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Original Article

DA DECISÃO À VIVÊNCIA DA CESARIANA: A PERSPECTIVA DA MULHER

FROM DECISION TO CESARIAN: THE WOMAN PERSPECTIVE

DE LA DECISIÓN A LA VIVENCIA DE LA CESÁREA: LA PERSPECTIVA DE LA MUJER

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RESUMO

Objetivo: descrever o processo de decisão da mulher primípara pela via de nascimento, compreendendo a vivência da cesariana pela mesma. **Método:** trata-se de uma pesquisa do tipo descritiva, com abordagem qualitativa. As participantes foram dez puérperas primíparas que vivenciaram a cesariana. Na coleta de dados, utilizou-se a técnica de entrevista aberta com posterior análise temática, aplicando a técnica Laurence Bardin. **Resultados:** Foram levantadas duas categorias: A decisão pela via de nascimento e o momento da cesariana. Na primeira, foi possível perceber que a maioria das mulheres já chega ao consultório decidida sobre a via de nascimento, no entanto, nem todas conseguiram prosseguir com a escolha inicial. Na segunda, retrata-se como foi vivenciar a cesariana, estando a mulher amparada pelos entes queridos e apoiada pelos profissionais de saúde. **Conclusão:** Ressalta-se a importância de a equipe de saúde atuar efetivamente no compartilhamento de informações e na construção do vínculo, desde o pré-natal até o puerpério, em que a mulher exerce o real protagonismo do parto.
Descritores: Cesárea; Saúde da mulher; Tomada de decisões; Enfermagem.

ABSTRACT

Objective: to describe the primiparous woman's decision process for the birth way, understanding the cesarean experience by the same woman. **Method:** This is a descriptive research with a qualitative approach. The participants were ten primiparous women who underwent cesarean section. In the data collection, the technique of open interview with thematic analysis, applying the Laurence Bardin's technique. **Results:** There were two categories: the decision by birth and the time of cesarean section. In the first decision, it was possible to notice that most of the women already arrive at the office decided about the birth way, however, not all of them were able to proceed with the initial choice. The second one portrays how it was to experience the cesarean section, the woman supported by their loved ones and supported by health professionals. **Conclusion:** It is important to emphasize the importance of the health team to act effectively in information sharing and in the bond building, from the prenatal to the puerperium, in which the woman performs the real role of childbirth.
Descriptors: Cesarean section; Women's health; Decision-making; Nursing.

RESUMEN

Objetivo: describir el proceso de decisión de la mujer primípara por la vía de nacimiento y comprender la vivencia de la cesárea por la misma. **Método:** se trata de una investigación del tipo descriptivo, con abordaje cualitativo. Las participantes fueron diez mujeres que hubieran dado a luz primíparas que experimentaron la cesárea. En la recolección de datos, se utilizó la técnica de entrevista abierta con posterior análisis temático utilizando la técnica Laurence Bardin. **Resultados:** Se levantaron dos categorías: La decisión por la vía de nacimiento y el momento de la cesárea. En la primera, fue posible percibir que la mayoría de las mujeres ya llega al consultorio decidida sobre la vía de nacimiento, sin embargo, no todas han logrado proseguir con la elección inicial. La segunda retrata cómo fue vivir la cesárea, estando la mujer amparada por los seres queridos y apoyados por los profesionales de la salud. **Conclusión:** Se resalta la importancia del equipo de salud actuar efectivamente en el intercambio de informaciones y en la construcción del vínculo, desde el prenatal hasta el puerperio, en que la mujer ejerce el real protagonismo del parto.
Descriptores: Cesárea; Salud de la mujer; Toma de decisiones; Enfermería.

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INTRODUCTION

In the last decades, there has been a growing increase in the number of cesareans, with Brazil being the country with the highest rates in the world[1], so that 52% of births happen through this route, private sector, where this number reaches 88%[2]. According to the World Health Organization (WHO), rates greater than 10% are not associated with the reduction of maternal and neonatal mortality[3].

In this scenario, with a view to reducing cesarean rates in Brazil and valuing the right to choose the form of partaking, several public policies have been consolidated, such as the Humanization Program in Pre-Natal and Birth, the National Policy of Integral Attention to Women's Health, the Pact to Reduce Maternal and Neonatal Mortality, the Baby Friendly Hospital Initiative and the Stork Network[4-5].

The indiscriminate indication of cesarean section is associated with greater maternal and fetal morbidity and mortality, however, if correctly indicated, this birth route becomes beneficial for the mother-concept binomial, since part of the complications are reduced during pre-partum and childbirth[6]. Among its indications are Human Immunodeficiency Virus (HIV) Infection, placenta previa, placental accretismo and pelvic presentation[7].

Multiple factors are involved in the choice of cesarean section, such as regional and cultural differences, the relationship established with the woman in prenatal care, the way maternity hospitals are organized, and the fact that the interventions are still centered on the physician figure[8]. The study "Born in Brazil" showed that the model of care in the country, in the private sector, is the presence of a physician assistant from prenatal to delivery and the number of obstetric nurses and reduced doulas[9].

A research carried out in Belo Horizonte shows that the profile of women who undergo cesarean section is similar to those of Brazil: "are women whose delivery occurs at lower gestational ages, private institutions of white race/color, over 32 years of age, economy class. " In this state, it includes women with health insurance and with companions[9].

It is noted that the woman's desire for a cesarean section is based on fear, whether it is not to endure pain, to die, to be torn as well as the feeling of not being able to give birth. The ability to schedule and plan also contributes to the choice, as well as the physician's influence and disinformation. The vaginal delivery route is considered by many pregnant women as a risky experience. In contrast, the surgical act is perceived as safe and less painful[5].

The experience of other women has a great influence on the choice of the pregnant woman, especially the family or friends[1]. In the same way, it is observed that during the gestation, for fear of a negative outcome, the decision by the way of birth is influenced by the health professionals, being the decision of the woman, weakened by the "convincing power" of the professionals[10]. In this sense, when the professional seeks to establish a relationship of exchange and empowerment of the pregnant woman in the process of parturition, the choices become more conscious and with the effective participation of the same.

In this perspective, the participation of women in educational practices allows the development of a relationship of trust with the health professionals involved, favors a calmer gestation, since there is a physical and psychological preparation of the woman, besides enabling the empowerment of the pregnant woman through of information and clarifications so that the same one can choose, in a conscious and safe way, by the best way of birth, besides favoring the bond mother-baby[11].

From the above, it emerges as a guiding question: how did the primiparous woman decide by the way of birth? How was it for the woman, for the first time, to experience the cesarean from the expectations raised in prenatal care? The studies "Born in Brazil" and "Born in Belo Horizonte" highlight the high rates of unnecessary cesarean sections as a public health problem[9]. Therefore, knowing the determining factors for their choice, even when there is no absolute indication for it, contributes to the professionals preparing the woman still in prenatal care for the time of delivery, clarifying doubts and demystifying reports that contribute to the refusal of normal delivery. This study proposed to know these questions to help the professionals involved, including those in Nursing, to rethink the care provided to women from prenatal to puerperium, based on an integral care that empowers them in the choices, so conscious, allowing you to experience this important moment in full.

Considering the above considerations, this study aims to describe the decision process of the primiparous woman through the birth route,

including the experience of the cesarean section by the same.

METHOD

It is a study of descriptive nature and qualitative approach, where the basic and initial resource used is the description itself. In the Human and Nature Sciences, data and concepts cannot be expressed accurately and accurately, but rather observed and apprehended in the sensitive intuition, where they can be described in words, constructing inaccurate concepts[12].

The study was developed in a philanthropic hospital in the interior of Minas Gerais. The institution has 105 beds, being 26 apartments, 64 beds of infirmary, six beds from an adult ICU and nine beds from a neonatal ICU. Currently, it is recognized as a teaching hospital, with the offering of Medical Residency Programs in Gynecology and Obstetrics, Pediatrics, General Surgery and Radiology.

Access to the women and the interview took place in the maternity ward, both in the private and in the public sector, being recognized as a macro-regional reference in Care to the High Risk Pregnant Woman.

As participants, ten women participated in the immediate puerperium who underwent cesarean section. The inclusion criteria were women older than 18 years of age, of low gestational risk and who underwent cesarean section by choice. Exclusion criteria were situations in which women experienced some intercurrence during pregnancy or labor that made natural delivery unviable and some disorder, whether physical or psychological, incapacitating them to answer questions. The participants were individually informed about the objectives, possible risks and benefits of the research, as well as the presentation of the Free and Informed Consent Term (FICT).

Data collection was performed through an open interview, between July and September 2017, with the following guiding questions: How was the birth route chosen for you? In gestation, how did you expect or thought your C-section would be? How did you experience cesarean for you? How you were guided in prenatal care by the team of professionals about normal delivery and cesarean section?

Participants were approached after 12 hours of cesarean section, respecting a time for the woman to reestablish and have a closer contact with the newborn. The place for the interviews was the fourth one of the patients, in the hospital, in the public wing as well as in the private one.

At the moment, the newborn was in the care of the companion, or was sleeping. The interviews were recorded, with the permission of the women, using the digital recorder of a cell phone, and later they were transcribed in full, aiming to allow the reliable analysis and interpretation of the results. The end of the data collection was due to the saturation of the data[13]. The interviewer was an undergraduate nursing student, already in the conclusion phase of the course, after training with the teacher responsible for the research.

For the analysis of the data, the Laurence Bardin Content Analysis Technique was used, which proposes a sequence for analysis, based on three phases. The first one consists of the pre-analysis, which aims to systematize the material so that the analyst can conduct the successive analysis operations, being divided into four stages: floating reading, which is the establishment of contact with the data collection documents; the demarcation of what will be analyzed; the formulation of hypotheses and objectives; and the indexing of indexes and elaboration of indicators by means of text cuttings in the documents. Subsequently, in the second phase, the categories are defined and the units of registration are identified and, finally, the treatment of results, inference and interpretation[14].

In order to ensure confidentiality and anonymity for each participant, an alphanumeric code, represented by the letter "E" and followed by a number corresponding to the interview number, has been established. The research was conducted in accordance with the ethical principles set forth in Resolution 466/2012 of the National Health Council, which regulates research with human beings. This study was approved on April 12, 2017, under the number of opinion 2,014,480, CAAE: 65609517.7.0000.5153.

RESULTS AND DISCUSSION

The ages of postpartum women who participated in the study ranged from 19 to 34 years, with an average of 28 years. Regarding the marital situation, all had a stable relationship with a partner, and the majority, (seven) were married. Of the pregnant women, four had completed higher education, one was in higher education and five had completed high school. As

for the religion, the majority (nine) declared to be Catholic.

With regard to prenatal care, all were followed during pregnancy, with an average of 11 consultations, the majority (eight) being performed either by agreement (five) or private (three), with only two by UHS. From the interviews with the puerperal women, eight were addressed in the private ward and covenant and two in the public wing.

The discourses were grouped into two categories, according to the thematic proximity of the answers generated from the questions of the script that guided the present study. The first category deals with the decision by way of birth, while the second deals with the time of the cesarean section.

The decision of birth type

This study reveals that the choice through the birth route permeates from prenatal to the time of the birth itself. Therefore, in this category, women's discourses regarding decision making are presented, showing how this process was configured during prenatal care with the guidelines that strengthened their choices, the moment that precedes the child's birth, as well as the expectations and fears that surround them.

Some women reported that they had arrived at the prenatal clinic decided on the route of birth they would like to have, whether it was normal or a cesarean. They searched before going to the doctor's office or talked to people who also chose the same route because they wanted to build their opinions.

These meanings can be exemplified in the following snippets: "(...) I started with the option of caesarean section (...), I talked to people who had already made friends with people in my family, such as my sister, who had already delivered a cesarean delivery, there the doubts I had in parallel, I searched the internet ... to be able to form my own opinion "(E8). "(...) I arrived and I told her [doctor] that I really wanted to try normal labor, because I had already researched, already talked to other people, researched in mobile applications and general knowledge even about the advantages and disadvantages of each" (E10).

Some women admitted that in expressing their choices about normal delivery or cesarean delivery, doctors did not offer guidance and in some situations did not even provide information on the chosen birth route. The knowledge they possessed came from Internet research or reports of the experiences of people close to them. The following accounts show the above: "(...) we do not even talk about normal birth. She did not explain anything, just talked about the cesarean itself, what it would be like after the C-section, right?! "(E4). "Actually, during pregnancy, my doctor did not tell me anything about the pros and cons of each, (...) I did not talk about it, about childbirth" (E8).

Others received biased guidance from professionals, as can be seen in the following clipping: "she [the doctor] even told me that the normal people have the chance, the ease of having, as well as people who have more difficulty as well. The cesarean does not. The cesarean is like this, you came, you decided, you scored, you did, everything went well, without much delay, you can plan, everything goes something like " (E2).

Some women reported receiving advice from doctors about normal delivery and cesarean delivery, even when they positioned themselves as they wished. "(...) I arrived at the doctor's office with the idea of a normal birth ... but she never forbade me to do a cesarean, in fact she made it very clear that it could happen ... she explained to me the pros and cons of each type of childbirth, the recovery of each one, these things "(E3). "The doctor told me about the benefits of each one, about the harm (...), I came here knowing about the two deliveries" (E6).

Currently, there are several sources of information available, such as the internet, television, magazines, books, among others. Many women use these means to gain a better understanding during pregnancy, about what will happen, and so they can plan childbirth more consciously. It is also important to consider family influences such as grandparents, sisters, mother-in-law and, especially, mother, about the experience of childbirth, and it is often decisive for the woman to elaborate her own conception of ideal childbirth[1,15-16].

Despite these diverse sources of information, studies indicate the need for women to have access to knowledge that has a scientific foundation, knowledge that must be passed on by a professional, since much information passed by the media is not reliable[1,15-16].

Therefore, it is of great relevance the educational action during prenatal care, where the health professional, in the role of educator, provides reliable information about the risks and

benefits of each intervention, in order to ensure that the woman can exercise her participation active in the process, empowered by her rights and the risks and benefits that her choice can bring to her and her baby. This educational action should occur even when the woman arrives in prenatal care with a preference for the way of birth, allowing her to decide consciously[1, 15-16].

However, many professionals still pass on tendentious information to women and, most of the time, tend to perform cesarean section. Such conduct can be justified by social relations, economic interests and convenience. The biomedical interventionist model supports the training of many professionals, so caesarean section is perceived as something profitable and of short-term resoluteness, since it is more convenient to be programmed with the scheduling of the dates from their availability. In this sense, this path was highlighted in obstetric practice[5].

Another study corroborates the findings of the present study, evidencing the large number of women who arrive at the end of gestation without guidance on normal delivery and cesarean delivery. Often, the knowledge they possess comes from their own research in magazines, the internet, and conversations with others who have gone through this experience. It is noteworthy that this occurs mainly when women arrive at prenatal care with a decision about the way of birth, in which the professional does not expose the options that she has, let alone what will happen from the decision of that woman[17]. Considering that these are primiparous women, the disinformation becomes even more serious, because it underestimates the capacity of a woman who has never experienced that event in her life, withdrawing the possibility of being the protagonist in the process of parturition.

It is noted that some women expressed indecision between normal birth and cesarean section when they started prenatal care and declared that they had been instructed by professionals, making them aware of the advantages and disadvantages, and this helped them make a decision later.

"My doctor explained about the two of you, right ... but then I really preferred to have a cesarean section" (E7). "They explained to me, normal delivery is much healthier ... recovery is faster and the cesarean section takes a little longer. I think maybe this may have influenced me a bit more by wanting the normal birth, but I did not know " (E9).

In order for women to make the best choice, they must have knowledge, information and feel empowered and prepared to make that decision. It is at this moment that health professionals, through a clear dialogue, compatible with the level of education of women, should raise awareness and ensure clarification on the procedures to which they can be submitted, their risks and benefits, so that they can empowered in their choices[18].

It is noteworthy, in the testimonies, which the cesarean was not in the plans, but ended up happening. For some primiparous women still in prenatal care, the desire was to perform the normal delivery, but after the onset of contractions and hospital admission, they chose cesarean section. The main reason was the very strong pain, thus, they were unable to proceed with the delivery chosen previously. Revealed that, they had medical advice and, support for decision making.

"Until then, I had chosen the normal birth (...), I ended up opting for cesarean because the pain was unbearable ... the doctor said that if I waited, it was to try the normal birth, I I would stay there feeling pain, pain, pain and maybe I would not dilate "(E1). "I chose normal birth, but I could not stand it. (...) when I told her that I was not taking any more, at no time, she [the doctor] tried the opposite "(E3). "Actually, during my prenatal care, I had opted for normal delivery, but due to excessive pain during labor, I opted for a cesarean section. It was a decision of my own, with the support of my doctor, right? " (E6).

Studies show that most women accept the change in the option they had chosen during the prenatal care because they believe it is their well-being, as well as their child's, as well as a more peaceful and painless development. The participation and positioning of the professional at that moment exerts a great influence on the final decision[18], because the woman believes that it has theoretical knowledge and a consistent clinical practice to offer security to the mother-child binomial.

The preponderant model in Brazil is still centered on the figure of the doctor. It is important to emphasize that the power relationship between the professional who offers the assistance and the woman contributes to her being inhibited to question what she considers to be the best for her and, consequently, feels

deprived in freely choosing the path of birth of her child[19].

It is noted that, often when indicating cesarean surgery, the physician takes on the role of delivery instead of just watching the mother and her baby[19]. In a moment of fragility, the influence of doctors, nurses or doulas, contributes to the outcome is different from the one initially chosen. The deprivation of clear information, the absence of dialogue that establishes the empathy between the professional and the pregnant woman and the conditions of the public or private health system end up causing frustration and insecurity in the woman and the whole family[1].

The services of the Unified Health System (UHS) are organized to provide on-call staff in hospitals, prepared to receive full-time pregnant women in labor, which contributes to the normal outcome. In the institutions that make up the private network, this scenario is challenging. Prenatal care and childbirth are performed with the same physician, and for this, it must be present in different places. Thus, the professional must be available to accompany the pregnant woman full time and wait for the birth, exclusively attending the woman. It is believed that this mode of organization contributes to the increase of cesarean sections, in pregnant women of habitual risk, directly impacting costs with the surgical procedure[20].

Reports were shown, of women who, despite their choice of normal birth during prenatal care, found themselves unable to give birth naturally due to pain. This symptom, during normal delivery, has a very strong stigma of being unbearable, of being so strong, that not all women can bear it, and the moment of childbirth is where those fears take on a real and often much larger dimension of what it actually represents because of this prior association of normal delivery with pain. And often, this change of opinion during labor is due to the lack of offering of non-pharmacological methods of pain relief for these women[18].

It is at this point that the cesarean section emerges as a "salvation" and appears as the solution to pain and prolonged labor, presenting itself as a practical, agile and pain-free procedure. The lack of clarification during the prenatal period, regarding the duration of labor and other physiological factors that involve this moment, favors that these women arrive at the hospital with little information about the process of parturition and, often, the only knowledge comes from reports from other people, making painful feelings and fears greater. Faced with the fear of not being able to bear the pain, or that something bad may happen, they become more vulnerable to the acceptance and request of the cesarean section[5].

The desire to perform caesarean section since the prenatal period was referred to by other women, and this choice was justified because they believed that it was more comfortable for the possibility of planning the date and the husband was scheduled to be present, and considered to be safer. They thought that the chances of complications are lower and professionals are more prepared. In addition, they expressed that they would not like to feel pain.

The following excerpts exemplify this question: "It was what I really wanted [Cesarean section]. Because I thought it would be quiet, that I would feel less pain, the convenience of being able to dial, choose the day and everything else "(E4). "From the beginning, my husband and I defined the caesarean section (...). So we preferred to plan the way it would be and the best way was this, we decided on the planned cesarean, right now that there would be no risk of unforeseen complications, he could plan to be with me at the time of childbirth " (E8).

Other studies corroborate these findings by showing that the main factor influencing the choice of cesarean section is the belief that it is painless and safe, as well as the convenience of predicting and controlling the moment of birth. Often, this idea persists due to lack of guidance or a biased approach of the professional during prenatal care. Thus, women believe that when they undergo cesarean delivery, they will feel less pain and babies will not be exposed to risks because they are safer and more controlled[1,16,18].

In addition to the aforementioned questions, it is noted that complicity / proximity with the medical professional can also influence the decision by cesarean section. Many women feel more comfortable and confident when the professional who accompanied them in prenatal care is the same as the person who will perform the procedure. Therefore, in addition to the comfort for the family of the scheduled date for organization and family planning, there is also the convenience and convenience related to the professional, which will be programmed to be present at that moment, reducing the chances of

unforeseen events and the possibility of performing labor with another doctor[5].

It is important to emphasize that the justification presented by the woman for her decision by cesarean section, defined during the prenatal period, does not present scientific criteria, ie, they do not represent real clinical criteria for performing this surgical procedure and, even so they have support from their doctors, or they are indicated by them. Some studies question whether this biased approach of professionals is due to their formations. Most of the time, a biologists model, centered on technique/intervention, leads to a greater dominance of cesarean section and trivialization of natural childbirth[5,21].

The moment of cesarean section

The time of the cesarean section is marked by fear, since most of the primiparous were unaware of the environment of the surgical center, how the procedures were performed and, above all, the application of anesthesia. They expected to feel pain, to be very ill, to have a post-surgical complicated with many pains. This generated fear and anxiety before the delivery, as expressed in the excerpts: "I could not imagine what Cesarean delivery was, despite having chosen, having researched (...) I thought it would be much more complicated because there are people who complain that it hurts a lot (...). I did not know how it was in there either, I just imagined what it might be "(E2). "Even being what I had chosen, right, I was a little afraid of what it would be like when I got here. (...) it was the first time of everything, I had never entered the surgical block there, ... so I kept imagining everything... the anesthesia then, when she explained that it was in the column, I was terrified " (E4).

Other studies corroborate these findings by pointing out that the feeling of fear and apprehension in prenatal care are linked to the unknown and the lack of sufficient information on the subject. It is observed in clinical practice that, often, the conversation between the professional and the pregnant woman is unilateral, where the professional passes the information without clear explanations and the patient listens passively without clarifying their doubts. Facing the unknown and presenting a median knowledge on the subject, fears are feedback[1,17].

Seeing the doctor as unquestionable, possessing irrefutable and authoritative knowledge, it helps women feel afraid to question. Thus, they become passive before the possibilities of assuming for themselves the responsibility of their care[5,17]. On the other hand, when they are informed and clarified during prenatal care about their birth routes, they tend to become less anxious, nervous and experiences become positive[17].

In describing how the cesarean was experienced, it was noticed that the women had a positive report about the experience. When they entered the surgery, they were very agitated, afraid and with the emotional "to the skin". They revealed that the moment before surgery is marked by nervousness and anxiety, even by the desire to see the child soon.

"I was very nervous about this, of even imagining myself, because of the fear. And the nervousness to get in and out soon, too, I wanted it to be fast, that I'd be back in the room with my son "(E7). "(...) on arrival at the block, the emotional is the flower of the skin right?! That's how we get more sensitive right ... I was already anxious to see my daughter" (E8). "When I got inside, the anxiety was great to see the baby soon, so I was up a little agitated, because I wanted to see the little face of the baby, right?" (E10).

During the cesarean section, several feelings emerge, involving from the fear of intercurrences with the child to reports of contact with the newborn being the best experienced moment[22]. They want to ensure a smooth, pain-free and well-being[4]. However, in cases of cesareans, early contact with the baby may be impaired due to the risk of developing puerperal infection, the birth of premature infants, maternal and infant morbidity and mortality, among others[6].

The presence of a relative or a close person at the time of the child's birth serves as a fulcrum, offers greater security and helps to reassure, because feelings are raised. "My mother came with me, it was good to have her there with me. Pass some security for us right?! Have someone from the family there too" (E5). "My husband being with me also, at that moment, was very important for me, to give me support, to help reassure me, to see, with me, for the first time, our daughter" (E8).

The study points out that often the presence of a person close to the pregnant woman is a way to provide more tranquility, confidence, relaxation and calm, besides helping

to control anxiety [23]. The presence of the companion, legal right, contributes to the feeling of security, comfort and family bonding for the woman in a moment of fragility, constituting a strategy of humanization of care[24], especially for those who have never experienced birth of a son.

Even when their participation is passive, as is the case of cesarean, where the physician is responsible for performing the entire surgical procedure and maintaining aseptic techniques, the presence of the companion is essential to enable the birth experience to be a family event. In addition, there is evidence that the woman shows greater satisfaction with the attendance of the team when accompanied by someone of her confidence, realizing that she is more respected and more enlightened about the whole process[25].

Since 2005, under Law 11,108, hospitals and maternity hospitals are obliged to allow the presence of a person indicated by the pregnant woman to accompany her throughout the labor process. However, this law is still unknown by many, preventing women from exercising their right to have someone they trust at birth[26].

It was observed that the primiparous women considered as a positive aspect of the cesarean section the presence of a technically prepared and at the same time warm and caring staff who were always concerned about their well-being and reassured them. This support and attention, in a differentiated way, both inside the operating room and outside, in the post-anesthetic recovery room, were considered of great importance, as can be evidenced in the following statements: "The team helped me a lot, my husband was with me was also very important. I get there and see that inside, it was not the seven-headed creature I imagined. (...) everyone was very welcoming to me. (...) the nurse in the room let me hold her hand. It reassures people "(E4). "Actually, everyone was very thoughtful, I really enjoyed it.

Everyone was very worried about me, always asking me if I was okay, if I was doing well, that if I needed anything, I would just speak, just call. All the time I had a lot of help, both inside the room and after I left the room (...). It was too quiet. It was much better than I could imagine" (E2).

It is known that the moment of birth of the child is surrounded by much anxiety, apprehension and fears, especially in the first experience. The support of all the people involved, be they professional or family, strengthens and encourages the woman. Studies have shown that satisfaction or dissatisfaction with the experience of cesarean delivery or normal delivery is closely linked to the care provided by the team[16,27].

The women evaluate as positive the assistance given in a calm, caring, caring, supportive and comfortable way, going beyond the orientation about the procedure. By assuming a posture of rapprochement and bonding, professionals enable greater tranquility, security and confidence at birth[16,27].

When they chose cesarean, they concluded that it was the best choice for them and for the babies, and some show that they will perform the surgery again in a future pregnancy, without any problem, even if, at first, the choice was for normal delivery. "If I have another child (...) I would very much like to attempt normal childbirth (...) but, after this very peaceful experience, much better than I imagined, if I have to opt in the future, in a second gestation, have to choose the second cesarean too, nothing against also not" (E1). "That now when I have my next child I will surely do it again because it came out even better than I expected." (E2). "(...) so, for me, it's as good as the normal birth. So if I need to do it again, I'm sure to do [cesarean section]" (E9).

Studies indicate that satisfaction with the birth route, whether planned during prenatal or not, is very much related to the experience of the woman regarding the psychological support, attention and care received. In addition to these factors, satisfaction is also related to the well-being of both the baby and the post-cesarean mother, thus leading to the desire to repeat the choice through this route in future pregnancies[1,18].

CONCLUSION

It is possible to affirm that the woman arrives for prenatal consultation decided on the way of birth, supported by information without scientific evidence and influenced by friends and family. The dialogue with the doctor is not always enlightening, maintaining a vertical relationship, of little exchange and without the empowerment of the pregnant woman.

The experience of the cesarean section was positive, even for women who had the normal option as the first option. The presence of the companion and the support of the health team

was fundamental to make them feel safe and calm.

It is important to emphasize the importance of the health team to act effectively in the sharing of information and in the building of the link from the prenatal to the puerperium. It is known that professionals can contribute positively to women's choices and, therefore, they must be willing to make them responsible in this process, aware of all possible outcomes and exercising the real role of childbirth.

It is believed that Nursing has possibilities of acting in the different moments of the pregnancy cycle, offering qualified and humane assistance in the various care settings, informing about the risks and benefits of normal delivery and cesarean delivery. Regardless of the social and cultural level, it is important that the nurse intensify the educational process, still in the prenatal period, to reduce the risk of morbidity and mortality associated with high rates of cesarean section.

Obstetrics nurses working in normal delivery centers, based on evidence-based practices, should offer a welcoming environment in which women feel more comfortable in the circumstances of the moment, encouraging and valuing the needs of the parturient.

The limitation of the study is related to the investigation of primiparous women, portraying the experience of only a portion of the women who undergo caesarean section.

In addition, new studies are suggested that seek to reveal the experience of the cesarean section in the late postoperative period, since it is understood that these women may present other meanings when experiencing the repercussions of a surgical procedure at a time of care of the newborn and self-care.

REFERENCES

1- Nascimento RRP, Arantes SL, Souza EDC, Contreta L, Sales APA. Escolha do tipo de parto: Fatores relatados por puérperas. Rev Gaúcha Enferm. 2015;36(nesp):119-26. DOI: 10.1590/19831447.2015.esp.56496

2- Fundação Osvaldo Cruz (BR). Nascer no Brasil: Pesquisa revela número excessivo de cesarianas. Rio de Janeiro: Fiocruz; 2014.

3- Betran AP, Torloni MR, Zhang JJ, Gulmezoglu AM. WHO statement on caesarean section rates. BJOG 2016;123(5):667-70. DOI: 10.1111/1471-0528.13526

4- Martins APDC, Jesus MVN, Prado Júnior PP, Passos CM. Aspectos que influenciam a tomada de decisão da mulher sobre o tipo de parto. Rev Baiana Enferm. 2018;32:1-11. DOI: 10.18471/rbe.v32.25025

5- Copelli FHS, Rocha L, Zampieri MFM, Gregório VRP, Custódio ZAO. Fatores determinantes para a preferência da mulher pela cesariana. Texto Contexto Enferm. 2015;24(2):336-43. DOI: 10.1590/0104-07072015000430014

6- Costa MN, Silva JDFO, Silva LDA, Galdino CV, Brás MR. Parto: Direito de escolha da mulher. Saber Digital 2017 [citado em 20 set 2018]; 8(1): 146-63. Available in: http://revistas.faa.edu.br/index.php/SaberDigital/article/view/395/302

7- Brasil. Portaria nº 306, de 28 de março de 2016. Aprova as diretrizes de atenção à gestante: A operação cesariana. Brasília: Ministério da Saúde; 2016.

8- Freitas PF, Fernandes TMB. Associação entre fatores institucionais, perfil da assistência ao parto e as taxas de cesariana em Santa Catarina. Rev Bras Epidemiol. 2016;19(3):525-38. DOI: 10.1590/1980-549720160003000

9- Ribeiro LR. Nascer em Belo Horizonte: Cesarianas desnecessárias e prematuridade [dissertação]. Belo Horizonte: Universidade Federal de Minas Gerais; 2016.

10- Riscado LC, Jannotti CB, Barbosa RHS. A decisão pela via de parto no Brasil: Temas e tendências na produção da saúde coletiva. Texto Contexto Enferm. 2016;25(1):1-10. DOI: 10.1590/0104-0707201600003570014

11- Pereira ALF, Ribeiro LV. Avaliação dos grupos educativos na assistência pré-natal em casa de parto. Rev APS 2016 [citado em 28 de nov 2017]; 19(1):24-30. Available in: https://aps.ufjf.emnuvens.com.br/aps/article/view/1808/933

12- Martins J, Bicudo MAV. A pesquisa qualitativa em psicologia: Fundamentos e recursos básicos. 5a ed. São Paulo: Centauro; 2005.

13- Fontanella BJB, Luchesi BM, Saidel MGB, Ricas J, Turato ER, Melo DG. Amostragem em pesquisas qualitativas: proposta de procedimentos para constatar saturação teórica. Cad Saúde Pública 2011;27(2):388-94. DOI: 10.1590/S0102-311X2011000200020

14- Bardin L. Análise de conteúdo. Lisboa: Edições 70; 2011.

15- Pimenta LF, Ressel LB, Santos CC, Wilhelm LA. Percepção de mulheres sobre a escolha da vida de parto: Estudo descritivo. Online Braz J Nurs.

2013 [citado em 28 nov 2017]; 12(1):135-44. Available in: http://www.objnursing.uff.br/index.php/nursing/article/viewFile/3963/pdf_2

16- Velho MB, Santos EKA, Collaço VS. Parto normal e cesárea: Representações sociais de mulheres que os vivenciaram. Rev Bras Enferm. 2014;67(2):282-89. DOI: 10.5935/0034-7167.20140038

17- Tostes NA, Seidl EMF. Expectativas de gestantes sobre o parto e suas percepções acerca da preparação para o parto. Temas Psicol. 2016; 24(2):681-93. DOI: 10.9788/TP2016.2-15

18- Freire NC, Nunes IM, Gramacho RCCV. Parto normal ou cesárea? A decisão na voz das mulheres. Rev Baiana Enferm. 2011;25(3):237-47. DOI: 10.18471/rbe.v25i3.6027

19- Dias MAB, Domingues RMSM, Pereira APE, Fonseca SC, Gama SGN, Theme Filha MM, et al. 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. Ciênc Saúde Colet. 2008;13(5):1521-34. DOI: 10.1590/S1413-81232008000500017

20- Entringer AP, Pinto M, Dias MAB, Gomes MASM. Análise de custo-efetividade do parto vaginal espontâneo e da cesariana eletiva para gestantes de risco habitual no Sistema Único de Saúde. Cad Saúde Pública 2018;34(5):1-15. DOI: 10.1590/0102-311x00022517

21- Leão MRC, Riesco MLG, Schneck CA, Angelo M. Reflexões sobre o excesso de cesarianas no Brasil e a autonomia das mulheres. Ciênc Saúde Colet. 2013;18(8):2395-400. DOI: 10.1590/S1413-81232013000800024

22- Reis CC, Souza KRF, Alves DS, Tenório IM, Neto WB. Percepção das mulheres sobre a experiência do primeiro parto: Implicações para o cuidado de enfermagem. Cienc Enferm. 2017; 23(2):45-56. DOI: 10.4067/S0717-95532017000200045

23- Medeiros J, Hamad GBNZ, Costa RRO, Chaves AEP, Medeiros SM. Métodos não farmacológicos no alívio da dor de parto: Percepção de puérperas. Espaç Saúde 2015;16(2):37-44. DOI: 10.22421/1517-7130.2015v16n2p37

24- Vaz TH, Pivatto LF. Avaliação da presença do acompanhante no parto e puerpério em maternidade pública. Cogitare Enferm. 2014; 19(3):545-52. DOI: 10.5380/ce.v19i3.32046

25- D'Orsi E, Brüggemann OM, Diniz CSG, Aguiar JM, Gusman CR, Torres JA, et al. Desigualdades sociais e satisfação das mulheres com o atendimento ao parto no Brasil: Estudo nacional de base hospitalar. Cad Saúde Pública 2014; 30(supl 1):154-68. DOI: 10.1590/0102-311X00087813

26- Brasil. Lei 11.108, de 7 de abril de 2005. Altera a Lei n. 8.080, de 19 de setembro de 1990, para garantir às parturientes o direito à presença de acompanhante durante o trabalho de parto, parto e pós-parto imediato, no âmbito do Sistema Único de Saúde-SUS. Diário Oficial da República Federativa do Brasil 2005.

27- Oliveira ASS, Rodrigues DP, Guedes MVC, Felipe GF. Percepção de mulheres sobre a vivência do trabalho de parto e parto. Rev Rene 2010 [citado em 28 dez 2017]; 11(nesp):32-41. Available in: http://repositorio.ufc.br/ri/bitstream/riufc/4726/1/2010_art_mvcguedes.pdf

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