

Autonomy In the Choice of Childbirth in The Primiparous: Understanding Reality

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ABSTRACT

Every pregnant woman has the right to care during childbirth and postpartum, and that this is performed in a humane and safe way. To ensure autonomy, it is necessary to put the woman in control of labor and birth, providing the necessary knowledge that allows her to make decisions about her own body. The study aimed to know the autonomy and knowledge of primiparous women in choosing the type of delivery. This is a qualitative field research. The participants were primiparous women, who agreed to participate in the research by signing the Informed Consent Form. The interviews were conducted after approval by the Research Ethics Committee under protocol n. CPEA 31364620.8.0000.5428, opinion n. 4,300,350. In view of the results, the following themes emerged: Reception and neglected bond between health units and pregnant women, revealed by reports of negative and frustrated experiences in the parturition process. Factors that prevent the autonomy of the choice of delivery in pregnant women and negative experiences and frustrated expectations regarding the moment of delivery, in which the reports indicated a lack of explanation of the procedures, lack of communication and prejudiced decision of the physician in relation to the delivery. It was concluded that

the study showed the need for actions aimed at women's health in the pregnancy-puerperal period, which enable conditions for female empowerment in decision-making about the body itself.

Keywords: Women's health. Humanized childbirth. Personal autonomy. Obstetric violence.

1 INTRODUCTION

Cesarean delivery (CD) and normal delivery (ND) are the alternatives available for live births and, thus, it is expected that the pregnant woman has the right to analyze the risks and benefits to freely choose the route of delivery. But there are aspects related to childbirth care that still need to be discussed. The model of delivery care in Brazil is characterized by excessive intervention^[1].

According to the World Health Organization (WHO), 140 million live births occur worldwide each year; most without identification of risk factors. When performed for medical reasons, CD may reduce maternal and perinatal mortality and morbidity. However, there is no evidence that CDs are minimally beneficial when women or babies do not face major problems^[2].

In Brazil, however, the natural order is reversed. In 2020, the Unified Health System (UHS) performed 2,727,923 deliveries, of which 1,562,282 were CD^[3]. According to the WHO, Brazil has the second highest rate of cesarean sections (55%), second only to the Dominican Republic (56%). It is important to highlight that the international medical community considers that the ideal rate of CD is between 10% and 15%. César Fernandes, president of the *Brazilian Federation of Gynecology and Obstetrics*, understands that it is really necessary to change the current pattern.

ND is considered a physiological and natural process. When there are complications for the binomial in the face of complications or situations that can compromise life, the CD becomes a necessary intervention. However, in any situation, the pregnant woman should receive the necessary knowledge about the events that happen to her body, and effectively participate in decision-making^[2,4].

Studies on ND and CD have addressed the various problems associated with this organization of care, demonstrating a certain concern that involves the quality of care from prenatal care to birth^[5,6]. However, positive factors of CD were identified in women who experienced this delivery and chose to have it again electively. The reasons for their choice were the fear of the pain of the ND, the tranquility that the anticipation of childbirth brings and the feeling of security for the greater control of childbirth, thus, the feeling of security for greater control of childbirth^[7].

Regarding negative perceptions of CD, postpartum pain, difficulties in recovery, risks of surgery, previous concerns and experiences with anesthesia, higher levels of fear when compared to ND and difficulties in returning to sexual activities. Women who had CD, elective or emergency, were more displeased to remember the birth of their children^[5].

Satisfaction, preference or advantages associated with ND, regardless of the previous experiences of women with the type of delivery, were found in descriptions such as: little suffering, faster recovery, need for less care, feeling less pain after childbirth, possibility of returning to daily activities and being discharged

earlier. Having information about childbirth, having control over the event and the degree of relaxed are positive perceptions about childbirth. Other two important factors associated with satisfaction are: positive opinions about the team that attended, in a careful and affectionate manner, and the presence of a companion^[5].

Women, since the beginning of their lives, should be very well oriented in relation to their autonomy, choices and rights, especially during pregnancy, which is a period of great sensitivity and vulnerability caused by bodily transformations that will consequently result in a procedure, childbirth. Knowing whether to impose ourselves through theoretical foundations is fundamental for female empowerment, and instruments such as the delivery plan become an important tool for obstetric violence practices to be increasingly distant from reality^[4,8].

To ensure autonomy, it is necessary to put the woman in control of labor and birth, empowering her to actively decide on her own care, providing her feeling of security during this process. These actions are essential for women to identify and decide which care practices can favor or limit their autonomy^[4]. According to the Ministry of Health, every pregnant woman has the right to care during childbirth and puerperium, and that it be performed in a humanized and safe manner, according to the general principles and conditions established in medical practice^[9,10].

The study was developed based on the following questions: Is the choice of delivery in accordance with the needs of each woman? Is your decision respected without the influence of the multidisciplinary team, or professional decision? Thus, the research aimed to understand if there is autonomy in choosing the type of delivery by primiparous women who experienced this process.

2 METHODOLOGY

The study is qualitative, exploratory and descriptive, based on the testimonies of primiparous women. The selection criterion was > a participant in 18 years of age, primiparous, who underwent a ND or cesarean section, from January to December 2019, belonging to a women's health care unit in a municipality in the interior of São Paulo state.

The project was approved by the Research Ethics Committee, under protocol CPEA n. 31364620.8.0000.5428, under the opinion of n. 4,300,350. All participants signed the Informed Consent Form, in accordance with the provisions of Resolution 196/96 of the National Health Council, guaranteeing them anonymity and confidentiality of information.

The selected sample was composed of 20 primiparous women, eighteen of whom authorized and had good acceptance to participate in the research, there were two refusals. Data were collected between January and March 2021.

The reports were collected through an interview script prepared by the researchers, composed of eight questions about sociocultural data: schooling, marital status, family income, type of delivery, agreement, whether prenatal care was performed, if pregnancy was planned. The in-depth questions were recorded and transcribed in full, being based on the following questions: How was the reception received and the relationship with health professionals? How did the pregnant woman imagine the delivery, pregnancy and feelings in relation to childbirth? How was the delivery chosen, was it supported or not in the choice? How did family

members participate in the choice? How was the experience at the time of delivery? To preserve anonymity, the participants were identified as P1, P2, P3 and so on.

The interviews were conducted from November 2020 to January 2021 at the place chosen by the participant (domicile or health unit). Content analysis was used, inserted according to the thematic analysis modality, enabling the interpretation of the participants' statements, as argued by Cardoso et al.^[11], performing a thematic analysis consists of discovering the meaning nuclei that make up communication and whose frequency of appearance may mean something for the intended analytical objective. According to Silva et al.^[12], thematic analysis is the possibility of using a flexible and useful search tool, which can provide much more accurate and detailed but complex data analysis.

3 RESULTS AND DISCUSSION

The participants were 18 primiparous women from a city in the countryside of São Paulo, who gave birth in the maternity hospital of the same city. The age range ranged from 18 to 33 years. Regarding education, two have incomplete elementary school, six complete elementary school, six complete high school, four higher education, 8 married and 10 single. Regarding family income, there was a variation from one to four minimum wages in relation to the type of delivery, ten normal deliveries and eight cesarean sections were identified, all of which had prenatal care, but only four reported that pregnancy was planned (Table 1).

Table 1. Presentation of the participating primiparous.

Participants	Age	Education	Marital status	Family income	Type of delivery	Health insurance
P1	23	IC	Single	02 Wages	ND	UHS
P2	19	CPE	Married	03 Wages	ND	UHS
P3	22	IC	Single	02 Wages	ND	UHS
P4	18	IPE	Single	02 Wages	ND	UHS
P5	28	CC	Married	03 Wages	ND	UHS
P6	33	CC	Married	04 Wages	ND	UHS
P7	25	IC	Single	03 Wages	ND	UHS
P8	23	CHS	Single	02 Wages	ND	UHS
P9				WRP		
P10				WRP		
P11	21	IC	Married	03 Wages	CD	Private
P12	25	CHS	Single	04 Wages	CD	Private
P13	30	CHS	Married	04 Wages	CD	Private
P14	22	CC	Single	01 Wages	CD	UHS
P15	23	CHS	Single	02 Wages	ND	UHS
P16	27	CC	Married	03 Wages	CD	Private

P17	24	CHS	Married	03 Wages	CD	Private
P18	21	CHS	Married	03 Wages	CD	Private
P19	18	CPE	Single	01 Wage	CD	Private
P20	22	IPE	Single	02 Wages	ND	UHS

Note: (ND) Normal Delivery; (CD) Cesarean Delivery; (UHS) Unified Health System; (IC) Incomplete College; (CPE) Complete Primary Education; (IPE) Incomplete Primary Education; (CC) Complete College; (CHS) Complete High School; (WRP) Women who Refused to Participate. **Source:** The Authors, (2022).

After the detailed transcription of the reports, the data were grouped in order of similarity between the answers and from there the following themes emerged: 1st Embrace and neglected bond between health units and pregnant women; 2nd Factors that prevent the autonomy of choosing delivery in pregnant women; 3rd Negative experiences and frustrated expectations regarding the time of delivery.

3.1 Embrace and Neglected Bond between Health Units and Pregnant Women

Most of the interviewees demonstrated a lack of confidence in the team, creating a gap between the care provided and the real needs of women. The bond formed by the interaction between people, paying attention to individuals, clarifying doubts and supporting their decisions, can favor the approximation between health services and women during the pregnancy-puerperal period, minimizing anxieties, fears and increasing the safety and support needed for women^[13].

[...] I didn't do the prenatal right [...] many doubts I had I asked on the internet and with my friends P03.

[...] I missed some lectures to teach us things P04.

[...] in the FHS I have nothing to complain about, but in Santa Casa it is very mechanized, you know P05.

[...] I had a lot of doubts about breastfeeding, I think I could have explained more [...] I was very confused but my mother helped me a lot P08.

[...] the nurses at Santa Casa look like caged animals [...] my son didn't want to latch on and these women said that my son would not be able to [...] it was traumatic P13.

[...] many of the doubts I had I would go on the internet and research [...] I was ashamed to ask why some things seemed silly P17.

[...] it was good, but I think there is a need for greater support, you know how to show more how it works P20.

In the reports, it is noticed that the parturient women were not properly guided by the teams that accompanied them during pregnancy and delivery, because they showed fear and insecurity. Communication is an essential instrument, so it is necessary to establish communication accessible at all social levels so that the guidelines on medicines, conducts and care can be followed and thus to continue care for a pregnancy free of complications and injuries^[14].

The lack of information on pregnancy, childbirth and puerperium was evident in the reports cited. The preparation of women for delivery should occur during prenatal care by primary care professionals, either in individual consultations or in groups of pregnant women. The delivery plan has been shown to be efficient in the construction of knowledge about the pregnancy-puerperal process among women, allowing female empowerment in decision-making and favoring better preparation during childbirth^[8,15].

3.2 Factors that Prevent the Autonomy of Choosing Delivery in Pregnant Women

When a woman discovers that she is pregnant, everything she has heard about pregnancy before even imagining a mother, and what she hears during pregnancy is from her culture, from the environment in which she is inserted, from her family, or even from the multidisciplinary team that will assist her during pregnancy, will contribute to the choice of the type of delivery she should choose^[1,13].

[...] Everyone I know says that normal birth was easier and faster [...] P05.

[...] The doctor asked me when I wanted to schedule the cessation so I had no choice [...] P07

[...] My mother always told me that the normal birth was better because we get better sooner [...] P11.

[...] I wanted to have the baby with the doctor who did my prenatal care and he didn't have a normal birth, so I preferred to have it stopped [...] P13.

The reports clearly reveal that women are influenced during childbirth, either by people close to them or by professionals. At no time was there an express decision of the woman about the type of delivery, evidencing the lack of autonomy over the body itself. Of the 18 women interviewed, 10 had ND, where all reported having reached this choice through advice from family and friends. Of the 8 women who opted for CD, 7 were by medical indication and only 1 by family indication.

In this context, according to Ferrari^[16,17], autonomy presupposes the right of choice based on information transmitted transparently by responsible and committed professionals, attentive to the ethical duty of making the pregnant woman competent to make a choice.

In the question of the autonomy of the woman who desires the ND, the conflict between autonomy and beneficence does not apply, especially in the supplementary sector, because beneficence would only be justified in the face of a cesarean section for real medical reasons, and most women are submitted to unnecessary cesarean section^[18].

3.3 Negative Experiences and Frustrated Expectations Regarding the Time of Delivery

The reports show that women lack support, help and clarification, it is a moment of greater vulnerability, and uncertainties are constantly on the outcome of birth. Therefore, we emphasize the need for support and bonding between professionals who work during the pregnancy-puerperal process, with a view to female empowerment for decision-making, thus allowing conscious choices and autonomy in the choice of delivery.

[...] I missed them explaining things to me, you know how to breastfeed and change diapers P03.

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[...] this is the moment when we really need someone [...] I chose my husband to stay with me, and he doesn't know anything [...] you have no direction P13.

[...] it was really bad I thought it would be normal, I was in a lot of pain, feeling a little indifferent, you know, I just wanted to have my baby and leave, no, that's not what I had in mind P15.

[...] I expected better service, everything seemed very automatic P17.

Childbirth is a unique, special and long-awaited moment, natural childbirth in a humanized way is idealized by many women, but reality is opposite. The indifference and mechanization of the procedures, felt by the women in the face of the reports, ends up transforming childbirth into a traumatic event.

ND is perceived as a painful process, with greater than expected pain intensity, even for a short period, in addition to painful and unexpected procedures that contributed to increased pain levels, such as amniotomy or oxytocin administration to accelerate labor. Discomforts associated with epidural analgesia, episiotomy and type of delivery, with the exception of elective cesarean section, and the transformation of the female body into a work object. The role of women is not favored or respected, produced by the model of medicalization of care, which also contributes to the negative perception of childbirth^[5].

[...] I got scared, I felt powerless at the last minute, I even thought about doing it P02.

[...] it was traumatic, it hurt a lot, the women seem to have no patience, I don't know, it seemed that they were there out of obligation P04.

[...] I expected more, I don't know [...] it's such a unique moment to be transformed into a mechanized thing P05.

[...] if I were to have another baby, I would sell everything and do it, it would stop, [...] I would not have a normal birth again P18.

The interventionist and mechanistic model of childbirth neglects women's rights in the process of parturition and dominates their bodies, perpetuating gender violence, which in this context has been called obstetric violence^[6]. The vast majority of hospitals do not have specific techniques for pain reduction, at most they encourage the presence of the companion during labor and do not restrict to the bed^[19].

According to the Ministry of Health, in a CD performed by the UHS, the woman has the right to the anesthesiologist's duty, exclusive operating room for surgery and bedside follow-up by a team prepared for complications; in the case of ND delivery, the Ministry of Health recommends that, before offering labor analgesia, the hospital should offer non-pharmacological methods of pain relief, that offer fewer risks and can solve the problem of painful sensitivity without the risks of analgesia. These methods include continuous support, freedom of movement, access to water (such as shower and bathtub), access to ling's ladder, horse and stool that are physiotherapy instruments for the adoption of other positions for the ND, in addition to the support of the doula, the ambience of motherhood and privacy, methods present only in maternity hospitals, rare in the country^[20-22].

4 CONCLUSION

ND was the most observed in most cases, and preferable in view of the good recovery of both mother and baby. However, the present study made it possible to identify a multiplicity of meanings and perceptions for motherhood of women who experienced the first pregnancy, from receiving the confirmation of pregnancy to the meaning attributed to the child, evidencing the lack of autonomy of women throughout the process. During pregnancy, women often do not receive correct guidance on the benefits and harms of each delivery, so it is assumed that the choice of the type of delivery is not always the woman's, and that the ND is not encouraged, making the CD to deliver the culturally accepted and professionally induced "choice". It is emphasized that cesarean section is necessary and extremely important, provided that the intervention is performed when there is the correct indication of the responsible doctor. It is important to highlight the determinants of the choice of the type of delivery by pregnant women, one of the most relevant points for the knowledge of the risks and benefits of each type of delivery, thus allowing autonomy and conscious choice. In addition, it is up to the professionals responsible from prenatal care to the moment of delivery to provide all the information to the woman during the pregnancy-puerperal cycle.

For a humanized embracement and intervention, it is suggested the training of professionals who work prenatal care to the postpartum women, as it is fundamental for maternal and neonatal health, building a new look from primary outpatient care to the hospital environment.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

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