

Childbirth care models in Brazil: repercussions on fathers and mothers

Modelos de assistência ao parto: repercussões em pais e mães

Modelos de asistencia al parto en Brasil: repercusiones en padres y madres

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Abstract

The aim of this study was to look into the repercussions of childbirth care models on the experiences of fathers and mothers. A qualitative research investigation was carried out through a collective case study, in which 30 birth reports published on personal blogs dealing with pregnancy, childbirth and parenthood experiences were analyzed, 15 written by women and 15 by men. The results pointed to the helplessness felt by fathers and mothers in the face of technocratic assistance and to the idealization of childbirth care offered by health professionals who work according to the humanized model. The idea of choosing the mode of delivery appeared frequently in the reports, pointing to a scenario in which caesarean section is understood as a consumer good. It was concluded that care, support and respect for the parturient should be promoted by health professionals as fundamental requirements for childbirth care.

Keywords: Childbirth care; Humanized birth; Perinatal care.

Resumo

O objetivo deste estudo foi investigar as repercussões dos modelos de assistência ao parto nas vivências de pais e mães. Foi realizada uma pesquisa qualitativa, por meio de estudo de caso coletivo, no qual foram analisados 30 relatos de parto publicados em blogs pessoais sobre experiências de gestação, parto e parentalidade, sendo 15 escritos por mulheres e 15 por homens. Os resultados apontaram para o desamparo sentido por pais e mães diante de uma assistência tecnocrática, e para a idealização dos cuidados ofertados pelos profissionais que atuam de acordo com o modelo de assistência humanizado. A ideia de escolha da modalidade do parto apareceu com frequência nos relatos, apontando para um cenário em que a cesariana é entendida como um bem de consumo. Concluiu-se que o cuidado, o acolhimento e o respeito à parturiente devem ser mais valorizados pelos profissionais de saúde como requisitos fundamentais para a atenção ao parto.

Palavras-chave: Assistência ao parto; Parto humanizado; Assistência perinatal.

Resumen

El objetivo de este estudio ha sido investigar las repercusiones de los modelos de atención al parto en las experiencias de padres y madres. Se realizó una investigación cualitativa por medio de un análisis de caso colectivo, en que se analizaron 30 relatos de parto publicados en blogs personales acerca de experiencias de embarazo, parto y parentalidad, 15 escritos por mujeres y 15 por hombres. Los resultados señalaron la impotencia sentida por padres y madres frente a la asistencia tecnocrática, y a la idealización del cuidado ofrecido por profesionales que actúan según el modelo de atención humanizado. La idea de elegir la modalidad del parto surgió con frecuencia en los informes, apuntando a un escenario en que la cesárea es entendida como un bien de consumo. Se concluye que el cuidado, la recepción y el respeto a la parturienta deben ser más valorados por los profesionales de la salud como requisitos fundamentales para la atención del parto.

Palabras clave: Asistencia al parto; Nacimiento humanizado; Atención perinatal.

1. Introduction

In Brazil, until the twentieth century, children were born at home, and childbirth was an event restricted to the private

sphere. Birth care was responsibility of birth attendants, who, while not mastering scientific knowledge, were valued for their experiences concerning childbirth. Childbirth was an essentially female event that generally gave women confidence in their ability to give birth. Throughout the twentieth century the childbirth was institutionalized, being experienced in the public sphere and in the presence of the doctor, which enabled the male presence at birth. Gradually, the hospital childbirth became predominant, resulting in the delegation of labor to the figure of the doctor and turning the woman into an object in the parturition process. With increasing medical interventions, there was a decrease in maternal and infant mortality and also the medicalization of the female body (Nicida et al., 2020).

Currently, there coexist two models of care in Brazil: the technocratic and the humanized, the first being the hegemonic (Mendonça, 2015). Brazil stands out internationally because it is one of the countries that most perform cesarean sections in the world (Leal et al., 2014, WHO, 2018). In public health establishments, vaginal delivery is more frequent than in private establishments, which does not mean that parturients are not subjected to excessive interventions, such as administration of oxytocin, epidural anesthesia and routine episiotomy. In private care, restricted to those with higher purchasing power, cesareans are predominantly elective and pre-scheduled, constituting a choice of delivery valued by the Brazilian elite rather than a resource for possible complications in childbirth (Chaves, 2014; Leal & Gama, 2014).

The high cesarean rate indicates the degree of hypermedicalization at birth in the country. Hypermedicalization is a complex problem, involving: the health system traps that make cesarean sections more financially attractive to professionals; the almost exclusive role of obstetricians in childbirth, as well as the training of these professionals; and the belief of the population in the superiority of this type of delivery (Oliveira et al., 2020; Leal et al., 2021).

In the research study “Nascer no Brasil” [“Being Born in Brazil”], which was funded by the Ministry of Health, the power of mercantile logic stood out as an important element behind the epidemic of caesarean sections and superfluous interventions in childbirth in the country (Aquino, 2014). The difference between the care in the public health establishments and the private care feeds the existing social inequalities and acts in the social imaginary in order to overvalue the cesarean surgery as a consumer good. The possibility of performing a cesarean section is perceived, in this way, as access to modernity and technology, guaranteeing social prestige. Despite the discrepant percentage of cesarean deliveries in public and private care - 38% versus 89.9% (Leal et al., 2014) - in both sectors there is a lack of information on childbirth for the family, women’s autonomy is not respected and sometimes the right to have a companion is denied, making childbirth a solitary, unsafe and painful event (Aquino, 2014).

The use of health technologies favors the reduction of maternal and child morbidity and mortality. However, its excessive use promotes the exposure of women and babies to iatrogenic risks in childbirth. The high rates of unnecessary interventions, according to Chaves (2014), point to the sad reality that medical practice does not accompany the academic knowledge in the area. Interventions play a routine role, disregarding the patients’ clinical demand and scientific evidence in the field (Leal et al., 2014). Newborns are being subjected to unnecessary procedures in their first moments of life and, instead of coming into immediate contact with their parents, are taken away from them, delaying the moment of mutual recognition and making it difficult to strengthen the affective bond.

According to Leal et al. (2014), Ministry of Health initiatives such as the preparation of manuals for caregivers, for example, have proved to be insufficient to reverse the interventionist model of childbirth care - the technocratic care model - in the country. The World Health Organization and the Ministry of Health advocate the provision of fluid during labor, freedom of movement, use of non-pharmacological methods for pain relief, and the presence of a companion. These recommendations are based on scientific evidence and are followed by other countries with cesarean rates closer to those indicated by WHO - 15%, while in Brazil the rate has risen to 56% in 2016 (Agência Senado, 2018).

In the current Brazilian obstetric scenario, however, there is predominance of the technocratic care model, which

disregards the social and emotional aspects inherent to parturition, restricting birth to its biological character. The right of women to have a companion during childbirth and the right of men to be involved in the birth of their children is still denied in many institutions (Matos et al., 2021). The free movement of parturients, feeding during childbirth and the option of a childbirth without medical interventions are still poorly respected in Brazil (Paula et al., 2021). In this sense, the struggle to defend the delivery plan desired by the couple is still necessary in most of the country's maternity hospitals, leaving us still distant from a reality in which the couple is guaranteed an entirely safe environment to give birth.

As a critique of the hegemonic obstetric model, the Labor Humanization Movement began to gain strength in the 1980s, aiming at the re-empowerment of women in childbirth and advocating holistic care, integrating the physiological, emotional and cultural aspects of birth. From this movement, the Prenatal and Birth Humanization Program (Brasil, 2000) emerged, consolidating the existence of the humanized care model in Brazil. Among the humanization practices, emphasis is placed on the reinsertion of the companion, the encouragement of parental participation during the birth process, and the role of women in parturition (Deslandes, 2006; Morsch & Aragão, 2006; Carvalho & Silva, 2020).

Thus, understanding childbirth as a complex event that encompasses biological, psychic and cultural aspects, this article aimed to investigate the repercussions of childbirth care models in the experiences of fathers and mothers. This paper is part of a larger study that aimed to investigate the subjective experiences of men and women about childbirth in Brazil.

2. Methodology

The present research employed a qualitative, collective case-study approach, whose objective was not to reach an intrinsic understanding of each case, but rather to achieve a more global comprehension of the object of study (Stake, 2016). Employing this method, we sought to understand, based on the analyzed childbirth accounts, the social context in the experiences of those who become fathers and mothers in Brazil.

Participants

Participants (15 men and 15 women) were not selected directly to take part in the study. Instead, we selected childbirth stories published by them on personal web blogs. All of the births took place in Brazil, and the participants were from different parts of the country. On the blogs we have analyzed, data such as the participant's place of residence, age and social class were not given. However, most of the selected accounts refer to private-hospital or home births in large cities, pointing to the possibility that the fathers and mothers who wrote them belong mainly to the middle class. The participants' names were transcribed as they appeared on the blogs.

Instrument and Procedures

The "childbirth stories from personal blogs" were employed as a research instrument. They were selected according to several criteria, such as the fact of being published on personal blogs and written by fathers and mothers that wanted to share on the web their experiences relating to pregnancy, childbirth and parenthood. Another criterion was that the accounts could not be merely descriptive; they should also transmit each individual's singular perceptions and feelings at the time of birth. We selected stories about natural, normal and caesarean births in order to enhance learning about the childbirth experience. Nonetheless, births of twins and of babies with any type of syndrome were excluded so that the specific details would not overly broaden the experiences to be analyzed. The objective of such selection was to ensure diversity without emphasizing particularities. The stories were selected between July 2016 and March 2017, and the search words used on Google were "father's childbirth account," "childbirth account," "paternity blog childbirth account" and "maternity blog." We only selected stories posted after 2010 with a view to collecting contemporary childbirth accounts that occurred when most of the currently existing legislation

was already in effect. The selected accounts were published on blogs intended to share experiences, so commercial blogs, for example, were excluded.

Data Analysis Procedures

After selecting the accounts, the material underwent categorical aggregation (Stake, 2016), which consists of gathering together recurrent circumstances until it becomes possible to form a class, that is, a category; and the categories of analysis were subsequently defined. From the selected accounts, eight categories of analysis emerged. In order to achieve the present article's objectives, the following two categories will be analyzed: Technocratic childbirth: Focus on the procedures to the detriment of the subjects; and The role of the health team in the construction of the childbirth experience.

3. Results and Discussion

Technocratic childbirth: the procedures before the subjects

The care governed by the technocratic model appeared in the discourse of many fathers and mothers as a source of insecurity, generating painful experiences and promoting experiences of helplessness. The fact that cesarean delivery is the main form of birth in the Brazilian private system leads parents and mothers to an incessant search for professionals who do not work according to the current logic. Such a quest demands high energy investment in a moment of personal and family transformation in which the parental couple needs to be embraced. In the public sphere, where vaginal deliveries are a majority, the routine practice of medical interventions disregards the birth plans of each family and the non-compliance with the principles pointed out in the Prenatal and Birth Humanization Program (Brasil, 2000) is often experienced by mothers and fathers. Many of the reports analyzed pointed to feelings of powerlessness and helplessness in the context of childbirth care in the country, where medical procedures often become more important than the experience and feelings of the subjects. *"I just did not find professionals that I was sure would help me to achieve a normal delivery (people, that's ridiculous!)"* (Alessandra). *"Generalized (but not absolute) medical unpreparedness, violence disguised behind hospital childbirths, disregard of woman and child as the main protagonists, lack of belief in one's own body biology ..."* (Lucas)

Studies such as Nicida et al. (2020) and Rudey et al. (2020), point to the degree of hypermedicalization at birth in the country, with a significant rate of cesarean sections. According to the authors, one of the components of this complex problem involves the traps of the health system that make cesarean sections more financially attractive to professionals and hospitals. In this sense, the strength of mercantile logic appeared in the studies as an important component present in the epidemic of cesarean sections and unnecessary interventions in childbirth in the country. Corroborating these results, in the present study, the perception about the economic interests behind the epidemic of cesareans in the country was present in the speeches. *"São Paulo has the highest cesarean rate in Brazil (which is the country with the highest rate in the world!). São Paulo is also the state that generates more money in relation to childbirth. Doctors do very well and health plans are accessory"* (Gabriela C.).

Health plans play a fundamental role in maintaining the mercantile logic that governs childbirth in the private healthcare system, since they allow elective cesarean sections. In 2015, the National Health Agency determined as mandatory the completion of the partograph by physicians and instituted the mandatory disclosure of the percentage of cesarean sections performed by each medical doctor, both determinations in order to reduce the number of unnecessary cesareans in the country (ANS - RN 368/2015). In 2016, however, the Federal Council of Medicine (CFM), through Resolution 2144/2016, instituted as a right of the pregnant woman the option of elective cesarean sections from the 39th week of gestation. Although the argument in favor of elective cesareans is related to female protagonism in childbirth, the Resolution disregards WHO guidelines (WHO, 2010), which highlighted the risks inherent in elective cesarean. In this sense, the Resolution seems to be more at the service of

the medical category than of the protagonism and the autonomy of the parturients, who are still often disregarded as subject in the childbirths.

The feeling of being treated as an object appeared in the speeches of the mothers, illustrating what authors like Deslandes (2006), Morsch and Aragão (2006) and Leal *et al.* (2021) affirm on the disregard of women protagonism, the expropriation of knowledge about the physiology of their own body, and the depersonalization of the female body. The focus on biological processes, which refer to the notion of “machine body” (Duarte & Souza, 2018), was highlighted in the reports, which pointed to the disregard of the emotional aspects of childbirth. *“Then I felt him tearing the layers ... Very scary, then I felt him shaking everything. I even told a friend that I felt like a bag of potatoes...”* (Ana Raquel). *“Then a nurse asked me to lie down and tried several times to find a vein to infuse saline. At no point she explained to me the reason for the procedure, she just did it”* (Rebeca).

Studies such as White (2016) and Zanardo *et al.* (2017) point to the exclusion of care according to temporality of childbirth in the technocratic care model. In the public sector, the use of routine procedures during childbirth has as one of the justifications the acceleration of the process so that the beds are released more quickly. In the private sector, cesarean delivery is the fastest and most practical solution to reduce the time of labor and to provide care to a greater number of patients, in addition to increasing the fees of professionals and hospitals. In a moment of vulnerability, with the child about to be born, fathers and mothers oftenly are faced with professional speeches that, in line with the temporality of hospital institutions (White, 2016), increase their insecurity about natural evolution of labor. In this sense, as pointed by Domingues *et al.* (2014), it is common in the private health sector that women who wanted to have a vaginal delivery in early pregnancy end up undergoing an elective cesarean, taken for fear that something will happen to their baby or that they cannot be attended by the professionals who accompany them, if they decide to respect the temporality of the delivery. In the reports analyzed, the predominance of institutional temporality, both of the medical doctor and the hospital, was present.

(...) we were surprised with the following sentence: “I have already scheduled the childbirth for the next day 9. Be there at the Renowned Maternity Hospital at Paulista Avenue at 9 am in fasting that the childbirth will be at 12:30!” What? What do you mean? Why do you want to decide the date and time for my daughter to come to the world? Should not this choice be hers? Nor did we complete 40 weeks (...) DOCTOR: but I only have agenda for day 9! If you do not want I will clear it but the risk will be yours! (Fernando)

As pointed out by Jardim and Penna (2012), the institutionalization of childbirth has led to a tendency to an exaggerated increase in the use of some medical procedures that have become routine, such as administering silver nitrate in the baby’s eyes, tying the parturient in the litter and demanding lithotomy position (similar to the gynecological position). These routine procedures appeared in the reports, which showed the discomfort of parents with their use. *“I had to have an episiotomy (the surgical cut in the perineum) and was very uncomfortable the next day. I wish it had not happened, of course, I did not want any surgical procedure”* (Fernanda). *“(…)I was scared to fall into the hands of an obstetrician who was said to be humanized but who at the time of delivery performed unnecessary interventions such as episiotomy, analgesia, synthetic oxytocin or even unnecessary cesarean”* (Juliana).

Another cause of discomfort refers to the non-permission of a companion during childbirth, which is legally guaranteed in Brazil. However, as pointed out by Alves e Portes (2021) and by Matos *et al.* (2021), many hospitals still refuse to comply with such legislation, claiming that this practice disrupts the institutional routine and the evolution of childbirth, since the companion is unaware of the routine procedures involved in childbirth. In some reports such noncompliance with the law became evident, pointing to the need for the parturient or parental couple to have to fight for their rights at the time of childbirth. *“When I went to say goodbye to my parents, my husband was barred. ‘House Rules’. I insisted on his presence, but we both agreed out of fear of reprisal afterwards. How dumb”* (Rebeca).

Besides the non-compliance with the right to have a companion, it is common to have a medical decision prevalence and lack of incentive to the autonomy of the user, principle pointed out by the SUS (Law 8080 - Brasil, 1990). Reports such as those of Gisele and Ana S. are examples of noncompliance with this basic principle, which aims to empower the users of the health system to care for themselves, and ensure co-responsibility in decisions regarding their health. “*Cesarean section is a surgical procedure and obviously this will be a more serious, tense, and cold moment, without much interaction, it will be fast. You will not have power, who commands is the doctor, is part of the process. And I felt exactly that way: without power!*” (Ana S.).

I felt so fragile, so threatened and helpless that, obviously, the doctor's major decision prevailed again (...) “your son has to be born today”, I heard. Then I asked, “So you're going to induce labor?” - and the answer: “No way. Your baby can not handle it. There is no fluid for him my daughter.” With a big belly, I sat in the cold corridor of the hospital and started crying (Gisele).

Davis-Floyd (2001) and Sanfelice et al. (2014) describe the technocratic model of care as that which gives the medical doctor a leading role and promotes the alienation of the parturient in relation to the professional, while at the same time the doctor himself is alienated from the patient's personality in order to protect himself emotionally from anguishes and anxieties inherent in health/disease processes. In this scenario, it is common for mothers and fathers to fully trust the health of their babies to these professionals, often leaving aside their beliefs and their own feelings about the design of the childbirth plan. In this context, we find that men and women who wrote the reports analyzed felt helpless and suffered strong emotional pressure when they felt some insecurity about medical knowledge.

Our world collapsed ... my wife despaired ... our safe baby delivery was no longer so safe ... I then decided to call the medical doctor and see if we had no other choice if we could not wait until at least 41 weeks (in my research I discovered that it may be possible, if we wait up to 42 weeks, and this is considered normal in other countries) ... but then the conversation was THREATENING. (Fernando)

The separation of parents from babies in the first moments of life is a procedure contrary to what is recommended by the WHO (1996) and the Ministry of Health (Brasil, 2001). Nevertheless, this is also true for many women who have their children in Brazil. In reports, the pain of having their children taken away from them due to medical procedures after childbirth appeared in the speech of the mothers. “*I saw him and he was taken away from me (it hurts me to this day, he did not stay any longer close to me), so fast that not even a photo I remembered to take with him*” (Ana S.).

I also wish I had taken my daughter in my arms and felt her warmth in the first minute of her life. And I would like to have her breastfed in a short time after giving birth. To this day I wonder how she went while I was in the recovery room. My husband and our family took a photo of our little one in the nursery and it's funny how I feel a void in my heart when I see the photos because she seems to me totally unprotected.. (Mari)

The primacy of technical procedures to the detriment of the experience of those who become mothers and fathers, typical of the technocratic care model, is disseminated by professionals who assist childbirth. In this sense, the attitude of the team is essential to reverse this scenario of helplessness experienced by many families today in Brazil. Some professionals have already incorporated more careful practices in their behaviors and, in the analyzed reports, it was possible to see how these actions influence the construction of the childbirth experience, giving rise to the category “The role of the team in the construction of the childbirth experience”.

The role of the team in the construction of the childbirth experience

Based on the reports of childbirth analyzed, it was possible to perceive that the lack of embracement by the health team during childbirth contributed to the experience of extremely painful delivery experiences. The reports pointed to the impact that the team's posture had on the way mothers and fathers felt at the time of childbirth and, consequently, their willingness to receive the child at that time, corroborating the results found in the study by Leal et al. (2014).

For mothers and fathers, who are appropriating parenting at the time of the birth of their children, childbirth is a time of deep surrender, in which they need to feel supported to be able to connect with the temporality of the baby, and consequently, support him on his arrival into the world. However, many health professionals do not have adequate training in this regard and, because they are focused on the possible complications of childbirth, end up disregarding the affective demands of those who become fathers and mothers (Matos *et al.*, 2020).

"I'm going to take the baby because otherwise both of you are going to die, she's already in pain, there's no way to stabilize the pressure and we're going to have to stop the gestation here." Stop gestation? Take the baby?? My God, how I detest this expression, to me it's something very cold, indifferent, horrible!! It was not what I imagined for Paulinha's arrival, I could not even repeat in my mind what I heard. (Gabriela A.)

Studies such as those of Davis-Floyd (2001) and Andrade et al. (2017) emphasize the importance of the safety provided to the parturients by the professionals, since this conduct has direct consequences in the way women will experience the birth process and the progress of the process. According to the authors, the humanization of childbirth, typical of the humanized care model, is related to respect for female physiology, without unnecessary intervention; recognition of the social and cultural aspects of childbirth; and to the emotional support offered to the parturient and her relatives. Rebeca, author of one of the testimonies analyzed, reports extreme experience opposed to what is advocated by humanization policies: disrespectful speeches by professionals, centrality of medical power and feeling of helplessness. *"(...) he was very cold to me. He asked me to lie down and did the digital examination of cervix. I felt a lot of pain and complained. And he told me that if I complain of a miserable examination, I would not endure contractions of normal birth. And whenever he had the chance he gave a mockery of my choice"* (Rebeca).

In addition to highlighting the importance of the human environment in childbirth experiences, Zveiter (2005) and Andrade et al. (2017) also consider the structural and functional components of the obstetric center, indicating the impact these components have on the quality of care. In agreement with these studies, some reports of childbirth analyzed pointed to the relevance of aspects referring to the physical or organizational structure of the hospital in the childbirth experiences. Rebeca, for example, looked at the discomfort caused by the hospital's physical structure, and Karoline, who was hospitalized a few days before delivery, discussed the impact that a functional aspect - the turnover of professionals - had on her birth experience. *"I begged him (the resident) to stay close to me, not to leave me alone; the preterm room was empty, with super strong lights and very icy"* (Rebeca). *"As the doctor on duty changed every day, I had no reference"* (Karoline).

On the other hand, when professionals embrace and present themselves emotionally available to parturients, uttering comforting words, it seems possible to overcome pain and fear with more confidence. This fact explains the importance of word as a tool in health care processes, as pointed out by Oliveira, Collet and Vieira (2006). Professional care with both parents from prenatal consultations to childbirth, whether guaranteeing access to information, putting a song or simply making themselves present and available, appeared in the subjects' reports as a fundamental resource to feel safe at the moment of childbirth. *"One of the helpers brought a portable radio to the delivery room and set to play a CD with children's songs sung in several languages. We found this a gesture of affection of the assistant ..."* (Marco Antonio). *"The next day we found a doula, the first impression*

could not have been better, she was very rational and objective, attentive to our insecurity in making decisions, explained her role in the process. She became our safe haven in decisions” (Michel).

Both the research by Leal et al. (2014) and the research by Silva et al. (2017) - aimed at investigating the perception of puerperal women about care in a maternity ward in the state of Piauí that seeks to follow humanization policies - observed that the care provided during childbirth was extremely important for the satisfaction of women with the parturition process and to ease the fear of childbirth. These studies concluded that when the team is cordial, respects delivery time, establishes an effective communication channel and respects the physical, emotional, psychological, social and spiritual needs of the woman and her family, providing tranquility throughout the process, the parturients tend to feel protagonists in childbirth. Corroborating the results found in these studies, in the reports analyzed, the team’s posture appeared as fundamental for women’s empowerment and protagonism during childbirth. *“A simple conversation - when they asked Lia to give in to the pain, let go of everything that bothered her and let the process develop - was decisive in making Lia empower herself even more” (Guilherme).*

Studies such as Andrade et al. (2017) and Silva et al. (2017) consider the importance of the presence of a companion to make the woman feel safe, which reduces the probability of complications during childbirth. Some professionals, however, still tend to deny the exercise of this right, excluding the accompanying person from the process. In Rafa’s report it was clear the importance of the nurse’s sensitivity that allowed him to enter the delivery room, leading us to reflect on the importance of guaranteeing the companion’s law not only for the parturient, but also for the father. *“At that moment I realized that we had not been on the boat alone. We were in the storm, but not drifting. (...) While I was out there, distressed for not being near Lá, a nurse approached me and said that I should come and stay close to my wife. The nurses had told me to wait outside, but she said that I should come in and talk to the others” (Rafa).*

When discussing the humanized model, Nagahama and Santiago (2005) point to a care that considers human totality and understands care as essential professional practice. In the reports of parents who felt supported by the team, the relationship between a positive experience and the care provided by the professionals is clear. Many have thanked them in their speech, demonstrating the importance of caring for the integrality of the subjects at childbirth. *“I want to take advantage of and thank the entire medical team of MD Eduardo Zlotinik, MD Camila Martin and the nurses, they were all great and I felt calm and safe 100% of the time” (Fernanda).*

Thank you to all of you who have given us this beautiful moment. Manuh, for the massages, for the company and the new friendship that arose; Maíra, for all the information, all respect and, most important of all, for the friendship built; Marcella, for all the help and all the sweat that had been dedicated there at the time, ensuring that everything was ready; Nilza, for understanding our choice and to cheer up with us, with the possibility of having our baby home - that was very important! (Raoni)

In some reports, the subjects came to use the expression “angel” to define the care provided by the health professional, which denotes a curious belief that such behavior is extrapolating to the human, despite being in line with the constructivist perspective (Deslandes, 2006) of the humanized model. We understand that this fact marks a disbelief that care with the other is an eminently human attitude and that it can, rather, be a cultural guide of the ways in which a society is organized with regard to birth. In this sense, we relate here the statements of these parents with what Tornquist (2002) points out about the pitfalls inherent in the humanized model, which ends up reinforcing an a-historical conception of human being, in which the cultural dimension is problematized. *“I also looked for a doula, Gabriela Barreto, to accompany me during pregnancy and childbirth, and she was another angel for me” (Juliana). “As the contractions, at 1:30 in the morning were already lasting from 40 to 70 seconds, with intervals of 2 to 5 minutes, we decided to call and wake up our doula (kind of an angel woman who in addition to making the pain of childbirth more bearable also provides calmness and security to the couple)” (Cristiano).*

The posture of the professional staff at the time of delivery is directly related to how the subjects will experience the birth of their children. In the analyzed reports of childbirth the importance of the support of the team was clear so that the parents can trust in the temporality of the delivery, being extremely necessary that the professionals provide them with confidence and respect the time necessary to give birth.

4. Final Considerations

Brazil is one of the countries that most perform cesarean sections in the world, besides having high rate of medical intervention in the vaginal deliveries. The procedures are performed in order to avoid possible complications. However, childbirth ends up becoming a medicalized event, removing the role of mothers and fathers from the birth of their children. This fact ends up producing complications due to lack of protection for the fear and insecurity that mothers and fathers usually feel at birth, thus promoting iatrogenesis in childbirth.

The reports of childbirth analyzed pointed to the suffering generated by the attitude of professionals, when they focus on biological complications and leave aside the necessary support for those who become mothers and fathers. The subjects emphasized the importance of problematizing the routine use of the procedures, questioned the medical practice that disregarded the role of the woman in her delivery, and pointed to the need for care by the professionals so that they can feel welcomed in their anguish and, thus, receive the baby with greater affective availability. In this sense, the results point to the need of guidance of the professionals in order to provide careful care, also focused on the emotional aspects inherent to childbirth.

At the same time, some speeches reported childbirth experiences in which the team's attitude, careful and attentive to the emotional demands of the couple, was fundamental so that the birth of their children took place in tranquility and was marked in their memories as a pleasant and transformer experience. Some of these subjects came to call the caring professionals of angels, attributing them superhuman character. This fact denotes the disbelief in the possibility of care being a social practice inherent to childbirth care.

In this sense, it is concluded that the care in the relationships between professionals who attend delivery and the subjects who are giving birth - whether the mother concretely or the father psychically - is essential and needs to be increasingly disseminated so that society in general understand it as a fundamental requirement for childbirth care. We understand that, despite the fact that technocratic births are still the most frequent in Brazil, a movement by some professionals begins to grow, aiming to accommodate the demands of civil society and the directives of the Ministry of Health and the World Health Organization, in which there is more room for emotional support and care.

This study analyzed the repercussions of childbirth care models on the experiences of 15 fathers and 15 mothers, so it is not possible to generalize the results obtained for all the birth experiences, which is, of course, a limitation. However, we consider that the investigation of the issue in the accounts of parents that made public their inner feelings at the moment of birth is a relevant contribution to science. We emphasize the need to develop more studies that address the emotional experience of childbirth, since this topic is still poorly explored in the literature. Research that seeks to understand the psychic mechanisms that childbirth involves is fundamental for the construction of new actions in the field of family emotional health.

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