Birth as a radical experience of change

O nascimento como experiência radical de mudança

El nacimiento como experiencia radical de cambio

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The health care of newborns and their mothers lives a very special moment in our country and this issue of the *Cadernos de Saúde Pública*, very brilliantly, addresses critical issues for our understanding and stance required of health care managers for maternal and child health. I believe that talking about childbirth, in its various approaches is crucial for the academic and scientific thinking.

The moment of birth, precisely in the transition from fetal life to extra uterine life, involves multiple mechanisms of biological adaptation with the participation of various systems and organs of the baby, having as great mediator the endocrine system, and certainly, as a fundamental result, the establishment of breathing and oxygenation of the newborn. From that moment on, led by the newborn and very evidently no longer by the mother, through breathing the baby transitions to a biologically independent life. Never in his entire life, a human being will experience such radical change and of so much importance to existence. What we observe today is the near invisibility of this process, completely physiological, that when respected has the biggest observed expression, when labour and birth are normal. Unfortunately childbirth is almost trivialized by the caregivers.

The caesarean section rates and its consequences for the health of women and newborn, based on the *Birth in Brazil* research, confront us with a sad reality: clinical practice does not follow the accumulated scientific knowledge that has conquered the academic world.

For us paediatricians the focus of the discussion should be centred on the consequences of the model of care in the health of newborns, even without abandoning health and care of the mother. We are also caregivers for the mothers.

High rates of caesarean sections, mostly without a precise indication, and mainly the absence of the physiological mechanisms of adaptation at birth, implies in significant risk for the adaptation of babies. The worst outcomes can be evidenced by the high rates of prematurity, associated with respiratory disorders, albeit transient tachypnea or even hyaline membrane disease.

It is important to think of the system of care as a whole, essential to formulate health policies, but is also very important to individualize two major scenarios of care in our country, the private sector with a strong presence of health insurance plans and insurance companies and the public sector represented by the Brazilian Unified National Health System (SUS).

The studies published in this issue present results that should make us reflect. Caesarean section is pretty much the *modus operandi* for care in the private sector and women attended in this sector show a higher level of satisfaction

with regard to doctor patient relationship. While in another article evaluating the trajectory of women in defining the mode of delivery, reveals a preference for caesarean section in early pregnancy, lower in the public sector and higher in the private sector. We know that both the public and the private sector rates are high, especially higher in the private sector. If we think of birth as pregnancy outcome, and unnecessary caesareans as adverse health outcomes for babies, we conclude that, although women in the private sector have taken the initial choice for caesarean sections they are not being informed of the advantages and disadvantages of this mode of delivery and are not aware of the risks of prematurity and its consequences. I think that part of this result is due to an attitude of professionals who do not use their time to inform women antenatally about aspects related to the birth of their children. Amazingly in the private sector, where the purchasing power is greater and greater the choice, the results are worse. Certainly they are buying a pig in a poke.

When studies define favourable outcomes for newborns at term, such as early skin to skin contact, initiation of breastfeeding within the first hour of life, rooming-in and discharge from hospital with exclusive breastfeeding, these hospitals are classified as atypical, such as the Baby Friendly Hospitals, with health care teams on call and collaborative work between nurses, midwives and doctors, it is worth noting that this scenario is still infinitely small in the public sector in our country and even lower in the private sector. A relevant dichotomy, mainly because it is more naturally expected of a healthy pregnancy, as in the vast majority of women represented in the studies, is the birth of healthy children and thus care can be met with low intervention.

According to another article, we find a strong medical presence in antenatal care and childbirth regardless of the classification of the pregnancy risk. We know that medical led care in other countries, especially in Europe, for low-risk pregnancies has much lower coverage than in our country. This may have implications on the presented results, especially with regard to interventions in care.

In Brazil approximately three million children are born each year and the vast majority in hospitals. According to published data, one in every 10 children will need assistance to begin breathing, one in every 100 children will require intubation and one in 1000 will be submitted to intubation, ventilation, cardiopulmonary resuscitation and use of drugs for resuscitation. The indication for caesarean section between 37 and 39 weeks of gestation, even without risk factors for antenatal asphyxia, and without labour, according to the literature also raises the risk that ventilation at birth is indicated.

Anyway it is very important to state that healthy children should be cared as such and for children with complication at birth we must be prepared to intervene, especially with the final goal of preventing damage to their health for the rest of their lives.

Today there are models of care at birth focused on the recognition of risk signs that indicate the need for intervention. International Associations of Paediatrics, as well as the Brazilian Society of Paediatrics, publish in this direction. Four questions should be considered basic for the care of newborns in the delivery room: Is it a term pregnancy? Is there meconium? Does the baby cry or breathe? How is the muscle tone?

When all the answers to the above questions are in the affirmative, it is considered that the baby is healthy and that they should be placed in the lap of their mother and in this place the baby should be dried and attended. Recommendations are that the birthing room is cosy and heated for both mother and baby. The assessment of skin and mucous membrane colour immediately at birth is no longer valued in deciding interventions in the delivery room. Therefore a cosy, warm environment for mothers and newborns should include a minimal amount of lighting in the room.

We had the feeling, empirically, that paediatricians and obstetricians attending to the care of labour and birth consider healthy babies as true time bombs, programmed to explode anytime. The results published here with regard to inequalities in delivery care practices of healthy newborns in Brazil are revealing of that feeling. There were very high rates of aspiration (this rarely recommended), as well as oxygen use, incubators, non-skin-to-skin contact and the consequent absence of breastfeeding in the delivery room and in the first hour. Certainly the newborn either are being formally shown to their mothers at birth or are being unnecessarily treated away from them. It is noteworthy that timely clamping of the umbilical cord, one of the best practices in childbirth care assumes that care of babies kept in contact with their mothers even in adverse birth. The blood circulating in the whole baby/placenta, while the umbilical cord has not slowed down or stopped beating is vitally important at birth and throughout the first year of life for infants.

I believe it is challenging to define normality when studying normal labour and birth. We may come close to this understanding if we choose the definition of the absence of interventions.

Therefore, based on the studies published here that reveal that we are very far from this reality. Possibly we may never return to this stage of care at birth. But we need to reflect on the quality of the interventions, especially as a physiological phenomenon as it should be childbirth. In the potential scenario of normality we should first of all try to avoid damage and the use of unnecessary interventions as some scholars argue.

Fulfilled the research stage of *Birth in Brazil* and the results published, the challenge posed by the researchers is in the understanding and the consequent implementation of the results by health care managers and policy makers and those who are on the front line of care in everyday life in antenatal care, in the delivery room and in the care of infants.

I believe that the way a woman gives birth and how children are born may relate to our perception of nature, science, health and others.

In changing the way we give birth, we can try to improve the world, as already told us the scientist. We must challenge ourselves to this project. We have the tools for this.

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