DOI 10.18471/rbe.v34.38128 Original Article

SURGICAL DELIVERY: THE MULTIPLE EXPERIENCES OF WOMEN

PARTO CIRÚRGICO: AS MÚLTIPLAS EXPERIÊNCIAS DE MULHERES

EL PARTO QUIRÚRGICO: LAS MÚLTIPLES EXPERIENCIAS DE LAS MUJERES

Fanny Eicherberger Barral[1]
Telmara Menezes Couto[2]
Lilian Conceição Guimarães de Almeida[3]
Tânia Christiane Ferreira Bispo[4]
Graziele Matos Oliveira[5]
Natália Webler[6]

How to cite this article: Barral FE, Couto TM, Almeida LCG, Bispo TCF, Oliveira GM, Webler N. Surgical delivery: the multiple experiences of women. Rev baiana enferm. 2020;34:e38128.

Objective: to know the experiences of women who have experienced surgical delivery. Method: qualitative study. Interviews were conducted with ten women who experienced surgical delivery in a maternity hospital in Salvador, Bahia, Brazil. Afterwards the data were systematized through Bardin's Thematic Analysis. Results: women's experiences with surgical delivery are permeated by fear, linked mainly to raquimedular anesthesia. It has also evidenced that the behaviors adopted by professionals have a direct impact on these experiences, since they can suppress the genitor in the decision process about the type of childbirth, as well as hinder mother-baby contact. Positive experiences permeated by care were also pointed out. Conclusion: the study signals the need for changes in the surgical delivery scenario, which may contribute to a professional practice that prioritizes the quality of care offered and favors women's empowerment.

Descriptors: Cesarean. Women's Health. Obstetrics. Hospital Assistance.

Objetivo: conhecer as experiências de mulheres que vivenciaram o parto cirúrgico. Método: estudo qualitativo. Foram realizadas entrevistas com dez mulheres que experienciaram parto cirúrgico em uma maternidade de Salvador, Bahia, Brasil. Posteriormente os dados foram sistematizados mediante a Análise Temática de Bardin. Resultados: as experiências das mulheres sobre o parto cirúrgico são permeadas pelo medo, atrelado principalmente à anestesia raquimedular. Evidenciou também que as condutas adotadas pelos profissionais impactam diretamente sobre essas experiências, visto que podem suprimir a genitora do processo de decisão sobre o tipo de parto, bem como obstaculizar o contato mãe-bebê. Experiências positivas permeadas pelo cuidado também foram apontadas. Conclusão: o estudo sinaliza para a necessidade de mudanças no cenário do parto cirúrgico, o que poderá contribuir para uma prática profissional que prioriza a qualidade da assistência ofertada e favorece o empoderamento das mulheres.

Descritores: Cesárea. Saúde da Mulher. Obstetrícia. Assistência Hospitalar.

[1] Obstetrician Nurse. Master in Nursing. Obstetrician Nurse at Maternidade Climério de Oliveira. Salvador, Bahia, Brazil. fannybarral@hotmail.com. http://orcid.org/0000-0002-9126-3812.
[2] Obstetrician Nurse. PhD in Nursing. Professor at Universidade Federal da Bahia. Salvador, Bahia, Brazil. http://orcid.org/0000-0001-6836-8563.
[3] Obstetrician Nurse. PhD in Nursing. Professor at Universidade Federal da Bahia. Salvador, Bahia, Brazil. http://orcid.org/0000-0001-6940-9187.
[4] Obstetrician Nurse. PhD in Public Health. Professor at Universidade do Estado da Bahia. Salvador, Bahia, Brasil. http://orcid.org/0000-0002-5632-0973.
[5] Obstetrician Nurse. Universidade Federal da Bahia. Salvador, Bahia, Brazil. http://orcid.org/0000-0003-0166-440X.
[6] Nursing Student. Universidade Federal da Bahia. Salvador, Bahia, Brazil. http://orcid.org/0000-0003-4215-3526.

Objetivo: conocer las experiencias de las mujeres que han experimentado un parto quirúrgico. Método: estudio cualitativo. Se realizaron entrevistas a diez mujeres que experimentaron un parto quirúrgico en una maternidad de Salvador de Bahía, Brasil. Después los datos fueron sistematizados a través del Análisis Temático de Bardin. Resultados: Las experiencias de las mujeres con el parto quirúrgico están impregnadas de miedo, vinculado principalmente a la anestesia raquimedular. También se demostró que los comportamientos adoptados por los/las profesionales tienen un impacto directo en estas experiencias, ya que pueden suprimir a la genitora en el proceso de decisión sobre el tipo de parto, así como dificultar el contacto madre-bebé. También se señalaron las experiencias positivas impregnadas de cuidado. Conclusión: el estudio señala la necesidad de introducir cambios en el escenario de la prestación quirúrgica, lo que puede contribuir a una práctica profesional que dé prioridad a la calidad de la atención ofrecida y favorezca el empoderamiento de la mujer.

Descriptores: Cesárea. Salud de la Mujer. Obstetricia. Asistencia Hospitalaria.

Introduction

Surgical delivery is a procedure that, over the years, with technological advances, has become more and more common, being used as an alternative to normal delivery. Just like a surgical procedure, having the experience of a cesarean section can have a direct impact on the life and health of women, and it is necessary to ensure a successful experience for the mother-baby binomial.

The use of the surgical route of birth was incorporated into obstetric practice in the 18th century with the purpose of reducing the high rates of maternal-fetal mortality. However, despite the reduction of cases with imminent risk for mother and baby, the impact on these rates did not occur as expected, because when compared to vaginal delivery, the highest rates of maternal morbimortality were associated with surgical delivery[1]. This scenario is related to the precarious context of the surgeries in the beginning of their appearance, mainly in what concerns the hygiene conditions, the practice of sedation used and the surgical incision technique, which had negative repercussions on women's health[2].

This reality of high maternal morbimortality rates associated with surgical delivery has encouraged investment to improve the technique and demystify the procedure in the female imaginary. The technological advances achieved have resulted in a safer procedure and less feared by women; among the advances, it is possible to mention: the advent of antibiotics, the use of anesthetic techniques - no longer sedative - and the incorporation of sterilization and asepsis procedures[3]. Moreover, the medical obstetrician class, guided by capitalist logic, also saw benefits with the surgical delivery compared to vaginal delivery, since the cesarean section is more profitable for the professional and the institutions, as well as offering greater convenience in view of the possibility of scheduling.

In this sense, surgical delivery, which in its early days was performed only in conditions of extreme need, became routine and elective in maternity hospitals. The increase in the number of these procedures is directly linked to the widening of the range of indications for its realization, covering non absolute justifications, such as previous cesarean section, cephalo-pelvic disproportion, or even the female desire for tubal ligation after the birth of the baby[4]. This normatization of the practice by obstetricians has resulted in good acceptance by women, in the illusion of greater security and speed, as well as early return to sex life, when compared to the vaginal route. These elements contribute to the choice of the cesarean section as birth route[5].

Thus, although aversion to surgery is common in society in general, the choice for a cesarean section often does not seem to cause strangeness to obstetricians, who perform it in an elective manner. A study conducted with 920 puerperal women identified that the desire of cesarean section since the beginning of pregnancy was a condition associated to the procedure performed in the Brazilian Unified Health System (SUS) and in the supplementary network[6]. This reality

does not translate the real context of the elective surgical exposure, being sometimes minimized the implications that this can bring to the mother-baby binomial.

When experiencing surgical delivery, the parturient is subject to medical indications and is subordinated to this by nourishing the expectation that this professional recognizes the best option to ensure her well-being and that of her baby. In this context, it is perceived that this event is marked by the subjectivities that permeate it, such as values, beliefs and assigned meanings. Thus, this study aims to know the experiences of women who have experienced surgical delivery.

Method

This is a qualitative approach study. The choice for this type of study occurred because of the possibility of exploring and characterizing and/or describing a certain phenomenon, such as surgical delivery. The authors prioritized meeting all the criteria indicated in the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist during the design of the study and the other stages of the qualitative investigation.

The scenario of the study was a Maternity School of the public network of Salvador, Bahia, Brazil, linked to a public university, and exclusively meets the ambulatory, urgency/emergency and hospitalization demands of the Brazilian Unified Health System (SUS). Given the large number of women attended by the institution, the following inclusion criteria were established for participation in the survey: being over 18 years of age, being in the maternity ward, having received assistance during the gravidic-purperal period and being in the 48-hour post-childbirth period of a cesarean section. It was excluded those who presented some psychological commitment at the time of the interview and those who received the assistance provided by the researcher of the study that operates in the maternity ward in question.

Applying the survey criteria, ten women were interviewed individually, using a semi-structured script containing objective questions, which allowed the profile of the participants to be drawn, and subjective questions to learn about their experience with surgical delivery. After the data collection stage, which took place between the months of May 2017 and January 2018, a full transcript of the interviews was made, and their contents were systematized and interpreted from the perspective of Content Analysis proposed by Bardin[7]. In accordance with the methodological rigor of each stage, nuclei of meaning were identified in the speeches of the participants, enabling the organization of speech excerpts that presented similar central ideas of the experiences of women who experienced surgical delivery.

It is emphasized that the research meets the ethical precepts contained in Resolution No. 466/12 of the Brazilian National Health Council, and has the approval of the Research Ethics Committee of Maternidade Climério de Oliveira, under Opinion No. 2026663/2017. The consent of the participants was obtained by signing the Free and Informed Consent Term, made available at the time preceding the interviews. In order to ensure the confidentiality and anonymity of the participants, the interviews were held in a private room, to enable them to speak freely about their experience, and all had their names replaced by the letter E, followed by the number corresponding to the interview order. All transcripts will remain available for consultation for a period of five years, counted after data collection, stored in virtual folders of the responsible researcher, and may be revisited if necessary.

Results

The participants in the study were ten women between 22 and 44 years of age, seven of whom declared themselves brown and three black. Regarding schooling, two women had primary schooling, five had secondary schooling, and three had higher education. As for conjugal status, five were married and five were single.

Regarding the obstetric profile, nine women interviewed were not primigravidae; over

previous pregnancies, six evolved to childbirth, three to abortion and gestational loss due to ectopic pregnancy. Of the six women with previous deliveries, three had already had the experience of surgical delivery and the others, of vaginal delivery. About the current pregnancy, six women reported intercurrences during pregnancy, among them infection with the human immunodeficiency virus (HIV), oligodrania, urinary tract infection, hypothyroidism and hypertensive syndromes.

The participants' report revealed the experiences of women who experienced surgical delivery, illustrated in the following categories:

Experience of having to trust in medical conduct

The knowledge of medicine is complex for many people, being a science dominated by those who are specialized in it. So, before the thoroughness that involves it, it is up to those who do not know it to trust what is attested by the person expert in the subject. Among women there is a conformism to the professional's information, even if it is superficial.

> *The doctor just looked and said to intern because it was already the third cesarean section and there is no way to do a normal birth.* (E04).

> *I took the ultrasound exam that proved she was sitting. The doctor said she probably wouldn't turn, it would have to be a cesarean section..* (E10).

Experience of being suppressed from the decision-making process

The women interviewed reported in their speeches that the decision to give birth was exclusively made by the medical professional, and their participation in this process was suppressed, even if they tried to place themselves. They also pointed out that the baby's well being contributed to their passivity towards the medical decision.

> *The doctor evaluated and said that it would be a cesarean section, it was not my decision, it was something that I had to accept because of the size of the baby.* (E05).

> *The doctor was very adamant that my delivery would be an emergency cesarean section. I asked if there was a possibility to induce my birth, she said that only if it was for my baby to die* [...] *was not taken into account any desire of mine.* (E09).

Experience of living the fear of the surgical event

The reports of the interviewees evidence that the surgical delivery experience is permeated by fear. This was the feeling that marked the testimonies, but it was associated to the moment that preceded the surgical procedure, mainly the raquimedular anesthesia. In general, the participants felt frightened.

> *I was very afraid of the fact that it was a caesarian, it was always something I feared. I was scared to death of the spinal cord, they said it was terror.* (E07).

> *I got nervous because I had never taken anesthesia, I thought I would take a terrible fright when I got punctured.* (E08).

Experience of depending on the professional for the contact with the child

The interviewees point out that the immediate contact with the newborn (NB) occurs through an approach promoted by health professionals, being subject to the will of the professional, who may postpone and/or interrupt this moment. In general, the statements evidence that the care with the NB is prioritized soon after birth, to the detriment of the meeting with the mother.

> *The pediatrician received the baby and went to do that initial cleaning* [...] *the nurse picked him up, put him on my chest, put his face close to mine, it was very nice.* (E01).

> *After I heard his crying, the nurse took him to clean and straighten, to make that process of grief. After I had already done the whole procedure, the nurse brought him.* (E03).

Experience of being taken care of

The women also talked about the experience of being taken care of, about a humanized assistance that evidenced concern, affection and attention. The care implemented conveyed security and confidence for the realization of the procedure.

> *I always had a nurse who passed her hand on my head making affection and asked me if I was ok. I thought it was fantastic, it helps a lot. It doesn't cost to worry and treat with affection, to pass confidence, to encourage positively.* (E07).

> *I think the important thing is this, to pass to the patient what they are going to do, is not to get there and do it anyway and leave doubts. They made everything clear to me, informed me everything straight and I'm satisfied with everything.* (E08).

Discussion

The study points out that women's experiences with cesarean sections were multiple and individual, directly influenced by a number of factors, such as trust in the professional. Surgical delivery is a highly specialized procedure that requires technical knowledge of obstetricians. Therefore, the expertise that professionals accumulate, added to the lack of knowledge of the procedure, are sufficient for them to trust what is being said and not question the conduct. Trust is an important element to be established in relationships.

The human relationship is the basis of the work of health professionals, independent of the training area, being necessary the constant improvement of their skills, among them, of communication. Competency in communication contributes to maintain the relationship effectively and enables assistance based on ethical, legal, clinical and humanized bases. Communication is a tool that can be used to provide information, teach, discuss and generate behavior changes[8-9].

The communicative process is used to establish a bond, in a verbal dimension, through words that express thought, clarify fact or validate the comprehension of something, and also non-verbal, through postures and gestures, in a universe of meanings permeated by attitudes of sensitivity, acceptance and empathy among subjects[8-10].

Communication favors a relationship of trust, but it is relevant not to be restricted to the exchange of information. The information provided by health professionals, through explanations, when comprehensible and adapted to social reality, is adequate and contributes to the interaction with the patient in an effective way, being their right to receive all information pertinent to their health status[11].

Despite the complexity and specificity required to discuss surgical delivery, it is possible, through communication, to approach the woman to understand and take charge of her parturition process. However, communication is defective, as it does not favor the comprehension, argumentation, and basis.

All the participants referred, after the medical evaluation, to having been informed about the surgical delivery. The clinical evaluation was the key element to define the surgical conduct. It is interesting to notice how the reports express the understanding of this indication, they reproduce very clearly what was said and show agreement with the decision.

Thus, it is recognized that all the parturients were reported about the procedure, but the justifications were not necessarily absolute indications of cesarean section. The cesarean operation is essential for the reduction of maternal and child mobimortality, however, it must be performed under specific medical indications. Regarding quality care, it is necessary that this information be based on solid scientific evidence, clearly explaining the risks and benefits associated with the surgical procedure[12].

In this sense, misinformation places women in a vulnerable situation, which limits their decision power and their perception that it is natural to be submitted to the professional's decision.

In view of the increased percentage of cesarean sections in Brazil, a condition that was even considered epidemic, and the recognition of the abusive use of this procedure, some initiatives were taken by the Brazilian government in order to change this scenario of childbirth care. Among them, the Pre-Natal and Birth Humanization Program, Rede Cegonha, Normative Resolution no. 368, which states that doctors are required to provide the pregnant woman with an orientation note on risks that may be generated by cesarean section, and more

recently, the "Guidelines on Pregnancy Care: the cesarean section operation"[12-15].

In this study, it seems that the choice for the type of delivery was medical, used as an argument the context of risk already mentioned. The woman did not participate in the decision about the birth route, being a deliberation that fell to the medical professionals.

The dialogue and information about the time of delivery, both in SUS and in the private service, are insufficient. However, in the public service, this condition is even more compromised, since medical discourse is passively accepted by the pregnant woman. In this sense, it is noticeable that the decision about childbirth pervades the existence of a hierarchical relationship, in which scientific knowledge centered on the technical model favors a segmented and interventionist obstetric care. The trust in the professional enables the woman to authorize the doctor to command her parturition process [16-17].

Rarely would a pregnant woman be able to question the information obtained or contradict what is exposed by the doctor when the risks are projected on the baby. Ethical principles lead women to maximize benefit over risk. This type of intervention should be chosen and indicated as a last resort[18].

Another experience lived by women was to feel fear. Despite the scientific advances already reported, the expectation for the procedure arouses diverse feelings, and among the participants fear was the most common. Fear was specifically related to anesthesia. The lack of knowledge about the anesthetic procedure can favor anxiety and interfere with the well-being of the woman in labor..

It is necessary to identify the cause of fear, so that measures can be instituted at the appropriate time, that is, before the procedure. Fear can lead to physiological alterations, such as elevation of blood pressure and alterations in heart rhythm, which can postpone or compromise hemodynamic stability during the surgical act.

It is in this scenario that the pre-anesthesia consultation appears as an important strategy, because it enables to approach the users of the procedure, increasing their knowledge about the technique and diagnosing risk situations. A study carried out in a Brazilian university hospital, with 97 pre-surgical patients, identified the fears related to anesthesia: 70.3% reported fear of not waking up after anesthesia, 66.7% of losing memory, 64.2% of dying during anesthesia, 63.9% of feeling pain and 59.8% of feeling pain in the spine after anesthesia. During the pre-anesthetic consultation, the professional can guide, clarify doubts and reduce the preoperative tension[19].

Professional assistance can help reassure them, make them feel good and protected. The interaction before the surgery helps in the formation of a bond and can be performed by several professionals of the health team, prioritizing the specificities of each area. The nurse, in turn, can provide diverse information about the procedure, clarifying for the parturient everything that will happen. Educational tools, such as explanatory leaflets, can also be a good option to contribute in providing guidance.

All this care in the period before the procedure strengthens the woman, leaving her more secure; this is important so that she can position herself and verbalize her desires and yearnings to the professional.

Women appear in the scene of childbirth in a peculiar way, as coadjuvants, they do not seem to interfere in behaviors and procedures, the technique and systematic of the procedures are maintained and prioritized. On the other hand, the NB appears as the protagonist of care in the room. For the genitor, all decisions aimed at the well-being of the concept are valid. Thus, the professionals establish as priority the techniques and evaluations, in detriment of the implementation of the measures recommended by the Guidelines on Pregnancy Care, which include: ensuring and facilitating early skin-to-skin contact between the binomial, clamping the umbilical cord late, when there is no impediment, and offering support for the beginning of breastfeeding soon after delivery[12].

Thus, the meeting between women and children was postponed, was in second place, and although this early contact promotes

health and comfort for both was prioritized the implementation of cleaning, of bath. Throughout all this time there was someone who interfered in the woman's relationship with her child, someone who impeded longer moments of approach, of exchange of affection, however, the little space that was made possible for them was very valued.

The reports did not make it possible to identify the practices recommended by the guidelines, except for skin-to-skin contact, which seemed short, late and interrupted by procedures, by a technical assistance, which values the practice to the detriment of the subject. The professional, practical priorities supplanted the real priorities, the scientific evidences that speak about the benefits of skin-to-skin contact for the binomial.

The care routines delay or interrupt the contact between the binomial besides providing less willingness of these women to breastfeed. Cesarean sections have been pointed out as an important barrier to the early onset of breastfeeding, since they separate the mother and the baby even after the procedure is over, considered a risk factor more consistently associated with not breastfeeding in the first hour of life[20].

The need for prolonged contact is shared by both; the losses resulting from this abrupt break-up are shared, and have also been reported in other studies as being responsible for causing the break-up, not allowing one to experience the fullness of identification with the child, and dissatisfaction with the assistance received[21].

In this sense, faced with this first moment of interaction, full of expectations, health professionals must be moved to stimulate and enable this contact to happen immediately, early, strengthening the affection between mother and baby, benefiting not only the binomial, but also the whole family.

When breastfeeding has not been promoted immediately after birth, the statements orient to an ordering or organization that preceded this contact as a previous prioritization. In cesarean section, movement limitation may delay this process, and additional support and support to the woman is needed to start breastfeeding as soon as after the delivery[12]. Health professionals consider that the high demand for deliveries and the insufficient number of employees, as well as the cesarean section itself, which presents itself as a risk factor, contribute to this event[22].

The nurse stands out in this process and appears as an important instrument in encouraging breastfeeding, which corroborates a study conducted in Rio de Janeiro on the actions of this professional in the clinical management of breastfeeding, which emphasizes its importance in promoting and supporting breastfeeding and the need to be aware of their role in the process of care and education, being crucial to act with interest, responsibility and commitment[23].

Therefore, the importance of assistance by health professionals to assist women in this breastfeeding process should be exalted, especially in cesarean sections, since this procedure contributes to the separation of mother and baby, as well as limitation of movement by the woman.

In the model of assistance permeated by humanization and welcome, the health professional must be prepared to support women in their needs, to care for them and assist them in their specificities. Humanized assistance is presented when the professional shows concern with the woman's condition, in addition to behaving as a support and possessing the potential to favor the empowerment of women during the process. From this point of view, it is possible to notice that humanization does not start from a metaphysical perspective of "becoming human", but from the adoption of differentiated behaviors and attitudes, from the offer of quality care, aiming to overcome the frontiers of the different nuclei of knowledge/power[24]. This care that positively encourages was lived by the research women and was permeated by active listening, empathy and affection.

It is worth highlighting the importance of an attentive health team, imbued in favoring the mother-baby bond, in minimizing risks and complications, and intervening in an assertive manner prioritizing the binomial. For this, it

is necessary to respect choices, wishes, value dreams, and listen to what the woman has to say, because even if she is not an expert in the field, she has a lot to talk about and contribute, because she is the one who protagonizes the childbirth, even if it is surgical.

Hence, the study made it possible to know the experiences of women who experienced surgical delivery. They had to trust in the medical conduct, since they did not participate in the decision process about the birth route, they were only informed about the procedure to which they would be submitted, regardless of their agreement. The health professional appears sometimes approaching, sometimes keeping women away from their children, as they prioritize techniques over care. On the other hand, when women are cared for, welcomed, and have access to information on anesthetic induction, childbirth, and newborn care, they feel safer and more comfortable.

The limitations of the study were due to the fact that it did not aggregate the documental analysis of the medical records, since it would help to know the technical-scientific basis of the professionals to justify the implemented conducts. However, it presents as contributions to reflect on the possibilities of humanizing the care of parturients, in which communication is a founding element, since it allows to involve them in the care and approach them based on shared knowledge.

Conclusion

The study highlights the importance of wide dissemination of scientific evidence, as well as norms and guidelines that orientate the assistance to be provided to the binomial. In this sense, unrestricted access to official documents is a strategy that enables people to obtain information to charge and demand what they have the right to. Although knowledge does not guarantee compliance with the determinations, it favors empowerment, the search for a birth and birth permeated by integral, humanized and quality assistance.

The study signals the need for changes in the surgical delivery scenario, which can contribute to a professional practice that prioritizes the quality of the assistance offered and favors the empowerment of women.

Collaborations:

1 – conception, design, analysis and interpretation of data: Fanny Eichenberger Barral, Telmara Menezes Couto, Lilian Conceição Guimarães de Almeida, Tânia Christiane Ferreira Bispo, Graziele Matos Oliveira and Natália Webler;

2 – writing of the article and relevant critical review of the intellectual content: Fanny Eichenberger Barral, Telmara Menezes Couto, Lilian Conceição Guimarães de Almeida, Tânia Christiane Ferreira Bispo, Graziele Matos Oliveira and Natália Webler;

3 – final approval of the version to be published: Fanny Eichenberger Barral, Telmara Menezes Couto, Lilian Conceição Guimarães de Almeida, Tânia Christiane Ferreira Bispo, Graziele Matos Oliveira and Natália Webler.

References

1. Liabsuetrakul T, Sukmanee J, Thungthong J, Lumbiganon P. Trend of Cesarean Section Rates and Correlations with Adverse Maternal and Neonatal Outcomes: A Secondary Analysis of Thai Universal Coverage Scheme Data. AJP Rep. 2019;9(4):328-36. DOI: 10.1055/s-0039-1697656

2. Parente RCM, Moraes Filho OB, Rezende Filho J, Bottino NG, Piragibe P, Lima DT, et al. The history of childbirth (part 1): cesarean section. Femina [Internet]. 2010 [cited 2020 Jul 28];38(9):481-6. Available from: http://files.bvs.br/upload/S/0100-7254/2010/v38n9/a481-486.pdf

3. Todman D. A history of caesarean section: From ancient world to the modern era. Aust N Z J. Obstet Gynaecol. 2007;47(5):357-61. DOI: 10.1111/j.1479-828X.2007.00757.x

4. Viana TGF, Martins EF, Sousa AMM, Souza KV, Rezende EM, Matozinhos FP. Reasons for performing a cesarean section according to the puerperal women reports and the registry of medical records in maternity hospitals in Belo

Horizonte. REME rev min enferm. 2018;22:e-1073. DOI: 10.5935/1415-2762.20180003

5. Nakano AR, Claudia B, Teixeira LA. A normalização da cesárea como modo de nascer: cultura material do parto em maternidades privadas no Sudeste do Brasil. Physis. 2015;3:885-904. DOI: 10.1590/S0103-73312015000300011

6. Oliveira RR, Melo EC, Novaes ES, Ferracioli PLRV, Mathias TAF. Factors associated to caesarean delivery in public and private health care systems. Rev esc enferm USP. 2016;50(5):733-40. DOI: 10.1590/s0080-623420160000600004

7. Bardin L. Análise de conteúdo. São Paulo: Edições 70; 2016.

8. Coriolano-Marinus MW, Queiroga BA, Ruiz-Moreno L, Lima LS. Comunicação nas práticas em saúde: revisão integrativa da literatura. Saude soc. 2014;23:1356-69. DOI: 10.1590/S0104-12902014000400019

9. Rocha L, Melo C, Costa R, Anders JC. The communication of bad news by nurses in the context of obstetric care. REME rev min enferm. 2016;20:e981. DOI: 10.5935/1415-2762.20160051

10. Andrade CG, Costa, SFG, Lopes MEL. Cuidados paliativos: a comunicação como estratégia de cuidado para o paciente em fase terminal. Ciênc saúde colet. 2013;18(9):2523-30. DOI: http://dx.doi.org/10.1590/S1413-81232013000900006

11. Pedro DRC, Silva GKT, Molin TD, Oliveira JLC, Nicola AL, Tonini NS. Knowledge about patient hospital care received during your admission. REME rev min enferm. 2016;20:e978. DOI: 10.5935/1415-2762.20160048

12. Brasil. Ministério da Saúde. Portaria n° 306, de 28 de março de 2016. Aprova as Diretrizes de Atenção à Gestante: a operação cesariana. Diário Oficial da União [Internet]. Brasília (DF); 2016 [cited 2018 Fev 18]. Available from: http://bvsms.saude.gov.br/bvs/saudelegis/sas/2016/prt0306_28_03_2016.html

13. Brasil. Ministério da Saúde. Secretaria de Políticas de Saúde. Parto, aborto e puerpério: assistência humanizada à mulher [Internet]. Brasília (DF); 2001 [cited 2020 Jul 27]. Available from: https://bvsms.saude.gov.br/bvs/publicacoes/cd04_13.pdf

14. Brasil. Portaria n° 1.459, de 24 de junho de 2011. Institui, no âmbito do Sistema Único de Saúde - SUS - a Rede Cegonha. Diário Oficial da União [Internet]. Brasília (DF); 2011 [cited 2017 Dec 28]. Available from: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2011/prt1459_24_06_2011.html

15. Brasil. Ministério da Saúde. Agência Nacional de Saúde Suplementar. Resolução Normativa - RN nº 368, de 6 de janeiro de 2015. Dispõe sobre o direito de acesso à informação das beneficiárias aos percentuais de cirurgias cesáreas e de partos normais, por operadora, por estabelecimento de saúde e por médico e sobre a utilização do partograma, do cartão da gestante e da carta de informação à gestante no âmbito da saúde suplementar. Diário Oficial da União [Internet] Brasília (DF); 2015 [cited 2018 Apr 29]. Available from: http://bvsms.saude.gov.br/bvs/saudelegis/ans/2015/res0368_06_01_2015.html

16. Campos VS, Morais AC, Souza ZCS, Araújo PO. Conventional practices of childbirth and obstetric violence under the perspective of puerperal women. Rev baiana enferm. 2020;34:e35453. DOI: 10.18471/rbe.v34.35453

17. Martins APC, Jesus MVN, Prado Júnior PP, Passos CM. Aspects influencing women's decision making about the mode of delivery. Rev baiana enferm. 2018;32:e25025. DOI: 10.18471/rbe.v32.25025

18. Lino HC, Diniz SG. "You take care of the baby's clothes and I take care of the delivery" – Communication between professionals and patients and decisions about the mode of delivery in the private sector in São Paulo, Brazil. J Hum Growth Dev. 2015;25(1):117-24. DOI: 10.7322/jhgd.96825

19. Areias MALA, Ramos CRA, Lemos VM, Menezes SVS, Lins RSAM, Lins Filho RLM. Avaliação do conhecimento do paciente cirúrgico a respeito da função do anestesiologista. Rev bras anestesiol [Internet]. 2018 [cited 2018 Apr 25];68(Suppl 1):S186-S187. Available from: http://rba.elsevier.es/index.php?p=revista&tipo=pdf-simple&pii=X0034709418633242

20. Leal MC, Gama SG. Nascer no Brasil. Sumário Executivo Temático da Pesquisa [editorial Internet]. Rio de Janeiro: Fundação Oswaldo Cruz; 2014 [cited 2020 Jul 28]. Available from: http://www.ensp.fiocruz.br/portal-ensp/informe/site/arquivos/anexos/nascerweb.pdf

21. Reis CC, Souza KR, Alves DS, Tenório IM, Brandão Neto. 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

22. Antunes MB, Demitto MO, Soares LG, Radovanovic CA, Higarashi IH, Ichisato SM, et al. Amamentação na primeira hora de vida: conhecimento e prática da equipe multiprofissional. Av enferm. 2017;35(1):19-29. DOI: 10.15446/av.enferm.v35n1.43682

23. Costa EF, Alves VH, Souza RM, Rodrigues DP, Santos MV, Oliveira FL. Atuação do enfermeiro no manejo clínico da amamentação: estratégias para o aleitamento materno. Rev Pesqui. (Univ Fed Estado Rio J., Online). 2018;10(1):217-23. DOI: 10.9789/2175-5361.2018.v10i1.217-223

24. Oliveira LH, Mattos RS, Castro JB, Luz MT. Práticas corporais de saúde para pacientes com fibromialgia: acolhimento e humanização. Physis. 2017;27(4):1309-32. DOI: 10.1590/s0103-73312017000400023

Received: August 1, 2020

Approved: August 27, 2020

Published: October 22, 2020