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Original research articles based on limited empirical data

"Midwifing The Labor and Birth Journey" by a participant-guide

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Abstract

The active role of women in the labor and birth process is a central focus of humanized childbirth care models. This cartographic study aimed to understand the flows and living networks produced by a participant-guide in her search for humanized care, acting as the protagonist and manager of her own care production process. This qualitative research was based on the mapping of labor and birth care networks through the experience of a participant-guide who constructed her own history by navigating healthcare networks and other connections she wove throughout her life. This process leads us to a micro political dimension of healthcare, carried out through living networks and centered on the potential of soft technologies, emerging from the encounter with humanized childbirth and supported by a team that contributed to this experience. It is evident that such a trajectory of care remains distant from the reality experienced by many women who are entitled to this right. Comprehensive childbirth care must be consistently discussed in the spaces where it takes place.

Keywords: labor, delivery environment, humanized delivery, user guide, cartography

"PARTEJANDO O PROCESSO DE PARTO E NASCIMENTO" POR UMA USUÁRIA-GUIA

Resumo

A atuação ativa da mulher no processo do parto e nascimento é o que se preconiza nos modelos de humanização no cuidado ao parto. Nessa cartografia, objetivou-se compreender os fluxos e as redes vivas produzidas por uma usuária-guia em busca de uma linha de cuidado humanizado, como protagonista e gestora dos próprios processos de produção de cuidado. Esta pesquisa é uma abordagem qualitativa baseada na produção de redes cartografadas sobre o cuidado ao parto e nascimento por meio de uma usuária-guia como construtora da própria história na busca do seu cuidado nas redes de saúde ou outras redes que ela mesmo tece em sua vida. Essa produção nos remete a uma dimensão micropolítica da assistência em saúde, efetivada pelas redes vivas, com foco na potencialidade das tecnologias leves, inscritas no encontro com a humanização do parto e com uma equipe que contribuiu com esse processo. Percebe-se que essa trajetória de cuidado ainda está distante da realidade vivida por tantas mulheres que deveriam ter direito a essa assistência. Considera-se que a integralidade da atenção ao parto deve ser cotidianamente discutida nos espaços em que ela acontece.

Palavras-chave: trabalho de parto, entorno do parto, parto humanizado, usuária-guia, cartografia

"COMPARTIR EL PROCESO DE TRABAJO DE PARTO Y NACIMIENTO" POR UN USUARIO GUÍA

Resumen

El papel activo de la mujer en el proceso de trabajo de parto y nacimiento es lo que se advierte en los modelos de humanización en la atención al parto. En esta cartografía, el objetivo fue comprender los flujos y redes vivas producidas por una usuaria-guía en busca de una línea de cuidado humanizada, como protagonista y gestora de sus propios procesos productivos de cuidado. Esta investigación es un abordaje cualitativo basado en la producción de redes mapeadas sobre la atención del trabajo de parto y el parto a través de una usuaria-guía como constructora de su propia historia en la búsqueda de su atención en las redes de salud u otras redes que ella misma teje en su vida. Esta producción nos lleva a una dimensión micropolítica del cuidado de la salud, llevada a cabo por redes vivas, centrándose en el potencial de las tecnologías blandas, inscritas en el encuentro con la humanización del parto y con un equipo que contribuyó a este proceso. Se puede observar que esta trayectoria de cuidados aún está lejos de la realidad que viven tantas mujeres que deberían tener derecho a estos cuidados. Se considera que la integralidad de la atención al parto debe ser discutida diariamente en los espacios donde se desarrolla.

Palabras-clave: trabajo de parto, entorno de parto, parto humanizado, usuaria-guía, cartografía

This article, "*Partejando*[1] *o processo de parto e nascimento" por uma usuária-guia*, analyzes the provision of care during labor and birth within formal and informal networks, based on the experience of a Brazilian healthcare service user whose journey in a city in northern Minas Gerais, Brazil, guided the mapping process. Drawing on her account, the study explores the strengthening of the humanized childbirth model, which challenges the hegemonic, mechanical, and repetitive practices that characterize much of the obstetric care provided by various birth assistance services.

An initial approach to the topic shows that childbirth, once based on a female-centered model—women caring for other women in private settings—became medicalized, shifting to the control of male physicians within hospital settings. In this context, women assumed a supporting role, losing their protagonism. Hospital-based childbirth perpetuates the use of invasive techniques that, in most cases, are not beneficial to either the woman or her newborn (Leal, 2021; Rocha & Ferreira, 2020).

Among the practices characterizing the new obstetric profile, the high rates of cesarean sections performed on request—without plausible medical indications—stand out, driven by the convenience of scheduling and cultural myths surrounding childbirth in modern society. The Brazilian Unified Health System (SUS), established by the Federal Constitution of 1988 as a public health system to provide universal, comprehensive, and free access to the entire population without discrimination (Brasil, 2024), and the private healthcare system present the highest C-section rates in the world—40% and 84%, respectively. These rates contrast sharply with those in Europe and the United States, where cesarean rates range from approximately 20% to 30%. It is important to note that, since 1985, the international medical community has recommended that operative delivery rates remain between 10% and 15% (Brasil, 2019; Brasil, 2022; Rocha & Ferreira, 2020; WHO, 2021).

Many interventions have been introduced without adequate evaluation of their effectiveness. For this reason, efforts are directed toward deconstructing unnecessary and harmful practices and promoting the adoption of beneficial ones (Leal, 2021).

In this context, the path toward humanization remains a rhizomatic journey that must still be pursued arduously. It represents a challenge for all those involved in childbirth—society, health managers, healthcare institutions, government sectors, and healthcare professionals—as this transition is marked by advances, misunderstandings, and, at times, resistance. A break from medicalization is necessary, as childbirth—a natural event—has increasingly been treated as a medical procedure, dominated by hospital interventions and technologies (Nicida, Teixeira, Rodrigues, Bonan, 2020). Recognizing childbirth in its physiological dimension, while also acknowledging the social and cultural aspects of labor and birth, is essential to allow women to actively and autonomously participate throughout the labor and delivery process. This perspective also requires changes in hospital culture and physical structure, the provision of emotional

1 "*Partejando*" is the gerund form of the Portuguese verb "*partejar*," which means "to serve as a midwife for someone" (Online Portuguese Dictionary, 2024).

support for women and their families, the guarantee of their right to have a companion of their choice, the right to be informed about all procedures, and the assurance that their citizenship rights are respected (Dias & Domingues, 2005; Teixeira et al., 2021).

Given this context, the study was guided by the following question: How are the flows and living networks woven by a participant-guide in her pursuit of humanized labor and delivery care? Accordingly, the study aims to understand the flows and living networks produced by a participant-guide as she acts as the protagonist and manager of her own care processes in the search for a humanized childbirth experience.

Method

This qualitative study adopted cartography as its theoretical-philosophical framework. Grounded in the existential world, it seeks to explore human experiences and perceptions, delving into the realm of meanings, actions, and everyday relationships (Romagnoli, 2009; Passos, Kastrup, & Escóssia, 2015). Based on the principles of schizoanalysis, cartography allows for the mapping of psychosocial landscapes and the exploration of the geography of affects, movements, and intensities (Zambenedetti & Silva, 2011).

When mapping, it is not enough to focus solely on therapeutic itineraries; it is necessary to walk alongside service users and uncover the production of new networks of connections as they construct their own histories in the search for care within healthcare networks or other networks they weave throughout their lives (Feuerwerker, Merhy, & Silva, 2016; Jorge, 2020; Hadad & Jorge, 2018; Moebus, Merhy, & Silva, 2016; Priamo, 2020).

Mapped networks are composed of living maps that build a rhizome, characterized by an acentric structure with multiple entry and exit points. This configuration offers a glimpse of reality as a constantly transforming process, composed of planes of forms and forces—flexible lines, hard lines, and lines of flight—that coexist and interact through ongoing processes of agency (Deleuze & Guattari, 2012; Escóssia & Tedesco, 2017).

To map the paths taken by the participant-guide, we first immersed ourselves in the geographic territory of a healthcare network in a city located in northern Minas Gerais.

Montes Claros is the sixth largest city in the state of Minas Gerais, Brazil, with an estimated population of 417,478 people in 2020. The city has three facilities that provide childbirth and birth care for both usual and high-risk cases, with 6,207 births recorded in 2019—of which 3,159 were vaginal deliveries and 3,046 were cesarean sections. The maternal mortality rate was 103 per 100,000 live births, and the infant mortality rate was 9.99 per 1,000 live births (Brasil, 2019; IBGE, 2020).

Participant

Considering the study setting, we present the paths taken, guided by the hands of the participant-guide Eva—a fictitious name representing the postpartum woman who shares her stories from her journey through living networks in search of humanized childbirth care. Her

trajectory reveals the richness of what was produced through this encounter, confirming the potential of her role as a participant-guide and its value as a methodological strategy.

Eva was selected during the internal data validation phase of the *Laboratório de Estudos e Pesquisas Qualitativas Interdisciplinares em Saúde* [Laboratory of Interdisciplinary Qualitative Studies and Research in Health] (LabQuali).

Data Collection Instruments

Open-ended interviews were conducted using the following guiding questions: "Please tell me about your experience from the moment you found out you were pregnant until today," "What is your perception of the care provided during labor and delivery in your experience?" "Did this perception have another meaning before?" and "What has the humanization movement meant to you in your experience?"

Data Procedures and Analysis

Three researchers participated in this phase, engaging in an interpretive process through readings and re-readings of the meanings produced by the effects of this encounter. Based on Eva's recorded account from November 19, 2019, we were able to trace the paths taken by the participant-guide, allowing us to delve into each meaning of her story in the construction of a humanized care pathway during her labor and childbirth process. We began to problematize these issues during meetings of the LabQuali research group, aiming to activate and follow these networks while remaining open to demands beyond our own. Thus, we embarked on a pilgrimage, mapping Eva's paths in search of humanized care and systematizing them through the construction of a descriptive flowchart that analyzes production processes in the form of a graphic representation (Rodrigues et al., 2019). This flowchart was designed based on Eva's pilgrimage in search of a humanized care pathway, allowing us to identify the network she traveled—not only through the formal healthcare system, but also through the alternative networks she produced along her journey.

Next, discourse analysis was conducted by exploring the material through multiple readings of the interview to become familiar with the lived experience and to interpret the narrative.

The reflections presented a stem from a section of a larger investigation, "*(Res) significando o parto: uma análise cartográfica da vivência de mulheres e profissionais de saúde*" [(Re) signifying Childbirth: A Cartographic Analysis of the Experience of Women and Healthcare Professionals], which fully complied with Resolutions 466/12 and 510/16 of the Brazilian National Health Council. The study was approved by the Institutional Review Board under the corresponding opinion and CAAE: 16210619.3.0000.5146. Additionally, the participant confirmed her consent by signing a free and informed consent form.

Results

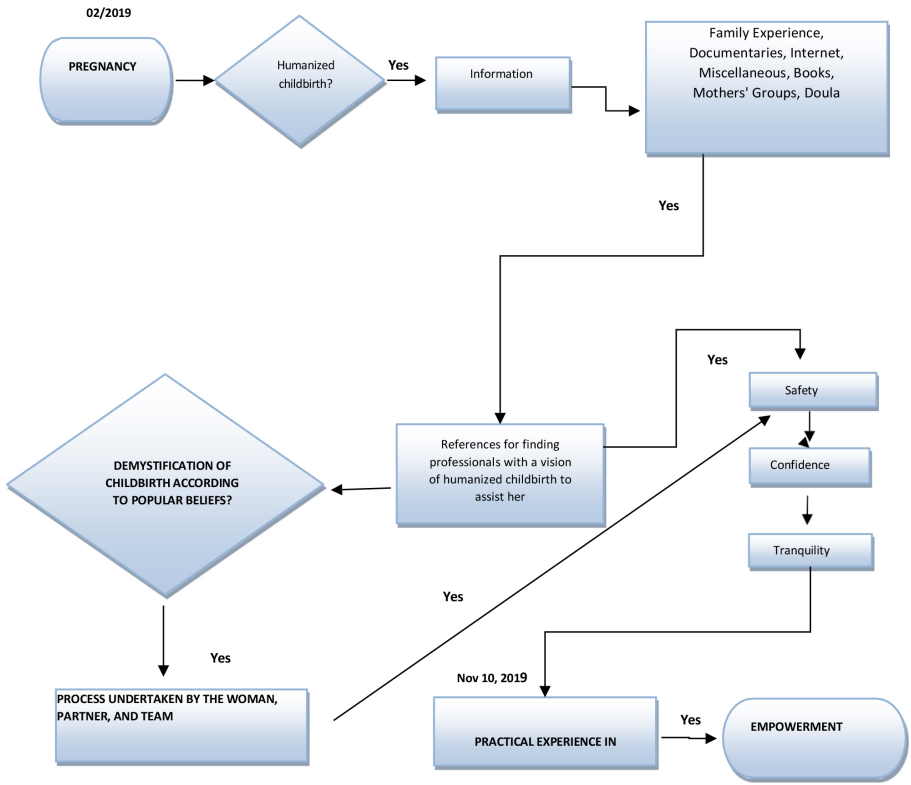
Who Is Eva? A healthcare service user who is the protagonist of her own care

Eva is a 29-year-old woman with a bachelor's degree, married, and living in Montes Claros, Minas Gerais, Brazil. She was nine days postpartum following the birth of her first child, who was born at term (40 weeks and 1 day). Eva attended 11 prenatal consultations in the private healthcare sector throughout her pregnancy, which progressed without complications. She was assisted by a multidisciplinary team during the progression of her labor and delivery, with the birth ultimately attended by the obstetrician of her choice.

The flowchart presented in Figure 1 provides a visual representation of the steps involved in the humanization of childbirth. Pregnancy, represented by an ellipse, is highlighted as the entry point into this process, marking the beginning of a trajectory that culminates in a humanized birth. From this starting point, Eva finds herself at a decision-making moment regarding humanized childbirth, represented by a rhombus, as she continues her search for this line of care. Information obtained through a support network and recommendations of professionals aligned with this perspective – represented by rectangles – allows for the demystification of childbirth beyond popular beliefs, leading to a new decision point, again represented by a rhombus. This path leads to Eva and her partner's firm commitment to humanized childbirth, an intervention process depicted by a rectangle, which fosters a sense of safety, confidence, tranquility, and practical experience, ultimately redefining her care experience. Female empowerment, represented by an ellipse, marks the exit point of this process.

Figure 1

Participant-guide descriptor flowchart Eva.



Source: Developed by the authors, 2022.

Creating spaces for protagonism in the experience of humanized care

Eva discovered she was pregnant with Adam in February 2019. At the time, she and her partner were living in another state due to their jobs as civil servants. From that moment, the couple expressed a desire for a natural childbirth and began seeking information, initially drawing on their family experiences.

> First, I learned about it from a cousin who was pregnant in the middle of last year. She would often talk to me, share her experiences, and tell me about everything she was doing—her research, everything. She was the person who most encouraged me to pursue this line of thinking, to research more about it, and she recommended that I watch the documentary *O Renascimento do Parto* [The Rebirth of Childbirth]. That was when I began to develop a deeper, more effective awareness of the humanized childbirth movement (EVA).

Following Eva's lead, we observe the positive role of social and literary media as territories that can contribute to legitimizing this type of care process.

> After I watched the documentary, I started looking for information on the Internet and in books. I then came across more technical books that helped me understand the process better, and I became increasingly convinced about choosing humanized childbirth, which practically became a necessity as I continued reading and studying. Humanized childbirth is part of an entire process, undertaken by the woman, the family, the partner, and the team that supports her (EVA).

> Humanization brings this empowerment through knowledge, allowing you to say, 'Oh, this is how it is because of this, this, and this.' So, for example, there is no reason for a C-section in a given case if it is not truly justified. I think you start to have greater command over what childbirth is and what the entire process involves. I believe you need knowledge to have the confidence and courage to make this choice with conviction – to turn this choice into a firm decision (EVA).

Thus, as we identified the markers of her journey throughout pregnancy in search of information, reflections emerged during this pilgrimage, particularly regarding the role of the father, as it represents unfamiliar territory for men.

> The logic of childbirth – natural childbirth, the whole issue of humanization – I think for men, for fathers, happens differently, especially because the changes for them are more gradual. So yes, the courses we attended helped a lot with this process of reflection, both for the father and for both of us, but mainly they created a space for the couple – a moment for the couple to rethink the changes and to reflect on what life would be like afterward (EVA).

The knowledge needed to provide safe and quality care accompanied Eva throughout her pregnancy. The experiences of other service users were important in encouraging her to seek information and to find professionals who shared the vision of humanized labor and childbirth in providing her care.

> I looked for medical recommendations through a group of mothers in Curitiba, and they recommended a doula to me. This doula then gave me recommendations of doctors. I felt more at ease because a recommendation coming from the doula meant there was a good chance the doctor would truly follow the humanized childbirth model (EVA).

> I tried to connect with professionals who also shared this perspective of childbirth (EVA).

This humanized perspective among the healthcare professionals helped Eva to feel even safer and more confident about the labor and birth process.

> Trusting the team helped reassure me that labor would be smooth and safe (EVA).

By continuing to follow the care pathway traced by Eva, we began to recognize the importance of the knowledge she acquired about humanized childbirth.

> Childbirth used to be associated with suffering, pain, and a very difficult postpartum period. So the view I had long before—even before thinking about having children – was shaped by this perspective (EVA).

> There were many situations in which only the negative side was talked about and reported (EVA).

However, we also observe that her narrative conveys detailed impressions shaped by previous perceptions rooted in popular beliefs, in which humanized childbirth was seen as an abstract process – lacking scientific basis, support, and relevance to our reality.

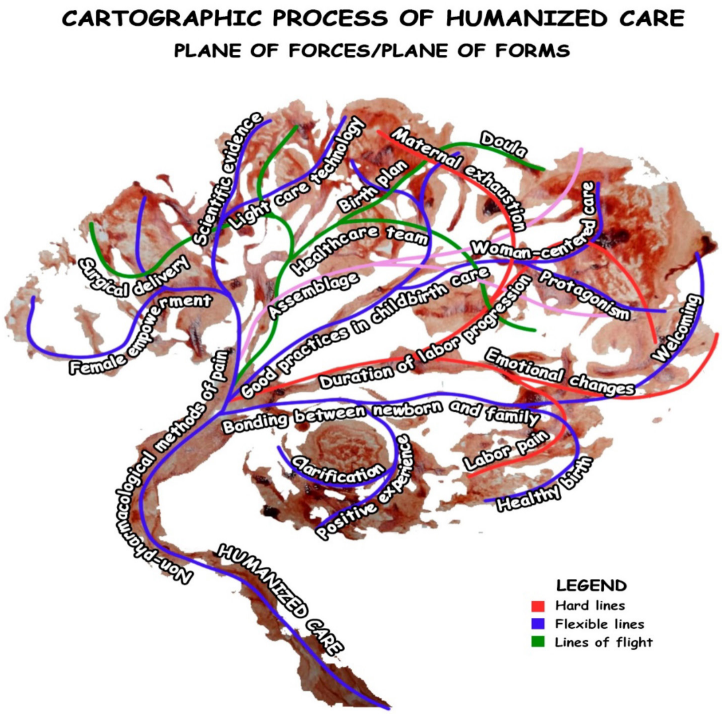
> I thought it was something more abstract and, at the same time, lacked clear criteria. So the impression I had was that it was something unusual in Brazil – something I associated more with the United States or Europe. I thought it was related to home birth, which is not necessarily true (EVA).
> So, people in general think that humanized childbirth is unassisted, something done without criteria, as if it were an idea for people who are, I don't know, more detached or alternative—people who want to give birth at home or in water, in a bathtub (EVA).

The power of humanized care: networks that weave bonds and empower women.

Eva's narrative allowed us to identify the plane of forms of humanized care, influenced by the plane of forces established through flexible, hard, and lines of flight, forming a living network in its multiplicity and constant assemblage. Accordingly, we present the rhizomatic aspect of humanized care, represented in Figure 2.

Figure 2

Rhizomated humanized care.



Source: Developed by the authors, 2022.

The flexible lines were produced through Eva's encounters with healthcare professionals in both home and hospital settings, representing light care technologies applied through good childbirth care practices, which allowed her to have a practical experience with humanized childbirth. These lines emphasized the formation of bonds, welcoming, clarification regarding childbirth care, and the protagonism of the participant-guide even before birth, with the doula playing an integral role in the production of humanized care along her line of flight.

> One day, I made the birth plan with the doula. In the birth plan, we basically defined aspects related to the moment of birth, deciding who we wanted to be present, how the procedures would be carried out, who would clamp the cord, and what the first care for the baby would be. We discussed all of this, and it was great because I think it's the moment when you really reflect on the circumstances. Even though the entire prenatal period is focused on preparing for this moment, sometimes you don't have the time – because of the rush, for many reasons – to truly reflect on the birth and how you want it to happen. Even though we

> know there can be variations and that some interventions may be necessary, it's important to think about your wishes for that moment. So, it was really good (EVA).

> It was me, my partner, and the doula. We were discussing the birth plan – some details that we sometimes don't even think about, but that are important to flow well in the moment (EVA).

Following the childbirth care protocol, Eva began labor induction on November 10, 2019, consistent with the circumstances at that moment. Care was provided in the hospital setting, always supported by a team that promoted evidence-based care throughout the progression of her labor and delivery, without losing sight of her protagonism. This approach helped reshape the scenario through woman-centered care and the use of available technologies in a less interventionist and more humanized manner (Rocha & Ferreira, 2020).

> We chose to induce labor with misoprostol to see how my body would respond to the induction. Misoprostol was inserted intravaginally, and after about an hour or so, we started activities to stimulate the onset of labor. We did exercises on the ball, danced, and walked. What stood out to me the most at that moment was how easy and calm the process felt. Everything that was done – the entire procedure and everything that was about to happen – was always explained to us by the team (EVA).

> The expulsive period was very long – it lasted almost three hours—but the same approach, the same logic, was maintained. I changed positions, and my choices were respected at all times. The obstetric nurse, the doula, and the obstetrician suggested different positions to help me feel more comfortable and to stimulate the phase I was in [the expulsive period]. I tried three or four positions, and finally, the obstetrician suggested that I stand on the bed, hold onto the bar. I remembered that when I had tried squatting while holding the bar before, it had felt more comfortable than using the stool or other positions I had tried earlier. And again, I felt greater comfort in that position (EVA).

The pain of childbirth, in its rhizomatic aspect, represents a line of flight for many women who ultimately undergo surgical delivery. However, it can be traversed by the flexible lines of good childbirth care practices, including non-pharmacological methods of pain relief – practices that were skillfully conducted, particularly by obstetric nurses, and experienced by Eva.

> At first, I felt pain similar to cramps – a very manageable situation – and I was still able to talk, dance, and behave normally. As the contractions intensified, it was as if I entered my own space, where only I could fit [laughs], and in that sense, labor progressed, and it was good that way. As the pain increased, I was able to cope with it. It became stronger, but at the same time, I was prepared for it, so I started feeling it more gradually (EVA).

> What helped a lot during the progression of labor, and even during the pain of the contractions, was the team constantly giving massages, offering support, and holding me. Sometimes they would hug me or help me change positions, and my choices were always respected. At one moment, I was on the ball; at another, I was in bed; then later, I was in the shower. Everything had a purpose – it was something I could feel, something that made me more comfortable in that moment, and from there, we would adjust as needed (EVA).

Although this care is recorded from the participant's perspective, maternal physical exhaustion was noticeable as a hard line, even as it was crossed by the flexible lines of confidence and tranquility leading up to the culmination of birth.

> I became more confident; I thought, 'Wow, it's already very close.' So, the worst is over [laughs], we've already progressed well. But at the same time that it gave me all this confidence, I started to feel that I was so close, and I think that brought a kind of excessive calmness, mixed with the tiredness of thinking I was so close—so close—that I lost heart (EVA).

However, these hard lines related to the emotional aspects and the duration of labor progression, which crossed the participant-guide's experience, did not diminish the beauty of the moment when her healthy child was born, nor the bond established between the newborn and the family, supported by the healthcare team.

> The moment he was born – today I was even trying to describe this to someone – is hard to put into words because it is a moment of enormous emotion, a really powerful feeling toward the baby and everything that is to come. At the same time, it is an intimate feeling; it brings joy, immense happiness, and the thought of how healthy this is for our child. How wonderful it is, how healthy it is for him (EVA).

> The team encouraged physical contact, so the baby could stay with his father and me. He stayed on my lap, and only afterward was the first care provided. Only the necessary care was performed – nothing that would harm the baby's health or was done merely out of protocol – and that's wonderful! Realizing that the team, as a whole, respects you and sees that process as something unique is incredible (EVA).

The most remarkable aspect of Eva's journey is her countless experiences throughout the care provided during labor. Her narrative reaffirms the practical experience of humanized childbirth, marking a singular and unique moment of female empowerment.

> The experience is unique. It is special for each person and unique to each person. You should never compare yourself or try to find a standard in someone else, because labor basically depends on you and on the team assisting and providing care. So there will never be one experience exactly like another, you know (EVA).

> Humanization is closely tied to feminism itself—to valuing women, to recognizing women as a force, as beings who act, think, produce, and seek. I believe that humanization, in general, brings all of this, and above all, it brings two things: knowledge and courage (EVA).

Discussion

Following the networks outlined by the participant-guide, the study highlights the relevance of information within this pathway. Women in the pregnancy-puerperal context may lack information that could expand their knowledge and autonomy regarding childbirth care, and support their nomadism and protagonism in the production of humanized care (Feuerwerker, 2016; Oliveira et al., 2019; Silva et al., 2012). This reveals that social and literary media encourage women to reflect on and plan the key events surrounding the birth of their children (Pasqualotto, Riffel, & Moretto, 2020). In addition, the process of natural childbirth continues to be a source of insecurity for both women and their families, as global obstetric models – particularly in Brazil – still sustain an epidemic of cesarean sections, characterized by medicalization and institutionalization. Furthermore, vaginal childbirth is culturally perceived as pathological by both society and healthcare professionals, while cesarean sections are often portrayed as "normal births" and as safe, complication-free procedures (Ayres, Henriques, & Amorim, 2018; Boerma et al., 2018; Rodrigues, 2019).

Such knowledge enables women to reclaim their autonomy over maternal rights and public policies on the humanization of childbirth, better recognize situations of violence committed against women, and contribute to changing the current paradigm of childbirth care (Trajano & Barreto, 2021).

There is a major challenge for healthcare institutions to have doctors on their staff who are willing to make changes in childbirth care. Resistance persists because the professional associations that represent them do not have clear protocols to support this type of care (Rodrigues, 2019).

Thus, academic training should implement holistic changes in the paradigm of Women's Health care, aiming to ensure the rights of women and their newborns by adopting a humanized model of care as an institutional philosophy – one that respects the physiology of childbirth and benefits all those involved in the birth process (Pereira et al., 2018; Uhatela et al., 2022).

Our analysis highlighted certain fragilities at specific strategic points in the living network, particularly regarding labor pain and its progression. The information contributed to demystifying previous perceptions of labor as a negative process, associated with pain, suffering, and difficulties rooted in popular beliefs. It is evident that the sociocultural influence surrounding labor pain is linked to death, thus constructing a perception of fear and an inability to give birth. Therefore, it is essential for women to understand that pain is a natural part of the labor process, that professionals can support them in coping with it in a healthy way, and that it is possible to have a positive experience during this phase (Oliveira et al., 2019; Reis et al., 2017).

Information must be truthful, and humanized childbirth should be understood as a model based on a set of practices, attitudes, and behaviors – one characterized by dialogue, empathy, and acceptance of women and their family members. This process should be permeated by information and guidance provided to women in labor, recognizing them as subjects with rights and needs. In addition, procedures that have been proven beneficial to both mother and child should be adopted, while unnecessary and invasive techniques should be abandoned. Therefore, healthcare professionals must be trained and consistently grounded in scientific evidence (Possati et al., 2017).

Caring is supportive; it is a form of support that produces life. It represents the production of human beings and the construction of webs of relationships and encounters that affirm life. The birth plan, built according to women's choices, dignifies the moment, enables professional support and support from those close to them, ensures informed decisions, and the absence of mistreatment, redefining labor and birth (Feuerwerker, 2016; Pasqualotto, Riffel, & Moretto, 2020).

Non-pharmacological pain relief methods are strategies that support a positive birth experience, using techniques such as walking, hip swaying, exercises with a birthing ball, and hydrotherapy. These techniques are perceived by women as positive practices that help in the progression of labor, relaxation, and pain relief. Within this context, the obstetric nurse acts as a facilitator in this act of care, providing comfort and safety to the parturient (Almeida, Gama, & Bahiana, 2015; Monte & Rodrigues, 2014; Taheri et al., 2018).

Labor is a complex moment in which women may experience a range of emotional changes, both positive and negative, such as confidence, tranquility, joy, insecurity, fear, discomfort, and fatigue. Therefore, professionals must adopt a supportive, emotionally reassuring, comforting, and welcoming attitude toward these circumstances of childbirth, contributing to greater satisfaction with childbirth care (Melo et al., 2018; Reis et al., 2017).

Thus, this study followed Eva's nomadism in her search for humanized care, enabling the rupture of gender violence perpetuated by male domination and internalized by some women. These women often do not question the obstetric violence they experience from healthcare professionals, manifested through negligence, verbal abuse, and physical violence (Grihom, 2021; Santos & Souza, 2015).

These findings allowed us to glimpse Eva assuming her guiding role in the production of the research, possibly because she positioned herself as the author of her own process, taking the lead. It taught us much more, prompting us to question the healthcare networks accessed by women during labor and birth care. Thus, further research is needed to broaden our understanding of new flows followed by other participant-guides in their childbirth experiences, which highlights a limitation of this study, as it addresses a specific reality and does not allow for generalizations.

Through Eva's journey, we were guided by her pursuit of a humanized birth experience. The production of care from the perspective of the participant-guide leads us to a micropolitical

dimension of healthcare provided through living networks, highlighting the potential of light technologies, embodied in the encounter with humanized birth and supported by a team that contributed to this process.

It is evident that this care pathway remains inaccessible to many women who are entitled to such assistance. Thus, the following concerns emerge: How many Evas circulate within the maternal and child health network, particularly in childbirth care? How many women have never heard of humanized childbirth or have had their rights violated, preventing them from becoming protagonists of their labor and delivery? These reflections alert us, as healthcare professionals and citizens, to the importance of nurturing these living micro politically networks with sensitivity, empathy, acceptance, and scientifically evidence-based practices, demystifying actions that weaken women's perception of childbirth. In most cases, care depends exclusively on the professional assisting the woman, enabling the centrality of the citizen-user and her newborn.

Finally, we suggest that the comprehensiveness of childbirth care be discussed daily in the spaces where it takes place – that is, in micropolitical spaces, in primary healthcare settings, in hospitals, and within management – always ensuring the participation and representation of users in these discussions.

The participant-guide Eva served as an important tool for analyzing the production of childbirth care, starting from a unique point of investigation and allowing us to visualize, from her perspective, the established networks of care, the connections formed, and the shifts they provoked in us as subjects who weave networks and create our own ways of existing.

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