding something, but we are not deciding anything. That's the big thing ... I think it's the big question, and I understood later the importance of having independent information because it won't be a doctor who will inform us, I feel today, it won't be the doctor who will inform us. (BM1)*

The information led to other practices that in conjoint helped to enforce their logics. Birth plan, for instance, worked as a formal instrument through which women could enforce and police health professionals to work accordingly their preferences, thus, mitigate the unilateral role of authority and decision making. Similarly, constructing a network with other actors besides providing support to women to this agentic role, helped in the share of authority and decision making, since there were more people involved in the birth process. The involvement of other actors, especially health professionals (doulas and obstetric nurses), also had a policing role. Their presence at the labour and birth stages was a way to police obstetricians' conduct too as they also had more technical knowledge and background formation and would be likewise able to opine if the medical conduct was inappropriate at the moment.

The very reframing of normal birth was unfolded from this. The conception of normal delivery as a search, a struggle implicitly evidenced the asymmetry relation of power, because, as exemplified in the following quote, achieving normal birth often depended on the mobilization of resources, that is, on the role of the agency to achieve it. Normal birth for many women, thus, although accomplished, was not something natural, provided by a joint decision, but the result of an achievement that the woman had to go after and demanded extensive effort toward it.

> *Today I see that normal birth is a woman's achievement, not something natural. If I tell you that I had a natural birth, it's not true because I had to fight for it, I had to read, I had to attend groups, to talk to people who had a normal birth, people who had a caesarean section, people who went to the same doctor as me, so I spent the whole pregnancy looking for it. I did not go through the pregnancy in a pleasant moment, quiet and in the end, the birth happened in a natural way, I think it cannot simplify that way. It was an achievement: I informed myself, I made a birth plan, I talked to doctors, to maternity hospitals, to nurses during labour. How could I relax knowing that at any moment I could be a victim? There is no way you can relax knowing everything that can happen; so really, during labour I got defensive, I knew that anything could happen at any moment, even when I was seven centimetres dilated, reaching the expulsive I had to sit down to talk to the doctor to explain to him that I did not accept an episiotomy, I did not authorize (Interview with a mother from a support group on 25/20/2013, by DUARTE, 2015)*

The act of power, especially the mobilization of the information resource, was of substantial importance in the case of Brazil because it acted as a breach of power that in many cases was veiled. In several instances, the asymmetry of power was expressed in a hidden manner from the perception of the subjugated mothers (Lukes, 1974), even in relation to the caesarean section or after birth care. By using dissuasion practices, like giving apparently medical justifications or using the threat of risk to repress the mothers' preferences, not involving and communicating the mother, many women, in turn, did not realize at the time the established asymmetry of power. Therefore, their responses encompassed dependence and complicity (Lukes, 1974). The further act of power, represented by the search for information and attendance to support groups, for example, worked as the relational force at play that surfaced the veiled power.

> *About the violence I suffered: Today I am vice president of an NGO called -- that works in the Amazon to eradicate obstetric violence. The birth of my son brought me here. We have a solid work, cohesive and respected by the affected institutions. I suffered, but I resignified! (BMS362)*

We can state that all these practices, educating, policing, constructing network with different actors, worked, then, as episodic forms of power (Lawrence, Winn, & Jennings, 2001; Lawrence, 2008; Lawrence, Morris, & Malhotra, 2012) that established new practices within and between mothers and health professionals. The enactment of those practices connected power and agency to provide the women’s capacity to influence the action of health

professionals towards their preferences, which, consequently, leaned to processes of change of the maternity field. I address them as disruptive practices because the enactment of those practices in response to the asymmetry of power generate changes in the way maternity care was commonly performed, differentiating it by the dominant incidences of caesarean section and interventions, for instance, and the characteristics of the technocratic model of childbirth attention (Davis-Floyd, 2001).

This agentic role geared a destabilization effect on the maternity field, moving toward processes of change and creation of different models of birth with new practices and other actors involved. For example, the decree of various regulations and laws in recent years in support of normal childbirth (Brasil, 2005a; ANS, 2007; MPF, 2010; Brasil, 2015; CFM, 2016), the encouragement of hiring more obstetric nurses and entry of doulas into hospitals (Leal, Gama, 2012; Brasil, 2016), the dissemination and encouragement of successful humanization experiences through awards, i.e. Galba de Araujo award, and projects, i.e. Adequate Birth and Child-Friendly Hospital, among others (Rattner, 2009b), based on WHO recommendations, evidence this. Although they may not generate much impact so far, as the incidence of caesarean section is still alarming, it is clear that all this movement is the result of disturbance of the current model and act as an important factor in the field (Reay & Hinings, 2005).

We can also notice a growing standardization of new structure and practices of delivery considered humanized, such as the maternity care provided by a multi-functional team (doula, nurse, obstetrician), and specific birth and postnatal care preferences, such as delay the cord cut, skin-to-skin contact, immediate breastfeeding, avoid bathing in the first 24h, and natural delivery free of interventions. Finally, for the first time since 2010, the number of caesarean sections in the public and private domains has not grown in the country. (Valadares, 2017). This may mean that disruptive practices are having an effect, even if at first, by little, with the stagnation of the current figures.

In this context, in accordance with Lukes (1974), using the relations of power as the lens provides a comparative view. The focus on the behaviours of actors as a response to decision making over issues that involved disagreement in preferences showed the change of birth experiences resulted from the mobilization of resources and acts of power (Avelino & Rotmans, 2009). Together, these findings suggest asymmetries of power as a relational force at play (Østerlund & Carlile 2005) that enacts agency role on Brazilian women to influence the configuration of the multi-logics field. Relations of power, then, were an integral part of the resulting new practice when comparing the first birth to the other considered humanized. Due to this capacity to specify differences and dependencies, it was possible a comparative view of

relations of power within institutional logics multiplicity, specifically the so-called humanized birth versus normal birth.

In closing, in the Brazilian case, disruptive practices fundamentally changed the relation of power between mothers and obstetricians in the maternity field. The adoption of these practices provided a stronger level of power to women. Hence, women's preferences were better met when these practices were enacted than in the cases without the enactment of those practices. The main maternity practices were more likely to be replaced with new alternatives, leading to different birth experiences, consequently the new model of maternity care. As a result, it can be supposed that there is a likely dynamic of change over time of the relationship between the institutional logics (Besharov & Smith, 2014), in which actions will happen within more compatible prescriptions leaning towards less conflict. Some changes in the care, such as multi-functional team, will enable to put women's preference more in the forefront, balancing the relation of power between actors.

*England*

The maternity field in England was configurated around two main dimensions of power. First, there was strong acting of the institutional power dimension. The structure of relations of power in England was fully legitimized by a system of cultural and normative assumptions (Lukes, 1974). The establishment of guidelines, the normal delivery as the assumed mode of delivery, the care provided mainly by midwives, who only assisted normal birth, the informed consenting law, all aided to legitimatize the field as its current setting and standardize how maternity care should be carried out. Power, then, was manifested in the conformation of preferences in the existing order of things both for not conceiving another alternative and by seeing it as natural (Lukes, 1974), i.e., it was what "*our guidelines say", "the default option"*.

When we look at the choice of birth, for instance, we noticed that as the assumption was for normal delivery, this was seen as the natural path to follow. This predetermined assumption, as pointed by Lukes (1974), sometimes led women to not even consider other options or among those who had a pre-established preference for a caesarean section to not express their own interests once it did not fit the norm (i.e. mother EM9, previously mentioned). Other common things in Brazil, such as choosing the date of birth, were also not even thought about because they came out from the regular assumptions. Thus, what is important to note was that these limitations to power were usually embedded in the practices. Women were given the right to choose, but in some cases, such as the mode of delivery, within those choices, there were already established the options they had to choose from.

> *… there was a paper from NICE, it came out a few years, that women could opt to choose what type of birth. That is not really supported it here and if a woman feels very strongly, they will have to go through along a counselling process. Some may get it but most wouldn't […] the normal assumption is just the wait until labour happens, that's the assumption. So, there's not a discussion so much, unless the woman raises about how she would like to deliver, it does only bring up more commonly when someone has had a c-section before. (EPMW2)*

On the other hand, looking at the second main dimension of power, the relational one, power was configurated as balanced. Information and authority were shared with women who were supposedly the ultimate decision-makers. Women were habitually involved in all the birth process and communicated about the practices performed. Therefore, most women expressed feeling that they had choices and autonomy to decide, even when they just followed the health professionals' recommendations. As a result, the incompatibilities between institutional logics became less visible. In the face of different outcomes and lack of preferences met, prescriptions were viewed as legitimate by the established system of cultural and normative assumptions, hence, without considering other alternatives as possible at the time. The contradictions between logics were generally not seen as inconsistent but attributed to a contextual boundary. This, in turn, demotivates agency that was more likely to enact practices that reinforced the configuration of the maternity field.

> *well I wouldn't say they were not respected but the things they are just so hard to follow and all depends on the situation then (EM4)*

To start with, embedding and routinizing practices were at the core of maintaining patterned care. The several guidelines, for example, ensured that professional conduct would be exercised similarly across the country and still legitimized when there was a need to act against the mother's preferences. As the process has always been to communicate and involve women, by presenting the guideline as justification, women usually felt respected and in a position of security and power to transfer their autonomy to health professionals, so, to rely on their recommendations, even if it was contrary to what they wanted. Thus, when they received undesired practices, such as episiotomy, instrumental deliveries, caesarean sections, or expressed that health professionals had to rush birth, these issues were not addressed to a professional fault, but to the situation. The agentic role, then, was demotivated as women tend to comply with the situation, which helped to maintain the underlying values of the dominant logic.

> *it feels a little bit like I had to just go for it because there are guidelines and there are concerns about the baby's well-being and stuff, so I sort of really just follow the medical staff's decision or advice at that point (EM4)*

> *they broke the water in the hospital to accelerate to labour process […] So, I think it's... at that point and from that point onwards, it was more the doctors' decision rather than my or the midwife's decisions. So yeah, I feel... yeah, it's all a little bit opposite to what I hoped for. But I wouldn't say it's completely against my will. I would just say, we just had to follow what happened. And then because everything gets a bit too complicated than I think I better just follow the doctors' decision (EM4)*

> *well, I was being asked, but it was also clear at the moment that it's better to consent than not to consent, they ask you, but you also feel that it's…a suggestion but it would be advisable to agree to this (EM5)*

> *she was in distress, so they need to get her fast, but I don't think that was... I think it was a genuine reason yeah (EM7)*

As can be seen from the above excerpts, in the face of overlapping medical conduct, the new practices were justified by the compatibility with the natural logic, that is, the practices were acceptable to continue normal delivery. Although women did not like it, they usually did not portray it in a revolting way, unlike in Brazil, even if they were related to the same practice. Here, most of the cases, it was accepted as justified regardless of being a good or bad experience. Thus, women tend to react in the next pregnancies continuing within the same prescriptions. Birth usually followed the same process and it was enacted the same practices as the former. Mobilization of resources and enactment of disruptive practices were not impacting.

Usually, the cases identified that women had opted for a change of the normal assumption, for example, they opted for a planned caesarean, were the ones considered higher risks, i.e. previous caesarean section or a specific complicated issue. In those cases, these practices continued to be seen as underlying the natural logic given that they were justified by the previous case and/or the increased uncertainty. This reaction, in turn, had also a stabilization effect, suggesting the reinforcement of the dominant typology of multi-logics maternity field. The overlapping of medical conduct or the promulgation of different practices – more technical or interventionist practices – were still seen as embedded in the same logics, as it was discursively justified.

Additionally, the practice of educating was also another way to maintain maternity care as it was supposed to. Contrary to what it was in Brazil, here educating practices were structured with a different role. Educating in England provided the actor with the necessary knowledge to engage in the practices available to them and interact about them with midwives and obstetricians. The purpose was to prepare woman and make her aware of the stages of labour, the options she had and the interventions that might be performed, so in case some of these practices were needed, woman could understand what was happening and would go along

with the professional recommendation, consenting to them, kind of a conformation role. Still, connected to educating, valorising and dissuasion practices also enabled the maintenance of the maternity system. By conveying the benefits of normal birth and evidencing the increased risks of performing a caesarean section, health professionals reinforced the normal birth as the default option and the attachment of the caesarean section to specific situations:

> *So our practice here is to kind of educate women as much as possible before they go into labour so that they understand when we speak to them about why we might want to do the caesarean section quickly, they know what we're talking about, or if they know, you know, yeah, so kind of addressing any of these issues or problems that might occur before the woman is in pain. (EPMW4)*

> *for me, the key thing is making... is allowing women to have their education when they're pregnant so that they know what choices there are, what they can expect. (EPP1)*

> *surgeries are risky for both the mother and the baby. There are always inherent risks of infection, haemorrhage, hysterectomy, you know, there's always a risk with an operation and women were brought to have to babies, you know, it's the physiological process of birth, it doesn't always go to plan, but inherently you know, that will be the safer route unless it's contract indicated. (EPMW3)*

According to health professionals, most women went along with them *("Most women will listen to our recommendations and then say, Yep, that's fine. Absolutely*" – EPMW4), resulting, therefore, on the reinforcing effects. When women, on the other hand, insisted on practices that differ from the guidelines and professional recommendations, or yet, when there were some complications or difficulties involved, there was a high incidence of enabling work practices. These practices were supposed to facilitate, supplement and provide support to the current institutional arrangements. So, while care was women-focused, when there was a conflict of interests, the normal course was to try to convince and dissuade the woman of her initial wishes. For example, in the case of a maternal request for caesarean section, the standard conduct was to forward women to phycological support with the consultant midwife or other professionals with expertise in mental health to try to change their mind. Also, in cases that prevent labour from progressing, such as some complications or women manifesting tiredness and weakness to carry on, health professionals usually advised the enactment of other enabling work practices, such as interventions and pain relief options. Those practices worked as a means to ease women to achieve normal delivery and make labour continue.

> *But maybe she's very insistent. And so, we just have to make sure that she's had a full discussion with one of our senior doctors or consultants. And we also have a consultant midwife, her speciality is talking to people and coming to an arrangement so they can find the safest path for both moms and their babies, but also taking into account, so if somebody has very strong views about the way that they want to give birth, it maybe isn't what we would recommend for safety, then we would refer her to --, who would meet her and really talk to her about why she feels that way (EPMW4)*

> *So, a lot of women who requests a caesarean, it's actually more because they're fearful of what feel. And a lot of those women, if you sit down, have a conversation about what you're going to do, and how you're going to do it, how you there to support them, and how you're going to make sure that they're not in agony hours along, and how you're going to intervene if there is any sign that their babies are in distress will turn around and say, Well, actually, OK, that's fine. I am happy enough to go with that. So that's the first step in at all […]. So ...yeah, the idea is, it's a joint effort rather than this is what you're going to do, this is how we're going to do (EPP2)*

> *if a woman has ideas that they don't match our guidelines, for example, someone that is very high risk come to have a home birth without any help, that's the worst scenario for us, so they will go through counselling, counselling they have support and they'll be given options but at the end of the day is their choice, so they will explain whatever it is, they will explain how the system works, how the system can support her and what options she could have, if there's any way of meeting in the middle of something and if that doesn't work is her decision, she would just have to have a well-documented discussions explaining all the risks and if that is still her decision she would go away with that (EPMW2)*

To sum up, what is important to note is that power relations within the maternity field in England posits that mothers were the main responsible for decision making. The guidelines and consenting law in England entitled mothers as more or less free to choose how they would like their birth, at least in principle, if not completely constant in practice. However, at the same time, the asymmetries of power that exist, mostly relating to caesarean section and date of birth choices, were already embedded into the practices. The lack of choice or its limitations were indirectly transmitted by already directing the women's choice among pre-established alternatives and not mentioning the issue. These alternatives were also legitimized through the guidelines. Thus, when talking about birth, women were entitled to choose but the choices comprised only the place of birth rather than the mode of birth. If women insisted on the caesarean section without a medical reason, there were practices to reframe that choice, such as talking to other professionals (obstetricians, consultant midwife) and receiving psychological assistance.

Apart from that, in most of the other situations, the relation of power was configurated as balanced. Women were involved and questioned for consent about the whole process. Therefore, when there was a conflict of interest between professional recommendations and maternal preferences, the ultimately responsible for the decision was the woman. On the other hand, a series of practices aimed at reinforcing the dominant maternal care was enacted. Practices such as educating women about how the care should be; the standardization of conduct into guidelines that justify changes in conduct or more interventionist practices; interventions that enable labour to continue and the achievement of normal birth; practices of convincing and dissuasion by specific professionals with expertise in mental health were some of the above examples that illustrated the practices with reinforcing effects. Consequently, such

effects led to the maintenance of the multi-logics maternity field even in situations that could disrupt their stabilization.

I addressed these practices as reinforcing practices because they enacted and cultivated self-regulating actions that institutionalize both the symmetries and asymmetries of power presented in the relation and in so doing, maintained the actual configuration of the maternity field as a dominant multi-logics field. Hence, although in England woman detained more power, the established relation of power demotivated the agentic role, because the asymmetries were not perceived as a lack of power but as a specificity of the situation. The practices enacted, in turn, had a stabilization effect which suggests the reinforcement of dominant typology of multi-logics maternity field. We can state, then, that power encompasses more than just an objective matter. It also comprises a cognitive domain in which not only the level of power actor holds impacts but also how this level is perceived by the actor involved.

We can observe this by the longitudinal rates that show the constancy of practices/values over the years, with predominance of normal delivery (Caesaren Section, 2002; HSCIC, 2015); and the strengthening of the midwives' role, for example, through their education and registering by the Nursing & Midwifery Council (NMC), and legitimacy of their role vis-à-vis physicians and society. As a result, the quadrant dynamics (Besharov & Smith, 2014) over time for a change can be assumed to be less radical, moving towards small incremental variations. Examples of that encompassed choosing private care (EM7), start attending support groups for mothers with unpleasant birth experiences, i.e. caesareans section (EM6), and some claims for less technical and more personalized care (survey). These acts were similar reactions found in Brazil, although in a smaller extension than it was there.

In closing, the analysis has highlighted that the institutional control of power shaped how the relation of power between health professionals and women were established and crucially how the right to choose came to be entitled to woman, specifically through a pre-established range of options. This pre-established range of options, mostly through taken-for-granted practices (i.e. Normal birth) and embedded and routine practices (i.e. Guidelines) worked as reinforcing practices that were fundamental in understanding the way disparities of power becomes institutionalized through a balanced relation of power, demotivating agency, hence leading to maintaining the actual multi-logics field relationship.

*Comparing the countries*

Finally, looking across both countries, we observed the strong influence of relations of power on the maternity practices, especially in regards to symbolic constructions that impacted

on the women's perception of their experiences with the maternity care. Despite I have found some similar incidences of the same practices, sometimes even higher in England than it was found in Brazil, the evaluations of birth experiences were very different. Tables 24 and 25 show the women's assessment of the health system of their countries. As we can see, despite some criticisms address similar issues, such as too interventionist, medical centred, lack of woman's voice, information, lack of cohesion/variation within health professional, the level of satisfaction between both sites were highly different. In England, 76,71% of women expressed a positive perception, while in Brazil, 76,56% had a negative perception. This is still aggravated if we consider that maternal care in England was a public majority, while in Brazil there was a large impact of private service and health insurance, especially on the data collected in the survey, which would, at first, supposedly imply a greater resource power to women in Brazil than in England.

*Table 24.* Assessment of maternity care by mothers in Brazil

| **Assessment of maternity care by mothers in Brazil** | |
|---|---|
| Positive | **23,44%** |
| Negative | **76,56%** |
| **Reasons for negative assessments** | |
| Terrible | 20,60% |
| Could/Should be better | 12,56% |
| Too focus on c-section | 10,30% |
| Precarious | 9,80% |
| Lack of physicians and support to normal birth / humanized care | 8,54% |
| Violent / disrespectful | 6,03% |
| Lack of information | 6,03% |
| Lack of respect for women's wishes/choices | 5,78% |
| Public is terrible | 5,28% |
| Focused on profit/ convenience/ ease of professionals and hospitals | 3,52% |
| Too interventionist | 2,51% |
| Regular | 2,51% |
| Others | 2,01% |
| Women deceiving / Not reliable | 1,51% |
| Medical Centred | 1,51% |
| Lack of cohesion of medical approaches | 1,51% |

*Table 25.* Assessment of maternity care by mother in England

| **Assessment of maternity care by mother in England** | |
|---|---|
| Positive | **76,71%** |
| Negative | **23,29%** |

| Reasons for negative assessments | |
|---|---|
| Understaffed | 23,21% |
| Medicalised birth/ Intervene too early/Less induction | 12,50% |
| Underfunded | 10,71% |
| Poor/ could be better | 10,71% |
| Discontinuity of care | 8,93% |
| Care varies within the country | 7,14% |
| Lack of women's control/ voice | 5,36% |
| More information should be given to women | 5,36% |
| No option for caesarean section / Anti caesarean section | 3,57% |
| Non-individualized care | 3,57% |
| Doctors should be in charge | 1,79% |
| Focus only on vaginal birth | 1,79% |
| Too focus on doctors/More midwives lead | 1,79% |
| Outdated approaches | 1,79% |
| Neglected care | 1,79% |

Similarly, during interviews, I noticed a high discrepancy as well in regards to the reports of difficulties related to birth. In England, the most difficulties pointed out by mothers were related to i) problems developed during pregnancy and labour (i.e. complication, higher risks) and ii) after birth difficulties (breastfeeding, taking care of a newborn baby). In contrast, all mothers interviewed in Brazil mentioned difficulties related to the unbalanced relation of power. The difficulties centred on i) information – the difficulty of obtaining quality and impartial information, especially from obstetricians; ii) physicians – difficult to find an appropriate physician, the lack of encouragement to normal birth by them, having to negotiate with them/ conflict of authority; iii) lack of structure in the hospital to support/enhance normal birth; iv) preconception of normal birth – to deal with the reaction and judgment of others for choosing normal birth, being deterred and dissuaded of their choices; v) fear of pain and suffering violence.

Consequently, we can state that relations of power influenced on the enactment of maternity practices and especially on the meanings infused in them. In some cases, the maternity field in England and in Brazil presented apparently similar practices, at least at first, but reflecting different reactions. Maternity practices in England and in Brazil were associated with different symbolic constructions, which reflected in the maintaining of different institutional arrangements (Zilber, 2002). Influenced by the relation of power established between the actors, the same practice enacted by the actors resulted in reinforcing and disruptive effects, which helps understand the different types of multi-logics fields. For

instance, the promulgation of more interventionist and invasive practices, such as episiotomy or intrapartum caesarean section were often criticized by women in Brazil. They were seen as due to medical misfeasance of an imbalanced relation of power, mediated by the incompatibility of logics multiplicity between the actors. These negative perceptions configurated as the kickoff for the enactment of their agency role which resulted in the change of birth experience in the further pregnancies generated by the promulgation of other practices with disruptive effects, or disruptive practices. In England, in turn, they were seen as necessary practices at the moment due to the specificity of situation, even if felt unpleasant experiences, thus, demotivating agency and enacting reinforcing practices that maintained the same birth process and already routinely practices for the next pregnancies. This highlights power constituted as both an objective and cognitive dimension, in which not only the level of power held by an actor matter but also how it was perceived and in which context it was embedded, as much that in similar situations across the sites, the assessments and experiences of actors were contrasting.

# 6 DISCUSSION

In this section, I go back to the two theoretical questions that emerged from the theoretical foundation: 1) What are the variations in practice enactment from multi-logics fields?; and 2) How do relations of power shape the adoption of practices in multi-logics fields and consequently how these effects implicate in the dynamic of multi-logics field?. By doing it, I aimed to connect the empirical findings with the theoretical background in order to extend previous work and theorize more generally (Bertels & Lawrence, 2016) about why heterogeneous practices are enacted in the same multi-logics fields, in the case, the maternity field, and what role relations of power have in this variation.

## 6.1 VARIATIONS IN PRACTICE ENACTMENT

The first theoretical research question investigates what are the variations in practices enacted in multi-logics fields. To answer this question, I first analysed the practices promulgated in each maternity field, presented in the findings section. Across the two sites, I identified that maternity practices could be grouped into seven categories of practices (Table 15), inspired from previous researches (Lawrence & Suddaby, 2006; Reay et al., 2013a). Sequentially, I found distinct effects resulting from each of these practices in terms of how they influence the multi-logics field, allowing me to gather two distinct configurations of practice variation: reinforcing and disrupting practices. Depicted in Figure 19, I present these findings and discuss each one in the sequence.

*Embedding and routinizing*

This first category involves embedded routines and repetitive practices. It comprises the infusion of normative assumptions in the actors' routine and frequently practices enacted in the field, in the case, related to maternity care. As a result, these practices engender a reinforcing effect by providing field stabilization through maintenance and reproduction of standardized practices and routines (Lawrence & Suddaby, 2006), and supplant the threat of substitution (Currie, Locket, Finn, Martin, & Waring, 2012).

Embedding and routinizing practices were identified in the maternity field in England through the standardizing conduct backed by the guidelines and routinely informed consent. What this represents is the embedding of maternity care via patterned procedures independently of who performs and receives the service and the sequent engagement of mothers to go along

with professional's recommendations backed by those guides. Thus, as could be seen from the empirical findings, having routinely defined and practised how maternal care should be like, the maternity field in England was maintained constant throughout the country, reinforcing the existing institutional arrangements. Actors, in the case, health professionals, already know how they should act in each situation because they have already a normative assumption behind it. Similarly, mothers recognize such practices as legitim because they are routinely enacted and normative backed, hence, they are more likely to consent it even having the right to deny it.

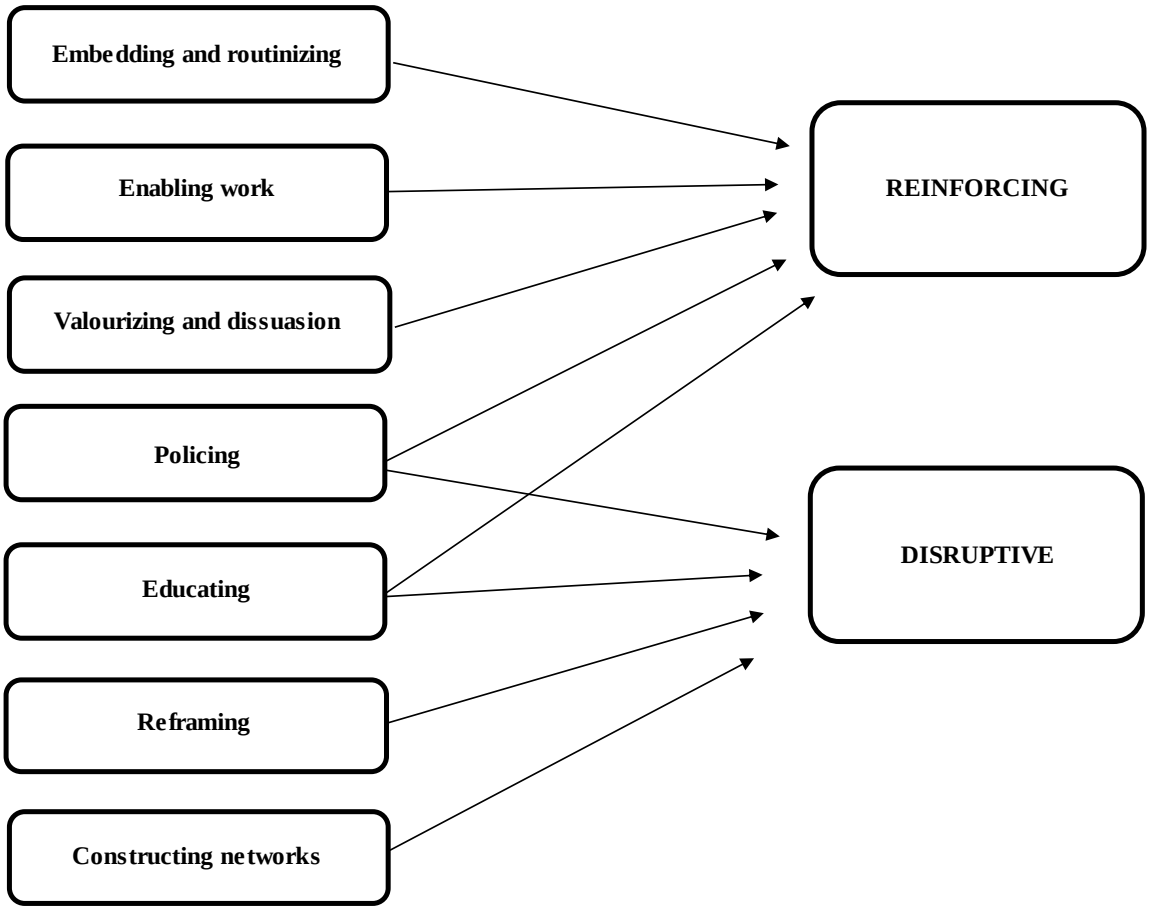


*Figure 19.* Variations in Practice

Other practices such as wait until entering into labour, after birth practices and always questioning the mother first if they accepted them were also routinized on the obstetric and midwifery-led units. By embedding these practices into routines, the practices continued to be reproduced regardless of the type of care and mode of delivery. Also, the routines provided assurance to mothers that it was the appropriate conduct, consequently perceiving them as natural and not considering other alternatives, for example, considering the caesarean section in normal conditions.

These findings are aligned with other forms of embedding and routinizing presented in the studies of Currie and colleagues (2012) and Venter and de Villiers (2013). In the first, drawing on eleven cases of sites from the NHS, the authors analysed the driven role for healthcare professionals focused upon Mainstreaming Genetics (MG). They found that actors engage in embedding and routinizing in pursuit of institutional maintenance. Embedding and routinizing practices were aimed at ensuring the delivery of genetics services within existing modes, preserving the dominance of the powerful institutional actors at their centre.

In turn, in Venter and de Villiers' (2013) study of the accounting academy in South Africa, the authors identified technical teaching as a key routinizing element ensuring the maintenance of profession-inspired institutions. Similar to my case, actors do not challenge the status quo because the activities, in their case, teaching, have been embedded and routine into the actors' daily lives. The education committee defined the educational syllabi uniquely detailed and onerous, as it was found with the NICE guidelines. Hence, departments when structure their courses and course content had to follow these guides criteria to the letter.

Therefore, I address embedding and routinizing as reinforcing practices because the infusion of normative foundations (Lawrence & Suddaby, 2006) leads to the definition of routinely and patterned activities that leaves hardly space for variation. Consequently, they contribute towards institutional maintenance, in my case, the maternity field in England as a dominant multi-logics field. Finally, this practice is also connected to policing as it provides standardization of practices that makes monitoring and control easier.

*Enabling work*

Enabling work comprises the practices that facilitate, supplement and provide support (Lawrence & Suddaby, 2006). They consist of the actions that allow the institutions' arrangements to carry on and ensure their survival, so, extensive efforts of actors to instantiate the intuitional logics they support. Despite Lawrence and Suddaby (2006) direct more those practices to the creation of rules, here they encompass the activities that enhance the maternity care work as it was supposed to or established by the normative assumptions (guidelines and consenting law, for example), so also connected to embedding and routinizing practices.

Enabling work practices, like the previous, were also identified in the England maternity field. In this case, as the natural logic was the dominant one, enabling work were expressed as means of ensuring its dominance in the field. It comprised the performing of interventions and instrumental deliveries and offer of a broad range of pain reliefs as means to ensure labour would progress and women would achieve normal deliveries. Also, since the

embedded routine was to obtain women consent, when there was a conflict of interest between mothers and health professionals, enabling practices also encompassed establishing authorizing agents (Lawrence & Suddaby, 2006; Greenwood, Suddaby, & Hinings, 2002). The appointments with the consultant midwife or higher authority professionals and psychological support were other forms of enabling work to assure the maternity care functions as established.

Consequently, this type of practice heads reinforcing effects because it aims to the maintenance of the dominant multi-logics field. When there are situations that can disturb the normal progress of things, both due to exogenous issues (i.e. complications, increased risk) as well as generated by the actors (i.e. maternal request for caesarean section, disagreement between actors), those practices are enacted in order to normalize possible disruptions and establish the natural path to be followed.

*Valorising and dissuasion*

Valorising and dissuasion correspond to practices discursive in nature that provide positive (valorising) and negative (dissuasion) assumptions in order to maintain the power of the beliefs. In so doing, these practices ratify the normative foundations of an institution (Lawrence & Suddaby, 2006) and ensure the maintenance of the field. Thus, valorising and dissuasion practice is connected with shaping the belief systems of actors. By confer greater value to an action, actors enhance the likelihood of this is internalized in a positive way, ergo, be easily enacted. While, when preferences are undermined, actors tend to see them as uncertainty, risky, so not so worth to take a chance.

This practice was identified in both sites, in Brazil and in England, however, contrarily addressed to the maternity institutional logics. In England, in accordance to the beliefs sustained by both logics, natural and medical, normal birth was seen as the best mode of delivery, while caesarean section should be considered in specific cases where there was increased risks or uncertainties. Thus, discourse practices from health professionals were directed to reinforce this, that is, valorising the benefits of normal birth in contrast to dissuading caesarean section without a medical reason. Also, interventions were portrayed as a minor thing, some help in case woman might need to allow labour to continue.

In contrast, in Brazil, we could notice the opposite scenario. The multiplicity of logics in this field manifests a high incompatibility, so, especially among health professionals, it was noticed a preference for caesarean section, which was considered a safer mode of delivery against the primary preference of mothers for normal birth. As a result, it was frequently discursive practices valorising the easiness of caesarean section, i.e., eliminating the possible

immediately risks and easy to be planned and controlled, and the hospital as the appropriate place of birth, with support of technical apparatus. At the same time, many women were dissuaded from having vaginal delivery for the unpredictably involved, conveyed as the riskier mode of birth. Yet, it was also observed dissuasion of humanized birth, birth plans and doulas from some obstetricians as these practices were considered means of women have power over their births.

It is important to point that in this practice, I opted by dissuasion instead of demonizing, as proposed by Lawrence and Suddaby (2006) because in demonizing, the focus is on negative examples. Considering the findings, I believe that dissuasion is more appropriate because the focus of these practices is to persuade (Harmon, Green Jr., Goodnight, 2015; Suddaby & Greenwood, 2005; Green, Jr., 2004) women that their preferences were not suitable to the professional recommendation and/or preference. As we could see on the former section, the focus was not necessarily on just giving negative examples, but through discursive practices, dissuade women from a preference or a prior choice by infusing fear, presenting risks and uncertainties, and not guaranteeing safety in performing them.

*Policing*

The fourth category involved ensuring compliance through enforcement and monitoring (Lawrence & Suddaby, 2006). Policing comprises the set of practices enacted to certify institutional logics and their demands are instantiated accordingly. Although this category was based on Lawrence and Suddaby (2006), policing here goes beyond their study by identifying the execution of policing in two distinct dimensions, institutional and individual dimensions and generating both reinforcing and disruptive effects respectively, each of which in one site.

Thus, policing practices were identified in the two fields. In England, it was mainly enforced by the institutional dimension. Institutions such as the NHS, Royal College of Obstetricians and Gynaecologists, the research institutions (Universities, NICE) have established how maternity care should be performed. With this, policing there aimed at maintaining the field, reinforcing the multi-logics field configuration by ensuring it was being done as established. Health professionals should document all the conduct and justify when it was not performed according to the guidelines. Also, frequently, all the team gathered together to discuss and understand what happened to cases that had unexpected outcomes. The NHS funding was attached to the compliance with the demands.

Supporting this analysis, the studies of Lawrence and Suddaby (2006) and Currie and colleagues (2012) also connect policing with maintenance effect. Currie et al. (2012) researched the health care field too and identified that policing was expressed by supervising practice and checking the work on a regular basis. However, contrary to the England case, policing in their research was instantiated at an individual level, by clinical geneticists closely supervising the nurses' practices.

Additionally, the findings extend these studies by identifying other effects provoked by these practices. That is, depending on how policing is directed, it can result in different aims. In Brazil, we noticed a contrasting effect. As in this field, there was a loose enforcement system, which allowed medical conduct to be more personal, policing practices were mostly enacted by less powerful actors as a way to substitute the role of institutional control that was lacking. That is, less powerful actors adopt policing practices to balance the relation of power, which was asymmetric, and to be able to enforce their preferences. Thus, birth plan and hiring a humanized team are some examples that women adopted to guarantee obstetricians would respect their preferences. I address they engender disruptive effects because the enactment of those practices changed the relation of power, ergo, the configuration of the multi-logics field.

In sum up, policing works as a mean of control. It represents coercive form, with prevalence in professionalized fields to monitor and assure work will be done accordingly in both maintain the demands of the dominant logic or as to balance an asymmetric relation of power when there is a loose enforcement system.

*Educating*

Educating practices comprise infusion actors with skills and knowledge (Lawrence & Suddaby, 2006). It is connected to the agency role to obtain mental resources. Similar to the former practice, here I identify educating as engendering both effects, reinforcing and disrupting, each one in one field. Despite referring to the same practices, their enactment was directed to different aims, in accordance with the relations of power previously established. As a result, we noticed contrary implications when comparing the Brazilian and English cases.

First, in England, educating practices consisted of providing the necessary knowledge to actors to engage them in the alternatives available and make them able to interact about it, so to easiness their consent when needed. Here, educating combine maintenance effect. Health professionals engage in educating mothers to support acceptance of their recommendations and ensure that mothers' preferences and acts would be aligned with the guidelines. As pointed by Lawrence and Suddaby (2006) and Currie et al., (2012), there is a strong relationship between

educating and control mechanisms. Consequently, educating buttresses institutional maintenance by reinforcing how institutional logics should be instantiated.

On the other hand, in Brazil, the resultant effect of educating is more in line with the aim of creating proposed by Lawrence and Suddaby (2006). Educating practices in Brazil also comprehended infusing actors with knowledge, but here in a way that allows them to engage in new practices or interact with new structures. That is, by holding new information and knowledge, actors disrupt with the main care backed in the technocratic model and found out new alternatives/models of birth. Again, educating worked as a mean to balance the relation of power and enable actors to pursuit their preferences. Thus, educating, in this case, is connected to other practices such as construct network and policing.

The distinctions of educating effects may also be related to the main deliver of this practice. In Brazil, educating usually departs from the women themselves. They generally started searching for information in sources other than the obstetrician, so to breach the asymmetry of power established between them. In contrast, in England, usually educating departed from health professionals. They engaged the mothers in educating practices by giving them leaflets and forwarding them to parental classes. Thus, educating encompasses the same sources, maintaining the relation of power as it was. As highlighted by Currie et al. (2012), the actors who deliver the education had control over the scope and content of the education, thus being able to dictate the boundaries.

Furthermore, this corroborates with Young and colleagues (2012) who state that people tend to rely more on the information they pursue than on the one that is available without seeking. This happens because actors interpret the act of searching for information as an indication that this is important to them. Consequently, as we could see in the Brazil case, such reasoning affects the extent to which people use the information and their perception during social interaction, which in turn, causes them to push harder to achieve better outcomes related to the information. In line with that, the way the language of educating is framed (Amis et al., 2018) also affects how information is understood. In England, women receive the information and this was communicated in an informative way, standardized on the guidelines and the NHS. In turn, in Brazil, especially when inserted in the humanization movement, information it is usually portrayed as an “activist” way, to alert women of the Brazilian scenario, showing the benefits of a natural birth not only for health issues but also as the transformation and empowerment of women and so, to conquer more people towards changing it.

*Reframing*

Reframing was based on micro-level theorizing through the actions of framing and justifying, proposed by Reay and colleagues (2013a:976). According to them, it involves efforts of "explaining and presenting the rationale for". Reframing, then, constitute the actions of re-making connections between practices and their meaningful foundations, usually, for issues that had already a previous rationale (Lawrence & Suddaby, 2006). It also involves practices discursive in nature but that implicated material actions in practice. Visible differences, then, can be noticed when comparing the same practices, as a result of reframing practices. Consequently, we can state that this category engenders disruptive effects because it leads to new meanings within equal contexts.

Reframing was observed in the Brazilian field. At this case, there were notable extensive efforts to re-signify normal birth and the pain involved in a way to enforce their compliance. Reframe allow actors to re-signify for their own setting. The fear of pain, for example, was presented in several women. It was pointed as one of the reasons women accepted or opted for caesarean section, especially because this surgery was attached to the painless option. However, when the pain was reframed as something proper from the body, something the body could handle, a *special pain*, women tend to pursuit normal birth with a stronger effort, regardless of any fear. While, others who had framed it differently, accepted more easily to have a caesarean section when obstetrician recommended to. This last understanding is in line with Currie et al.' (2012) study on the practice of theorizing. The authors found the important role of theorizing in significantly associating the concept of risk with any change in service delivery, which, as a result, was a persuasive concept to promote institutional maintenance.

A discernible difference was remarkable between the way normal birth was understood by mothers in England and in Brazil. Through reframing, mothers in Brazil conceived normal birth not only as of the healthier mode of delivery but also as an empowering experience through which they become mothers. By experiencing normal birth, they would be ready for any obstacle because they had already overcome labour. Consequently, more than just have their babies, they also wanted to have the experience of giving birth vaginally, feeling frustrated if they could not manage it. While in England, mothers usually just frame it by being the natural and healthier mode of delivery, so the natural choice. But, if it was not possible, it was just an unfortunate outcome. It was not identified the feeling to want to live it as it was in Brazil.

Finally, reframing was also pointed as highly important for health professionals in order to provide a humanized service. As quotes exposed in the findings because their professional

education was settled on a medical logic, ergo, very interventionist and medicalized, in order for them to start working differently, then, they needed to de-construct, or reframe, all their previous background that contrasts with the new values.

*Constructing network*

Finally, the last category refers to constructing inter-organizational connections with other actors and groups. The involvement of other actors and established of alliance within them buttresses normative compliance, monitoring and evaluation (Lawrence & Suddaby, 2006), thus, it constitutes also as an enforcing mean to achieve its preferences. This practice was observed in the Brazilian maternity field. Mothers construct a network with other mothers and health professionals connected to the Humanization Movement by joining support groups and participating on social media groups attached to the movement.

As highlighted by Lawrence and Suddaby (2006), the key observation in these accounts is that constructing networks consequently altered the relationship between actors in the field by changing the normative assumptions that connected them. Thus, mothers enhanced their agentic role by having more updated and technical information provided by these networks, looking for professionals that shared the same values, and receiving the support to enforce their preferences. As a result, the construct of networks engenders a disruptive effect as it changes the pattern of the relation of power in the field and enables new alternatives and models of birth alongside pre-existing ones. Hiring a multifunctional team, for instance, leads to a new model of birth construction in comparison to the one already existed. As mothers co-opted with doulas and obstetric nurses, the latter support the mothers' interests.

In line with the Currie et al. (2012)'s research, I also found a great connection between educating and constructing network practices. One practice leads to another and combined, they allow new practices to become naturalized. These joint practices, then, lead to disruptive effects as they enhance the position of less powerful actors, in the Brazilian cases, mothers, to a more balanced relation of power. Lastly, it is important to point that despite at first these practices may seem to have different effects than the one proposed by Lawrence and Suddaby (2006), creating institutions, I argue that these findings complement the previous study. The enactment of educating and constructing network practices in the maternity field of Brazil by the same time that reflect disrupting effects into the dominant established maternity arrangement, that is, the technocratic model of childbirth attention, it was also gradually conveying that this institutional arrangement is no longer adequate, thus, constructing

(creating) a new model of maternity care, the so-called humanized birth. So, here, the disruptive practices also lead gradually to the constructing of new patterns.

*Analysing variations in practice*

In summary, this section has explored the variation in how actors enact practices stemming from multi-logics field. By examining different configurations of the same field, the maternity field, I identify a typology of practices to institutional multiplicity. The identification of seven categories of practice both confirm and extend previous researches on organization responses to multiple institutional demands (Bertels & Lawrence, 2016; Smets et al., 2015; Pache & Santos, 2010; Lawrence & Suddaby, 2006; Clemens & Douglas, 2005; Oliver, 1991). Looking across the variations in practice and connecting them to the literature, my findings contribute to three key issues: variation heading contrasting effects; variation disconnected to material distinctions; and fluidity of practices.

Firstly, one important way that my research contrasts with these previous studies is that similar practices can engender different effects on reinforcing or disrupting the dynamic of the multi-logics field. By leading to institutional multiplicity (Lee & Lounsbury, 2015; Greenwood et al., 2011), actors can enact practices that reinforce how the field is configurated, maintaining the relationship between logics multiplicity or develop new alternatives of action that generates disruptive effects to the multi-logics field. Despite the literature had already acknowledged that practices can direct to creating, maintaining and changing institutions (Harmon, Green Jr. and Goodnight, 2015 Lawrence & Suddaby, 2006; Maguire et al., 2004), my findings extend by showing that these effects are not directly attributed to a specific practice, but how the practice is directed and to what aims. Thus, the same practice depending on the boundary context and towards what aim it is promulgated can unfold different implications. The variation exists also when leading to similar material enactments, but resulting in different outcomes.

For instance, while in England, policing practices contribute to reinforce (maintain) established maternity care, in Brazil, on the contrary, it works as to disrupt patterned technical behaviour and ensure an emerging one, the humanized, woman-focused. In turn, while educating practices in Brazil, in accordance to Lawrence and Suddaby (2006) reflect disrupting effects that consequently are constructing a new model of care, in England, this type of practice assists to reinforce the actual care by informing women how it is, what they can expect and what possibilities of care they can choose.

The second key issue refers to the content of those variations. Variation in practices is disconnected to material distinctions. That is, differentiation in practices involve both material

and symbolic efforts. The findings present the enactment of distinct responses to similar contexts. For example, in the case of the maternity field, we found the enactment of enabling work practices through the performing interventions in labour in England, versus policing practices through the birth plan and humanized team to avoid the interventions in Brazil. Next, variation also is expressed in distinct symbolic constructions when adopting the same practices but with those connected with different meanings (Zilber, 2002), for example, the reframing of normal birth in Brazil and in England or yet the interventions aforementioned. Variation also embraced both practical efforts and practices discursive in nature, as forms of valorising, dissuasion and reframing. Discursive practices worked as particular texts that re(enforce), persuade or deter to adhere to an institutional logic (Amis et al., 2018; Green Jr., Babb, & Alpaslan, 2008).

Lastly, a valuable contribution of the study is regarding this differentiation of meanings within the same practices. In accordance to the study of Zilber (2002), although in a first moment, we can see the enactment of the same practices, by looking into the symbolic construction embedded in those, we find they consist of different practices. We can state, then, that there is a fluidity of practices. That is, despite practices represent the material enactment of institutional logics (Friedland, 2014; Smets, Morris, & Greenwood, 2012; Sahlin & Wedlin, 2008), they are not attached exclusively to a specific logic. Depending on the relations of power between the actors who negotiate these practices, which I further discuss in the next section, and their own boundary contexts, practices can flow from one logic to another through meaning change. Therefore, this underpins the resulting different effects on the institutional arrangements.

Despite the field comprises similar practices, the variations within practices configure as heterogeneous institutional logics instantiations within the field. This helps comprehends why the same multi-logics fields can manifest different relationships between institutional logics (Besharov & Smith, 2014), hence, engendering different resulting effects. Also, this look allows to integrate the micro and macro level of interactions (Thornton, Ocasio, & Lounsbury, 2012; Cloutier & Langley, 2013), connecting actor, practice and institutional arrangements.

In closing, my study contributes to a better understanding of the interplay among logics, practices and meanings involved in multi-logics fields and, as also raised by Amis et al. (2018) and McCarthy and Moon (2018), it points to the importance of assessing practices within their own context to obtain a better understanding of this interplay and its implications in the dynamics of multi-logics field. Similarly, also in line with Hayes, Introna and Kelly (2018), it attempts to consider not only the actor, carrier of the logic, but also the wider meaning systems

embedded in practices that are aimed at affecting institutional arrangements (Lawrence, Suddaby & Leca, 2011; Lawrence & Suddaby, 2006). Therefore, in accordance with extant literature (Feldman & Orlikowski, 2011; Jarzabkowski, Smets, & Bednarek, 2013; Smets, Aristidou, & Whittington, 2017), the findings ratify the situational aspect of the practice. The implications of practices enactment are intrinsically linked to the social world and the environment where they are immersed. Within different contexts, or conveyed differently, similar practices may present variations and result in opposing outcomes in consequence.

## 6.2 RELATIONS OF POWER IN PRACTICES IN MULTI-LOGICS FIELDS AND THEIR MUTUALLY RECURSIVE EFFECTS

Lastly, I set out to explore how relations of power shape the adoption of practices in multi-logics fields. And, from this, to understand how these effects implicate in turn in the dynamic of multi-logics field. I was particularly interested in how the negotiation and social interaction (Hallet & Ventresca, 2006; Thornton, Ocasio, & Lounsbury, 2012; McPherson & Sauder, 2013) between actors holding different roles of power (Hinings & Greenwood, 1988; Bjerregaard & Jonasson, 2014; Pemer & Skjølsvik, 2016) had impact in the response to multiple and sometimes conflicting institutional demands (Greenwood et al., 2011), consequently adopting different types of practices (Bertels & Lawrence, 2016; Nicolini et al., 2016). In turn, looking at this reaction whether it reinforces the field or moves towards changing it.

In accordance with studies that have looked inside organizations and approached institutions as inhabited by individuals (Hallet & Ventresca, 2006; Pemer & Skjølsvik, 2016; Bertels & Lawrence, 2016), my interest was settled in connecting how macro prescriptions of behaviour, that is, institutional demands from multiple institutional logics (Bévort & Suddaby, 2015), are manifest and instantiated by actors. Previous researches have acknowledged that there is an influence of actors in the animation of responses (Bertels & Lawrence, 2016; Nicolini et al., 2016). Actors filter institutional pressures beforehand and negotiate with each other to what and how to respond. The promulgation of practices, then, is dynamically negotiated and experience through social interactions (Hallet & Ventresca, 2006; Wright & Zammuto, 2013; Micelotta, Lounsbury, & Greenwood, 2017 Nicolini et al., 2016; Thornton, Ocasio, & Lounsbury, 2012).

In addition, studies also point out the interrelation of social interaction with power (Wrede, 2001, Bjerregaard & Jonasson, 2014; Greve & Zhang, 2017). Actors occupy different

structural positions and have differential power (Hinings & Greenwood, 1988). Consequently, they invest resources, effort, and power to instantiate their own logics and, subsequently, the practices that animate those (Kim et al., 2007; Reay & Hinings, 2005). Thus, although it is recognized that there is an influence of actors in the response to the multiplicity of logic and that the power they hold, influences their ability to negotiate and act, there is little knowledge bringing them together and trying to understand the impact of relations of power on practice. This research, then, re-introduces power and agency into institutional explanations (DiMaggio, 1988; Lawrence & Sudabby, 2006) and also provides foundation towards the effects of actors and their relations of power into practice, ergo, multi-logics fields.

Analysing the empirical findings, primarily attention was drawn to the fact that similar cases generated opposite reactions. Practices promulgated in England maintained the field's configuration, while in Brazil lean on destabilization. So, by grouping those at the effects they engender, reinforcing and disrupting, I tried to understand what shaped this role by adopting the lens of power. My research identified a recursive relationship between them. I argued that relation of power affects how the actor perceives the differences - inconsistencies or not, of the multiplicity of logics and from that how manifest on it, that is, subsequently affecting the promulgated practice.

When relations of power are configurated by imbalance relations, in which there is a dependence of the less powerful actors (mothers) on the more powerful actors (physicians), the inconsistent instantiations between logics become more visible. In this case, actors do not have the same ability to give voice to their institutional logics (Greenwood et al., 2011). So, outcomes reflect the result of coercive enforcement (Lukes, 1974; Kashwan, 2016) and imposing of logics upon the less powerful ones (Nicholls & Huybrechts, 2016). Greater power backing an institutional logic makes its incarnation more likely to occur (Greve & Zhang, 2017; Greenwood et al., 2011; Seo & Creed, 2002).

The incompatibilities between the institutional logics, then, become clearer. However, due to that, actors perceive the differences in practices negatively, which implicate in contrasting views of insiders and outsiders of an institutional logics (i.e. Table 9 depicted before). Practices are not agreed within actors but are imposed or pushed to compliance. As the dominant group sometimes tries to reinforce its values and practices to less powerful actors which may differ from their preferences, even though these are justified, in our case, giving medical reasons, the inconsistencies and reactions of actors over time become more apparent. This may lead to a gradual increase in conflict. Practices, then, are translated showing lower

degrees of compatibility and becoming more latent the levels of dissatisfaction, even if it is discursive in nature or by different symbolic embeddedness.

In the context of maternity field in Brazil, we found more asymmetries of power and enactment of practices linked or justified by it. At a first moment, this was evident in i) the high incidence of caesarean sections and interventions; ii) the performing of valorising and dissuasion practices by obstetricians; iii) in the mothers' reports of not being aware nor involved in decision making and the performing of those practices; as well as iv) their high dissatisfaction in regards to their experience and maternity care mainly due to issues centred on imbalanced relation of power. The difference of perception in relation to the relation of power was even more noticeable when comparing the experiences with professionals linked and not linked to the Humanization Movement. In particular, the practice of valorising and dissuasion was done through delegitimizing the contesting logics (natural birth) and its proponents (for example home birth, *unprepared* care providers), by getting to see it as inappropriate or disguising practices associated with the preferred logic using terms taken from the opposing logic (Pemer & Skjølsvik, 2016), using the risk as intimidating factor to dissuade.

In a second moment, however, we noticed a higher effort towards change. Asymmetries of power evidence incompatibilities of logics more easily which, in turn, motivates a greater agentic role. And in so doing, as actors seek to achieve an integrative solution (Mannix & Neale, 1993; Ocasio & Radoynovsk, 2016), they can assume different positions as determinants of varying responses to the political dynamics (Bjerregaard & Jonasson, 2014). Mothers, then, enacted strategic acts of mobilization (Lawrence, Winn, & Jennings, 2001; Lawrence, 2008), as educating and constructing networks, in order to enhance their ability to negotiate and enforce their own preferences.

In consonance with Lawrence (2008), my empirical findings evidenced that these acts involved mobilizing resources, for example, the search of information and enforcement of birth plan; engaging in contests, i.e. by joining the Humanization Movement and negotiating more with their obstetricians; and enacting support or attack forms of discourse and practice, such as reframing practices and involving other actors for support. So, actors are more likely to adopt disrupting practices in response to the imbalance relation. Such practices disrupt because they alter the core practices of the field, for example, caesarean section *versus* normal birth; they insert improvisations, such as arriving late to hospital when in labour; or yet they adopt new ones (Kim et al., 2007; Besharov & Smith, 2014; Micelotta, Lounsbury & Greenwood, 2017), as hiring multi-functional team and organizing blessing shower.

Specifically, the search for information is found as a key input in balancing relation of power. The higher degree of information provided mothers with a greater repertoire of negotiation and argumentation to their interests. It helped to increase the quality of agreements and, consequently the achievement of better outcomes along the negotiation process (Stuhlmacher & Champagne, 2000; Fatima, Wooldridge, & Jennings, 2002; Carstensen & Schmidt, 2016), which could be seen by the differences between the first and the second pregnancies. So, instead of submitting to physicians' arguments, mothers were more likely to adopt a more active position, increasing their participation during social interaction process (Shetzer, 1993; Young et al., 2012) and mobilizing others resources that backed this negotiation processes, such as policing practices. Additionally, in line with McCarthy and Moon (2018), information was found to be connected to consciousness-raising. It led women becoming aware of their position and the imbalance relation with physicians, bringing power and privilege into focus.

Thus, by motivating agency, the mothers adopted actions towards a more balanced relation that led to the destabilization of the current configuration of the field. In their next pregnancies, mothers looked to relate with actors within similar logics, that is, that presented higher compatibility between the maternity logics, exemplified by the changing of obstetricians at the end of pregnancy or in the next ones. This, in turn, allows us to suppose that there is a likely dynamic over the time of a quadrant change of the type of multiplicity (Besharov & Smith, 2014), extending it by showing that the authors' model is not static but subject to changes over time. In the case of Brazil, as women start looking for professionals with whom they can establish more balance relations of power, and considering the unstable scenario we noticed, with constant acts from women and regulatory institutions, I can suggest that this change might be from the contested quadrant to the aligned, where conflicts gradually diminish. Therefore, I propose the following:

> **Proposition 1:** Disrupting practices are more likely to be enacted in multi-logics fields in response to imbalanced relations of power that make incompatibilities between logics more visible and motivate agency.

On the other hand, when relations of power are configurated by more balance relations, the inconsistent instantiations between multiple logics become more difficult to be perceived. In the face of low differences of power, the various actors involved exercise strong influence on the instantiation of institutional logics (Besharov & Smith, 2014; Pache and Santos, 2010;

Hinings and Greenwood, 1988). Given that power is more symmetric, actors tend to be involved and participate more in communicating and negotiation process. They exert a more active position, having higher participation during the negotiation process (Shetzer, 1993; Young et al., 2012), entitled by informed consent. Efforts of collaboration and complementarity among the multiple logics and actors' preferences are more likely manifested from local negotiations. Thus, actors are more likely to reach agreements with higher joint gains when relations of power between them are equally balanced (Mannix & Neale, 1993), which leads to practice translation in accordance with the main supposedly shared values.

As actors, in our case, mothers felt embraced, the promulgation of practices, unlike the former case, is not seen as imposed, but agreed or chosen. Consequently, potential incompatibilities and contractions between institutional logics become less visible and noticeable by actors when preferences were not met. Overall, in the face of negative experiences, these are not addressed to inconsistencies of multiple logics due to lack of power, but to contextual boundaries that limited the achievement of the preferences. As also evidenced by Goodrick and Reay (2011), practices reflect the interaction of multiple logics, enabling cooperative efforts, as trying to reach mutual agreements by the meetings with the consultant midwives. For the persistence of the relationships in the field, common discourses are developed so can span the boundaries between inconsistencies. Actors use the institutional material available to generate meanings and discourses appropriate to their own core of logics (Nicholls & Huybrechts, 2016), that is justifying on the shared values. This, in turn, demotivates agency, whose actions lead to stabilizing the field.

Actors are more likely to enact reinforcing practices that translate the higher degrees of compatibility and disguise possible levels of dissatisfaction. This was particularly evident in the English maternity field. The maternity care in England was established by reinforcing practices that lead to its maintenance, such as enabling work and embedding and routinizing. This eases the enactment of practices that buttress the configuration of the field and how maternity care was settle. Additionally, all the maternity practices performed were backed by informed consent, so, regardless of the primary preference of the mother, her involvement in either negotiating or being communicated about it, was portrayed as collaborative efforts, which, in consequence, demotivate agency when the professional conduct moved towards lack of preference met.

In particular, the practice of valorising and dissuasion, like in Brazil, was also performed through delegitimizing preferences by getting to see it as inappropriate (caesarean sections) or adopting practices associated with the opposing logic (Pemer & Skjølsvik, 2016)

(interventions). However, in England, they were translated backed by women-focused care. This implicated that they were seen from a joint decision, even whether there was not so conjoined. That is, when mothers just relied on other actors (Duflo & Saez, 2003; Kashwan, 2016) - the recommendations of midwives and physicians-, the fact that they were communicated and suggested about it, still made them feel with autonomy. They percept themselves as having power.

Hence, we noticed a higher effort towards maintenance. Symmetries of power make more difficult to notice incompatibilities which, in turn, demotivates the agentic role. In cases that went out normality or uncertainty were involved, mothers in England tended more easily to adherence, alliance or even complicity (Lukes, 1974) to health care conduct as they were revolved around shared beliefs (Lawrence, 2008). So, actors enact more likely reinforcing practices in response to the balance relation. Thus, by demotivating agency, the mothers adopted actions that sustained the balanced relation, consequently leading to stabilization of the current configuration of the field. Women in the next pregnancies followed the maternity care as in the existing order of things (Lukes, 1974), which sustained the higher compatibility.

In the face of an uncertainty or higher risk and yet a disagreement of conducts between mothers and health professionals, usually, mothers defer to professionals the decision making, either to secure benefits (having the baby healthy) or in order to avoid additional costs that may incur (Kashwan, 2016) (incidence of higher risks and complications). Especially, this reliance is also facilitated because contradictions that may be perceived revolve around means – how to accomplish the goal -, i.e. accepting an undesired intervention, but not the goal itself (Pache & Santos, 2010), i.e. to have a normal birth. This, in turn, allows us to suppose that there is a likely stabilization of the dynamics of the multi-logics field. Therefore, I propose the following:

> **Proposition 2:** Reinforcing practices are more likely to be enacted in multi-logics fields in response to balanced relations of power that make incompatibilities between logics less visible and demotivate agency.

As illustrated in the discussion, the general empirical findings correspond to each case to one corresponding site. In Brazil, the relation of power was found more asymmetric while in England was found more symmetric. Nevertheless, some exceptions found within the sites confirm the findings by automatically fitting the other case. For instance, in England, the case of mother EM6 that reported lack of power, despite her situation was similar to other mothers, her perception of asymmetric power led her, even after birth, to start studying, looking for

information and engaging with other mothers and groups who had caesarean or failed induction. She also stated that in the next pregnancy she will not accept the same situation, considering even to go to another country to give birth. Hence, we can notice an agentic role motivated by the perceptions of imbalanced relation of power and moving towards disruptive practices. In Brazil, in turn, when mothers were assisted by professionals linked to the Humanization team, interventions and caesarean section when performed were not interpreted as violence or medical malfeasance, as it was with obstetricians not connected to the movement, but as medically justified due to the situation because they perceived themselves as holding power.

Consequently, in a final step, it is still important to connect these findings at the micro level to the macro prescriptions of behaviour, that is, the multiple institutional demands, especially given that the cases analyzed evidence different types of logics multiplicity. As pointed out by Cloutier & Langley (2013), the empirical findings showed that things are not judged legitimate based on being right or wrong but on the basis of conformity to institutional prescriptions. So, for example, caesarean section is recognized in many cases as the sensible option in Brazil, even several studies and the WHO itself associating surgery with increased risks for mother and baby. Notwithstanding, women start to question the institutional status quo, by perceiving the contradictions between institutional logics (Seo & Creed, 2006) and judging as wrong or unfair. Consequently, the natural logic of maternity in Brazil emerged as women and other actors involved in the Humanized Movement started to question the excessive incidence of caesarean section as wrong and the performance of interventions as violence.

I expand the points raised by Cloutier and Langley (2013) by looking at this relation into practice. When compatibility between multiple institutional logics is low, as in the Brazil case, actors tend more likely to view practices as illegitimate. Since conventions and symbolic constructions are based on conflicting and often incongruous prescriptions, practice translation often brings aspects of dependency and power imbalance into focus. Incompatibilities become more perceptible being manifested into practices. As a result, we can find variation in practices as an expression of asymmetries of power. Different practices are enacted as a response to different levels of power, being these variations, as previously discussed, expressed as a material or symbolic effort.

Looking at the Brazilian case, for instance, overall, caesarean section is connected to the medical logic. However, when its performance was necessary to mothers assisted by the considered humanized obstetricians, it was common to address it as a humanized caesarean section or yet a “well-indicated” caesarean section, as a way to reinforcingly distinguish it from

the one performed under a different logic. The humanized caesarean section differentiates by being performed under discussion and joint agreement with the woman, attentive treatment by the professionals, who would explain the procedures, and allow immediate contact between mother and baby and breastfeeding still in the operating room. This distinction, consequently, helped to reinforce the competition between institutional logics by clearly highlighting their incongruent differences. Thus, I further propose that:

> **Proposition 3**: When the relationship of multi-logics is highly incompatible in a field, asymmetries of power between actors are translated into distinct practices reinforcing the logics competition.

On the other hand, when compatibility between institutional logics is greater, actors tend to accept practices as legitimate, even if they are contrary to their initial preferences or if their enactment is due to an asymmetry of power. As conventions and symbolic constructions are based on common prescriptions, practice translation embeds these inconsistencies, and practice is performed according to the supposedly shared core values, blurring aspects of dependency and power imbalance. As a result, the practices tend to reinforce the collaboration of logics and the stabilization of their relationship.

In the maternity field of England, for instance, embedding and routinizing practices infuse the normative foundations of the trust's regulations into the actors' day-to-day routines and maternity practices (Lawrence & Suddaby, 2006). So, women are allowed to choose the place of birth instead of the mode of birth. Thus, asymmetric relations of power were in a way maintained and reproduced through the stabilizing influence of the standard practices, guides and taken-for-granted practices, which were based on the higher compatibilities between logics. By offering the possibility of women to choose from a predetermined list of alternatives, the NHS maintained the asymmetry of the power vested in a symmetric relation of power. So, integrating the findings at the macro level, the logic multiplicity, the discussion leads to lastly propose:

> **Proposition 4**: When the relationship of multi-logics is highly compatible in a field, asymmetries of power relations between actors are implicitly translated into practices as a way of balancing the differences and stabilizing relationships.

Looking across these last propositions and connecting them to the resource of information as a consciousness-raising (McCarthy & Moon, 2018), the practice of

interventions in Brazil exemplifies these both propositions. First, as reported by the mothers BM6 and BM8, before they getting informed, they thought that interventions such as episiotomy and Kristeller manoeuvre were common practices related to normal birth, that conceived as natural and inevitable. Therefore, in this initial conception, the asymmetry of power between them and their obstetricians was implicitly embedded into these practices by seen as legitime, the natural way to have a vaginal delivery. However, according to them, once they started informing themselves and attending support groups connect to the Humanization Movement, they realized that those practices were only performed by medical convenience and reframed them as obstetric violence. So, becoming aware was a rupture in previous understandings of institutional arrangements leading actors to attach of new conceptions.

## 6.3 AN INTEGRATIVE MODEL OF RELATIONS OF POWER IN PRACTICES IN MULTI-LOGICS FIELD

The aim of this study was to extend previous research on the heterogeneous ways that practices are enacted in multi-logics fields by analysing the role of power on that. Previous researches have argued that individuals have influence on institutional logics interpretation and enactment (Bertels & Lawrence, 2016; Nicolini et al., 2016; Bevort & Suddaby, 2015) and that they have different roles of power in a field (Ranson, Hinings, & Greenwood, 1980; Hinings & Greenwood, 1988; Bjerregaard & Jonasson, 2014; Pemer & Skjølsvik, 2016) that affect the social interaction and negotiation between them but left the linking between both relatively unexplored. The main findings, summarized in the four propositions, presented above, directly address this aim. In the remainder of this section, I draw on these findings to present an integrative model of relations of power in practices stemming from multi-logics field, depicted in Figure 20 that helps make sense of the interplay among multiplicity of logics, power and practices in the two cases I studied and can serve as foundation for future research.

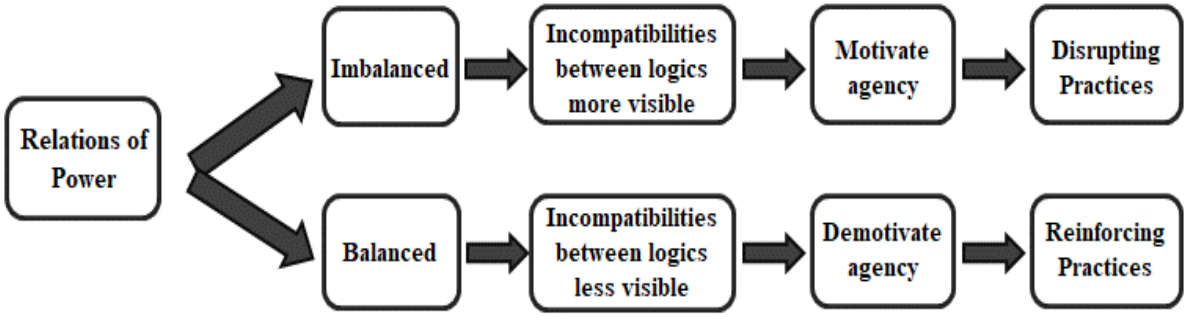


*Figure 20.* An integrative model of relations of power in practices in multi-logics field.

Figure 20 presents an integrated process model of the findings that revolves around two key concepts – *relations of power* and *practices stemming from multi-logics field*- and suggests a recursive relationship between them. Fields characterized by multiple logics can both constrain and enable agency (Bertels & Lawrence, 2016; Reay & Hinings, 2009), who hold different structural positions and have asymmetric relations of power (Hinings & Greenwood, 1988; Bjerregaard & Jonasson, 2014; Greve & Zhang, 2017). Agency involves how actors search for new resources and means, or yet memberships with other social actors to reverse the imbalance relations of power established to respond to institutional demands in practices. Responses towards it, then, are not uniform (Goodrick & Salancik, 1996; Greenwood et al., 2011).

I argued that actors adopt practices within the institutional framework guiding them and that the relations of power established between different actors affect this choice within the multi-logics they are inserted into. By implication, the agency's impacts on standard practices are greatest when relations of power are configurated as imbalanced. In this case, actors enacted strategic acts of mobilization in order to balance their dependence and enforce their preferences. On the other hand, when relations of power are configurated as balanced, the agency expressed a confined role, being more likely to enact reinforcing practices.

I further summarized this in Figure 21. As can be seen from it, relations of power shape the adoption of different practices, which in turn affect the dynamics of the multi-logics field. The variation of practice incorporates or not mobilizing acts of power, depending on how the relations of power are manifested and perceived between actors, which consequently motivates or demotivates agency. The variations in practices enactment by actors have a consequential effect on the dynamic of multi-logics field, enabling to engender stabilizing or destabilizing effects.

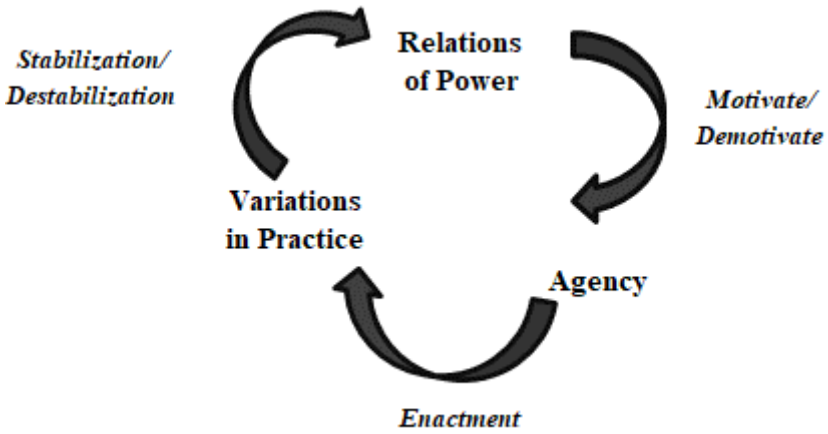


*Figure 21.* The interplay between relations of power, agency and practice

Consequently, looking across these findings, I extend Besharov and Smith' (2014) work by suggesting it as a dynamic model, illustrated in Figure 22. Despite we can classify the typology of multiple logics within a quadrant, I argue that such classification is not static, but subject to change over time. Also, I argue that this likely dynamic is moderated by relations of power between the actors inside the field. Depending on how the interplay exposed in Figure 21 is expressed, we can have different configurations of the logics' relationship along time. The circle of arrows in the midst of power relations seeks to represent Figure 21 acting in the quadrants' typology.

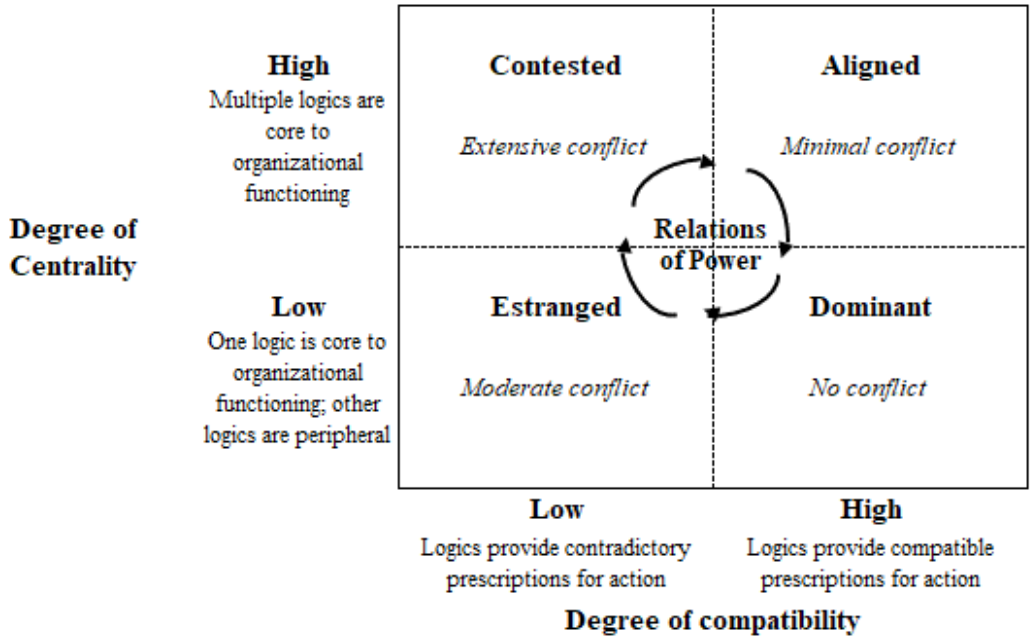


*Figure 22.* The interplay between types of logic multiplicity and relations of power

The role that relations of power can take on can also affect the resulting enactment of practices in the field. My study suggests that as practices take on different configurations, and engender different effects - reinforcing and disruptive, they connect the multiple logics relationship to different stabilizing or destabilizing mechanisms that consequently affect the basis for their institutionalization. The relations of power within the maternity field in Brazil, for instance, presented higher asymmetries that surfaced more easily incompatibilities between logics, i.e. birth as a medical event versus a natural process. The agency-driven response of the actors in return may lead to a situation in which new models of birth start to emerge, underpinning the conflict scenario and gradually disturbing the configuration of the field. Different cases are spread within it, tending to destabilizing mechanisms. In contrast, balanced relations of power mediating practice enactment in England hindered incompatibilities between logics and embed possible inconsistencies and asymmetries in the routine care and taken-for-

granted practices, inhibiting agency to act outside the pattern. Variations in practice then, revolved around reinforcing effects that provoked stabilizing mechanisms.

In closing, relations of power work as trigger both to instability and stability of institutional demands. Institutional demands influence actors' perception to experience it as natural and unquestionable. Such experience renders possible incompatibilities to be imperceptible. Through the empirical cases, I argued that such influence undergoes the interpretation of actors that are affected by the relations of power established with other actors they were involved. Relations of power can sometimes interfere and break the blinders imposed on actors by such institutional demands. Depending on how power is manifest, it may facilitate a change of actor's awareness, or as stated by McCarthy and Moon (2018), consciousness-raising, that may motivate them to transform these relations and, consequently, how institutional demands are instantiated as to supply their preferences too. As a result, this help in the understanding why there is a heterogeneity of practices in multi-logics field and the conditions it arises (Besharov & Smith, 2014).

# 7 CONCLUSION

In this study, I have explained the heterogeneous ways in which multiple institutional logics are instantiated as a dynamic interplay between relations of power and practices. These two separate components of institutionalization are interrelated. As so, a conception and empirical investigation of institutional multiplicity should include them both. In so doing, I explored in this research the variation in how maternity practices in Brazil and in England are enacted from multiple logics and the role of relations of power in shaping this variation. By examining a field which is well-recognized by being a contested domain, the maternity field, my study confirmed that relations of power affect how actors translate the practices and consequently respond to multi-logics, either by maintaining the field's configuration or looking for new and creative alternatives, consequently heading reinforcing and disruptive effects respectively.

Focusing just on practices and multi-logics field would portray an incomplete vision of how institutional demands are translated and instantiate by actors. We might incur the risk to portray actors as just recipients who process and respond to institutional stimulus from a macro perspective, lacking to explain how conflicts are resolved at the micro-level (Cloutier & Langley, 2013). Instead, when focusing on the influence of the relations of power on the interplay between them could we appreciate the mutual relationship linking individual and macro prescriptions affecting the institutionalization basis of the field through cross-level interaction effects (Thornton, Ocasio, & Lounsbury, 2012; Bertels & Lawrence, 2016; Micelotta, Lounsbury, & Greenwood, 2017).

Furthermore, acknowledging the role of actors as not only institutional carriers (Zilber, 2002), but as also invested by agency, subject to strategic choice (Cloutier & Langley, 2013; Ocasio & Radoynovska, 2016) who not only can react but also disrupt and diverge in responses, and the political dynamic involved within these processes, were all crucial for understanding the variation presented in multi-logics fields. Thus, in this last section, I aimed to summarize some valuable contributions that this study makes, explore some implications for future researches and point the limitations within it.

Initially, by looking at the relationship between multi-logics field and maternity practices in the two sites, the empirical findings evidence a typology of practices to different kinds of institutional multiplicity: embedding and routinizing, enabling work, valorising and dissuasion, policing, educating, reframing, and constructing networks, inspired from previous researches. This group of practice confirms them (Bertels & Lawrence, 2016; Reay et al.,

2013a; Currie, Locket, Finn, Martin, & Waring, 2012; Pache & Santos, 2010; Lawrence & Suddaby, 2006; Oliver, 1991) in showing different ways actors interpret and respond to institutional prescripts. Variations in practices involved material and discursive nature, aligned with Bertels and Lawrence (2016)'s study, and variation of meanings, as pointed by Zilber (2002).

It also extends these researches by evidencing different effects resulting from these practices. As described in the two sites, similar practices embedded in different wider meanings systems can implicate different outcomes. Similar practices can both lead to reinforcing or disrupting effects in the configuration of multiple logics within the maternity field, as the case of policing and educating practices, contrasting to previous studies that attached a practice to a single effect (Currie, Locket, Finn, Martin, & Waring, 2012; Lawrence & Suddaby, 2006). Thus, our practice classification complements the set of practices adopted in response to institutional multiplicity and shows that actors creatively develop different practices in order to align with the institutional logic they represent. Such efforts involve not only the development of new practices, such as adopting a birth plan in the next pregnancies, as found in the Brazil site but also the infusion of new meanings in the same practices, such as reframing practices. This practice, for example, also identified in Brazil, shows how actors employ other tactics to respond to competing logics to improve their compatibility. Reframing the importance of normal birth for women to become a mother, for instance, makes this practice more legitim over the remains, which facilitate the efforts actors made to increase alignment with other less dominant logics and ensure its instantiation, i.e. the natural logic in Brazil.

Additionally, analysing the variation of meanings within the same practices, the second implication concerns the relationship between practices and institutional logics. My study builds on pivotal studies that describe practices as an incarnation (Haveman & Rao, 1997) or actualization (Friedland et al., 2014) of institutional logics. Nonetheless, in contrast to Haveman and Rao (1997), my study shows that even though practices give form to an institutional logic, and reflect its materialization, they are not restricted to it, being able to decouple. In other words, I argue that there is a fluidity of practice. The wider meaning system in which they are embedded is also impacting, in a way that similar practices can flow from one logic to another depending on the meanings they were constructed and how actors interpreted them. Practices are not restricted to a particular logic, but their symbolic values may vary depending on how they are translated in regard to logics. As pointed by Hallett and Ventresca (2006), meanings arise through social interaction. Hence, my findings suggest that cognition plays an important role in connecting or disconnecting logics and practices and future

researches can benefit from sensemaking (Thornton, Ocasio, & Lounsbury, 2012). I suggest, then, studies that look at how actors construct the meanings of practices in ways to connect or disconnect them to institutional logics.

Another important implication of my study is that variations in practice are contingent on relations of power. It may be understood as a result of social interaction and negotiation processes that are shaped by a recursive interplay between relations of power between actors and the configuration features of field expressing different relationships between multiple logics. While a symbolic identification propels institution arrangements, leading by satisfaction or dissatisfaction with preferences, it is also the relative abilities of actors to express and protect those meanings and interests that constitute an important piece in understanding the resulting outcomes (Hinings & Greenwood, 1988), a role of power.

In the discussion of power, Lawrence (2008) argues that a better approach to address it is to integrate how institutions and actors relate to each other in terms of power relations, including institutional control, agency and resistance. My study built on these ideas suggesting that including political dynamics may provide a more complete understanding of how institutional logics may diverse in their instantiation, given that actors are provided with higher orders -institutional control- but they also produce justifying accounts and negotiate what is legitimate or not - institutional agency- (Cloutier & Langley, 2013; Thornton, Ocasio, & Lounsbury, 2012). My argument that asymmetries of power make it more likely the enactment of disruptive practices is in line with Seo and Creed (2002) that incompatibilities trigger instability and that, as raised by Suddaby and Greenwood (2005), change results from how new alternatives, in terms of practices and values, are deemed appropriate, motivating agency.

Thus, I explored the link of power asymmetries to disruptive practice as an engine of institutional instability that can lead both to potential change, as new practices developed in birth, or the creation of new institutional arrangements, such as a new model of birth – humanized birth, increasingly growing in Brazil, both from an increase role of agency. On the other hand, power symmetries are linked to reinforcing practices, that act as a stabilizer, maintaining the current institutional configuration and demotivating agency to act. This study, then, expands the boundaries of research on the multi-logics field to show how responses to institutional multiplicity in a field are contingent on relations of power between actors in the field. Relations of power either exacerbate or mitigate the incompatibilities between multiple logics in a field (Besharov & Smith, 2014; Greenwood et al., 2011), interfering into the valuation of how actors experience and perceive such incompatibilities.

In this context, my research also highlights the importance of some power resources, especially mental resources – information-, as a key input to break through blinders imposed by power imbalance and, consequently, incompatibilities between logics. Information was found in Brazil as the main responsible for making women aware of their deprivileged position in the field and lack of ability to give voice to her logic (Greenwood et al., 2011). Consequently, this stimulated them to rupture actual arrangements through acts of power (Lawrence, Winn, & Jennings, 2001). In many cases, the lack of capacity of women to perceive institutional logics' contradictions foster by imbalance relations of power was due to hegemony of knowledge and power of obstetrical practice by physicians, corroborating with the studies of Freire and colleagues (2011) and Hopkins (2000). Information motivated women to disrupt the patterned of care and find creative ways to enforce a new one with their preferences being met.

In consonance with that, this study also has implications for the focus of individual-level on institutional logics perspective. The perspective of institutional logics has given the agency little space in institutional processes such as maintenance, creation and change. Usually, the focus was on the process of conformity generated by institutional demands with agency expressed through "hypermuscular acts" of deviations from those prescriptions. Within the institutional theory, individuals are not granted much freedom to choose amongst logics or deviate from them (Bévort and Suddaby, 2015:17). Thus, the study contributes not only to showing individual choices in regards to the multiplicity of logics but also to how they creatively react to power asymmetries in order to be able to enforce their logics. This reaction consists both from major actions, as legally registering a birth plan and threating health professionals if they do not follow it, or through smaller actions, such as deceiving and lying to family members and professionals.

Hence, my research contributes to disclose agency from only these hypermuscular actions (Bévort and Suddaby, 2015) of institutional entrepreneurship as capable to disrupt institutions. It evidences that minor practices can also engender disruptive effects, especially when they are disclosed through social networks which, by being spread within other actors, reinforce its institutionalization and, consequently, gradually impact in maintenance, creation and change processes. Thus, I also encourage future researches to be more interpretative and adopt methods that engage this micro process, evaluate the symbolic aspects and capture the interaction and negotiation unfolding of the actors, so we can embrace their understandings and consequent influence.

Furthermore, my study broadens the understanding of institutional complexity in organization studies, showing that it can manifest in long-term occurrences and be expressed

differently amongst actors, not necessarily resulting in substitution (Thornton & Ocasio, 1999; Dunn & Jones, 2010). In England, for example, where institutional logics are more compatible, actors manage to instantiate and respond primarily to natural logic, as the dominant one- and only address the medical logic in situations where uncertainty is higher. So, while it may create some short-term inconsistencies, when both are instantiated and are in conflict, addressing each one to specific situations benefits the complexity of the field to coexist on an ongoing basis. On the other hand, in Brazil, where the compatibility between logics is lower, we could notice that the natural logic is portrayed differently by the obstetricians, presenting different levels of incompatibilities between maternity logics. While some health professionals construct natural logic complementary to the medical logic, similar to what we found in England, in others they were expressed in a more contrasting way. This highlights not only the variation in practices, as previously discussed but also the potential for institutional logics to be instantiated differently among actors both reinforcing the conflicts unfolded from such institutional complexity and institutionalizing the creation of new arrangements, such as the model of birth. Thus, in this case, institutional complexity can also generate benefits. With the humanized birth, we notice the construction of a new market, new facilities (birth centres), new consumption practices, and new actors to inhabit it (Picheth & Crubellate, 2019). Therefore, again, whereas, usually the scope of institutional complexity studies is on the tensions involved, my research broadens by evidencing complementary and benefits caused by it.

Additionally, I also believe that the findings offer important implications for institutional change. Looking at the Brazilian site, especially, the scenario of new rules and regulations related to childbirth, it evidences that disruptive processes originated mostly from a bottom-up movement, instead of the opposite. Many of these regulatory actions resulted from women's initiatives that demand institutional enforcement. The very veto of the term obstetric violence by CFM, which was later withdrawn, was very much due to the manifestation of the actors, mostly within social media, later generating action by the Public Ministry. In this context, we can also acknowledge the importance of social networks as a key agent of this change process. They act as drivers to spread new institutional arrangements, the humanized birth and to facilitate the distancing of women from many taken-for-granted assumptions connected to the medical logic in order to embrace and demand novel ways to delivery.

Finally, my study also contributes to practical implications by offering subsidies for a deeper reflection on fostering improved maternity care. Given the relevance of the empirical setting, the findings help to enhance the health care in both countries, but especially in Brazil, as its scenario is portrayed as a public health problem and women were found with asymmetric

power relation with health professionals. Comparing it with the English system helped to comprehend the Brazilian scenario and the barriers imposed to change its care. Although we could observe the decree of public and private policies, governmental initiatives and investments made to decrease the incidence of caesarean-sections, we found a loose enforcement system. Still, medical logic posits this surgery as a safe and uncertainty-free mode of delivery, making it a truly legitim option of birth, both in contrast to England. These aspects help to understand the inefficiency of those policies and regulations in changing maternity care.

On the other hand, we could also notice a great desire and efforts made from mothers to vaginally deliver, with high motivation to exercise their agency role. Additionally, still in comparison with England, we could also observe the role of midwives and birth centres as key to facilitating normal birth, with similar importance identified in Brazil too, although with limited scope due to medical hierarchy. So, I believe that regulatory institutions, rather than focusing on policies which lack further enforcement and may be barred by the influence of the medical logic, thus, proven to be ineffective, they should prioritize influencing these actors – women - by supporting the midwifery legitimacy as care providers; providing better and new spaces focused on normal birth, with infrastructure that enable it, such as the birth centres and specific equipment (birth ball, bath, shower, birthing chair, padded flooring); encouraging the opening and operation of support groups; supporting and legitimizing the role of doulas in birth assistance; and especially improving information access to women through educating practices. These actions have proven to be highly effective in the England site and made the difference for women in Brazil to have better birth experiences, giving support to be encouraged and widespread in the country.

While I believe my research makes important contributions, it also has some limitations. First, although I trust the empirical case offers an excellent setting in which to examine the theoretical questions, being adequate to capture the multiplicity of logics and power issues and also having great relevance for practical implications, it is also quite unusual. In particular, the Brazil site is very rich in offering a discrepancy of childbirth models worldwide, but for this reason, on the other hand, it is very atypical in comparison to other countries and may influence and limit the findings. It is important, therefore, to examine other cases and compare to other countries where such discrepancy may be limited. Yet, I further suggest comparing cases within the same quadrant of the typology of logics' multiplicity (Besharov & Smith, 2014).

Second, I believe the groups of mothers I interviewed in each country presented some imbalance. In Brazil, I focused on interviewing women cross over the country, approaching at least one mother from each region. In England, due to time and resources constraints,

interviews were concentrated in the county of Oxfordshire. Only two interviews were related to birth experiences in other counties, one in Greater London and other in Buckinghamshire. So, while attempting to mitigate any possible divergence or peculiarity addressed to a specific county by triangulating the interviews with survey data, which covered 83% of the counties, some difference in the findings may also have impacted. Moreover, the fact that this research is empirically cross-sectional, although with a longitudinal perspective, limits the scope of analysis, especially to verify more deeply processes of maintenance, change and creation. I tried to mitigate such limitation by adopting the longitudinal perspective mainly in the documentary data and in the comparison between the first and other pregnancies or expectations for the next, however, I am aware that it still limits further findings.

Finally, I also would like to point that the fact of dealing with health care posits a lot of challenges, especially ones that involve life-threating cases. This research, however, did not analyse the medical evaluation of each case, such as the risks involved and medical indications, given it was not the focus here or my background formation. So, despite I know that depending on the gravity of the case, it may change the conduct, my focus was not capturing the correct or appropriate medical conduct in each case, which would probably be more suitable for a medicine research, but to capture how actors act in similar situations, unfolding the practices adopted and the symbolic and power issues involved. And from that, comprehend how these situations were experienced by themselves and in relation to others involved.

Considering all that, an important direction for future research would be to adopt broader cases both including other countries and other fields, thus, bringing a greater diversity of the effects of relations of power in multi-logics fields with different types of field and of institutional logics multiplicity. In the first case, it seems valued to especially compare countries that present the same type of logics multiplicity and also between different types of multiplicity not addressed by this study (aligned and estranged). While in the second case, it would be important to analyse if differences are found when involving not such atypical empirical settings as mine, i.e. other types of fields. Lastly, as part of the findings observed a significant influence of social groups on the mobilization of political and regulatory actions, future researches would benefit for including a cross-level analysis looking also to a meso level of impact, that is, how can societal groups unfold institutional changes.

In concluding, I argue in this doctoral dissertation that multi-logics field may become vulnerable to further change and disruption if institutional practices are associated with asymmetries of power between actors. In those cases, similar practices may be associated with different meanings that reflect contrasting effects as a result, engendering stabilization or

destabilization mechanisms. When actors start to question the natural condition of things and reframe practices connected to peripheral logics, a dynamic change may occur. In contrast, the continuous promulgation of practices and meanings associated with symmetries of power reinforces and maintains institutional arrangements, taking routines as taken-for-granted and not conceiving other alternatives. This does not imply, on the other hand, that current configuration of multi-logics field tends toward equilibrium, rather, that there is a tendency to maintenance through stabilization mechanisms driven by reinforcing practices.

**REFERENCES**

Almandoz, J. (2014). Founding teams as carriers of competing logics: When institutional forces predict banks' risk exposure. *Administrative Science Quarterly*, 59(3), 442-473.

Almeida, M. (2017). Justiça reafirma que cobrança de taxa extra pelo parto é ilegal. *Exame*. Retrieved from: https://exame.abril.com.br/seu-dinheiro/justica-reafirma-que-cobranca-de-taxa-extra-pelo-parto-e-ilegal/

Amis, J. M., Munir, K. A., Lawrence, T. B., Hirsch, P., & McGahan, A. (2018). Inequality, institutions and organizations. *Organization Studies*, 39(9), 1131-1152.

ANS. Agência Nacional de Saúde Suplementar. (2007). Resolução Normativa n.167, de 9 de janeiro de 2007. *Agência Nacional de Saúde Suplementar*. Retrieved from: http://www.ans.gov.br.

ANS publica resolução para estimular parto normal na saúde suplementar. (2015). *Agência Nacional de Saúde Suplementar*, Rio de Janeiro, 06 Jan. 2015. Retrieved from: http://www.ans.gov.br/aans/noticias-ans/consumidor/2718-ministerio-da-saude-e-ans-publicam-resolucao-para-estimular-parto-normal-na-saude-suplementar.

Após recomendação do MPF, Ministério da Saúde reconhece liberdade do uso do termo violência obstétrica. (2019). *Ministério Público Federal*. São Paulo. Retrieved from: http://www.mpf.mp.br/sp/sala-de-imprensa/noticias-sp/apos-recomendacao-do-mpf-sp-ministerio-da-saude-reconhece-liberdade-do-uso-do-termo-violencia-obstetrica.

Atualização das taxas partos na saúde suplementar. (2015). *Agência Nacional de Saúde Suplementar*. Rio de Janeiro. Retrieved from: http://www.ans.gov.br.

Avelino, F., & Rotmans, J. (2009). Power in transition: an interdisciplinary framework to study power in relation to structural change. *European Journal of Social Theory*, 12(4), 543-569.

Barrett, M., Oborn, E., Orlikowski, W. J., & Yates, J. (2012). Reconfiguring boundary relations: Robotic innovations in pharmacy work. *Organization Science*, 23(5), 1448-1466.

Barros, A.J.D. et al. (2011). Patterns of deliveries in a Brazilian birth cohort: almost universal cesarean sections for the better-off. *Revista de Saúde Pública*, 45(4), 635-643.

Battilana, J., & Dorado, S. (2010). Building sustainable hybrid organizations: The case of commercial microfinance organizations. *Academy of Management Journal*, 53(6), 1419-1440.

Battilana, J., Besharov, M., & Mitzinneck, B. (2017). On hybrids and hybrid organizing: A review and roadmap for future research. In: Greenwood, R., Oliver, C., Lawrence, T.,

Meyer, R. (Eds.). *The Sage handbook of organizational institutionalism*. Sage, 2, 128-162.

Bertels, S., & Lawrence, T.B. (2016). Organizational responses to institutional complexity stemming from emerging logics: The role of individuals. *Strategic Organization*, 14(4), 336-372.

Besharov, M.L., & Smith, W.K. (2014). Multiple institutional logics in organizations: Explaining their varied nature and implications. *Academy of Management Review*, *39*(3), 364-381.

Betrán, A. P. et al. (2007). Rates of caesarean section: Analysis of global, regional and national estimates. *Paediatric and Perinatal Epidemiology*, 21(2), 98-113.

Betrán, A.P. et al. (2015). What is the optimal rate of caesarean section at population level? A systematic review of ecologic studies. *Reproductive Health*, 12(57), 1-10.

Betrán, A. P. et al. (2016). The increasing trend in caesarean section rates: Global, regional and national estimates: 1990-2014. *PloS ONE*, 11(2), 1-12.

Bévort, F., & Suddaby, R. (2016). Scripting professional identities: How individuals make sense of contradictory institutional logics. *Journal of Professions and Organization*, 0, 1-22.

Binder, A. (2007). For love and money: Organizations' creative responses to multiple environmental logics. *Theory and Society*, 36, 547-571.

Bjerregaard, T., & Jonasson, C. (2014). Organizational responses to contending institutional logics: The moderating effect of group dynamics. *British Journal of Management*, 25(4), 651-666.

Blower, A. P. (2019). MPF contesta resolução que dá autonomia a médicos contra vontade das grávidas. *O Globo*. Retrieved from: https://oglobo.globo.com/sociedade/mpf-contesta-resolucao-que-da-autonomia-medicos-contra-vontade-das-gravidas-23981096.

Bourdieu, P. (1989). *O poder simbólico*. Rio de Janeiro: Bertrand Brasil.

Bourdieu, P. (2007). *A Economia das trocas simbólicas*. São Paulo: Perspectiva.

Brasil. (2001). Ministério da Saúde. Parto, aborto e puerpério: assistência humanizada à mulher. Brasília: Ministério da Saúde.

Brasil. (2005a). Presidência da República. Lei n.11.108, de 7 de abril de 2005. Brasília. Retrieved from: http://www.planalto.gov.br.

Brasil. (2005b). Presidência da República. Portaria MS/GM n.2.418, de 2 de dezembro de 2005. Brasília. Retrieved from: http://www.saude.mppr.mp.br.

Brasil. (2012). Ministério da Saúde. Cadernos de Atenção Básica: Atenção ao pré-natal de baixo risco. Brasília: Editora do Ministério da Saúde.

Brasil. (2015). Presidência da República. Resolução normativa n.368, de 6 de janeiro de 2015. Brasília. Retrieved from: http://www.ans.gov.br.

Brasil. (2016). Presidência da República. Resolução normativa n.398, de 5 de fevereiro de 2016. Brasília. Retrieved from: http://www.ans.gov.br.

Bryman, A. (1989). *Research methods and organization studies.* New York: Routledge.

Bryman, A. (2012). *Social research methods*. New York: Oxford University Press.

Caesarean sections (2002). Postnote No. 184. London: Parliamentary Office of Science and Technology. Retrieved from: https://www.parliament.uk/documents/post/pn184.pdf.

Cain, C. L. (2019). Agency and change in healthcare organizations: Workers' attempts to navigate multiple logics in hospice care. *Journal of Health and Social Behavior*, 60(1), 3-17.

Cancian, N. (2019). Ministério da Saúde veta uso do termo 'violência obstétrica'. *Folha de São Paulo*, 07 mai. 2019. Retrieved from: https://www1.folha.uol.com.br/amp/cotidiano/2019/05/ministerio-da-saude-veta-uso-do-termo-violencia-obstetrica.shtml.

Carstensen, M. B., & Schmidt, V. A. (2016). Power through, over and in ideas: Conceptualizing ideational power in discursive institutionalism. *Journal of European Public Policy*, 23(3), 318-337.

Casciaro, T. & Piskorski, M. J. (2005) Power imbalance, mutual dependence, and constraint, absorption: a close look at resource dependence theory, Administrative Science Quarterly, 50(2): 167-199.

Cervo, A. L., & Bervian, P. A. (1996). *Metodologia Científica.* São Paulo: Makron Books.

CFM. Conselho Federal de Medicina. (2016). Resolução n.2.144, de 17 de março de 2016. *Diário Oficial da União*, n.118, seção 1, p.138. Retrieved from: http://pesquisa.in.gov.br/imprensa/jsp/visualiza/index.jsp?jornal=1&data=22/06/2016&pagina=138.

CFM. Conselho Federal de Medicina (2019). Resolução n. 2.232, de 17 de julho de 2019. *Diário Oficial da União*, n.179, seção 1, p.113. Retrieved from: http://www.in.gov.br/en/web/dou/-/resolucao-n-2.232-de-17-de-julho-de-2019-216318370.

Chade, J. (2018). Com novas recomendações, OMS tenta frear explosão de cesáreas. *O Estado de S. Paulo*. Retrieved from: https://saude.estadao.com.br/noticias/geral,com-novas-recomendacoes-omstenta-frear-explosao-de-cesareas,70002190283

Child, J. (1972). Organizational structure, environment and performance: The role of strategic choice. *Sociology*, 6(1), 1-22.

Clegg, S., Courpasson, D. & Phillips, N. (2006) Power and Organizations, London: Sage.

Clemens, B. W., & Douglas, T. J. (2005). Understanding strategic responses to institutional pressures. *Journal of Business Research*, 58(9), 1205-1213.

Cloutier, C., & Langley, A. (2013). The logic of institutional logics: Insights from French pragmatist sociology. *Journal of Management Inquiry*, 22(4), 360-380.

CNDH. Conselho Nacional dos Direitos Humanos (2019). Recomendação nº05, de 09 de maio de 2019. Brasília. Retrieved from: https://www.mdh.gov.br/informacao-ao-cidadao/participacao-social/conselho-nacional-de-direitos-humanos-cndh/Recomendao1MP870CONSEA.pdf.

Cofen apoia a manutenção do termo "violência obstétrica". (2019). *Conselho Federal de Enfermagem*, 8 mai. 2019. Retrieved from: http://www.cofen.gov.br/cofen-apoia-a-manutencao-do-termo-violencia-obstetrica_70783.html.

Colyvas, J. A., & Jonsson, S. (2011). Ubiquity and legitimacy: Disentangling diffusion and institutionalization. *Sociological Theory*, 29(1), 27-53.

Colyvas, J. A., & Maroulis, S. (2015). Moving from an exception to a rule: Analyzing mechanisms in emergence-based institutionalization. *Organization Science*, 26(2), 601-621.

Comptroller and Auditor General (2013). Report on the Maternity Services in England. *National Audit Office*, HMSO, London.

Creswell, J. W. (2007). *Projeto de pesquisa:* métodos qualitativo, quantitativo e misto. 2.ed. Porto Alegre: Artmed.

Currie, G., Lockett, A., Finn, R., Martin, G., & Waring, J. (2012). Institutional work to maintain professional power: Recreating the model of medical professionalism. *Organization Studies*, 33(7), 937-962.

Currie, G., & Spyridonidis, D. (2016). Interpretation of multiple institutional logics on the ground: Actors' position, their agency and situational constraints in professionalized contexts. *Organization Studies, 37*(1), 77-97.

Dahl, R.A. (1957). The concept of power. *Behavioral Science,* 2(3): 201-215.

Davis, A. (2012). *Modern motherhood:* Women and family in England, c. 1945–2000. New York: Oxford University Press.

Davis-Floyd, R. (2001). The technocratic, humanistic, and holistic paradigms of childbirth. *International Journal of Gynecology & Obstetrics*, 75, S5-S23.

Dias, J. F. (2007). *O renascimento do parto*: discurso e identidade. Tese de doutorado, Programa de Pós-Graduação em Linguística, Universidade de Brasília, Brasília, Brasil.

Dias, M. A. B. et al. (2008). Trajetória das mulheres na definição pelo parto cesáreo: Estudo de caso em duas unidades do sistema de saúde suplementar do estado do Rio de Janeiro. *Ciência & Saúde Coletiva,* 13(5), 1521-1534.

DiMaggio, P.J. & Powell, W.W. (1983) The Iron Cage revisited: institutional isomorphism and collective rationality in organizational fields, *American Sociological Review*, 48(2): 147-160.

DiMaggio, P. I. 1988. Interest and agency in institutional theory. In L. G. Zucker (Ed.), *Institutional patterns and organizations:* Culture and environment, 3-22. Cambridge, MA: Ballinger.

Diniz, C. S. G. (2005). Humanização da assistência ao parto no Brasil: os muitos sentidos de um movimento. *Ciênc Saúde Coletiva,* 10(3), 627-37.

Domingues, R. M. S. M., et al. (2014). Processo de decisão pelo tipo de parto no Brasil: da preferência inicial das mulheres à via de parto final. *Cadernos de Saúde Pública, 30,* S101-S116.

Driscoll, D. L., Appiah-Yeboah, A., Salib, P., & Rupert, D. J. (2007). Merging qualitative and quantitative data in mixed methods research: How to and why not. *Ecological and Environmental Anthropology*, 3(1), 19-28.

Duarte, F. L. (2015). *Identidades e empoderamento:* Grupo Maternati e a humanização do parto na cidade de Maringá. Dissertação de mestrado, Programa de Pós-Graduação em Ciências Sociais, Universidade Estadual de Maringá, Maringá, Brasil.

Duflo, E., & Saez, E. (2003). The role of information and social interactions in retirement plan decisions: Evidence from a randomized experiment. *The Quarterly Journal of Economics*, 118(3), 815-842.

Dunn, B., & Jones, C. (2010). Institutional logics and institutional pluralism: the contestation of care and science logics in medical education 1967–2005. *Administrative Science Quarterly*, 55, 114–149.

Durand, R., Szostak, B., Jourdan, J., & Thornton, P. H. (2013). Institutional logics as strategic resources. In: *Institutional Logics in Action, Part A*, 39A, 165-201. Emerald Group Publishing Limited.

Eisenhardt, K. M. (1989). Building theories from case study research. *Academy of Management Review*, 14(4), 532-550.

Emerson, R.M. (1962) Power-dependence relations, *American Sociological Review*, 27(1): 31-41.

Etzioni, A. (1964). *Modern organizations*. Englewood Cliffs, NJ: Prentice-Hall.

Fatima, S. S., Wooldridge, M., & Jennings, N. R. (2002). The influence of information on negotiation equilibrium. *Lecture Notes in Computer Science*, 180-193.

Faúndes, A., & Cecatti, J. G. (1991). A operação cesárea no Brasil: incidência, tendências, causas, consequências e propostas de ação. *Cadernos de Saúde Pública*, 7(2), 150-173.

Faúndes, A. et al. (2004). Opinião de mulheres e médicos brasileiros sobre a preferência pela via de parto. *Rev. Saúde Pública*, 38(4), 488-494.

Feldman, M. S., & Orlikowski, W. J. (2011). Theorizing practice and practicing theory. *Organization Science*, 22(5), 1240-1253.

Felix, P. (2016). Parto humanizado: 'A dor faz parte, mas a sensação final é mágica'. *O Estado de S. Paulo*, 07 de abril de 2016. Retrieved from: https://saude.estadao.com.br/noticias/geral,a-dor-faz-parte--mas-a-sensacao-final-e-magica--diz-mulher-que-optou-pelo-parto-humanizado,10000025186.

Fetters, M. D., Curry, L. A., & Creswell, J. W. (2013). Achieving integration in mixed methods designs—principles and practices. *Health Services Research*, 48(6pt2), 2134-2156.

Field, A. (2005). *Discovering statistics using SPSS*:(and sex, drugs and rock'n'roll). 2nd edition. Sage.

Finkelstein, S. (1992). Power in top management teams: Dimensions, measurement, and validation. *Academy of Management Journal*, 35(3), 505-538.

Frasão, G. (2016). Ministério lança protocolo com diretrizes para parto cesariana. *Portal da Saúde – Ministério da Saúde.* 06 abr. 2016. Retrieved from: http://portalsaude.saude.gov.br/index.php/o-ministerio/principal/secretarias/sas/saude-da-mulher/noticias-saude-da-mulher/23000-ministerio-lanca-protocolo-com-diretrizes-para-parto-cesariana.

Freire, N. C., Nunes, I. M., Almeida, M. S., & Gramacho, R. C. V. (2011). Parto normal ou cesárea? A decisão na voz das mulheres. *Revista Baiana de Enfermagem*, 25(3), 237-247.

Freitas, P. F. et al. (2005). Desigualdade social nas taxas de cesariana em primíparas no Rio Grande do Sul. *Revista de Saúde Pública*, 39(5), 761-767.

Friedland, R. (2014). Divine institution: Max Weber's value spheres and institutional theory. *Religion and Organization Theory*: Research in the Sociology of Organizations, 41, 217-258.

Friedland, R., & Alford, R. (1991). Bringing society back in: symbols, practices, and institutional contradictions. In: Powell, W., & DiMaggio, P. (Eds.). *The new institutionalism in organizational analysis.* Chicago: The University of Chicago Press, 232-263.

Friedland, R., Mohr, J., Roose, H., & Gardinali, P. (2014). The institutional logics of love: measuring intimate life. *Theory and Society*, 43(3-4), 333-370.

Giddens, A. (1984). *The constitution of society*. Berkeley: University of California Press.

Glynn, M. A., & Lounsbury, M. (2005). From the critics' corner: Logic blending, discursive change and authenticity in a cultural production system. *Journal of Management Studies*, 42(5), 1031-1055.

Goer, H. (2004). Humanizing birth: a global grassroots movement. *Birth*, 31(4), 308-314.

Goodrick, E., & Reay, T. (2011). Constellations of institutional logics: Changes in the professional work of pharmacists. *Work and Occupations*, 38(3), 372-416.

Goodrick, E., & Salancik, G. R. (1996). Organizational discretion in responding to institutional practices: Hospitals and cesarean births. *Administrative Science Quarterly*, 41, 1-28.

Green Jr, S. E. (2004). A rhetorical theory of diffusion. *Academy of Management Review*, 29(4), 653-669.

Green, Jr. S., Babb, M., & Alpaslan, C. (2008). Institutional Field Dynamics and the Competition Between Institutional Logics. *Management Communication Quarterly*, 22(1), 40-73.

Greenwood, R.; Hinings, C. R. (1996). Understanding radical organizational change: Bringing together the old and the new institutionalism. *Academy of Management Review*, 21(4), 1022-1054.

Greenwood, R., Suddaby, R., & Hinings, C. R. (2002). Theorizing change: The role of professional associations in the transformation of institutionalized fields. *Academy of Management Journal*, 45(1), 58-80.

Greenwood, R., & Suddaby, R. (2006). Institutional entrepreneurship in mature fields: The big five accounting firms. *Academy of Management Journal*, 49(1), 27-48.

Greenwood, R., Díaz, A. M., Li, S. X., & Lorente, J. C. (2010). The multiplicity of institutional logics and the heterogeneity of organizational responses. *Organization Science*, 21(2), 521-539.

Greenwood, R., Raynard, M., Kodeih, F., Micelotta, E., & Lounsbury, M. (2011). Institutional complexity and organizational responses. *Academy of Management Annals*, 5, 317-371.

Greenwood, R., Hinings, C., & Whetten, D. (2014). Rethinking institutions and organizations. *Journal of Management Studies*, 51(7), 1206-1220.

Greve, H. R., & Zhang, C. M. (2017). Institutional logics and power sources: Merger and acquisition decisions. *Academy of Management Journal*, 60(2), 671-694.

Griboski, R. A., & Guilhem, D. (2006). Mulheres e profissionais de saúde: o imaginário cultural na humanização ao parto e nascimento. *Texto e Contexto Enfermagem*, 15(1), 107-114.

Guetterman, T. C., Fetters, M. D., & Creswell, J. W. (2015). Integrating quantitative and qualitative results in health science mixed methods research through joint displays. *The Annals of Family Medicine,* 13(6), 554-561.

Gulati, R. & Sytch, M. (2007). Dependence asymmetry and joint dependence in interorganizational relationships: effects of embeddedness on manufacturers' performance in procurement relationships, *Administrative Science Quarterly*, 52(1). 32-69.

Hallett, T., Ventresca, M. (2006). Inhabited institutions: social interactions and organizational forms in Gouldner's Patterns of Industrial Bureaucracy. *Theory and Society*, 35(2), 213-236.

Harmon, D. J., Green Jr, S. E., & Goodnight, G. T. (2015). A model of rhetorical legitimation: The structure of communication and cognition underlying institutional maintenance and change. *Academy of Management Review*, 40(1), 76-95.

Haveman, H., & Rao, H. (1997). Structuring a theory of moral sentiments: Institutional and organizational coevolution in the early thrift industry. *American Journal of Sociology*, 102(6), 1606-1651.

Hinings, C., & Greenwood, R. (1988). *The dynamics of strategic change.* New York: Basil Blackwell.

Hoffman, A. J. (1999). Institutional evolution and change: Environmentalism and the US chemical industry. *Academy of Management Journal*, 42(4), 351-371.

Hopkins K. (2000). Are Brazilian women really choosing to deliver by cesarean? *Social Science & Medicine,* 51, 725-740.

HSCIC. Health & Social Care Information Centre. (2015). *NHS Maternity Statistics – England 2013-2014.* Retrieved from: http://www.gov.uk.

Jarzabkowski, P. (2004). Strategy as practice: recursiveness, adaptation, and practices-in-use. *Organization Studies*, 25(4), 529-560.

Jarzabkowski, P., Smets, M., Bednarek, R., Burke, G., & Spee, P. (2013). Getting institutional work to work: Generating actionable insights from a practice approach to institutional ambidexterity. In: Lounsbury, M. & Boxenbaum, E. (Eds.), *Institutional logics in action, Research in the Sociology of Organizations*, 39B, 349–373. New York: Emerald Press.

Kashwan, P. (2016). Integrating power in institutional analysis: A micro-foundation perspective. *Journal of Theoretical Politics*, 28(1), 5-26.

Kerlinger, F. N. (1980). *Metodologia da pesquisa em ciências sociais:* Um tratamento conceitual. São Paulo: EPU - Editora Pedagógica e Universitária.

Kim, T. Y., Shin, D., Oh, H., & Jeong, Y. C. (2007). Inside the iron cage: Organizational political dynamics and institutional changes in presidential selection systems in Korean universities, 1985-2002. *Administrative Science Quarterly*, 52(2), 286-323.

Lawrence, T. B. (2008). Power, institutions and organization. In: Greenwood, R., Oliver, C., Sahlin, K., & Suddaby, R. (Ed.). *The Sage handbook of organizational institutionalism*. Sage, 170-197.

Lawrence, T. B., Winn, M. I., & Jennings, P. D. (2001). The temporal dynamics of institutionalization. *Academy of Management Review*, 26(4), 624-644.

Lawrence, T. B., Mauws, M. K., Dyck, B., & Kleysen, R. F. (2005). The politics of organizational learning: integrating power into the 4I framework. *Academy of Management Review*, 30(1), 180-191.

Lawrence, T. B., & Suddaby, R. (2006) Institutions and institutional work. In: Clegg, S. R., Hardy, C., Lawrence, T. B., & Nord, W. R. (Eds.). *Sage Handbook of Organization Studies*, 2nd Edition: 215-254. London: Sage.

Lawrence, T., Suddaby, R., & Leca, B. (2011). Institutional work: Refocusing institutional studies of organization. *Journal of Management Inquiry*, 20(1), 52-58.

Lawrence, T. B., Malhotra, N., & Morris, T. (2012). Episodic and systemic power in the transformation of professional service firms. *Journal of Management Studies*, 49(1), 102-143.

Lawrence, T. B., & Dover, G. (2015). Place and institutional work: Creating housing for the hard-to-house. *Administrative Science Quarterly*, 60(3), 371-410.

Leal, M. C., & Gama, S. G. N. (2012). *Nascer no Brasil*: inquérito nacional sobre parto e nascimento. Rio de Janeiro: ENSP/Fiocruz.

Leblebici, H., Salancik, G. R., Copay, A., & King, T. (1991). Institutional change and the transformation of interorganizational fields: An organizational history of the US radio broadcasting industry. *Administrative Science Quarterly*, 333-363.

Lee, M., & Lounsbury, M. (2015). Filtering Institutional Logics: Community Logic Variation and Differential Responses to the Institutional Complexity of Toxic Waste. *Organization Science*, 26(3), 847-866.

Lefsrud, L. M., & Meyer, R. E. (2012). Science or science fiction? Professionals' discursive construction of climate change. *Organization Studies*, 33(11), 1477-1506.

Leibel, E., Hallett, T., & Bechky, B. A. (2018). Meaning at the source: The dynamics of field formation in institutional research. *Academy of Management Annals*, 12(1), 154-177.

Lewis, J. (2003). Design Issues. In: Ritchie, J., & Lewis, J. (Ed.). *Qualitative research guide:* a guide for social science students and researchers. Sage, 47-76.

Lok, J. (2010). Institutional logics as identity projects. *Academy of Management Journal*, 53(6), 1305-1335.

Lounsbury, M. (2002). Institutional transformation and status mobility: The professionalization of the field of finance. *Academy of Management Journal*, 45(1), 255-266.

Lounsbury, M. (2007). A Tale of Two Cities: Competing Logics and Practice Variation in the Professionalizing of Mutual Fund. *Academy of Management Journal*, 50, 289-307.

Lounsbury, M., & Boxenbaum, E. (2013). Institutional logics in action. *Research in the Sociology of Organizations*, 39, 3-22.

Lukes, S. (1974). *Power:* A radical view. London: The Macmillan Press.

Lynch, M., & Mah, C. (2017). Using internet data sources to achieve qualitative interviewing purposes: A research note. *Qualitative Research*, 1-12.

Maguire, S., Hardy, C., & Lawrence, T. B. (2004). Institutional entrepreneurship in emerging fields: HIV/AIDS treatment advocacy in Canada. *Academy of Management Journal*, 47(5), 657-679.

Mannix, E. A., & Neale, M. A. (1993). Power imbalance and the pattern of exchange in dyadic negotiation. *Group Decision and Negotiation*, 2, 119–133.

Mare, A. (2017). Tracing and archiving 'constructed' data on Facebook pages and groups: Reflections on fieldwork among young activists in Zimbabwe and South Africa. *Qualitative Research*, 1-19.

Marquis, C., & Lounsbury, M. (2007). Vive la résistance: Competing logics and the consolidation of US community banking. *Academy of Management Journal*, 50(4), 799-820.

Maxwell, J. A. (1996). *Qualitative research design:* An interactive approach (Vol. 41). Sage Publications.

McCarthy, L., & Moon, J. (2018). Disrupting the gender institution: Consciousness-raising in the cocoa value chain. *Organization Studies*, 39(9), 1153-1177.

McPherson, C., & Sauder, M. (2013). Logics in Action: Managing Institutional Complexity in a Drug Court. *Administrative Science Quarterly*, 58(2), 165-196.

Mendonça, A.P. (2015). Saúde pública e saúde privada. *O Estado de São Paulo*. Retrieved from: https://economia.estadao.com.br/noticias/geral,saude-publica-e-saude-privada,1618631.

Mendoza-Sassi, R. A. et al. (2010). Risk factors for cesarean section by category of health service. *Revista de Saúde Pública,* 44(1), 80-89.

Meyer, J. W., & Rowan, B. (1977). Institutionalized organizations: Formal structure as myth and ceremony. *American Journal of Sociology*, 83(2), 340-363.

Micelotta, E., Lounsbury, M., & Greenwood, R. (2017). Pathways of institutional change: An integrative review and research agenda. *Journal of Management*, 1-26.

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis:* An expanded sourcebook. Thousand Oaks: Sage.

Ministério da Saúde (2001). *Parto, aborto e puerpério*: Assistência humanizada à mulher. Brasília: Ministério da Saúde.

MPF – Ministério Público Federal. (2010). *Ação Civil Pública.* Retrieved from: http://www.prsp.mpf.gov.br/sala-de-imprensa/pdfs-das-noticias/Inicial%20-%200017488-30.2010.4.03.6100_cesarianas.pdf.

MPF recomenda ao Ministério da Saúde que atue contra a violência obstétrica em vez de proibir o uso do termo. (2019). *Ministério Público Federal,* 7 de maio de 2019. São Paulo. Retrieved from: http://www.mpf.mp.br/sp/sala-de-imprensa/noticias-sp/mpf-recomenda-ao-ministerio-da-saude-que-atue-contra-a-violencia-obstetrica-em-vez-de-proibir-o-uso-do-termo.

Munir, K. A. (2015). A loss of power in institutional theory. *Journal of Management Inquiry*, 24(1), 90-92.

NHS (2016). Better Births: Improving outcomes of maternity services in England: A five year forward view for maternity care. *National Maternity Review*. NHS England, London.

NHS (2017). *Consent Information*. Report on Maternity Information, NHS Royal Berkshire.

NHS (2019). Maternity Services Monthly Statistics, England, June 2019. *NHS Digital*. Retrieved from: https://digital.nhs.uk/data-and-information/publications/statistical/maternity-services-monthly-statistics/june-2019/births.

NICE (2011). Caesarean section: Clinical Guideline (CG132). *National Institute for Health and Care Excellence*. Retrieved from: nice.org.uk/guidance/cg132.

Nicholls, A., & Huybrechts, B. (2016). Sustaining inter-organizational relationships across institutional logics and power asymmetries: The case of fair trade. *Journal of Business Ethics*, 135(4), 699-714.

Nicolini, D., Delmestri, G., Goodrick, E., Reay, T., Lindberg, K., & Adolfsson, P. (2016). Look What's Back! Institutional Complexity, Reversibility and the Knotting of Logics. *British Journal of Management*, 27, 228-248.

Nigam, A., & Ocasio, W. (2010). Event attention, environmental sensemaking, and change in institutional logics: An inductive analysis of the effects of public attention to Clinton's health care reform initiative. *Organization Science*, 21(4), 823-841.

Nota da Sociedade Brasileira de Medicina de Família e Comunidade a respeito do despacho do Ministério da Saúde que orienta a abolição do termo violência obstétrica em documentos oficiais do órgão. (2019). *Sociedade Brasileira de Medicina de Família e Comunidade*, 7 de maio de 2019. Rio de Janeiro. Retrieved from: https://www.sbmfc.org.br/noticias/nota-da-sociedade-brasileira-de-medicina-de-familia-e-comunidade-violencia-obstetrica/.

OAB repudia despacho do Ministério da Saúde que elimina o termo violência obstétrica (2019). *Ordem dos Advogados do Brasil*, 8 maio de 2019. Brasília. Retrieved from: https://www.oab.org.br/noticia/57183/oab-repudia-despacho-do-ministerio-da-saude-que-elimina-o-termo-violencia-obstetrica.

Ocasio, W. (1997). Towards an attention-based view of the firm. *Strategic Management Journal*, 18, 187-206.

Ocasio, W., Loewenstein, J., & Nigam, A. (2015). How streams of communication reproduce and change institutional logics: the role of categories. *Academy of Management Review*, 40(1), 28-48.

Ocasio, W., & Radoynovska, N. (2016). Strategy and commitments to institutional logics: Organizational heterogeneity in business models and governance. *Strategic Organization*, 14(4), 287-309.

Oliver, C. (1991). Strategic responses to institutional processes. *Academy of Management Review*, 16(1), 145-179.

OMS. Organização Mundial Da Saúde. (1996). *Assistência ao parto normal:* um guia prático. Brasília: Ministério da Saúde.

Østerlund, C., & Carlile, P. (2005). Relations in practice: Sorting through practice theories on knowledge sharing in complex organizations. *The Information Society*, 21(2), 91-107.

Pache, A. C., & Santos, F. (2010). When worlds collide: the internal dynamics of organizational responses to conflicting institutional demands. *Academy of Management Review*, 35(3), 455-476.

Paciornik, M. (1985). Parto em casa? *Femina*, 13(9), 798-800.

Pemer, F., & Skjølsvik, T. (2016). Purchasing policy or purchasing police? The influence of institutional logics and power on responses to purchasing formalization. *Journal of Supply Chain Management*, 52(4), 5-21.

Pense SUS (s.d.). Público x Privado. Retrieved from: https://pensesus.fiocruz.br/p%C3%BAblico-x-privado.

Pereira, A. L. F. (2006). Atuação da enfermeira obstétrica na política pública de humanização ao parto no Rio de Janeiro. *Revista Mineira de Enfermagem*, 10(3), 233-239.

Perkmann, M., McKelvey, M., & Phillips, N. (2019). Protecting scientists from Gordon Gekko: How organizations use hybrid spaces to engage with multiple institutional logics. *Organization Science*, 30(2), 298-318.

Pfeffer, J. (1981) *Power in organizations*, Marshfield, MA: Pitman.

Pfeffer, J. & Salancik, G.R. (2003) *The External Control of Organizations*: A Resource Dependence Perspective. Stanford, CA: Stanford Business Classics.

Picheth, S. F., Crubellate, J. M., & Verdu, F. C. (2018). A transnacionalização do parto normal no Brasil: um estudo das últimas cinco décadas. *História, Ciências, Saúde-Manguinhos*, 25(4), 1063-1082.

Picheth, S. F., & Crubellate, J. M. (2019). Mudança, lógicas institucionais e emergência de novos atores: a renaturalização da maternidade no Brasil. *Organizações & Sociedade*, 26(90), 486-512.

Pinheiro, P. (2019). Ultrassom na gravidez: quando fazer e para que serve. *MD.Saúde.* Retrieved from: https://www.mdsaude.com/gravidez/ultrassom-gravidez/

Potter, J. E. et al. (2001). Unwanted caesarean sections among public and private patients in Brazil: Prospective study. *BMJ*, 323(7322), 1155-1158.

Quirke, L. (2013). Rogue resistance: Sidestepping isomorphic pressures in a patchy institutional field. *Organization Studies*, 34(11), 1675-1699.

Ranson, S., Hinings, B., & Greenwood, R. (1980). The structuring of organizational structures. *Administrative Science Quarterly*, 25(1), 1-17.

Rattner, D. (1996). Sobre a hipótese de estabilização das taxas de cesárea do Estado de São Paulo, Brasil. *Rev. Saúde Púbica*, 30(1), 19-33

Rattner, D. (2009a). Humanizing childbirth care: brief theoretical framework. *Interface - Comunicação, Saúde, Educação,* 13(Suppl. 1), 595-602.

Rattner, D. (2009b). Humanização na atenção a nascimentos e partos: ponderações sobre políticas públicas. *Interface - Comunicação, Saúde, Educação,* 13(Suppl. 1), 759-768.

Reay, T., & Hinings, C. R. (2005). The recomposition of an organizational field: Health care in Alberta. *Organization Studies*, 26(3), 351-384.

Reay, T., & Hinings, C. R. (2009). Managing the rivalry of competing institutional logics. *Organization Studies, 30*(6), 629-652.

Reay, T., & Jones, C. (2016). Qualitatively capturing institutional logics. *Strategic Organization*, 14(4), 441-454.

Reay, T., et al. (2013a). Transforming new ideas into practice: An activity-based perspective on the institutionalization of practices. *Journal of Management Studies*, 50(6), 963-990.

Reay, T., Goodrick, E., Casebeer, A., & Hinings, C. B. (2013b). Legitimizing new practices in primary health care. *Health Care Management Review*, 38(1), 9-19.

Relph, T. (2006). Why I still believe in home births. *The Telegraph.* mai. 2006. Retrieved from: http://www.telegraph.co.uk/news/health/3339528/Why-I-still-believe-in-home-births.html.

Ritchie, J. (2003). The applications of qualitative methods to social research. In: Ritchie, J., & Lewis, J. (Ed.). *Qualitative research guide:* a guide for social science students and researchers. Sage, 24-46.

Ritchie, J., Lewis, J., El am, G. (2003). Designing and selecting samples. In: Ritchie, J., & Lewis, J. (Ed.). *Qualitative research guide:* a guide for social science students and researchers. Sage, 77-108.

RNFS. Rede Nacional Feminista de Saúde, Direitos Sexuais e Direitos Reprodutivos. (2002). Dossiê humanização do parto. *Rede Feminista de Saúde.* São Paulo: [s.n.].

Ross, E. (1993). *Love and toil:* Motherhood in outcast London, 1870-1918. New York: Oxford University Press.

Sahlin, K., & Wedlin, L. (2008). Circulating ideas: imitation, translation and editing. In: Greenwood, R., Oliver, C., Sahlin, K., & Suddaby, R. (Ed.). *The Sage handbook of organizational institutionalism*. Sage, 218-242.

Salancik, G. R., & Pfeffer, J. (1977). Who gets power—and how they hold on to it: A strategic-contingency model of power. *Organizational Dynamics*, 5(3), 3-21.

Salancik, G. R., & Pfeffer, J. (1978). A social information processing approach to job attitudes and task design. *Administrative Science Quarterly*, 23(2), 224-253.

Sanfelice, C. F. O., & Shimo, A. K. K. (2014). Home childbirth: progress or retrocession?. *Revista Gaúcha de Enfermagem*, 35(1), 157-160.

Schatzki, T. R. (2001). Introduction: practice theory. In T. R Schatzki, K. D. Knorr-Cetinam & E. Von Savigny (Eds.). *The practice turn in contemporary theory*. London: Routledge.

Scheffer, M. et al. (2018). *Demografia Médica no Brasil 2018*. São Paulo, SP: FMUSP, CFM, Cremesp.

Scott, W. R. (1995). *Institutions and organizations*. Califórnia: Sage

Selltiz, C., Wrightsman, L. S., & Cook, S. W. (1976). *Research methods in social relations*. Holt, Rinehart and Winston.

Seo, M. G., & Creed, W. D. (2002). Institutional contradictions, praxis, and institutional change: A dialectical perspective. *Academy of Management Review*, 27(2), 222-247.

Shetzer, L. (1993). A social information processing model of employee participation. *Organization Science*, 4(2), 252-268.

Smets, M., Morris, T., & Greenwood, R. (2012). From practice to field: A multi-level model of practice-driven institutional change. *Academy of Management Journal*, 55(4), 877-904.

Smets, M., & Jarzabkowski, P. (2013). Reconstructing institutional complexity in practice: A relational model of institutional work and complexity. *Human Relations*, 66(10), 1279-1309.

Smets, M., Jarzabkowski, P., Burke, G. T., & Spee, P. (2015). Reinsurance trading in Lloyd's of London: Balancing conflicting-yet-complementary logics in practice. *Academy of Management Journal*, 58(3), 932-970.

Smets, M., Aristidou, A., & Whittington, R. (2017). Towards a practice-driven institutionalism. In R. Greenwood, C. Oliver, T. B. Lawrence, & R. Meyer (Eds.), *The Sage handbook of organizational institutionalism*, 2nd ed.: London: Sage. 384-411.

Stuhlmacher, A. F., & Champagne, M. V. (2000). The impact of time pressure and information on negotiation process and decisions. *Group Decision and Negotiation*, 9(6), 471-491.

Suddaby, R. (2010). Challenges for institutional theory. *Journal of Management Inquiry*, 19(1), 14-20.

Suddaby, R., & Greenwood, R. (2005). Rhetorical strategies of legitimacy. *Administrative Science Quarterly*, 50(1), 35-67.

Taxas de partos cesáreos por operadora de plano de saúde. (2017) *Agência Nacional de Saúde Suplementar*, Rio de Janeiro. Retrieved from: http://www.ans.gov.br/planos-de-saude-e-operadoras/informacoes-e-avaliacoes-de-operadoras/taxas-de-partos-cesareos-por-operadora-de-plano-de-saude.

Tew, M. (1995). *Safer Childbirth?:* A critical history of maternity care. 2 ed. London: Chapman & Hall.

Thornton, P. H. (2002). The rise of the corporation in a craft industry: Conflict and conformity in institutional logics. *Academy of Management Journal*, 45(1), 81-101.

Thornton, P. H., & Ocasio, W. (1999). Institutional logics and the historical contingency of power in organizations: Executive succession in the higher education publishing industry, 1958-1990 1. *American Journal of Sociology*, 105(3), 801-843.

Thornton, P., Ocasio, W., & Lounsbury, M. (2012). *The institutional logics perspective*: A new approach to culture, structure, and process. Oxford University Press.

Tornquist, C. S. (2004). *Parto e poder:* O movimento pela humanização do parto no Brasil. Tese de doutorado, Programa de Pós-Graduação em Antropologia Social, Universidade Federal de Santa Catarina, Florianópolis, Brasil.

Valadares, C. (2017). Pela primeira vez número de cesarianas não cresce no país. *Portal da Saúde*, Brasília. Retrieved from: http://portalsaude.saude.gov.br/index.php/o-ministerio/principal/secretarias/sas/sas-noticias/27787-pela-primeira-vez-numero-de-cesarianas-nao-cresce-no-pais

Venter, E. R., & de Villiers, C. (2013). The accounting profession's influence on academe: South African evidence. *Accounting, Auditing & Accountability Journal*, *26*(8), 1246-1278.

Vieira, M. M. F. (2004). Por uma boa pesquisa (qualitativa) em administração. In: Vieira, M. M. F.; Zouain, D. M. (Orgs.). *Pesquisa qualitativa em administração.* Rio de Janeiro: FGV, 13-28.

Viellas, E. F., et al. (2014). Assistência pré-natal no Brasil. *Cadernos de Saúde Pública*, 30, S85-S100.

Villar, J. et al (2006). Caesarean delivery rates and pregnancy outcomes: The 2005 WHO global survey on maternal and perinatal health in Latin America. *The Lancet*, 367, 1819-1829.

Waldorff, S. B., Reay, T., & Goodrick, E. (2013). A tale of two countries: How different constellations of logics impact action. *Institutional logics in action, Part A,* 99-129.

Weber, M. (1978). *Economy and Society*: An Outline of Interpretive Sociology. Berkeley, CA: UC Press.

WHO global survey on maternal and perinatal health in Latin America. (2015). *The Lancet*, 367, 1819-1829.

WHO. World Health Organization (2018). WHO recommendations: non-clinical interventions to reduce unnecessary caesarean sections. Genebra.

Wooten, M., & Hoffman, A. (2017). Organizational Fields: Past, Present and Future. In: Greenwood, R., Oliver, C., Lawrence, T., Meyer, R. (Eds.). *The Sage handbook of organizational institutionalism*. London: Sage, 55-74.

Wrede, S. (2001). Introduction to Part I. In: De Vries, R. et al. (Ed.). *Birth by design:* Pregnancy, maternity care and midwifery in North America and Europe. Routledge, 3-6.

Wright, A. L., & Zammuto, R. F. (2013). Wielding the willow: Processes of institutional change in English county cricket. *Academy of Management Journal*, 56(1), 308-330.

Wry, T., Cobb, J. A., & Aldrich, H. E. (2013). More than a metaphor: Assessing the historical legacy of resource dependence and its contemporary promise as a theory of environmental complexity. *The Academy of Management Annals*, 7(1), 441-488.

Ye, J., Zhang, J., Mikolajczyk, R., Torloni, M. R., Gülmezoglu, A. M., & Betran, A. P. (2016). Association between rates of caesarean section and maternal and neonatal mortality in the 21st century: A worldwide population-based ecological study with longitudinal data. *BJOG: An International Journal of Obstetrics & Gynaecology*, 123(5), 745-753.

Yin, R.K. (2001). *Estudo de caso*: Planejamento e métodos. 2. ed. Porto Alegre: Bookman.

Young, M. J., Bauman, C. W., Chen, N., & Bastardi, A. (2012). The pursuit of missing information in negotiation. *Organizational Behavior and Human Decision Processes*, 117(1), 88-95.

Zilber, T. B. (2002). Institutionalization as an interplay between actions, meanings, and actors: The case of a rape crisis center in Israel. *Academy of Management Journal*, 45(1), 234-254.

# GLOSSARY[1]

**Amniotomy**: artificial rupture of the amniotic sac (contains the fluid surrounding the fetus) via vagina to induce labour.
**Auscultation:** listening directly to the fetal heart sounds via a trumpet-shaped tube.
**Birth Plan:** a record of what you would like to happen during your labour and after birth.
**Breech Baby:** the position where the baby is sitting in the uterus. The opposite of this, favourable position for birth, is cephalic, that is, upside down.
**Doula:** women who give physical and emotional support to other women before, during and after childbirth. They offer measures of physical comfort through massages, relaxation, breathing techniques, bathing, and suggestion of positions and movements that assist the progress of labour and decrease pain and discomfort, as well as, informational support explaining medical terms and hospital procedures.
**Dystocia:** difficult or abnormal labour
**Eclampsia:** dangerous maternal complication following **pre-eclampsia** which is signalled by raised blood pressure (hypertension), oedema, and protein in the urine that may occur during pregnancy or childbirth, making it more prone to risks for both mother and baby.
**ECV manoeuvre:** External Cephalic Version - a manoeuvre to turn the fetus to a more favourable presentation by manipulation through the abdominal wall before labour
**Enema:** intestinal lavage. A solution is applied in the intestine so that its contents are then eliminated.
**Epidural Analgesia:** anaesthesia - Injection of a local anaesthetic agent into the epidural space in order to block the spinal nerves and cause total numbness of the lower trunk and limbs.
**Episiotomy:** cut in the genital region to facilitate or accelerate the exit of the baby during childbirth.
**Forceps**: instrument consisted of a pair of metal spoons used by obstetricians to pull the baby out of the mother by the traction of the head.
**Kristeller's manoeuvre:** obstetric manoeuvre considered obsolete whereby the baby is pushed out of the mother by pressure applied to the upper part of the uterus.
**Lithotomy:** gynaecological position.
**Midwife:** health care professional who has had special training to help women give birth.
**Parturient**: being in labour; relating to childbirth (parturition).
**Prostaglandins:** Substances produced in human cells and having an oxytocic effect on the mechanical properties of cervical tissue. It is also fabricated to induce labour.
**Synthetic oxytocin:** synthetic hormone used to stimulate uterine contractions, accelerate labour and control bleeding.
**Tens machine:** a machine that put at the back and sends electrical messages to relief pain
**Trichotomy:** pubic hair removal.
**Vacuum extractor / Ventouse**: another instrument to pull the baby out. Consist of a method of assisting delivery by attaching a metal cup by suction to the fetal scalp and pulling gently in time with uterine contractions.

[1] This Glossary was built based on the glossaries of Dias (2007) and Tew (1995).

## APPENDIX A - Interview guide for mothers in Portuguese

1. Você tem quantos filhos? Qual idade dele(s)? Com quantos anos você o(s) teve?
2. Antes de ter seu filho, como você desejava que fosse seu parto? Por quê?

Se for cesárea: qual foi a motivação?

3. O que te influenciou nessa escolha?
4. Como foi a discussão sobre a escolha do parto com a equipe médica? O médico expressou alguma preferência?
5. Seu médico te instruiu sobre as vantagens e riscos de cada parto?
6. Como foi a gestação? (consultas, pré-natal, aprendizado sobre as etapas).
7. E como foi o parto?

Onde (hospital público ou privado)? / Com plano de saúde ou não?

8. (Se foi cesárea eletiva) Seu médico solicitou que você assinasse termo de consentimento para agendar a cesárea previamente?
9. (Se foi cesárea eletiva) como foi a escolha da data? O médico que marcou? Ele deu justificativa do dia?
10. (Se houve mudança) O que/Quem te levou a mudar de escolha?
11. Como você avalia sua experiência com o parto? Você repetiria numa próxima gravidez?
12. Você teve que tomar alguma providência especificamente para ter o parto que queria? O que? Por quê?
13. Como foi a escolha por essas práticas? Partiu de quem?
14. Você buscava informações sobre gestação/parto? De que fonte você as buscava?
15. Essas informações lhe ajudavam a discutir com o médico/equipe as escolhas do parto? Como?
16. O que você achou mais difícil na busca pelo parto?
17. Como era sua relação com seu médico/equipe médica? (em relação à troca de informações, decisões, ...)
18. Você entrou em algum conflito com o médico/equipe nas escolhas do parto? Como foi resolvido?
19. Qual a sua percepção do contexto de maternidade atualmente?
20. Você conhece o índice de cesarianas no Brasil? Considera alto ou baixo? Por que? O que acha a respeito?
21. Qual sua idade?
22. Qual seu grau de escolaridade?

## APPENDIX B - Interview guide for mothers in English

1. How many children do you have? How old are they? How old were you when they were born?
2. Before you had your child, how did you want your child to be delivered? Why?
3. What/Who has influenced you in this choice?
4. How was the discussion about choosing the type of delivery with the medical staff? Has anyone expressed any preference?
5. Has the health care team instructed you about the advantages and risks of each type of delivery?
6. How was the gestation? (Appointments, antenatal care, learning about the stages).
7. And how was the birth?

    Where (freestanding midwifery units, alongside midwifery units, obstetric units, home)? With or without health insurance?
8. (If it was elective caesarean section) How was the date chosen? Who chosen? If was the doctor, did he justify the day?
9. (If there was a change) What / Who led you to change your delivery choice?
10. How do you evaluate your experience with childbirth? Would you repeat the same type of delivery in the next pregnancy?
11. Did you have to take any specific steps to have the type of delivery you wanted? Which? Why?
12. How was the choice made by these practices? Who decided?
13. Did you look for information on gestation/delivery? What source of information did you look for?
14. Did this information help you discuss the birth choices with your doctor/team? How?
15. What did you find most difficult in regards to the childbirth?
16. How was your relationship with your doctor/medical staff?
17. Have you had any conflict with the doctor/staff regarding the birth choices? How was it solved?
18. How old are you?
19. What is your level of education?

## APPENDIX C - Interview guide for health professionals in Portuguese

1. Há quanto tempo você trabalha com obstetrícia? (Doula - na assistência ao parto?)
2. Como é sua experiência na obstetrícia/assistência ao parto? Por que escolheu essa área? Sua jornada do início de atuação até hoje.
3. O que você acha mais importante na assistência ao parto?
4. Qual tipo de parto você aconselha? Por quê?
5. Como é feito a decisão pelo tipo de parto?
6. Quando deve ser definido o parto a ser feito? Tem que ser discutido desde o começo ou só no final da gestação?
7. Há diferenças no procedimento e na escolha do primeiro parto e para os demais?
8. Quais fatores influenciam na escolha pelo parto? A idade da mulher influencia no aconselhamento sobre o tipo de parto?
9. Como lidar com o desejo da mãe por um tipo específico de parto? (Plano de parto)
10. E se ele diferir do que você aconselha?
11. Quais práticas você acha essencial para que o parto ocorra bem? Por quê?
12. Como é feito a decisão por essas práticas adotadas?
13. Quais profissionais você considera importantes na assistência do parto? Qual o papel de cada um? (Médico/Doula/Enfermeira)
14. Você já entrou em algum conflito com algum membro da equipe (médico/ enfermeiro/ doula)? Como foi resolvido?
15. E com alguma mãe?
16. Quais principais fontes você acha importante para estar informado sobre a assistência ao parto?
17. Você acredita que a formação acadêmica (médica/enfermagem) induz/prepara melhor para uma postura específica na assistência ao parto? E para um tipo de parto?
18. (Se for linha humanizado) Você sempre seguiu a linha humanizada? Se não, o que te levou a mudar?
19. Recentemente, novas regulamentações foram definidas no Brasil pela ANS (nº 368/2015; nº 398/2016) e pelo CFM (nº 2.144/2016) para o parto, o que você acha a respeito?
20. Qual a sua percepção do contexto de maternidade atualmente?
21. O que você acha do índice de cesarianas no Brasil? Considera alto ou baixo? Por quê?
22. Qual sua porcentagem de partos realizados? PN x Cesárea
23. Qual sua idade?
24. Gênero:

## APPENDIX D - Interview guide for health professionals in English

1. How long have you been working with obstetrics/childbirth care?
2. How is your experience in obstetrics/childbirth care? Why did you choose this area?
3. What do you think is most important in childbirth care?
4. What kind of delivery do you advise? Why?
5. How is the decision of the type of delivery made? Who decides?
6. When should the type of delivery be defined? Does it have to be discussed from the beginning or only at the end of the gestation?
7. Are there any differences in the procedure and choice of the first birth to the others?
8. Which factors influence the choice of the type of delivery?
9. How to deal with the mother's desire for a specific type of childbirth? (Birth Plan)
10. What if it differs from what you advise?
11. What practices do you think are essential for the delivery to go well? Why?
12. How is the decision for these practices made?
13. What professionals do you consider are important in childbirth care? What is the role of each? (Doctor / Doula / Midwife)
14. Have you ever been in any conflict with a staff member (doctor/midwife/doula)? How was it solved?
15. And with any mother?
16. What major sources of information do you find important to be aware of delivery assistance?
17. Do you believe that academic education (medical/nursing) induces a specific posture in childbirth care or to a specific type of delivery?
18. Regarding your approach with childbirth and in relation to the mother, did you approach differently from when you started? How? Why?
19. Is the interaction with the patient the same along with your career?
20. What is the percentage of deliveries you usually assist? (Normal birth x Caesarean section)
21. How old are you?
22. Gender:

## APPENDIX E – Questions survey in Portuguese

Prezada,
Gostaria de convidá-la a participar como voluntária da pesquisa intitulada "Poder x informação: analisando as práticas de maternidade no Brasil e na Inglaterra a partir de múltiplas lógicas institucionais e dos interesses dos grupos".
Objetivo da pesquisa: Esta pesquisa pretende representar a tese para o cumprimento do programa de doutorado em Administração na Universidade Estadual de Maringá (UEM) e tem por objetivo compreender as diferenças entre os sistemas obstétricos brasileiro e inglês.
Participação na pesquisa: Ao participar deste estudo, você está sendo convidada a preencher um questionário on-line que busca identificar suas experiências de parto. A estimativa de tempo necessária para o preenchimento do questionário é de aproximadamente 5 (cinco) a 10 (dez) minutos. A pesquisa não acarretará nenhum risco para você e sua identidade será preservada. Os dados coletados serão confidenciais, usados apenas pela pesquisadora e para os fins desta pesquisa.
Contato: Por favor, sinta-se à vontade para entrar em contato se você tiver alguma dúvida relacionada à pesquisa e ao preenchimento do questionário ou necessite de maiores esclarecimentos, pelo seguinte e-mail: sarafpicheth@gmail.com

| |
|---|
| Se tiver mais de um filho, por favor, responda para o primeiro filho as questões abaixo: |
| Você trocou de médico durante a gravidez? ( ) Sim ( ) Não |
| Quantos filhos: _____ Qual a idade deles:_____ |
| Idade quando teve o primeiro filho: |
| Cidade e Estado que seu filho nasceu: _____ |
| Local do nascimento de seu filho: ( ) hospital público ( ) hospital privado ( ) em casa ( ) casa de parto ( ) outro: _____ |
| Seu pré-natal foi (pode marcar mais de uma): ( ) plano de Saúde ( ) SUS ( ) privado |
| Seu parto foi (pode marcar mais de uma): ( ) plano de Saúde ( ) SUS ( ) privado |
| Seu bebê nasceu com quantas semanas: _____ |
| Você foi assistida por quais profissionais (pode marcar mais de uma):<br>( ) médico obstetra ( ) enfermeira obstetra ( ) doula ( ) Outros: _____ |
| 1.1) Qual tipo de parto desejava antes do nascimento: ( ) cesárea ( ) parto normal<br>1.2) Você teve o parto que queria? ( ) Sim ( ) Não ( ) Não se aplica<br>1.3) Na busca pelo parto que desejava, você teve que adotar alguma das opções abaixo para conseguir?<br>( ) Agendar para uma data antes do que queria ou antes de entrar em trabalho de parto<br>( ) Trocar de médico<br>( ) Contratar enfermeira obstétrica<br>( ) Contratar doula<br>( ) Ter o parto em outra cidade<br>( ) Participar de grupos de apoio<br>( ) Induzir o parto.<br>( ) Aceitar alguma intervenção que não gostaria.<br>( ) Não<br>( ) Não se aplica<br>( ) Outro: _____ |
| 2) Por que desejava esse tipo de parto? |

| |
|---|
| 3) Como foi o parto?<br>( ) cesárea eletiva/agendada ( ) cesárea intraparto (após entrar em trabalho de parto<br>( ) cesárea de emergência ( ) parto normal com intervenção ( ) parto normal sem intervenção |
| 4) Caso não tenha tido o parto que desejava ou da forma que desejava, qual foi o motivo da mudança? O que/quem te influenciou a mudar? |
| Se <u>não</u> trocou de médico:<br>5) Quando você comunicou sua preferência de parto ao seu médico, ele (pode marcar mais de uma):<br>( ) Disse que fazia ( ) Disse que não fazia ( ) Tentou me convencer de que era arriscado ( ) Tentou me convencer que outro tipo de parto era melhor ( ) Disse que dependia de vários fatores ( ) Disse que era muito cedo para definir ( ) Disse que fazia, mas colocava empecilhos durante as consultas ( ) Outra _____ |
| Se <u>trocou</u> de médico<br>5.1) Quando você comunicou sua preferência de parto ao seu <u>primeiro</u> médico, ele (pode marcar mais de uma):<br>( ) Disse que fazia ( ) Disse que não fazia ( ) Tentou me convencer de que era arriscado ( ) Tentou me convencer que outro tipo de parto era melhor ( ) Disse que dependia de vários fatores ( ) Disse que era muito cedo para definir ( ) Disse que fazia, mas colocava empecilhos durante as consultas ( ) Outra _____<br>5.2) Quando você comunicou sua preferência de parto ao <u>segundo</u> seu médico, ele (pode marcar mais de uma):<br>( ) Disse que fazia ( ) Disse que não fazia ( ) Tentou me convencer de que era arriscado ( ) Tentou me convencer que outro tipo de parto era melhor ( ) Disse que dependia de vários fatores ( ) Disse que era muito cedo para definir ( ) Disse que fazia, mas colocava empecilhos durante as consultas ( ) Outra _____ |
| 6) A escolha pelo seu parto:<br>( ) Não foi discutida/ Segui as recomendações do médico<br>( ) Expus ao meu médico minha preferência, mas segui a recomendação dele<br>( ) Foi moderadamente discutida com o médico e equipe no início e final da gestação<br>( ) Foi amplamente discutida com o médico e equipe durante toda a gestação como seria |
| 7.1) Você queria que seu marido ou outra pessoa ficasse junto durante o trabalho de parto e parto? ( ) Sim ( ) Não<br>7.2) Você teve o acompanhante de sua escolha ao seu lado? ( ) Sim ( ) Não ( ) Não se aplica<br>7.3) Você teve que tomar alguma providência para conseguir? ( ) Sim ( ) Não ( ) Não se aplica Quais?_____ |
| 8.1) Para o nascimento do seu filho, você tinha o desejo por um período/data específico? (Ex: para quem teve cesárea: um dia ou semana de gestação/ ou quem teve parto normal: após entrar em trabalho de parto)? ( ) Sim ( ) Não<br>8.2) Seu filho nasceu no momento que desejava? ( ) Sim ( ) Não ( ) Não se aplica |

8.3) Você precisou tomar alguma providência para que isso acontecesse? ( ) Sim ( ) Não ( ) Não se aplica Quais?_____

9.1) Você tinha preferências específicas quanto à forma do parto? (Plano de parto, Local, pessoas presentes, data, procedimentos adotados, posição,...) ( ) Sim ( ) Não
9.2) Essas preferências foram atendidas? ( ) Sim ( ) Não ( ) Não se aplica
9.3) Você teve que tomar alguma providência para conseguir isso? ( ) Sim ( ) Não ( ) Não se aplica Quais?_____

10) Ainda sobre a realização do parto:
( ) Fui comunicada pelo médico de como seria feito e não opinei/me opus
( ) Discutimos sobre a impossibilidade/dificuldade da minha preferência e diante do motivo aceitei mudar/seguir suas recomendações
( ) Fui comunicada da impossibilidade/dificuldade, mas tentei discutir se havia outra opção, preferia não ter mudado/ter feito desse modo
( ) Foi discutido e definido em conjunto com a equipe a melhor opção

11) No seu trabalho de parto e/ou parto, você recebeu alguma dessas práticas? Pode marcar mais de uma:
( ) Agendamento da cesárea antes de entrar em trabalho de parto
( ) Agendamento da cesárea para uma data antes do que queria/de completar 40 semanas
( ) Analgesia (anestesia)
( ) Episiotomia (corte na região genital)
( ) Jejum
( ) Ocitocina sintética (hormônio para estimular as contrações e acelerar o trabalho de parto)
( ) Aminiotomia (rompimento da bolsa)
( ) Litotomia (posição ginecológica)
( ) Monitoração fetal contínua
( ) Enema (lavagem intestinal)
( ) Tricotomia (raspagem dos pelos)
( ) Manobra de Kristeller (pressionar a parte superior do útero)
( ) Puxos precoces ou dirigidos (estímulo a fazer força antes da hora ou continuamente)
( ) Fórceps e vácuo extrator (instrumentos para puxar o bebê para fora)
( ) Aceleração do processo de delivramento (saída da placenta)
( ) Exames de toque contínuos sem indicação clara
( ) Restrição a andar/liberdade de movimentos
( ) Outros: _____
( ) Não

12) A realização dessas práticas:
( ) Foi amplamente discutida com o médico e equipe antes de adotá-la
( ) Foi moderadamente discutida com o médico e equipe antes de adotá-la
( ) Médico justificou a necessidade e segui sua recomendação
( ) Não foi discutida, médico realizou-a(s) sem me informar/minha opinião
( ) Não se aplica

13) Ainda sobre a realização dessas práticas:
( ) Foi discutido e definido em conjunto com a equipe como seria feito

( ) Fui comunicada da necessidade, mas não queria/preferia não ter feito
( ) Fui comunicada da necessidade e aceitei realizar
( ) Foi decisão do médico, não consenti/opinei sobre a realização
( ) Não se aplica

14) Sobre sua experiência com o tipo de parto realizado:
( ) Foi conforme médico me instruiu que era o melhor para mim
( ) Não era meu desejo inicial, mas foi o mais adequado para o meu caso
( ) Não foi como eu desejava, gostaria que tivesse sido diferente
( ) Foi conforme combinado com o médico/equipe durante a gestação

15.1) Você tinha preferências específicas quanto aos primeiros cuidados com seu filho? (Banho, corte do cordão umbilical, uso de colírio de nitrato, vitamina K,...) ( ) Sim ( ) Não
15.2) Essas preferências foram atendidas? ( ) Sim ( ) Não ( ) Não se aplica
15.3) Você teve que tomar alguma providência para conseguir isso? ( ) Sim ( ) Não ( ) Não se aplica Quais?_____

16.1) Você queria receber seu filho no colo e/ou amamentá-lo logo após de seu nascimento? ( ) Sim ( ) Não
16.2) Você o recebeu e/ou amamentou-o logo após seu nascimento? ( ) Sim ( ) Não ( ) Não se aplica
16.3) Você teve que tomar alguma providência para conseguir isso? ( ) Sim ( ) Não ( ) Não se aplica Quais?_____

17) Sobre as consultas com o médico:
( ) Eram bem práticas, o médico me avaliava, pedia os exames, me passava instruções
( ) Eram bem práticas, para me avaliar. Quando eu tinha dúvidas questionava e as informações que ele me passava eram suficientes.
( ) Além da avaliação, ocasionalmente eu discutia sobre minhas dúvidas e preferências e ouvia suas opiniões a respeito
( ) Além da avaliação, na maioria das consultas, eu conversava bastante com o médico, tirava dúvidas, e discutíamos sobre como seria o parto e sobre minhas preferências

18.1) O médico que realizou o teu parto te instruiu sobre os benefícios e os riscos da cesárea?
( ) Não ( ) Sim ( ) Só sobre os riscos ( ) Só sobre os benefícios
18.2) Com que frequência ele te instruiu? Raramente 1 2 3 4 Muitas vezes
18.3) Essas informações foram úteis para te ajudar nas escolhas do parto? Nada úteis 1 2 3 4 Muito úteis

19.1) O médico que realizou o teu parto te instruiu sobre os benefícios e os riscos do parto normal?
( ) Não ( ) Sim ( ) Só sobre os riscos ( ) Só sobre os benefícios
19.2) Com que frequência ele te instruiu? Raramente 1 2 3 4 Muitas vezes
19.3) Essas informações foram úteis para te ajudar nas escolhas do parto? Nada úteis 1 2 3 4 Muito úteis

20) Onde e com qual frequência você buscava informações para decidir sobre o parto? Sinta-se a vontade para marcar quantas opções quiser:
( ) Do médico Raramente 1 2 3 4 5 Muitas vezes

| |
|---|
| ( ) Grupos de apoio Raramente 1 2 3 4 5 Muitas vezes<br>( ) Livros e artigos a respeito Raramente 1 2 3 4 5 Muitas vezes<br>( ) Cursos de gestante Raramente 1 2 3 4 5 Muitas vezes<br>( ) Doula Raramente 1 2 3 4 5 Muitas vezes<br>( ) Enfermeira Obstétrica/Parteira Raramente 1 2 3 4 5 Muitas vezes<br>( ) Redes sociais e blogs Raramente 1 2 3 4 5 Muitas vezes<br>( ) Documentários Raramente 1 2 3 4 5 Muitas vezes<br>( ) Relatos de outras mulheres Raramente 1 2 3 4 5 Muitas vezes |
| 21) As informações dessas fontes foram úteis para te ajudar nas escolhas do parto?<br>( ) Médico Nada útil 1 2 3 4 5 Muito útil<br>( ) Grupos de apoio Nada útil 1 2 3 4 5 Muito útil<br>( ) Livros e artigos a respeito Nada útil 1 2 3 4 5 Muito útil<br>( ) Cursos de gestante Nada útil 1 2 3 4 5 Muito útil<br>( ) Doula Nada útil 1 2 3 4 5 Muito útil<br>( ) Enfermeira Obstétrica/Parteira Nada útil 1 2 3 4 5 Muito útil<br>( ) Redes sociais e blogs Nada útil 1 2 3 4 5 Muito útil<br>( ) Documentários Nada útil 1 2 3 4 5 Muito útil<br>( ) Relatos de outras mulheres Nada útil 1 2 3 4 5 Muito útil |
| 22) O que acha do sistema obstétrico do seu país? |
| 23) Gostaria de fazer algum comentário sobre alguma questão ou sobre sua experiência? |
| Idade: |
| Grau de escolaridade: ( ) Ensino Fundamental incompleto ( ) Ensino Fundamental completo ( ) Ensino Médio incompleto ( ) Ensino Médio completo ( ) Graduação ( ) Pós-graduação |
| Trabalha em qual área: Profissão: |
| Renda Familiar:<br>( ) Até R$954,00 ( ) de R$ 955,00 a R$ 2.862,00 ( ) de R$ 2.863,00 a R$ 5.724,00 ( ) de R$ 5.725,00 a R$ 9.540,00 ( ) de R$ 9.550,00 a R$ 13.356,00 ( ) Acima de R$ 13.400,00 |

## APPENDIX F – Questions survey in English

Dear Mother,
I would like to invite you to participate as a volunteer in the research entitled "Power versus information: Analyzing the maternity practices in Brazil and England from multiple institutional logics and groups' interests".
Purpose of the research: The research intends to represent the fulfilment of requirements for the degree of PhD in Business Administration of the State University of Maringa/Brazil, with a period of research in the University of Oxford. The study aims to comprehend why Brazilian and English health systems have different practices regarding childbirth care. By comparing Brazil with England, it is believed to help to comprehend the Brazilian scenario which is so distant from a global pattern.
Taking part in the research: The inclusion criteria are women who had their antennal and delivery in England regardless of their age, type of delivery and type of care (NHS or private). If you are happy to take part in the research, you are invited to fill an online questionnaire that aims to identify your birth experiences. The estimated time to complete the questionnaire is approximately 5 (five) to 10 (ten) minutes. The research will not pose any risk to you and your identity will be preserved. The data collected will be confidential, used only by the researcher and for the purposes of this research.
The research has been judged as meeting appropriate ethical standards, and accordingly, approval has been granted:
Ref No: SSH_SBS_C1A_18_71
Contact: If you have a concern about any aspect of this study or yet would like to undertake an interview, please speak to the relevant researcher:
Sara Picheth
sara.picheth.dphil@said.oxford.edu
+44 7840839034

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| If you have more than one child, could you please answer the following questions to the first childbirth? |
| How many children do you have? _____ How old are they?_____ |
| Your age when your first child was born? |
| City and County that your child was born: _____ |
| Birth location of your child: ( ) Home birth ( ) Freestanding midwifery units ( ) Alongside midwifery units ( ) Obstetric unit ( ) Other: _____ |
| Your antenatal care was (you can mark more than one): ( ) NHS ( ) Private ( ) Other:____ |
| Your birth was (you can mark more than one): ( ) NHS ( ) Private ( ) Other:_____ |
| Your baby was born how many weeks gestation: _____ |
| You were assisted by which professionals (you can check more than one): ( ) Midwife ( ) Obstetrician ( ) G.P ( ) Doula ( ) Other: _____ |
| 1.1) What kind of childbirth/delivery did you want before birth? ( ) vaginal birth ( ) caesarean section ( ) No preference<br>1.2) Did you have the delivery you wanted? ( ) Yes ( ) No ( ) Not applicable<br>1.3) To have the type of delivery you wanted, did you have to adopt any of the options below?<br>( ) Schedule for a date earlier than you wanted or before entering into labour<br>( ) Change doctor/midwife |

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| ( ) Hire a private midwife<br>( ) Hire a doula<br>( ) Have the childbirth in another city<br>( ) Participate in support groups<br>( ) Induce labour<br>( ) Accept some intervention you would not like<br>( ) No<br>( ) Not applicable<br>( ) Other: _____ |
| 2) Why did you want this kind of delivery? |
| 3) How was your childbirth?<br>( ) planned caesarean section ( ) intrapartum caesarean section (after going into labour)<br>( ) caesarean section of emergency ( ) vaginal birth with intervention ( ) vaginal birth without intervention |
| 4) If you did not have the kind of delivery that you wanted or in the way you wanted, what was the reason for the change? What/who has influenced you to change? |
| 5) When you have communicated your delivery preference to your doctor or midwife, he/she (can check more than one):<br>( ) Said he/she would do it ( ) Said he/she would not do it ( ) Tried to convince me that it was risky ( ) Tried to convince me that another kind of delivery was better ( ) Said that it depended on several factors ( ) Said it was too early to define ( ) Said she/he would do it, but put obstacles during the consultations ( ) Other _____ |
| 6) The choice for your delivery:<br>( ) It was not discussed / I followed the doctor's/midwife's recommendations<br>( ) I told the doctor/midwife my preference but I followed his/her recommendation<br>( ) It was moderately discussed with the doctor/midwife and professional team at the beginning and end of gestation<br>( ) It was extensively discussed with the doctor/midwife and professional team throughout the gestation. |
| 7.1) Did you want your husband or someone else to stay with you during labour and birth?<br>( ) Yes ( ) No<br>7.2) Did you have the person of your choice by your side? ( ) Yes ( ) No ( ) Not applicable<br>7.3) Did you have to take any action to get it? ( ) Yes ( ) No ( ) Not applicable Which actions?_____ |
| 8.1) For the birth of your child, did you prefer a specific date/time? (E.g., who had a caesarean section: a day or week of gestation / or who had a vaginal birth after having been into labour)? ( ) Yes ( ) No<br>8.2) Was your child born at the moment you wanted it? ( ) Yes ( ) No ( ) Not applicable |

8.3) Did you have to take any action to make it happen? ( ) Yes ( ) No ( ) Not applicable Which actions?_____

9.1) Did you have specific preferences of how you would like to give birth? (Birth plan, location, people present, delivery position, procedures adopted,...) ( ) Yes ( ) No
9.2) Were these preferences met? ( ) Yes ( ) No ( ) Not applicable
9.3) Did you have to take any action to achieve this? ( ) Yes ( ) No ( ) Not applicable
Which actions? _____

10) Still about the delivery:
( ) I was informed by the midwife/doctor of how it would be done and I did not opine/oppose
( ) We discussed the impossibility/difficulty of my preference and in view of the reason I agreed to change/follow their recommendations
( ) I was informed of the impossibility/difficulty, but I tried to discuss if there was another option, I'd rather not to have changed or done this way
( ) It was discussed and decided together with the team the best option

11) In your labour and delivery, did you receive any of these practices? You can check more than one:
( ) Scheduling caesarean section before entered into labour
( ) Scheduling caesarean section for a date earlier than you wanted or completing 40 weeks
( ) Epidural (anaesthesia)
() Episiotomy (cut in the genital region)
() Fasting
() Synthetic oxytocin (hormone to stimulate contractions and accelerate labour)
() Amniotomy (artificial rupture of amniotic sac)
() Lithotomy (gynaecological position)
() Continuous fetal monitoring
() Enema (intestinal lavage)
() Trichotomy (pubic hair removal)
() Kristeller's maneuver (press the upper part of the uterus)
() Early or directed pushing (stimulus to push before time or continuously)
() Forceps and vacuum extractor (instruments to pull baby out)
() Acceleration of the process of placenta delivery (exit of the placenta)
() Continuous vaginal examinations without clear indication
() Restriction to walking/freedom of movement
( ) Others: _____
( ) No

12) The implementation of these practices:
() It was widely discussed with the midwife/doctor and team before adopting it
() It was moderately discussed with the midwife/doctor and team before adopting it
() The doctor/midwife justified the need for doing it and I followed his/her recommendation
() It was not discussed, the doctor/midwife performed without informing me
( ) Not applicable

13) The realization of the interventions during your birth (signed in question 11):
() It was discussed and decided together with the team how it would be done

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| () I was communicated of the need, but I didn't want/I rather hadn't done<br>() I was informed of the need and agreed to<br>() It was the doctor's/midwife's decision, I did not consent/manifest my opinion about its realization<br>( ) Not applicable |
| 14) Regarding your experience with the type of delivery performed:<br>() It was as the doctor/midwife instructed that it was the best for me<br>() It was not my initial wish, but it was the most appropriate for my case<br>() It was not how I wished, I wish it had been different<br>() It was as agreed with the doctor/team during pregnancy |
| 15.1) Did you have specific preferences regarding the early care of your child? (Bath, umbilical cord cut, use of nitrate eye drops, vitamin K, ...) () Yes () No<br>15.2) Were these preferences met? () Yes () No () Not applicable<br>15.3) Did you have to take any measures to achieve this? () Yes () No () Not applicable<br>Which? _____ |
| 16.1) Did you want to receive your child on your lap and/or breastfeed him/her just after delivery? ( ) Yes No<br>16.2) Did you receive and /or breastfeed him/her just after delivery? () Yes () No () Not applicable<br>16.3) Did you have to take any measures to achieve this? () Yes () No () Not applicable<br>Which? _____ |
| 17) About the doctor's/midwife's appointments:<br>() They were very practical, the doctor/midwife evaluated me, asked for exams, gave me instructions<br>() They were very practical, mostly to evaluate me. When I had doubts I asked questions, and the information he/she gave me was enough.<br>() Besides evaluating me, I occasionally discussed my doubts and preferences and hear his/her opinions about them<br>() Besides evaluating me, in most appointments, I talked a lot with the doctor/midwife, questioned some doubts, discussed how the delivery would be like and talked about my preferences |
| 18.1) Did the doctor/midwife who assisted your birth instructed you about the benefits and risks of caesarean section?<br>() No () Yes () Only about risks () Only about benefits<br>18.2) How often did he/she instruct you? Rarely 1 2 3 4 Often<br>18.3) Was this information useful in helping you make birth choices? Not at all useful 1 2 3 4 Very useful |
| 19.1) Did the doctor/midwife who assisted your birth instructed you about the benefits and risks of normal birth?<br>() No () Yes () Only about risks () Only about benefits<br>19.2) How often did he/she instruct you? Rarely 1 2 3 4 Often<br>19.3) Was this information useful in helping you make birth choices? Not at all useful 1 2 3 4 Very useful |

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| 20) Where and how often did you seek information to decide on childbirth? Feel free to mark as many options as you want:<br>() Doctor Rarely 1 2 3 4 5 Often<br>( ) Support groups Rarely 1 2 3 4 5 Often<br>( ) Books and articles Rarely 1 2 3 4 5 Often<br>( ) Parental classes Rarely 1 2 3 4 5 Often<br>( ) Doula Rarely 1 2 3 4 5 Often<br>( ) Midwife/Nurse Rarely 1 2 3 4 5 Often<br>( ) Social networks and blogs Rarely 1 2 3 4 5 Often<br>( ) Documentaries Rarely 1 2 3 4 5 Often<br>( ) Other women's sharing experience Rarely 1 2 3 4 5 Often |
| 21) Was this information from these sources useful to help you with childbirth choices?<br>() Doctor Not at all useful 1 2 3 4 5 Very useful<br>( ) Support groups Not at all useful 1 2 3 4 5 Very useful<br>( ) Books and articles Not at all useful 1 2 3 4 5 Very useful<br>( ) Parental classes Not at all useful 1 2 3 4 5 Very useful<br>( ) Doula Not at all useful 1 2 3 4 5 Very useful<br>( ) Midwife/Nurse Not at all useful 1 2 3 4 5 Very useful<br>( ) Social networks and blogs Not at all useful 1 2 3 4 5 Very useful<br>( ) Documentaries Not at all useful 1 2 3 4 5 Very useful<br>( ) Other women's sharing experience Not at all useful 1 2 3 4 5 Very useful |
| 22) What do you think about the obstetric system in your country? |
| 23) Would you like to add other comments on any question or regarding your birth experience? |
| How old are you? |
| What is your level of education: () Incomplete elementary school () Complete elementary school () Incomplete high school () High school () Undergraduate () Postgraduate |
| Which field do you work? What is your profession?: |
| What is your family income?<br>( ) Up to £1,331.00 ( ) £1332,00 to £3,993.00 ( ) £3,994.00 to £7,986.00 ( ) £7,987.00 to £13,310.00 ( ) £13,311.00 to £18,634.00 ( ) Above £18,634.00 |