

Speech of women on the experience the normal birth and cesarean section*

Discurso de mulheres sobre a experiência do parto normal e da cesariana

Habla de las mujeres en la experiencia el parto y normal cesareo

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ABSTRACT

Objective: This study aimed to comprehend the experience of vaginal delivery and caesarean section in women from Riachão Jacuipé-Ba. **Method:** A descriptive exploratory qualitative research study was conducted. Ten residents women between 20 years or greater in the immediate postpartum period were interviewed. Data were collected through semi-structured interview and analyzed by Fiorin speech analysis technique. **Results:** The analysis revealed that the technocratic model of childbirth care, dominant today, has been influencing the experience of women, both in relation to vaginal birth and caesarean section. It was further proved the lack of guidance from professionals that accompanied the prenatal of the interviewees. **Conclusion:** A woman to be an active part in childbirth, she needs to be clarified about this since pregnancy.

Descriptors: Delivery, Natural Childbirth, Cesarean Section.

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RESUMO

Objetivo: Compreender a vivência do parto normal e cesáreo por mulheres de Riachão do Jacuípe-Ba. **Método:** Pesquisa exploratória de caráter qualitativo. Foram entrevistadas dez puérperas com idade maior ou igual a 20 anos. Os dados foram coletados através de entrevista semi-estruturada e analisados por meio da técnica de análise de discurso segundo Fiorin. **Resultados:** A análise indicou que o modelo tecnocrático de atenção ao parto vem influenciando a vivência das mulheres, tanto com relação ao parto normal quanto em relação à cesariana. Faltaram também orientações por parte dos profissionais que acompanharam o pré-natal das entrevistadas. **Conclusão:** Para que a mulher seja protagonista no parto, é preciso que ela esteja esclarecida sobre isso desde a gestação.

Descritores: Parto Obstétrico, Parto Normal, Cesárea.

RESUMEN

Meta: comprender la experiencia del parto normal y cesáreo por mujeres de Riachão do Jacuípe-Ba. **Método:** estudio exploratorio de carácter cualitativo. Diez mujeres de edad mayor o igual a 20 años fueron entrevistadas en el período inmediatamente después del parto. Los datos fueron colectados a través de entrevista semi estructurada y analizados mediante técnica de análisis de discurso según Fiorin. **Resultados:** El análisis reveló que el modelo tecnocrático de atención al parto viene influyendo en la experiencia de las mujeres, tanto con respecto al parto normal cuanto al cesáreo. **Conclusión:** Para que la mujer sea un sujeto activo en el parto, es necesario aclarar con esto desde el embarazo.

Descritores: Parto Obstétrico, Parto Normal, Cesárea.

INTRODUCTION

Childbirth is the resolving stage of gestation, the birth of the being that formed in the previous months. In daily health services, it is observed that users of the public health network do not usually participate in the decision by type of delivery, which is defined by medical conduct. Users of the private network also tend to undergo elective cesarean, due to the greater convenience, both for the woman and for the medical professional.

In the scheduled cesarean section, the woman can have a scheduled delivery, performed by the same professional who had her prenatal follow-up. For the medical professional, you have the following advantages: do not require time for the follow-up of labor, be able to set the date and time of birth according to your schedule, business hours and the maternity in which you work. It is more advantage to receive a cesarean section, in which the professional does not spend more than one hour, and can perform several surgeries on the same day, bringing more pay, than assisting a normal delivery, which demands much more Time, as labor may last up to twenty-four hours.¹

Normal delivery has several advantages, such as: it allows the woman to recover more quickly, as well as the faster return of the uterus to normal size, a lower risk of hospital infection, a lower incidence of respiratory discomfort in the

newborn, and the immediate interaction between mother and child after childbirth.²

Other advantages of normal delivery in relation to cesarean section are: rarer puerperal infection, very low risk of death and less risk for future pregnancies. This way of delivery contributes to the maturity of the child and facilitates breastfeeding, in addition to the natural cost of the childbirth.³ Therefore, normal delivery is safer and involves fewer risks, which is possible in most cases.

The rate of cesarean section recommended by the World Health Organization (WHO) is 15%, considering its use only in cases where there is life threatening to the mother and / or the child. Currently, in Brazil, cesarean rates are higher than normal delivery. In 2011, 46% of all births in the country were of normal delivery, 53% were cesareans, and 1% were ignored.⁴ The proportion of births in hospitals according to the administrative sphere was as follows: Public: 61, 7% vaginal - 38.3% cesarean; Nonpublic: 34% vaginal - 65.9% Caesarean section.⁵

It is recognized that the determinants of cesarean sections are quite complex, including financial conditions, cultural and social attitudes, both of patients and of society itself.⁶ In a study that aimed to investigate the existence of induction of cesarean demand in Brazil, it was verified that Non-clinical factors play a more important role than clinical factors in determining the use of cesarean sections in the country.¹ It was verified in the author's research that there is induction of cesarean by the health provider, be it physician or hospital, which corroborates studies of other authors.⁷⁻⁸

A high proportion of this procedure in Brazil is unnecessary, since many conditions are associated with the indication of cesarean without scientific support, such as: non-reassuring fetal heart rate; Amniotic fluid with meconium; Narrow basin; Fetal macrosomia; Previous cesarean section; Twin pregnancy; Diagnosis of cephalopelvic disproportion before labor, among others.⁹

All these indications of unnecessary cesarean sections can increase the complications caused by this type of delivery, both for the mother and for the child. Maternal morbidity related to cesarean section is increased with increased risk of new cesarean section, placenta previa and placenta accreta in subsequent gestation, and hysterectomy due to repeated surgeries. For the concept, particularly in elective caesarean sections, there is an increased risk of perinatal morbidity, especially of admission to the neonatal intensive care unit and newborn respiratory distress syndrome.¹⁰

The obstetric indications for cesarean section are divided into absolute and relative. The absolute indications are: cephalopelvic disproportion, previous body uterine scar, transverse fetal situation, active genital herpes, cord prolapse, total occlusive placenta

previa, maternal death with live fetus. Relative indications are: unreacted fetus in labor, HIV positive pregnant (depending on viral load), placental abruption (depending on the stage of delivery), pelvic presentation, twin pregnancy (depending on fetal relationship), cesarean section fetal macrosomia, unfavorable cervix to labor induction, psychopathy.³

The delivery of the cesarean section can save the life of both the mother and the fetus when correctly indicated. This indication should occur when there are situations in which it is not possible to opt for normal birth. Most cesarean indications are relative.⁹ In a literature review of the best available scientific evidence on cesarean indications, the authors concluded that they are an absolute indication of cesarean: cord prolapse; Placental abruption with a live fetus outside the expulsive period; Placenta previa partial or total; Vasa previa; Genital herpes with active lesion and cortical presentation during labor.

Given the data on the excessive number of births performed in Brazil by artificial means, we can see that the so-called technocratic model still prevails in childbirth care, in which technical and/or rational solutions predominate, neglecting the relational, emotional, social and cultural aspects of women. This model is based on the notion that the female body is incapable of giving birth without intervention, when in fact it does not consider the force and the role of women in the parturition process.

Frequent delivery assistance mechanically causes the humanization in care to be forgotten. This humanization, besides providing the formation of the mother / child bond immediately after childbirth, makes labor more rewarding for the woman and more valued by the professional, which increases the confidence and preference of the woman for normal delivery.

In the face of dehumanization and excessive medicalization in childbirth care that is observed today, it becomes relevant to investigate the experience of each type of delivery for women. Nursing also plays a prominent role in this area, especially with the creation of the Stork Network, which has been implementing the construction of Normal Delivery Houses, in which the obstetrician nurse acts with greater autonomy, since it has legal support and technical assistance for normal low-risk deliveries. The more humanistic training of the nurse facilitates humanized attention, which may contribute to the reduction of unnecessary interventions and the number of surgical deliveries in Brazil.

Because she was the main author living in the city of Riachão do Jacuípe, in Bahia, she was worried about local health, especially with regard to women's health, and hearing several reports of women about childbirth. Childbirth experience for women in the municipality. Thus, a scientific investigation was decided to answer the following question: How did women experience normal and cesarean delivery in Riachão do Jacuípe-BA?

METHODS

The research was carried out in the municipality of Riachão do Jacuípe, which is 160 kilometers from Salvador and has a population of 33,172 inhabitants. In 2011, 423 normal deliveries and 207 cesareans occurred in the city.¹¹

The study participants were ten women aged 20 years or older who were in the mid-term postpartum and who wanted to participate by signing the Free and Informed Consent Term (TCLE). Among these, five had normal delivery and five had cesarean sections. Exclusion criteria were women below this age, in order to avoid the participation of adolescents, for whom the experience of childbirth can be emotionally more shocking. Participants were identified by names that refer to Greek goddesses, to ensure anonymity.

Data were collected through a semi-structured interview. The interviews were recorded and transcribed in full. The data collection instrument was a script composed of open and closed questions, containing questions directed to the characterization of the subjects and questions that specifically addressed the experience of each type of delivery. The principles of Resolution 196/96 of the National Health Council were met, which deal with research involving human beings at the time of collection, since Resolution 466/2012 is currently in force. This study was approved by the Ethics and Research Committee (CEP) of the State University of Feira de Santana - BA (UEFS) through Opinion N° 123.768 / 2012 and CAAE Number: 02847512.0.0000.0053

The data were analyzed using the discourse analysis technique.¹² In order to proceed to the treatment of the data by means of this technique, we sought to identify, in the text, its most abstract level. Initially, all the text was traversed trying to locate all the recurrences, that is, figures (concrete elements) and themes (abstract elements). Once the central themes were deprecated, the data were grouped into blocks of meaning that gave rise to the empirical category presented in this article, being analyzed in articulation with the pertinent literature.

RESULTS AND DISCUSSION

Technocratic attention model influencing the experience of childbirth by women

The technocratic attention model influencing the experience of childbirth by women was the subject of greater abstraction extracted from the interviewees' testimonies. It was found that, among the participants of this study, the experience of labor, both normal and cesarean, has been influenced by the model of obstetric attention prevalent in the present day, and this occurs not only with the study participants and residents in the municipality of Riachão do Jacuípe, but with most Brazilian women, since this model continues to be hegemonic in most of Brazil. In this model, technology takes precedence

over human relations, and normal birth attendance is usually dehumanized, so that the woman does not act as a protagonist, but she submits passively to the commands of the professionals.

On the other hand, the cesarean section is seen as a procedure that allows comfort to the professional and / or the woman. Women who choose to undergo cesarean delivery want to get rid of the pain of labor, as well as the dehumanized care that produces the representation of normal birth as an experience of terror, marked by intense pain and suffering. This representation is transmitted from one woman to another, creating more resistance to normal birth.

The exercise of the technician model about the woman in her parturition, reinforced by the culture of the cesarean stimulus, makes her feel more and more incapable of giving birth. The set of obstetric procedures reflects the degradation of the role of women in childbirth, exemplified by the ease with which professionals prescribe rest and by the automatic advice that women should lie down, devaluing their central role during labor.¹³ This Introjection of the inability to give birth is evidenced, especially, when the woman does not participate in any way in the choice by the type of delivery. The testimony of one of the participants reflects the absence of this action:

It was no choice at all. I had no choice, it had to be C-section. There was no way, it did not dilate. It had to be cesarean. (Hera)

Hera's speech expresses the medical professional's reference to the absence of sufficient dilatation for normal delivery to occur. It is often the use of the expression "had no way". However, it is known that the term "passage", in fact, does not exist in the medical literature. The woman understands this information from the professional as a sentence. She often believes that she has not had any degree of dilation or even that she will never have this "passage" in the case of another birth, that is, her body is not able to give birth. However, it is known that most women are able to have dilatation for a normal birth, by simply waiting for the time necessary for the evolution of labor.

From the moment that the woman does not exercise the reproductive right to choose the type of delivery she prefers to experience, she begins to be submissive to the professional decision, becoming increasingly passive object of a process that physiologically belongs only to her, Being that it would be up to the professional only the accompaniment and the aid in the necessary moments, without many interventions.

In this context, the high rates of cesarean births nowadays show the transformation of the delivery of the physiological process into a pathological one, permeated by often unnecessary interventions, which can be exemplified by early amniotomy, electronic fetal monitoring and excessive drug use, mainly oxytocin Synthetic. This view on childbirth

has been transforming some maternities into high-tech laboratories and human beings into objects of technical procedures.¹³

Doctors and patients tend to believe that technology is synonymous with progress, modernity, and knowledge; With this, that its indiscriminate use would not be harmful, which contradicts the scientific evidence accumulated so far.¹⁴

However, the excessive use of technology and interventions, characteristic of the predominant obstetric and neonatal care model in Brazil, has not had a positive impact on the morbidity and mortality of women and children. This contradiction is called the Perinatal Paradox.¹⁵ Women nowadays have more access to health services, have more prenatal consultations, have better immunization, better screening for the diagnosis of infections, and a greater number of postnatal consultations.¹⁵ However, rates of maternal and perinatal mortality, as well as of prematurity in Brazil, are still very high.

The infant mortality rate (MRL) in Brazil in 2011 was 15.3 deaths per 1,000 live births and the maternal mortality ratio (MMR) was 63.9 per 100,000 live births.⁵ Complications due to premature birth are the leading cause of newborn deaths and the second leading cause of child deaths.¹⁶ Given this context, the need for more effective actions to reduce unnecessary cesarean sections is stressed, since it constitutes a risk factor for prematurity, low birth weight, neonatal and maternal mortality.

The risks pointed out by the medical professionals to justify the high rates of cesarean section generally do not have scientific basis, leading to the banalization of the surgical delivery, without clinical indication. The use of sedatives, artificial hormones to stimulate labor, epidural anesthesia and others, as well as frequent cesarean sections in order to reduce risks, often introduce new risks for both mother and baby.¹³

Many professionals choose cesarean section to do another procedure together, which is tubal ligation. Most often, women who have multiple children or only two are tempted to perform the tubal ligation. Since the doctor gives her this option, the woman agrees to go through a cesarean section without question. This was evident in the testimony of one of the participants:

It's about childbirth, I decided to do it, I did, because I wanted to, but I was a bit scared, like I never did, right? I received [guidance] from the doctor who accompanied me. He said that if that's what I wanted there, I said that I was determined that this was what I wanted. (Aphrodite)

What these professionals do not know, or do not take into account, is that there is a prohibition of cesarean section with the purpose of making tubal ligation, as expressed in the Family Planning Law.¹⁷ This article reads as follows: "Surgical sterilization in women during periods of labor or abortion is prohibited, except in cases of proven need, by

previous successive cesarean sections” (translated).¹⁷ The professional who carries out the cesarean in association with the ligature is exposed to penalties, according to article 15, sole paragraph, of the same law.

In order for the woman to choose a type of delivery, she must first be aware of the advantages and disadvantages of each. However, what is observed in practice is that most of them consider the supposed absence of cesarean pain as the main advantage of surgical delivery and as sufficient reason to perform it.

In fact, the pain that women do not experience in this case, because they do not go into labor, may be greater in the postpartum period, since cesarean section is a large surgery, involving the section of several tissues, which will inevitably cause pain, and consequently require the use of various analgesics. The pain of labor becomes more intense when the woman takes a passive stance, does not actively participate in the process and has not respected her right to an escort. Women also need to be advised that there are several pharmacological and non-pharmacological methods for pain relief during labor so that their choice is clarified.

It is also worth noting that, in many situations, guidance from midwifery practitioners is lacking on the short, medium and long term risks involved in a cesarean section. Thus women, while believing in the great advantage of the absence of pain, are not making a conscious choice. On the contrary, they are taking a risk of which they are not aware. This is also convenient for many professionals and reflects the exercise of their power over women, since if they were adequately informed of those risks, they probably would not make such a frequent choice for a cesarean section.

The woman asks for the cesarean section to close quickly a process that becomes painful and lonely, in which she does not have the right to accompany her, she has to wait a long time between hospital admission and childbirth, because admission is made very early, sometimes before the woman is actually in labor, being subjected to unnecessary and painful actions, and not being offered pain relief techniques during this period.¹⁸

In this study, among the five participants who had a surgical delivery, all reported the reasons mentioned previously, three of whom underwent cesarean section in association with tubal ligation. It is also evidenced that the preference for cesarean section occurred mainly among middle-class women who performed this procedure in the private network.

In Brazil, the technocratic model of childbirth care performs, in the duality between the public and private spheres, the fullness of its two legitimate possibilities: an interventional “normal” delivery and the excess of cesarean sections, respectively. While public services, which have access to the lower-income population, offer their women

the normal traumatic delivery, private services, in which users establish a relationship of consumption, offer cesarean section as a mark of differentiation and “modernity” (Maia, 2010, p.49, translated).

Methods of pain relief during labor are often not used within health services within the hegemonic model of childbirth care. In addition, these methods are unknown to most women. In this perspective, many interviewees who opted for cesarean section did so mainly to avoid pain, as can be seen in the lines below:

...But I actually wanted a cesarean, but for the pain, got it? On the issue of pain. (Hebe)

... I wanted to have a cesarean because the pain is less right? (Gaia)

For the study participants, cesarean delivery, besides being seen as a procedure that does not involve pain, is still related to a decent and respectful care. It is inferred that in cesarean, the woman behaves even more passively than in normal delivery, facilitating the performance of the procedure. Consequently, she does not become anxious, does not complain, does not cry, does not feel anything. This makes surgical delivery easier, more convenient and practical for professionals, who earn merit and status for it and treat them well. Added to this is the overvaluation of technology in today's society, making those who act in the procedure are seen as super professional, skilled and competent, which is evident in the following testimonies of women who had a surgical delivery:

They are trained. They are professionals with very, very patient care. As I said, the whole team, the anesthesiologist, the obstetrician, the nurses who were present, were all very capable. They did very well, very carefully. (Iris)

I have nothing to say. They treated me very well. Doctor, anesthesiologist, nurses, all the hospital staff treated me very well. (Hera)

Congratulations, because I was very well attended. Oh, the staff themselves who operated me also handled me super well. They treated me super well, they treated me super well. (Athena)

It can be observed, with respect specifically to the personal experience of the delivery, that there is a kind of emptiness in the reports of the women who had cesarean. Since the cesarean is most often elective, the woman is not expected to go into labor, which would indicate that the fetus is ready to be born and breathe outside the womb.

Thus, the woman does not experience the childbirth in her physical body, does not experience the childbirth in its multiple dimensions. In addition, the model of care centered on procedures causes the woman to be reduced to the object of an intervention.

The modern cesarean section is considered a safe technique, contributing for this type of delivery to be preferred for most medical professionals.²⁰ This factor, along with others associated with convenience, often for women, but especially for these professionals, makes With which they invest in justifications so that the women are induced to opt for this type of delivery. The woman finds herself in a moment of vulnerability, once her sensibility is aroused. In addition, he does not seek information so that he can become the subject of decisions and end up accepting to participate in this technical process, either for the child's sake or for a risk that often does not exist.

Allow women the right to choose to demand more investment from the professionals, since in order to make a choice, it is necessary to be aware of all the options, ie, the professional should explain to the woman the Advantages, disadvantages and risks involved in each type of delivery.

"In the technical-service model, women are considered as passive beings, without right over their parturition, given to hospital professionals who hold power because of their specialized knowledge." (translated).^{21:306} Lack of women's autonomy in decision by type of delivery was evidenced in the following statements:

Today doctors, they guide the cesarean delivery, so much I wanted to be normal and the doctor did not commit to do my delivery because I choose the normal. If it was Cesarean, he would do it, mark it, schedule it. And that's why I did not go back to him. I did it with Dr ... because he made himself available to make it normal or I decided to do a caesarean. Why do they prefer cesarean? Because it's easier, it's comfortable. Just mark it, go there to cut and goodbye. And the normal one loses a lot of time. And I wanted to be normal ... (Iris)

Boy, if they decide to do the cesarean, so who am I to say no? (Aphrodite)

My birth was cesarean. He explained to me that it would be like this, it's a surgery, right up to scratch, and I was going to take an anesthetic, the raqui. He asked me if I was interested in calling and I called. I told him I had it. I called and everything is okay. (Hera)

Iris's speech states that a cesarean section is a more comfortable procedure for the doctor. She also recognizes cesarean delivery as a mechanized delivery, realizing that normal delivery means a waste of time for the doctor. In this case,

the woman's will was not respected, and the interests of the professional prevailed.

Aphrodite reveals in her speech how much she considers herself incapable of negotiation or participation in decision by type of delivery. She believes that she would not be questioned about professional conduct and takes a position of total submission to these decisions, putting herself as a simple object of the procedures.

Hera's speech reveals the medical tendency to induce a woman to undergo caesarean section. The professional even mentions one of the risks related to surgery, trying to be politically correct. However, at the same time, she questions the woman's desire to undergo tubal ligation. Thus, the professional's contradictory discourse is biased towards the woman's choice or ill-informed acceptance. This interviewee also describes cesarean as a seemingly simple procedure, especially considering the "it's all right" result, although she believes the medical professional has fulfilled the role of alerting her to the risk of cesarean because it is a surgery.

Professionals use subtle devices for the maintenance of their know-how, such as demonstration of availability for help and moral appeals.²² Thus, if one is helping the other, whether through scientific knowledge or attitudes of improvement, Nobody will dare to distrust this professional. The author refers to the politics of care as a necessary instrument for the rupture of power relations and the construction of more democratic and emancipatory relationships in which people can become subjects of care and exercise their autonomy.

Every woman has the right to a conscious decision about her health, which must also happen in her parturition process. Sharing clear information about the care to be provided is a duty of the health professional and gives women participation throughout the period of pregnancy and childbirth. Unfortunately, most of the time, the health professional does not fulfill this role, disrespecting the reproductive rights of the woman. This position is supported by the biomedical model, in which the professional actions are based on the technique, devaluing the subjectivity of the woman and the establishment of bond with the pregnant woman. This, in turn, is totally oblivious to what is happening to her and her child. The testimony of two interviewees illustrates the lack of guidelines on childbirth during prenatal care:

She did not guide me at all. She just listened to the child's heart rate and measured the belly and spoke only that everything was fine. She did not comment. (Athena)

I did not have any, so on the birth, how is the birth I had no guidance at all. I knew word of mouth with pregnant women who was there during the same period of prenatal care, but to say that those who accompanied me informed me, I would be lying. (Thea)

In the speech of Athena, she appears submissive to the assistance, being that it was restricted to the technical procedures of the prenatal consultations. Thea's speech reveals that she seeks to know about the types of birth with other women who were prenatal because she did not get this information through the professional. Thus, women run the risk of hearing misinformation and reproducing representations and myths of common sense about childbirth, losing the opportunity for clarification with scientific rationale, a role that should be exercised by the professional. In both cases, there was an omission on the part of the professional who accompanied the prenatal care, since the woman did not receive guidance on the delivery. In addition, the right of women to participate in a process in which she is the main stakeholder and of which she should be the protagonist is hurt.

When we asked about the choice of type of birth, other women interviewed demonstrated the preference for vaginal delivery evidenced in the following speeches:

It was good. Normal. I chose it myself, because normal is the best birth you can have. Better than cesarean because I think cesarean has more risks. (Artemis)

I chose because I do not like to depend on anyone and so the recovery is faster. I think it's healthier and for me to be a mother that has to go through all this, so I know, so I can value my own, right? To really know what it is to be a mother. Then I thought of being normal for this, for recovery, for everything. (Thea)

Artemis's discourse denotes a woman's choice for normal birth, since she acknowledges that a cesarean section is a risk-taking procedure. In Thea's speech, one perceives that she preferred to act as an active subject of childbirth; On the other hand, we see the reference to the Christian need of women suffering during childbirth, which has long prevailed in the popular and professional imaginary, making it impossible to use methods of pain relief. This type of conception is still shared by many people and health professionals.

The woman's attitude toward pain changes as she becomes confident in herself and exerts her ability to lead the delivery.²³ Thus, the woman can take a leading role, acting in this event as actively as possible. An active birth is instinctive.²³ A woman can give birth naturally and spontaneously, following her own will and using her body as she prefers.

Normal birth was considered the most "correct" by some interviewees. We believe that this may be related to the belief of normal childbirth as a natural phenomenon, or to represent a remnant of a time when normal childbirth was the most frequent, since today there is little incentive for this, not only by part of professionals, who, as we have seen, are not accustomed to providing

adequate guidelines on childbirth; But also by the management bodies, which do not usually campaign in favor of normal birth.

Because the cesarean culture leads to a belief in the inability to give birth, women who decide for natural childbirth are seen as strong and courageous. Some women also say, prefer normal delivery because they consider the recovery fast, thus, there is less need for rest. The following testimonies reveal the representations of the normal birth by some of the participants:

...But the best delivery is the normal, because the shelter is much smaller and recovery is much faster than the cesarean section. The cesarean you have to have that security that you will not, it will not... It can slip because it can... The point can ignite, the inner point. There may be something, too. That's more, what's more, what you're talking about, cesarean delivery is more complicated. (Aphrodite)

I do not even want to know what a c-section is, because it's two months on the bed and I would not have the patience to stay two months on the bed. I'm very electric and normal is so fast... I'm feeling well myself. I already do everything. The only thing I do not do is crouch, jerky movements, but I'm already good. (Thea)

I think the right is the normal. But if I can not I have nothing against the cesarean today. (Iris)

Because it's normal. It was something that God left and God did not leave the Cesarean delivery for anyone. And normal birth is the best thing you have. (Artemis)

Although most women claim that they prefer normal birth, technician and dehumanized assistance makes birth for many of them a terrifying experience, which leads to rejection of the idea of normal childbirth and contributes to the spread of caesarean section, especially among middle-class women, who consider childbirth a degrading experience, to which they do not want to expose themselves. Normal childbirth as a negative experience, marked by intense pain and suffering, can be observed in several excerpts from the same testimony:

It was a very bad experience. I do not want anyone to go through that, because to me it was in another world, because of the pain, everything, I'm talking like this, now everything seems to be in my head, that moment, Hail Mary, suffering too much... I, from what I've been through, I do not want anyone to get through it. Only pain, suffering. I only felt joy when I saw him being born, it is, when I saw the chorinho... I think that for you to choose a profession, you have to go there with love and do everything with love. And I did not feel that about them. It's people like that, super, yeah, how can I talk, my

God, thick, you know? Thick people, who does not give you a word, so, comfort, understood? Yeah, when I went to touch myself, it seemed like I was doing an animal or an animal you can do it, so I think they're professionals, I think the area of medicine you have to know to choose well, because You're dealing with lives there. (Hebe)

The negative experience of normal birth brings to light other experiences of the woman's life, reinforcing even more the rejection by the same. However, this experience could become less painful and more rewarding if measures such as: respect for the woman as the protagonist of childbirth, use of pharmacological and non-pharmacological methods of pain relief, and respect for the rights of an accompanying person were adopted. It can also be noticed the difference in the care received between women who had normal birth and those who had cesarean, and the latter reported having been treated very well. For only one of the interviewees in this study, normal delivery was a magical, refreshing, empowering experience, as we can see in the following testimony:

I was surprised, because it's nothing people tell me. I did not suffer. I do not know if it's because I worked my psychological for the whole nine months ... I wanted to know what the pain was, but if I said that today I can tell you what it's like, I'd be lying. The staff spoke to me well as soon as I forgot. He said, "Oh, people, what a cool people, how can you forget a pain? And forget it. It's magic. When the child leaves you forget. Today I stop and keep trying to remember what that pain was like. I remember that I felt a pain in the back, an unusual pain, but if I told you that I can explain in detail what this pain is, I do not know it today, I really forgot. It's magic, it's God's thing. (Thea)

We see in Thea's speech that the normal birth experience for her was spiritual, divine. This participant did not deprive herself of experiencing the experience of labor, even with the negative reports of other women. She was previously desirous of this experience. Perhaps the fact of being from the health area has contributed to this. The delivery went without suffering, which she associated with the emotional preparation she had. This was also the only deponent who mentioned the child regarding the experience of childbirth, causing the pain to be forgotten soon after the child was born.

Childbirth, because it represents the emergence of a new life, should be for all women a rich and transforming experience for both women and their families. This will only be possible by replacing the current obstetric care model with a model that respects the woman as a protagonist, as a citizen of rights and that deserves to be respected. To this end, it is imperative that the health professionals involved in pregnancy and childbirth care reflect on their actions and also that health managers promote the necessary technical and material conditions the changes. With regard to technical

conditions, it is necessary to offer constant training for these professionals, as well as space where they can discuss their own practices within the services. With regard to material conditions, it is necessary to modify the physical and organizational structure of the services, so as to enable comfort, privacy and the presence of companions.

CONCLUSION

The analysis of the discourse of the participants of this study revealed that the technocratic model of attention to childbirth, dominant nowadays, has influenced the experience of women, both in relation to normal delivery and in relation to cesarean section. This phenomenon is a reflection of the predominant model of childbirth care at the national level, in which the woman is eliminated from the place of the subject at birth, being actively led by the physician (or other health care provider who provides delivery assistance). In addition, childbirth that occurs in the hospital environment is permeated by interventions, most of the time, unnecessary and that are potential complicating factors for the mother and / or the child.

Within this model, the right of the woman to the presence of a companion is not respected; No measures are used for pain relief; Feeding or some kind of movement out of bed during labor is not allowed. Add to all this, the know-how of the professionals, which leads to provide commands, which the woman feels obliged to obey passively, believing to be the best for her. All this context creates, among women, the representation of normal childbirth as an experience of terror, which is being transmitted from one woman to another. On the other hand, especially for middle-class women, normal birth is somewhat degrading, so they do not admit to experience, which contributes to the higher incidence of cesarean delivery among women of this social class.

The culture of excessive cesarean section has made women the object of care. In this type of delivery, women behave even more passively and there is greater use of technology, generating in women the representation of the professionals involved in this care, as super trained and competent. As a cesarean is a procedure considered more practical for professionals, it ends up being seen as a way to promote respect for women. In this case, the experience of good delivery is associated with the absence of pain and respectful care.

It is observed, then, that the birth is not lived by the woman in the physical body, but rather as a procedure. The absence of the suffering of labor is seen by many women as the great advantage of cesarean section and as sufficient reason to carry it out. However, this is often not a conscious choice, since medical professionals are not in the habit of guiding women about the short, medium and long term risks of this surgical intervention. The cesarean section is usually stimulated by these professionals, since it also represents the

convenience of a scheduled delivery. This professional attitude prevents women from exercising their right to choose in an informed manner.

The analysis also revealed the lack of guidance from the professionals who accompanied the prenatal care of the interviewees, so that they were not well informed about the delivery. In order for the woman to be a protagonist in childbirth, she must be aware of everything that has been happening to her since her pregnancy, that is, she must be an active participant from the gestation period.

We hope that this article can provoke reflections that allow changes in the professional practices, both in attention to childbirth and attention to gestation. Therefore, we suggest to the health managers, especially the Municipality of Riachão do Jacuípe-Ba, to promote capacities and spaces for discussion of professional practices within the health services themselves. In addition, we consider it necessary to listen to women, since they are the main actors involved in the process.

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