Normal or cesarean birth in adolescence...



ORIGINAL ARTICLE

NORMAL OR CESAREAN BIRTH IN ADOLESCENCE: WHO IS THE DECISION? PARTO NORMAL OU CESÁREA NA ADOLESCÊNCIA: DE QUEM É A DECISÃO? PARTO NORMAL O CESÁREA EN LA ADOLESCENCIA: DE QUIÉN ES LA DECISIÓN?

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ABSTRACT

Objective: to investigate the participation of women in decision making during recurrent deliveries in adolescence. *Method*: this is a qualitative, descriptive study, based on the Theory of Social Representations. Thirty women who experienced recurrent birth during adolescence were part of this study. Data were collected through a semi-structured interview and analyzed based on the Discursive Textual Analysis. Results: women who do not know about the process of parturition are anchored in negative feelings and transfer the decision on the type of delivery to medical knowledge. In the counterpoint, when they obtain knowledge, they demonstrate active voice in the decision making as to the type of delivery that they want. Conclusion: it was possible to verify that the pillar of the decision making regarding the type of birth experienced is closely linked to the provision of information to the woman because when there is knowledge, there is empowerment in the process of gestating and giving birth. Descriptors: Midwifery; Parturition; Natural Childbirth; Cesarean section; Decision Making; Adolescent.

Objetivo: averiguar a participação da mulher na tomada de decisão durante os partos recorrentes na adolescência. *Método*: estudo qualitativo, descritivo, fundamentado na Teoria das Representações Sociais. Fizeram parte desta pesquisa 30 mulheres que vivenciaram o parto recorrente na adolescência. Os dados foram coletados por meio de entrevista semiestruturada e analisados com base na Análise Textual Discursiva. Resultados: mulheres que não possuem conhecimento a respeito do processo de parturição ancoram-se em sentimentos negativos e transferem a decisão sobre o tipo de parto ao saber médico. No contraponto, quando obtêm conhecimento, demonstram voz ativa na tomada de decisão quanto ao tipo de parto que desejam. Conclusão: foi possível constatar que o pilar da tomada de decisão em relação ao tipo de parto vivenciado está intimamente ligado ao fornecimento de informações à mulher, pois quando há conhecimento surge o empoderamento no processo de gestar e parir. Descritores: Tocologia; Parto; Parto Normal; Cesárea; Tomada de Decisões; Adolescente.

RESUMEN

Objetivo: averiguar la participación de la mujer en la tomada de decisión durante los partos recurrentes en la adolescencia. Método: estudio cualitativo, descriptivo, fundamentado en la Teoría de las Representaciones Sociales. Fueron parte de esta investigación 30 mujeres que vivieron el parto recurrente en la adolescencia. Los datos fueron recogidos por medio de entrevista semi-estructurada y analizados con base en el Análisis Textual Discursivo. Resultados: mujeres que no poseen conocimiento al respecto del proceso de parturición se ancoran en sentimientos negativos y transfieren la decisión sobre el tipo de parto al saber médico. Sin embargo, cuando obtienen conocimiento, demuestran voz activa en la tomada de decisión cuanto al tipo de parto que desean. Conclusión: fue posible constatar que el pilar de la tomada de decisión en relación al tipo de parto vivido está intimamente ligado al fornecimiento de informaciones a la mujer, pues cuando hay conocimiento surge el empoderamiento en el proceso de gestar y parir. Descriptores: Partería; Parto; Parto normal; Cesárea; Toma de Decisiones; Adolescente.

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INTRODUCTION

To give birth is considered a unique, special and single process in a woman's life

and one of the most important events in human life. It is a social and biological process that is related to the woman's life history, beliefs, and values. For this reason, the context and the experience of women must be respected to make them protagonists of this

The history of childbirth care is closely linked to the home environment. This moment the beginnings of civilization accompanied at home by midwives, women of confidence or of great experience in the community and who had knowledge about parturition. Over time, this intrinsically feminine and shared among women, began to acquire formality, inserting empirical and efficient elements of a magicreligious medicine. Talismans, prayers, and magic recipes were used to ease the pain of contractions.3

In the twentieth century, there were scientific and technological advances in childbirth care that brought benefits to highrisk deliveries and resulted in lower maternal and infant mortality rates. However, these advances prioritized the medicalization of the parturient during childbirth, making the medical-surgical parturition, process with the technicist excessive use interventionist practices applied in low-risk childbirth, increasing the number of cesarean sections and the abuse of technological interventions.4

Besides to causing harm to maternal and newborn health, the medicalization of childbirth can trigger feelings of fear, insecurity, and anxiety in the teenager, which will affect difficulties in the evolution of their labor, often due to the loss of human contact and presence of the family.⁵

According to data from the Ministry of Health, the number of cesarean sections rose from 40.2% in 1996 to 50% in 2008. In the research conducted by the Oswaldo Cruz Foundation (FIOCRUZ) in partnership with scientific institutions in Brazil, in 2012 reached 52% of births, and in the private sector it is 88%.^{6,7}

Thus, , the fifth objective among the eight Millennium Development Goals is to improve maternal health, which is an immense challenge for Brazil and the world. Among these challenges is the need to facilitate women's access to health services, to control the medicalization of childbirth by reducing the number of unnecessary surgical deliveries, as well as to guarantee equal opportunities for

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health care in a comprehensive and humanized way.²

In the perspective of offering qualified care the woman to provide information regarding the types of delivery, it is a humanized care in which the professional uses his knowledge to empower the woman about the choice of the type of delivery to be experienced. The health professional needs to report the benefits of normal delivery as a physiological process, as well as clarify the indications of cesarean delivery, noting that cesarean delivery should not be a routine event for women, as it may become a risk mother and the newborn. The woman will have the opportunity to participate in decisions regarding the experience of her delivery.8

To prepare the study, it was assumed that the adolescent to discover that she is pregnant can assimilate the new phase of life and adapt to the process. However, she does not have an active voice in decision-making about her first labor experience because of a lack of knowledge about the process, as well as the fear of being judged. However, when experiencing recurrent childbirth, their attitude towards decisions changes and begins to participate actively in the process, seeking to assert their rights of qualified care.

OBJECTIVE

• To investigate the participation of women in decision-making in adolescent recurrent births.

METHOD

Descriptive qualitative research, based on the Theory of Social Representations proposed by Serge Moscovici.9 It was carried out in six Basic Health Units (UBS) of a city in the southern state of Rio Grande do Sul. Thirty adult women gestation and recurrent childbirth in adolescence. The choice of interviewing women rather than adolescents was justified by believing that time is primordial for reflecting on the facts experienced, and with maturity the woman can express in a more concrete way the social representations about recurrent Inclusion criteria were women over 20 years old; who have experienced two or more births between ten and 19 years old, according to the chronological criteria for adolescence of the World Health Organization; residing in the urban perimeter of the municipality of Pelotas; being conscious and situated in time and space; agreeing with the dissemination and publication of results in academic and scientific circles; allowing the use of tape

recorder during interviews.

The procedure for data collection was performed using the Snowball technique, an intentional sampling method that allows the definition of a sample through the indications given by people who share or know others with common characteristics of study interest.¹⁰

The data were collected in the period between May and August 2015, through a semi-structured recorded interview, based on the following questions: teenage pregnancy; experience of childbirth and recurrence; formation of knowledge about the gestation process; and parturition and support networks.

The analysis of the data was made under the light of the Discursive Textual Analysis (ATD),¹¹ seeking support in the theoretical reference of the Theory of Representations (TRS), in the Moscovician side. ATD advocates the disassembly of texts. The first moment of the analysis occurs through the process of unitarization that seeks to identify the constituent units of the phenomenon under study. The second moment is the establishment of relationships that aims at categorization by the combination and classification of the constituent units. In the third moment, there is the capture of the new emergent, it is the renewed understanding of the whole made possible by the two previous stages.

The research was developed in accordance with Resolution 466/2012 of the National Health Council. 12 The project was approved by the Research Ethics Committee of the Faculty of Nursing - Federal University of Pelotas, 0166 085 and Opinion CAAE 43861015.7.0000.5317. The Informed Consent Form (TCLE) was signed by all the participants of the research and the anonymity was assured through the use of the initial "M" referring to the woman plus the current age and numerical order of the interview, M.25.1; M.23.2.

RESULTS AND DISCUSSION

Deciding about the way of delivery usually triggers clinical discussion. However, the woman does not participate in this decisionmaking process, and it is only informed of it. Thus, the fact that this decision the concentrated in power of professionals, without considering the opinion of the parturient, has been considered as a factor for the high number of surgical well delivery, as as for negative representations of the parturition process. 13

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It is understood that the participation of women in the decision-making process of their parturition process is extremely relevant to the humanized and physiological delivery since the presence of women in the decision-making process is closely linked to their knowledge about the childbirth event, as well as their empowerment to claim their rights.

In this study, it was possible to observe that some women were active in the decision about normal delivery.

> In caesarean they would open the belly and then sew as in surgery, then in my head I built a thought that I wanted normal birth. (M.28.6)

> After the first, I was even surer that I always wanted normal birth. (M.23.13)

In the second it was easier, I wanted it to be normal birth and be quiet than the first, because despite the fear, my delivery was very good. (M.25.12)

Normal delivery was always my choice, I think no one influenced me, but of course, as I told you, I had already heard about the cesarean, but I also heard about the normal birth, and even then, I wanted to be normal because I was faster and recover more fast too. (M.45.22)

When I got pregnant the second time, I wanted it to be a normal birth again, because it is calmer and easier. (M.24.25)

When I got pregnant again I wanted it to be normal birth too, because at first I did not feel any pain. (M.30.30)

The doctor told me that normal delivery would be much better and easier than cesarean, because in normal delivery you will be able to walk, you will be able to take your daughter on her lap and that the cesarean must have those care, take care of the stitches, not being able to do things at home, then I decided that I wanted normal birth. (M.23.8)

The speeches report the desire of women to experience normal childbirth. For this decision, they were anchored in previous experience or in the provision of information during prenatal care. This finding is in line with a study carried out in Argentina with 29 pregnant women without an indication of cesarean delivery, who found that the actual cesarean rates were incongruent with the mode of delivery for which the women said they had a preference. Most of the pregnant women in this study showed interest in vaginal delivery. The reasons cited include culture, personal and social aspects. Vaginal birth was seen as normal, healthy, and a natural rite of passage from femininity to motherhood, in which pain was associated with something natural, being termed as a "light with positive results."14

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In the United Kingdom, 153 women were interviewed to investigate decision making about vaginal delivery or cesarean delivery. The results show that decision-making in the type of delivery is related to the construction of knowledge (medical, non-medical, written, verbal, visual) from multiple sources (family, friends, media, health professionals), with different degrees of influence at different points of time, in a continuous process that begins before gestation and lasts until the moment of delivery. The study also showed that although they are aware of the types of delivery, in practice, women's autonomy ends up being limited, sometimes by health professionals, or by individual circumstances. Many women reported not expressing their opinion about the type of delivery because they relied on the decisions of caregivers. 15

In this context, it is necessary to emphasize the educational actions during pregnancy, allowing the exchange of information about the physiological event of childbirth, as well as the types of delivery, indications and complications. Pre-childbirth knowledge will enable women and their families to express their opinions when they are submitted to procedures without indication.

some However, study participants expressed a lack of knowledge about the process.

> I did not know what birth was, the birth that would be better, the prenatal doctor told me that I had all the conditions to have a normal delivery, then I believed in it. (M.41.7)

> In the second pregnancy, it was a bit different because I thought it might be normal birth because I already knew what it was like. And I actually think they only have a second cesarean if the first one was a Csection. (M.26.3)

> I did not know anything about delivery, I just learned in the gestation that being a Cesarean because the doctor said that I was very little girl to experience a normal birth. (M.24.21)

> I never thought about how the birth would be, and at that time they did not even talk about cesarean, I think they only had a cesarean if the woman or the child was at risk of life, I had in my head to have to suffer with the labor pains, and that was normal. (M.61.17)

The speeches of M.41.7, M.24.21 and M.61.17 demonstrate the (lack of) knowledge of the women about the birth experience, they end up entrusting the professionals with the decision about their parturition process.

This fact corroborates with the one pointed out in the study in which women do not know the process of parturition, as well as their meanings and impacts on their health and health of their baby. Lack of knowledge contributes to their taking a passive and uncritical attitude toward the content of other sources of information, such as soap operas, stories of other women built by the social milieu, and their own experience of previous births. This creates a behavior of doubts and apprehensions. Feelings such as fear and insecurity sometimes cause women to choose and/or undergo cesarean section. 13

The speeches demonstrate that women transfer the decision on the type of delivery to the physician, anchoring in the social representation of normal delivery being synonymous with pain, so faithfully believe that cesarean is the best choice of the moment.

In this context, a study conducted in England with 115 women in a postnatal ward related the decision to perform cesarean delivery to medical professionals, the women understood that I only wanted cesarean because my mother always had a cesarean section of my siblings and said that I had to be cesarean because it was better, I would not feel pain, I was lucky because during the prenatal the doctor told me it would be cesarean because I was already under very high pressure and it would be difficult to control the pressure. (M.21.1)

I did not think about anything, at prenatal the doctor told me that it would be cesarean, he did not explain clearly because, but in every consultation, he always told me to go preparing myself that I would probably be a C-section. (M.22.2)

The doctor said that I was very small and could traumatize a normal birth, as I do not understand much of it and I was afraid of the pain I thought it was better. (M.22.15)

when undergoing cesarean delivery were being protected from the unnecessary stress they believed to be vaginal delivery. They justified the concern of professionals with maternal and child well-being and that technological intervention was necessary for the birth of a healthy newborn. This study concluded that women faithfully believed in the professional who was providing care and that doctors would not perform a cesarean if it were not necessary.16

In contrast to the women who transferred the decision to medical knowledge, those who have an active voice appear before their delivery and opt for elective cesarean section.

> During my first pregnancy, I did a course of pregnant women, they talked about the importance of normal birth, which has less health risks for mother and child, showed the delivery room, taught to wash and clean the navel, spoke that the normal delivery was faster so we could leave, even knowing about it at the time of delivery, I wanted to

have a C-section because I was very scared of the pain. (M.25.5)

Another difference was making sure that I wanted cesarean from the other times too, I never thought about having a normal birth, and my doctor always respected my decision and my family. (M.20.19)

It can be seen that the aforementioned women seem to have autonomy in making decisions about elective cesarean section. It is seen that they demonstrated knowledge about the benefits of normal birth and nevertheless expressed an interest in experiencing elective cesarean.

In this line of thinking, a study carried out with 14 Australian women pointed out the fear of childbirth, issues of control and safety, and devaluation of the female body and birth process as the main reasons for women's requests for cesarean delivery. Women reported that medical discourses supported by their prior knowledge assisted in the decision by elective cesarean who considered it to be a safe and responsible decision to protect their health and the health of their baby. ¹⁷

In this sense, in Taiwan, a study was carried out with 20 primiparous women to understand the decision-making process in elective cesarean section. The women interviewed reported that natural childbirth was linked to history and negative thoughts, from the Chinese cultural value of filial piety, which builds childbirth as an effort that mothers must endure and a mortal crisis to sublimate the greatness of mothers. However, the cesarean section was related to the famous film and television, calling this method an elegant way of childbirth. ¹⁸

Regardless of the choice for the type of birth experienced, it is understood that the pillar of the decision-making process of the parturition process is in providing information to the pregnant adolescent, because when it is known the empowerment comes naturally, and then the expressions "too little girl to experience the normal birth" and "you are too small for so much suffering" will not be grounds for medical decision by surgical delivery.

with these justifications Faced indication of cesarean section, it is necessary to emphasize the need for health education actions in primary care, which appears as a space for practices for the humanization of birth. In the activities developed at the Basic (UBS), Health Unit such as prenatal consultation, pregnant women, lectures in the waiting room, it is possible to exchange horizontalized knowledge among health professionals and women to empower them Normal or cesarean birth in adolescence...

decision-making process in their parturition process.

CONCLUSION

This study enabled to investigate the participation of women in decision making during childbirth in adolescence. It was possible to verify that the pillar of the decision making regarding the type of birth experienced is closely linked to the provision of information to the woman because when the knowledge is known, empowerment emerges allowing women to be protagonists of their choices.

The results of this research showed that the adolescent to discover that she is pregnant can assimilate the new phase of life and adapt to the process. However, she does not have an active voice in decision-making about her first labor experience because of a lack of knowledge about the process, as well as the fear of being judged. However, when recurrent childbirth, experiencing attitude towards decisions changes, begins to actively participate in the process, seeking to rights assert their of qualified confirming the initial assumption of the study.

It is known that social interaction allows new representations to be born in society and to orient the thinking and behavior of the subjects since they are not static, they undergo intergenerational changes, at the same time they are shared by the social group. Thus, it is relevant to make health professionals aware of their role as promoters of knowledge in the social environment, and it is important to provide information on the types of delivery still in the gestation of the primiparous adolescent, since when the woman receives information builds reconstructs their representations about the process of gestating and giving birth and acts before their labor and delivery empowered by such (re) constructed social representation.

In this study, it was found that the Theory of Social Representations was an important referential to know the social representations of the recurrent parturition process in adolescence, outlining strategies to qualify the care provided to this population, and also subsidized the confirmation of the assumptions initials of this study.

It is recommended that further studies be conducted to deepen the social representations of the parturition process in the field of health professionals, as well as the relatives of women who were mothers in adolescence, since it is understood that both are the primary source for reconstruction, recreation, and re-presentation of social

representations of the process of parturition in adolescence.

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