PARTICIPATION OF WOMEN IN DECISION-MAKING IN THE PROCESS OF PARTURITION

PARTICIPAÇÃO DA MULHER NA TOMADA DE DECISÃO NO PROCESSO DE PARTURIÇÃO PARTICIPACIÓN DE LA MUJER EN LA TOMA DE DECISIÓN EN EL PROCEDIMIENTO DE PARTICIPACIÓN

Ana Paula de Lima Escobal¹, Greice Carvalho de Matos², Kamila Dias Gonçalves³, Pricilla Porto Quadro⁴,
Susana Cecagno⁵, Marilu Correa Soares⁶

ABSTRACT

Objective: to know the participation of the woman in the decision-making about the type of birth experienced. **Method:** integrative review of literature in full articles in English, Portuguese or Spanish, using a temporal cut from January 2004 to January 2014, using the LILACS, MEDLINE and SCIELO virtual libraries. We used as descriptors Normal Childbirth, Humanized Childbirth, Cesarean Section, Decision-Making and Qualitative Research, using the "and" and "or" Boolean operators as a tool for crossing. **Results:** 16 articles categorized in two thematic axes were considered relevant to the topic of this study: Vaginal birth after cesarean and Cesarean section: medical decision or maternal decision? **Conclusion:** the studies made it possible to perceive that it is necessary to persist in the search for the humanization of the parturition process, abdicating standardized actions, technological and medicalizing interventions that disregard the woman's decision about the process of parturition experienced. **Descriptors:** Natural Childbirth; Humanizing Delivery; Cesarean Section; Decision-Making; Qualitative Research.

RESUMO

Objetivo: conhecer a participação da mulher na tomada de decisão sobre o tipo de parto vivenciado. **Método:** revisão integrativa de literatura de artigos completos em inglês, português ou espanhol, utilizando recorte temporal de janeiro de 2004 a janeiro de 2014, por meio das Bases de dados LILACS, MEDLINE e da biblioteca virtual Scielo. Utilizou-se como descritores Parto Normal, Parto humanizado, Cesárea, Tomada de Decisões e Pesquisa Qualitativa, sendo utilizado os operadores booleanos "and" e "or" como ferramenta para o cruzamento. **Resultados:** foram considerados relevantes à temática deste estudo 16 artigos, categorizados em dois eixos temáticos: Parto normal pós cesárea e Cesárea: Decisão médica ou decisão materna? **Conclusão:** os estudos permitiram perceber que é preciso persistir na busca pela humanização do processo de parturição, abdicando de ações padronizadas, intervenções tecnológicas e medicalizadoras que desconsideram a decisão da mulher sobre o processo de parturição vivenciado. **Descritores:** Parto Normal; Parto Humanizado; Cesárea; Tomada de Decisões; Pesquisa Qualitativa.

RESUMEN

Objetivo: conocer la participación de la mujer en la toma de decisión sobre el tipo de parto vivenciado. **Método:** revisión integradora de la literatura trabajos completos en Inglés, portugués o español, utilizando marco temporal de enero 2004-enero 2014, a través de las bases de datos LILACS, MEDLINE y biblioteca virtual SciELO. Se utilizó como descriptores Parto Normal, Parto humanizado, Cesárea, Toma de Decisiones e Investigación Cualitativa, siendo utilizado los operadores booleanos "and" y "or" como herramienta para el cruce. **Resultados:** fueron considerados relevantes a la temática de este estudio 16 artículos, categorizados en dos ejes temáticos: Parto normal post cesárea y Cesárea: Decisión médica o decisión materna? **Conclusión:** los estudios permitieron percibir que es necesario persistir en la búsqueda por la humanización del proceso de parturição, abdicando de acciones estandarizadas, intervenciones tecnológicas y medicalizadoras que desconsideran la decisión de la mujer sobre el proceso de parturição vivenciada. **Descritores:** Parto Normal; Parto Humanizado; Cesárea; Tomada de Decisiones; Investigación Cualitativa.

^{1,2,5}Doctoral students, Graduate Program in Nursing, Federal University of Pelotas (Universidade Federal de Pelotas/PPGFEn-UFPEL). Pelotas (RS), Brazil. E-mail: anapaulaescobal@hotmail.com ORCID iD: <https://orcid.org/0000-0002-2601-9098>; greicematos1709@hotmail.com ORCID iD: <https://orcid.org/0000-0003-4479-4896>; ORCID iD: <https://orcid.org/0000-0002-3953-0688>; ³Masters student, Graduate Program in Nursing, Federal University of Pelotas (Universidade Federal de Pelotas/PPGFEn-UFPEL). Pelotas (RS), Brazil. E-mail: kamila_goncalves@hotmail.com ORCID iD: <https://orcid.org/0000-0002-2632-2660>; ⁴Undergraduate student in Nursing, Faculty of Nursing, Federal University of Pelotas (Universidade Federal de Pelotas/PPGFEn-UFPEL). Pelotas (RS), Brazil. E-mail: pricillaporto@hotmail.com ORCID iD: <https://orcid.org/0000-0003-1363-9199>; ⁶Doctor, Faculty of Nursing, Federal University of Pelotas (Universidade Federal de Pelotas/PPGFEn-UFPEL). Pelotas (RS), Brazil. E-mail: enfmar@uol.com.br ORCID iD: <https://orcid.org/0000-0001-9171-1083>

INTRODUCTION

Childbirth means for the woman one of the most important events of her life, a remarkable experience in which the feelings experienced will be remembered minutely for ever. Childbirth is a historical event in which care for labor and delivery took place in the home environment, the woman was assisted by another woman, usually a midwife of her confidence and supported by her relatives. In the twentieth century, in order to reduce the high rates of maternal and infant mortality, the institutionalization of childbirth occurred, shifting care from the woman's home to the hospital and consequently the medicalization.¹

With the institutionalization of childbirth the work of health professionals with women should be based on humanized care. However, the medicalization of the parturient has made medical-surgical delivery, technician and non-humanistic, treated through technologies and equipment and the pain of childbirth as a pathological symptom. Thus, medicalization and interventionist actions in the parturition process resulted in the excessive amount of cesarean deliveries and in the abuse of technological interventions.²⁻³

According to Ministry of Health data (MH), the number of caesarean sections increased from 40.2% in 1996 to 50% in 2008. Surgical delivery is a rapid, programmed and controlled event, providing calls in a short time³. In addition, this intervention results in high rates of profits for physicians and institutions. However, this type of delivery when performed routinely is a risk factor for low birth weight, prematurity, and neonatal and maternal mortality.³

In the context of qualified care, it is up to the health professional to provide information to the parturient regarding the types of delivery, valuing the benefits of vaginal delivery as a physiological process and clarifying the indications of cesarean delivery. In this way, the relationship between health professionals and pregnant women, when carried out through dialogue and trust, will enable women to participate in decisions regarding the experience of their delivery⁴. Therefore, it is necessary to value women's previous experiences, as well as their values, beliefs, fears and information obtained from other sources, since these factors can interfere in the decision-making of the pregnant woman.⁵

In this perspective, this study presents the following guiding question: What is the participation of the woman in the decision-

making about the type of birth experienced? Looking for answers to this questioning, this study aimed to understand the scientific publications produced in the last ten years about the participation of women in decision-making about the type of birth experienced.

OBJECTIVE

- To know the participation of the woman in the decision-making about the type of birth experienced.

METHOD

Integrative review⁶ in compliance with the following steps: 1) establishment of the hypothesis and objectives of the integrative review; 2) establishment of criteria for inclusion and exclusion of articles (sample selection); 3) definition of the information to be extracted from the selected articles; 4) analysis of results; 5) discussion and presentation of the results; and 6) presentation of the review⁷. It is emphasized that all processes were permeated by the collective discussion and the validation by pairs of the stages covered.

This integrative review sought to answer the following guiding question: What is the participation of the woman in the decision-making about the type of birth experienced?

After the definition of the subject, we defined as descriptors Normal Childbirth, Humanizing Delivery, Cesarean Section, Decision-Making and Qualitative Research previously consulted in the Descriptors in Science and Health (DECS) and Medical Subject Headings (MESH), using the Boolean operators AND and OR as a tool for crossing. The Latin American and Caribbean Center for Health Sciences Information (LILACS), the Scientific Eletronic Library Online (SCIELO) and the Medical Literature Analysis and Retrieval Sistem on-line (MEDLINE) database were used.

The inclusion criteria of the publications for this integrative review were: manuscripts written in the English, Portuguese and Spanish languages, published between January 2004 and January 2014, which addressed the participation of women in decision-making about the type of birth experienced.

We excluded studies that were not available in full, dissertations, theses and newspaper articles that were not of a scientific nature and which did not fall within the established time frame.

The selection of the sample was performed by means of floating reading of the titles and summaries followed by reading the articles in

full. For the analysis and subsequent synthesis of the articles that met the inclusion criteria, a synoptic framework specially designed for this purpose was used, which included the following aspects: identification of the study; authors; journals; goals; methodology and results.

RESULTS

In the MEDLINE database were found for the descriptor Natural Childbirth 2,047 publications, with the descriptor Humanizing Delivery appeared 24 results, the descriptor Cesarean Section presented 34,690 publications, Decision-Making brought 180,924 publications, and Qualitative Research the result was 86,953 publications. After the descriptors were crossed, 33 publications were found, with 14 publications contemplating the study objective, the others punctuating aspects that did not mention the inclusion criteria of the study.

In the LILACS database were found 311 publications for the descriptor Normal Childbirth, for the descriptor Childbirth 227 publications, the descriptor Cesarean Section presented 2,732 publications, Decision-Making brought 657 publications, and Qualitative Research the result was 2,103 publications. After the intersection of the descriptors a publication was found.

In the SCIELO virtual library, 65 publications were found for the descriptor Humanizing Delivery, for the descriptor Childbirth 70 publications, the descriptor

Cesarean Section presented 300 publications, Decision-Making brought 25 publications and Qualitative Research the result was 498 publications. After the intersection of the descriptors a publication was found.

At the end of the article selection stage, 16 articles were considered relevant to the topic of this study.

During the analysis of the data it was observed that in terms of time evolution in the period from 2009 to 2013 they concentrated more than half of the studies that permeate this review.

As for the place of origin of the publications, Australia presented the largest quantity, with five publications, followed by the United Kingdom with four, Brazil two and Canada, Argentina, Sweden, Norway and Taiwan with one publication each.

DISCUSSION

After reading in full the publications of this review, the studies were grouped into two themes, considering the similarity of contents, namely: Vaginal birth after cesarean (VBAC) and Cesarean section: Medical decision or Maternal decision?

◆ Vaginal Birth After Cesarean (VBAC)

▣ Theme 1. Vaginal Birth After Cesarean (VBAC)				
Title	Author	Journal	Aim	Results
'Groping through the fog': a metasynthesis of women's experiences on VBAC (Vaginal birth after Caesarean section).	Lundgren I, Begley C, Gross MM, Bondas T.	BMC Pregnancy Childbirth	To integrate results and deepen understanding of VBAC women's experiences.	The main results are presented with the metaphor groping through the fog; for women the issue of VBAC is like being in a fog, where the decision making and information system and health care professionals, both during pregnancy and birth, is not clear and contrasting.
Bioethics and birth: insights on risk decision-making for an elective caesarean after a prior caesarean delivery.	McGrath P, Phillips E, Ray-Barruel G.	MonashBioeth Rev.	To explore, from the perspective of the mothers, the process on the mode of delivery for a subsequent delivery after a previous cesarean decision.	Contrary to the clinical literature, most mothers in this study were strongly of the opinion that a vaginal birth after cesarean section (VBAC) represented a higher risk than an elective cesarean section (EC).
Women's views on the use of decision aids for decision making about the method of delivery following a previous caesarean section: qualitative interview study.	Frost J, Shaw A, Montgomery A, Murphy DJ.	BJOG.	To obtain women's opinions about their decision-making experiences about the method of delivery after an earlier caesarean section and the role of decision-makers in this process.	The main themes were: decision support role in reducing decision conflict and uncertainty during pregnancy; impact of decision aids on knowledge and anxiety; the relationship between past preferences, decisions and actual results; and the role of decision support mediator.
'I wanted desperately	Phillips	Contemp	To explore the reasons	VBAC mothers aim to achieve a

to have a natural birth': mothers' insights on vaginal birth after Cesarean (VBAC).	<u>E, McGrath P, Vaughan G.</u>	<u>Nurse.</u>	that motivate women to try vaginal birth after cesarean.	vaginal birth as a significant aspect of their femininity and an important event in a woman's life.
Decision making about mode of delivery among pregnant women who have previously had a caesarean section: A qualitative study.	MA Moffat, JS Bell, MA Porter, S Lawton, V Hundley ,PDaniel ian,S Bhattach harya	BJOG	To prospective exploration of women's decision-making on the type of delivery after a previous caesarean.	Women were influenced by their own previous experiences and expectations, as well as the final decision on the type of birth, often developed during the course of pregnancy. Most have acknowledged that any decision is provisional and may change if circumstances so require.
Believing in birth-choosing VBAC: the childbirth expectations of a self-selected cohort of Australian women.	<u>Fenwick J, Gamble J, Hauck Y.</u>	<u>J Clin Nurs.</u>	To explore the expectations of labor and knowledge of women who had a cesarean section and prefer a vaginal birth in a subsequent pregnancy.	For this group of women, their experience in cesarean section reinforced their expectations previously held about natural childbirth. Women had strong opinions about the importance of working with their bodies to achieve a vaginal birth, which was considered an integral part of being a woman and a mother.
Interventions for supporting pregnant women's decision-making about mode of birth after a caesarean.	<u>Horey D, Kealy M, Davey MA, Small R, Crowther CA.</u>	<u>Cochrane DatabaseS yst Rev.</u>	To examine the effectiveness of interventions to support decision making on vaginal birth after a cesarean section. And the specific objectives are to identify issues related to the acceptability of any intervention to parents and the feasibility of their implementation.	Evidence is limited to independent and mediated decision support. Research is needed on interventions to support shared decision-making for women in the birth mode considering a pregnancy after a cesarean birth, taking into account the performance of care providers.

Figure 1. Articles grouped in Theme 1 after synoptic table analysis “Vaginal birth after cesarean (VBAC)”. Pelotas (RS), Brazil, 2017.

Vaginal Birth After Cesarean (VBAC) is an important issue to be discussed as the increasing in the number of cesarean sections in the world brings concerns. Health professionals and women need to be aware that VBAC is recommended and safe, and is the best type of postpartum delivery, since it is a safe practice that is related to the reduction of complications with the double mother-baby, such as reduction of maternal and neonatal mortality rates.⁸

The present theme consists of studies related to the VBAC and seeks to understand the participation of health professionals and women in decision-making by the VBAC.

A meta-synthesis was conducted in Sweden, aiming to deepen the understanding of VBAC women's experiences. The results were presented with the metaphor "groping through the fog". The authors concluded that experiencing normal delivery after a cesarean section, is like feeling through the fog. The women reported their interest in experiencing vaginal birth, however when searching for

information about VBAC during pregnancy, they did not get clear answers from health professionals, so it is like being in a fog in search of an exit, that is, lack of information about VBAC. The health system is in favor of the VBAC, however, the professionals do not show support regarding the choice of the woman and do not provide positive information about the normal birth.⁸

In contrast to the Swedish study, an approach taken in Australia in which women strongly believed that VBAC poses risks to maternal child health over elective cesarean section. The mothers of the study reported their concern about the support they should receive from health professionals when choosing an elective cesarean section.⁹

Thus, the results of this study represent concerns regarding the participation of professionals in the consent of information to women who experience a birth after a previous cesarean, as there is a worrying and documented tendency of the increase of cesarean births, and it is the responsibility of

the professionals to fight for the decrease of these rates.

In this context of (mis)information, the need for health education during prenatal care is perceived in order to guide women about the indications of vaginal delivery after an earlier cesarean section, since knowledge empowers women to participate in the decision-making during the parturition process.

In this context, a study conducted in the United Kingdom to obtain women's opinions about their decision-making experiences about the method of delivery after an earlier cesarean section revealed that women who received information and professional support during prenatal care had greater safety in VBAC decision-making¹⁰. Thus, professionals need to consider the biopsychosocial context of women, providing them with sufficient knowledge to assist them in making decisions about the mode of delivery.

Another study carried out in this same country pointed out that the decision on the type of birth experienced begins during the gestation and women wish to be involved in decision-making, requiring a more individualized care with reliable information. Maternal opinions oscillate considerably, many women do not agree to decide the mode of delivery alone, aiming for the presence and professional support throughout the process of gestation and delivery.¹¹

In two studies developed in Australia, women expressed the value of natural childbirth as a natural physiological process that brings benefits to mother and child, being the best method of birth even after a previous cesarean section.

The first study pointed out that mothers who chose VBAC expressed a strong belief in the importance of a natural birth as the best way to come to the world for a child. Health

professionals were of the utmost importance at this time, striving to reduce unnecessary medical interventions throughout labor, in addition to believing in breastfeeding and hoping for an early bond with their baby.¹²

Regarding the link, the recommendations of the World Health Organization (2000) point out as indispensable the early contact between mother and child, since in addition to favoring the bond and giving tranquility to the puerpera about the well-being of their child, it allows the beginning of breastfeeding in the first hour of postpartum.¹³

The second study, however, stated that despite having had a cesarean section, women continued to be involved in a natural childbirth, considered a social event of physical, emotional and spiritual significance. They reported that the will to experience natural birth is not easy, because the world today is closely linked to interventionist practices; in which the medical discourse often ends up promoting the elective cesarean section.¹⁴

In this way, the importance of the health professionals' awareness about its importance in the aid of decision-making on the mode of delivery after previous cesarean section is emphasized.

The analysis of this theme made it possible to perceive that women who experienced cesarean delivery sought vaginal delivery. However, the lack of information contributes to the emergence of doubts and questions regarding which mode of delivery to experience after an earlier cesarean section. Therefore, the importance of health professionals in providing information and fostering reciprocal knowledge in a climate of trust and learning is reinforced so that women feel supported by experiencing VBAC.

♦ Cesarean Section: Medical decision or Maternal decision?

Theme 2: Cesarean Section: Medical decision or Maternal Decision?				
Title	Author	Journal	Aim	Results
First-time mothers' wish for a planned caesarean section: deeply rooted emotions.	Sahlin M, Carlander-Klint AK, Hildingsson I, Wiklund I.	Midwifery.	To describe the underlying reasons for the wish for a cesarean section in the absence of medical indication in pregnant women for the first time.	The overall theme formulated to illustrate the meaning of the underlying wish for a planned cesarean was based on deeply rooted emotions.
Preferences for mode of delivery in nulliparous Argentinean women: a	Liu NH, Mazzoni A, Zamberlin N, Colomar M, Chang OH,	ReprodHealth.	Understand women's preferences and motivational factors for the mode of	Most women preferred vaginal delivery because of cultural, personal and social factors. The same was seen as normal,

qualitative study.	<u>Arnaud L</u> , <u>Althabe F</u> , <u>Belizán JM</u> .		delivery.	healthy, and a natural rite of passage from the condition of woman to motherhood.
Misrecognition of need: Women's experiences of and explanations for undergoing cesarean delivery.	Tully KP, Ball HL.	SocSci Med.	To record the circumstances in which cesarean section was considered appropriate in a UK hospital through the eyes of women and their partners experiencing the surgical delivery of their baby.	The results suggest the need for some cesareans is due to non-recognition of indications from all involved. The underlying factors for many cesareans can actually be modifiable.
Decision-making process for choosing an elective cesarean delivery among primiparas in Taiwan.	<u>Huang SY</u> , <u>Sheu SJ</u> , <u>Tai CJ</u> , <u>Chiang CP</u> , <u>Chien LY</u> .	<u>MaternChild Health J</u> .	Understanding the decision-making process when choosing an elective caesarean delivery (ELCD) among primiparous women in Taiwan.	The central category that describes the ELCD decision-making process among primiparous women is "to control the risks of childbirth and ensure well-being". The decision process can be divided into three phases: (1) Predecision: the perception of risk; (2) Decision-making: risk assessment; (3) Post-decision: moving forward fearlessly. At different decision-making stages, women revealed different concerns, although the sequence of phases is not necessarily unidirectional.
Decision making in patient-initiated elective cesarean delivery: the influence of birth stories.	Munro S; Kornelsen J; Hutton E	J Midwifery Womens Health.	To explore the birth stories and cultural knowledge women use to inform the decision about an elective cesarean without a medical indication.	The results indicate that women who participated in this study relied heavily on social and cultural knowledge in forming their decision to give birth by elective caesarean section. Although the number of women seeking a cesarean for social reasons is still small, persuasive influence on parturients of positive cesarean stories and negative vaginal histories should be considered.
Choice and birth method: mixed-method study of caesarean delivery for maternal request.	<u>Kingdon C</u> ; <u>Neilson J</u> ; <u>Singleton V</u> ; <u>Gyte G</u> ; <u>Hart A</u> , <u>Gabbay M</u> ; <u>Lavender T</u> .	<u>BJOG</u> .	To investigate whether women see decision-making around vaginal delivery or cesarean delivery as their choice.	The results of this large exploratory study suggest that choice may not be the best concept by which the current UK birth scheme approaches. In addition, they challenge the notion of choice that currently prevails in international debates about cesarean for maternal request.
Why do women request caesarean section in a normal, healthy first pregnancy?	<u>Fenwick J</u> ; <u>Staff L</u> ; <u>Gamble J</u> ; <u>Creedy DK</u> , <u>Bayes S</u> .	<u>Midwifery</u>	To describe the Australian women's cesarean request in the absence of medical indicators in their first pregnancy.	These findings help women and health professionals to better understand how childbirth can be built as an event without fear. In light of the evidence on the risks associated with surgical delivery, health professionals need to explore these perceptions with women and develop strategies to promote

			women's confidence and competence in their ability to give birth naturally.	
Social Representations and Decisions of Pregnant Women on Parity: the role of women	Pereira, RR; Franco SC; Baldin, N.	Saúde Soc.	To understand, from the feminine social representations, the protagonism of the woman in the decision about the parturition.	The content analysis of the reports allowed three empirical categories to emerge: fears and concerns; experiences and sociocultural influence. With this theoretical-methodological substrate, the social representation of women in the process of parturition, which is symbolized by conflicts of feelings, doubts and apprehensions originated mainly by the fear of the suffering imposed by pain, was analyzed. Such a view is supported by the biomedical model and the media.
Need for care and wish to participate in the delivery of pregnant women living in Londrina-Paraná.	Sodré, TM; Bonadio, IS; Jesus, MCP; Merighi, MAP.	Texto Contexto Enfermagem	To understand the need for care and the wish to participate in decisions about the delivery of pregnant women in Londrina-PR.	The results showed that, although they wish to participate in their delivery and verbalize their needs, choices and preferences, women do not find favorable conditions for their care needs and the wish to participate in decisions on childbirth to be made viable; which interferes with face-to-face relationships and impedes the right to informed choice in relation to childbirth.

Figure 2. Articles grouped in Theme 2 after synoptic table analysis “Cesarean Section: Medical decision or Maternal decision?”. Pelotas (RS), Brazil, 2017.

Over the last few years, there has been a considerable increase in the number of elective cesarean sections worldwide. Fifteen countries with about 12 million births per year have cesarean section rates above 30%. In Latin America, 9 of the 12 countries have rates above the 15% limit recommended by the World Health Organization. The increase in these rates is not associated with the reduction of maternal and perinatal mortality; on the contrary, this mode of delivery when used without indication may increase the risk of maternal complications such as hemorrhage, puerperal infections, pulmonary embolism, anesthetic risks. In addition, in infants, it can lead to respiratory problems, physiological jaundice, iatrogenic prematurity, hypoglycemia and anoxia.¹⁶

The increase in the number of elective cesarean sections emphasizes interventionist and medicalized procedures, favoring the commercialization of health care. In this premise, this theme aims to address the participation of women and medical professionals in the decision-making about the mode of delivery experienced.

In a study carried out in Argentina with 29 pregnant women with no indication of cesarean delivery, it was found that the actual cesarean section rates seem incongruent with the mode of delivery for which women claim to have a preference. Most of the pregnant women in this study showed an interest in vaginal delivery. The reasons cited include aspects related to culture, personal and social. 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." Women have associated cesarean delivery as a medical decision, an exclusion procedure that leaves them "out of control" of the situation.¹⁶

In the United Kingdom, 153 women were interviewed to investigate decision-making about vaginal delivery or cesarean delivery. The results point out that the decision-making regarding the mode 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 the autonomy of women ends up being limited, sometimes by health professionals, or by individual circumstances. Many women reported not expressing their opinion about the mode of delivery because they relied on the decisions of caregivers.¹⁷

Another study that related the decision to perform cesarean delivery to medical professionals was the one carried out in England with 115 women in a postnatal ward. The women understood that when they underwent cesarean delivery they 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 provider who was providing care and that the doctors would not perform the cesarean section if it was not necessary.¹⁸

It can be seen that the women participating in the studies mentioned above do not seem to have autonomy in the decision-making about the mode of delivery to be performed. There are those who do not show knowledge about the indications of cesarean delivery, and for this reason, do not express their opinions regarding the care that will be submitted. They placed their trust in the professionals who provided care, understanding that care is related to the well-being of the mother and baby.

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 modes of delivery, indications and complications. Pre-birth knowledge will enable women and their families to express their opinions when they are subjected to procedures without indication.¹⁸

Regarding the choice of mode of delivery, a study of 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 cesarean delivery. The women reported that medical discourses supported by their prior knowledge assisted in the decision by elective caesarean section who considered it to be a safe and responsible decision to

protect their health and the health of their baby.¹⁹

In this sense, a study was conducted in Taiwan with 20 primiparous women, aimed 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. In the counterpoint the cesarean section presented itself related to the famous of films and television, denominating this method like an elegant way of delivery.²⁰

In Canada, a study with 17 primiparous women submitted to elective cesarean section without a medical appointment pointed out that cesarean section was a choice based on information from the media and the birth experiences of mothers linked to social networks and social, physiological, historical and practical influences.²¹

The elective cesarean section of choice for the parturient is a rare phenomenon that is directly related to previous experiences, beliefs and fears. Women go the opposite way of diagnosis-intervention and opt for this delivery even without medical indications. In this way, the health worker needs to invest in reversing this choice, ensuring that women understand the risks and benefits of their decision making.²²

At this juncture, the decision-making process for elective caesarean section can be divided into three phases: pre-decision (risk perception phase), decision (risk assessment phase) and post-decision (front without fear). Depending on the stage the woman is in, different concerns are experienced. Thus, health professionals need to be aware of these phases in order to clarify and assist women in decision-making regarding the mode of delivery, and secondly in the first two phases it becomes easier to point out the potentialities and fragilities regarding modes of delivery.²⁰

A study conducted in Brazil with 45 pregnant women in the last trimester of pregnancy that sought to understand the female social representations about the role of women in the decision regarding parturition. The results pointed out that the birth process is closely related to the technical-scientific knowledge in detriment of the physiological, reinforcing the asymmetry of decision-making power between doctor and pregnant woman.

In addition, the above study highlighted that women are not aware of the parturition process, as well as their meanings and impacts on their health and health of their baby. Ignorance contributes to their taking a passive and uncritical attitude about the content of other sources of information, such as soap operas, stories of other women built by the social milieu, and their own experience in previous births. This creates a behavior of doubts and apprehensions. Fragile, undergo a cesarean section programmed to avoid physical and emotional pain caused by fears.²³

In this perspective, pregnant women interviewed in Brazil reported that they did not find support and care capable of healing their health needs and participation in decisions about childbirth. In the vast majority of cases, there is no horizontal relationship with the professionals, which impedes the right to an informed choice in relation to childbirth. Thus, resistance by professionals, the conditions of the public and private system in this country, lack of information during prenatal care, feelings of fear and insecurity end up producing frustrations in women who do not live the process of parturition they have always dreamed of.²⁴

The analysis of this theme allowed to assume that the medical knowledge still has domain in the process of parturition. Women, often deprived of prior knowledge, end up undergoing the medical and interventionist practices without adequate indication. Faced with this, it is highlighted the need for health education actions in primary care, which emerges as a space for practices for the humanization of birth. In the activities developed at the Basic Health Unit (BHU), such as a prenatal consultation, a pregnant group, lectures in a waiting room, it is possible to exchange horizontalized knowledge among health professionals and women in order to empower it to decision-making process in their parturition process.

CONCLUSION

This integrative review allowed to understand publications about the participation of the woman in the decision-making about the mode of birth experienced. It was evidenced that in the period of 2009 to 2013 the largest number of publications on the subject were concentrated, with Australia and the United Kingdom being the countries with the greatest number of productions of this research.

The publications related to the topic Vaginal Birth After Cesarean (VBAC) allowed

us to assume that the majority of women - even after experiencing a previous cesarean section - show an interest in experiencing normal delivery. However, they do not find information during gestation about the possibility of experiencing normal birth, and they end up being subjected to subsequent cesarean sections.

In the theme Cesarean Section: Medical Decision or Maternal Decision? The publications have shown that women are often deprived of prior knowledge and end up undergoing medical and interventionist practices, such as cesarean sections without adequate indications and that can lead to complications for the double mother-baby. Thus it was perceived that medical knowledge still has mastery in the process of parturition.

From this perspective, the emergence of health professionals becomes aware of the need to carry out health education actions on pregnancy, labor and delivery, modes of delivery, benefits and indications. The basic attention is a space for practices in favor of the humanization of the birth and of empowering the pregnant woman in the decision making during the process of parturition.

At this juncture, it should be noted that the studies addressed in this review have made it possible to perceive that it is still necessary to persist in the search for the humanization of the parturition process. Childbirth remains the target of standardized actions, technological and medicalization interventions that disregard the woman as the protagonist of the parturition process. There is still a need for new studies to effectively and consolidate the participation of women in decision-making on the birth experience, since it is necessary to guarantee safe motherhood and birth with the active participation of the woman and her family throughout the process of gestating, giving birth and be born.

REFERENCES

1. Lopes CV, Meincke SMK, Carraro TE, Soares MC, Reis SP, Heck RM. Experiências vivenciadas pela mulher no momento do parto e nascimento de seu filho. Cogitare Enferm. 2009;14(3):484-90. Doi: <http://dx.doi.org/10.5380/ce.v14i3.16178>

2. Carraro TE, Knobel R, Radunz V, Meincke SMK, Fiewski MFC, Frello AT, et al. Cuidado e conforto durante o trabalho de parto e parto: na busca pela opinião das mulheres. Texto & contexto enferm. 2007;5(n.esp.):97-104. Doi: <http://dx.doi.org/10.1590/S0104-07072006000500011>.

3. Ministério da Saúde (BR). Secretaria de Políticas de Saúde. Saúde da mulher. Rede Cegonha. Brasília; 2011.
4. Matos, GC. Grupos de gestantes: espaço de troca de saberes e práticas na atenção ao parto [trabalho de conclusão de curso]. Pelotas (RS): Universidade Federal de Pelotas; 2013.
5. Pinheiro BC, Bittar CML. Expectativas, percepções e experiências sobre o parto normal: relato de um grupo de mulheres. *Fractal rev psicol.* 2013;5(3):585-602. Doi: <http://dx.doi.org/10.1590/S1984-02922013000300011>.
6. Polit DF, Beck CT, Hungler BP. Fundamentos de Pesquisa em Enfermagem: métodos, avaliação e utilização. 5 ed. Porto Alegre: Artmed; 2004.
7. Mendes KDS, Silveira RCCP, Galvão CM. Revisão integrativa: método de pesquisa para a Incorporação de evidências na saúde e na enfermagem. *Texto & Contexto Enferm.* 2008;17(4):758-64. Doi: <http://dx.doi.org/10.1590/S0104-07072008000400018>.
8. Lundgren I, Begley C, Gross MM, Bondas T. 'Groping through the fog': a metasynthesis of women's experiences on VBAC (Vaginal birth after Caesarean section). *BMC Gravidez Parto.* 2012;12(85):2-11. PMID: 16948722
9. McGrath P, Phillips E, Ray-Barruel G. Bioethics and birth: insights on risk decision-making for an elective caesarean after a prior caesarean delivery. *Monash Bioeth Rev.* 2009;28(3):1-19; 2009. PMID: 20131527
10. Frost J, Shaw A, Montgomery A, Murphy DJ. Women's views on the use of decision aids for decision making about the method of delivery following a previous caesarean section: qualitative interview study. *BJOG.* 2009;116(7):896-905. PMID:17524009
11. Moffat MA, Bell JS, Porter MA, Lawton S, Hundley V, Danielian P, Bhattacharya S. Decision making about mode of delivery among pregnant women who have previously had a caesarean section: a qualitative study. *BJOG.* 2007;114(1):86-93. PMID: 19720338
12. Phillips E, McGrath P, Vaughan G. 'I wanted desperately to have a natural birth': mothers' insights on vaginal birth after Caesarean (VBAC). *Contemp Nurse.* 2009;34(1):77-84. PMID: 20230174
13. Organização Mundial de Saúde, Organização Pan-Americana de Saúde, Ministério da Saúde (BR), Sociedade Brasileira de Pediatria. Os dez passos da alimentação saudável para crianças brasileiras menores de dois anos. 2000.
14. Fenwick J, Gamble J, Hauck Y. Believing in birth - choosing VBAC: the childbirth expectations of a self-selected cohort of Australian women. *J Clin Nurs.* 2007;16(8):1561-70. PMID: 17655545
15. Horey D, Kealy M, Davey MA, Small R, Crowther CA. Interventions for supporting pregnant women's decision-making about mode of birth after a caesarean. *Cochrane Database Syst Rev.* 2013;7. PMID:17077251
16. Liu NH, Mazzoni A, Zamberlin N, Colomar M, Chang OH, Arnaud L, et al. Preferences for mode of delivery in nulliparous Argentinean women: a qualitative study. *Reprod Health.* 2013;10(1):2. PMID: 23317141
17. Kingdon C, Neilson J, Singleton V, Gyte G, Hart A, Gabbay M, Lavender T. Choice and birth method: mixed-method study of caesarean delivery for maternal request. *BJOG.* 2009;116(7):886-95. PMID: 19385961
18. Tully KP, Ball HL. Misrecognition of need: Women's experiences of and explanations for undergoing cesarean delivery. *Soc Sci Med.* 2013; 85:103-11. PMID: 23540373
19. Fenwick J, Staff L, Gamble J, Creedy DK, Bayes S. Why do women request caesarean section in a normal, healthy first pregnancy? *Midwifery.* 2010;26(4):394-400. PMID: 19117644
20. Huang SY, Sheu SJ, Tai CJ, Chiang CP, Chien LY. Decision-Making Process for Choosing an Elective Cesarean Delivery Among Primiparas in Taiwan. *Matern Child Health J.* 2013;17:842-851. PMID: 22706999
21. Munro S, Kornelsen J, Hutton E. Decision Making in Patient-Initiated Elective Cesarean Delivery: The Influence of Birth Stories. *J Midwifery Womens Health.* 2009;54(5):373-9. PMID: 16948722.
22. Sahlin M, Carlander-Klint AK, Hildingsson I, Wiklund I. First-time mothers' wish for a planned caesarean section: Deeply rooted emotions. *Midwifery.* 2013;29(5):447-52. PMID: 22901601
23. Pereira RR; Franco SC; Baldin N. Representações Sociais e Decisões das Gestantes sobre a Parturição: protagonismo das mulheres. *Saúde Soc.* 2011;20(3):579-89. Doi: <http://dx.doi.org/10.1590/S0104-12902011000300005>
24. Sodr TM, Bonadio IS, Jesus MCP, MerighiMAP. Necessidade de cuidado e desejo de participao no parto de gestantes residentes em Londrina-Paran. *Texto & Contexto Enferm.* 2010;19(3):452-60. Doi: <http://dx.doi.org/10.1590/S0104-07072010000300006>.

Submission: 2017/03/16

Accepted: 2017/09/18

Publishing: 2018/02/01

Corresponding Address

Ana Paula de Lima Escobal
Rua Gomes Carneiro, 01
Universidade Federal de Pelotas - Faculdade
de Eermagem
CEP: 96010-610 – Pelotas (RS), Brazil