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THE FATHER'S EXPERIENCE IN CESAREAN BIRTH AT THE OBSTETRIC CENTER: CONTRIBUTIONS TO CARE

A vivência do pai no nascimento por cesariana no centro obstétrico: contribuições para a assistência

La experiencia del padre al nacimento por cesárea en el centro obstétrico: contribuciones a la asistencia

Vanessa Cristina de Vasconcelos Grossi[1]
Marcele Zveiter[2]
Cristiane Rodrigues da Rocha[1]

ABSTRACT

Objective: the study's goal has been to describe the experience of the accompanying father in the birth process by caesarean section at the Obstetric Center and point out the favorable and unfavorable conditions that influence this process. **Methods:** qualitative research, carried out at a University Hospital from august to september 2016 with 10 accompanying parents. The data collection was established by a semi-structured interview, submitted to Bardin's content analysis. **Results:** through the analysis, two categories emerged: possibilities and limitations in the experience of accompanying parents and emotional aspects in the birth process, which include the physical aspects of the operating room, the welcoming and guidance of the multidisciplinary team and the feelings presented by the parents. **Conclusion:** the father's participation in the cesarean delivery provides positive impacts for the mother-child-family trinomial, making crucial his presence since prenatal care and the physical adequacy of the cesarean environment.

DESCRIPTORS: Obstetric nursing; Cesarean section; Fathers; Paternity; Parturition.

[1]Universidade Federal do Estado do Rio de Janeiro, Rio de Janeiro, RJ, Brasil.
[2]Universidade do Estado do Rio de Janeiro, Rio de Janeiro, RJ, Brasil.

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Corresponding Author: Vanessa Cristina de Vasconcelos Grossi, E-mail: vanessavgrossi@edu.unirio.br

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RESUMO

Objetivo: descrever a vivência do pai acompanhante no processo de nascimento por cesariana no Centro Obstétrico e apontar as condições favoráveis e desfavoráveis que influenciaram neste processo. **Métodos:** pesquisa qualitativa, realizada em um Hospital Universitário de agosto a setembro de 2016 com 10 pais acompanhantes. A coleta de dados se estabeleceu por meio de uma entrevista semiestruturada, submetida à análise de conteúdo de Bardin. **Resultados:** pela análise, emergiram duas categorias: possibilidades e limitações na vivência do pai acompanhante e aspectos emocionais no processo de nascimento, que compreenderam: os aspectos físicos da sala de cirurgia, o acolhimento e orientação da equipe multiprofissional e os sentimentos apresentados pelos pais. **Conclusão:** a participação do pai no parto cesárea proporciona impactos positivos ao trinômio mãe-filho-família, tornando cruciais a sua presença desde o pré-natal e a adequação física do ambiente da cesárea.

DESCRITORES: Enfermagem obstétrica; Cesárea; Pai; Paternidade; Parto.

RESUMEN

Objetivo: describir la experiencia del padre acompañante en el proceso de parto por cesárea en el Centro de Obstetricia y señalar las condiciones favorables y desfavorables que influyeron en este proceso. **Métodos:** investigación cualitativa realizada en un Hospital Universitario de agosto a septiembre de 2016 con 10 padres acompañantes. La recopilación de datos se estableció mediante una entrevista semiestructurada, sometida al análisis del contenido de Bardin. **Resultados:** por análisis, surgieron dos categorías: posibilidades y limitaciones en la experiencia del padre acompañante y aspectos emocionales en el proceso del parto, que incluyeron los aspectos físicos de la sala de operaciones, la bienvenida y la orientación del equipo multidisciplinario y los sentimientos presentados por los padres. **Conclusión:** la participación del padre en la cesárea proporciona impactos positivos para el trinomio madre-hijo-familia, lo que hace que su presencia desde la atención prenatal y la adecuación física del entorno de la cesárea sean cruciales.

DESCRIPTORES: Enfermería obstétrica; Cesárea; Padre; Paternidad; Parto.

INTRODUCTION

Historically, the insertion of the father in the scenarios of labor and birth has emerged since the beginning of civilizations. Births were performed in homes, in the family environment by midwives and the man, despite not witnessing the birth of his child, would approach the binomial soon after it.[1]

However, in the 1950s, there was the phenomenon of the institutionalization of childbirth built on the medical discourse about the safety of childbirth, medicalization, and the medical appropriation of women's bodies, permeated by institutional norms and routines, removing the companion from the birth scenario and causing a break with the physiology of this event.[1]

The entry of fathers into the delivery environment emerged in developed countries in the 1970s, aiming to recover the bond with the binomial and the family unit due to the removal of parents caused by the institutionalization of childbirth. It is directly related to the change in the focus on fatherhood in the upbringing and care of children from 1950 on, the entry of women into the labor market, feminist organizations, and the movement for the humanization of labor and birth.[2,3]

The movement for the humanization of labor and birth originated from the efforts of the feminist network from the 1970s, the Network for Humanization of Labor and Birth (REHUNA), and the World Health Organization (WHO), fostering the implementation of programs and public policies in Brazil such as the Program for Humanization in Prenatal and Birth (PHPN) in 2000, the National Policy for Integral Attention to Men's Health (PNAISH) in 2009 and the Stork Network in 2011 highlighting the importance of fatherhood in men's sexual and reproductive health and their participation in labor and birth scenarios. [4]

Regarding the legal aspects, in Brazil, only in 2005 with the Federal Law 11.108 of April 7, 2005, it was assured to the woman the right to a companion of her choice during labor, delivery and immediate postpartum.[5] This legislation aims to protect the rights of women, since many times the recommendations of permanence of the companion during childbirth established by programs and public policies were not followed in most institutions.

The support of the father's participation in the birth process in policies and laws is due to the fact that this practice should be performed and encouraged because its benefits are clear, such as: protection, support, consolidation of the paternal role, and strengthening of the family relationship from his presence in labor and birth scenarios.[6]

Gender, historical, and cultural aspects still permeate the paternal role, making it essential to understand the difficulties that fathers face today, as well as the development of new programs and policies aimed at stimulating paternal participation in the gravidic-puerperal cycle, since the development of fatherhood and male insertion in childbirth are processes that directly influence the adaptation to this new role.[7,8]

The difficulties experienced by fathers in insertion at the moment of birth are more frequently found in cesarean sections compared to normal deliveries. Health professionals still find the presence of a companion in cesarean sections strange, questioning the real need, stating that the surgical environment does not have the proper conditions for accommodation of the companion and that he/she is not prepared for the complexity of

this scenario, and may intervene and misunderstand the actions of the multiprofessional team.[9]

The obstetric nurse has fundamental importance in the inclusion of the accompanying father in the gravidic-puerperal cycle, as part of the care and, consequently, as a way to promote the humanization of birth care through actions that aim at co--responsibility from pregnancy to birth.[10]

Based on the above, this research was justified by the importance of the presence of the father accompanying the woman and the newborn in cesarean births, a practice that should be encouraged, with positive effects such as: greater satisfaction of the woman at birth, safety, prevention of obstetric violence, physical and emotional support of the woman, early formation of the father-baby bond, better neonatal outcomes, strengthening of the bonds between the couple and the family, affirmation and appreciation of fatherhood, and facilitation of the transition to parenthood.[11]

In addition, when searching the Virtual Health Library (VHL) from 2010 to 2020 by crossing the previously consulted descriptors in the Descriptors in Health Science (DeCS) "cesarean section," "father" and "childbirth" using the Boolean operator AND between them, only nine articles on the subject were identified. The highest prevalence of research is established on the father's participation in normal birth and its benefits, thus, it is necessary a greater focus by health professionals for the father's participation in cesarean birth from the development of research to overcome this knowledge gap.

This research was developed from the research question: "What was it like to be the father accompanying the patient from hospitalization to cesarean birth in the Obstetric Center?", and the following objectives were established: to describe the experience of the accompanying father in the cesarean birth process in the Obstetric Center and point out the favorable and unfavorable conditions that influenced this process.

METHODS

The study in question was a descriptive research with a qualitative approach.

The setting of this research was the Pedro Ernesto University Hospital, chosen for being a reference for high-risk pregnancies, presenting a high proportion of cesarean sections and ensuring the presence of the companion during labor, delivery and postpartum.

The interviews were conducted in a room located in the rooming house of the Perinatal Center of the Hospital, which guaranteed the privacy of the interview.

The research was carried out with 10 parent participants, being observed the redundancy of speech in the eighth participant and confirmed the saturation with the last two.[12]

The participants were chosen by convenience, and anonymity was ensured by identifying them by the alphanumeric code represented by the capital letter corresponding to the father's initial "P" followed by the number designated by the order in which the interviews were conducted (P1 to P10).

The inclusion criteria were: being the newborn's biological father, accompanying the newborn from hospitalization until the cesarean section, and being over 18 years of age; and the exclusion criteria were: being the vaginal delivery's accompanying father and being the newborn's accompanying father, but not being the newborn's father.

Data collection was based on a semi-structured interview conducted from August to September 2016. In this interview, few questions are addressed to the interviewee and there is a verification whether the points of the agenda are being addressed in the interview.[13]

The data collection instrument was composed of data on the characterization of the participants (age, color, education, occupation, marital status, number of children, and whether they had participated in the birth of previous children), as well as open questions about the participation of the accompanying father from the woman's hospitalization until the cesarean section and about his knowledge about the reason for performing the cesarean section, with five guidelines established: 1) moment of hospitalization, 2) preparation for cesarean section, 3) information about cesarean section and baby's health, 4) paternal feelings, and 5) positive and negative experiences in the birth scenario.

Regarding characterization data, simple descriptive statistics were used to represent the profile of the participants.

The interviews were recorded in MPEG-1/2 Audio Layer 3 (MP3) and transcribed for analysis. The data analytic process was Bardin's content analysis, defined as "a set of communication analysis techniques", which consists of three phases: pre-analysis, material exploration, and treatment of results, inference, and interpretation.[14]

Initially, the interviews were transcribed and coded and, subsequently, 213 registration units were identified, which gave rise to 17 meaning units and were grouped into 2 analytical categories, the first being: possibilities and limitations in the experience of the accompanying father in the Obstetric Center with 2 subcategories: the assessment of the physical space of the Obstetric Center and the reception and guidance of the professionals in the Obstetric Center and the second: the emotional aspects in the cesarean birth process in the Obstetric Center.

The research was forwarded and authorized by the Ethics and Research Committee of the Pedro Ernesto University Hospital on March 1, 2016 having the opinion 1,431,777, meeting the criteria established by Resolution 466 of December 12, 2012 of the National Health Council / Ministry of Health, which provides for the conduct of research with human beings, with prior to the interview, the reading and signing of an Informed Consent Form by the participants.[15]

RESULTS

The profile of the interviewees was: average age 33 years, six (60%) declared themselves white and four (40%) black, six (60%) finished elementary school, three (30%) finished high school, and one (10%) completed higher education.

About the type of marital relationship: five (50%) were married to their partner and five (50%) had a stable union.

Regarding the number of children, four (40%) said they were following the birth of their first child, six (60%) said it was not the birth of their first child. The parents who already had children reported not having participated in the birth of these children, two (20%) did not participate due to the institutional impediment of the hospital unit, and four (40%) because they did not want to participate.

Regarding their partners, nine (90%) were classified as high gestational risk. Regarding the pathologies presented by the women, three (30%) had type 2 diabetes mellitus, four (40%) had hypertensive syndromes, one (10%) gestational diabetes mellitus, one (10%) had antiphospholipid antibody syndrome and one (10%) had no pathology being classified as usual risk.

After data organization, according to the content analysis proposed by Bardin, two categories of analysis were identified and will be described below:

Analytical category 1: Possibilities and limitations in the experience of the accompanying father in the Obstetric Center.

Subcategory 1: Evaluation of the physical space of the Obstetric Center.

In this subcategory, we observed the perceptions of parents about the conditions of the environment of the Obstetric Center.

> *I found everything well organized, everyone oriented me and explained to me that the surgical environment had to be careful not to touch things, it was a once in a lifetime experience.* (P2)

> *The doctors told me that I could not move much, not touch anything, just stay by her side, there were many professionals in the room, I had to respect the space of the doctors, they are more important.* (P3)

Subcategory 2: Reception and guidance by professionals at the Obstetric Center.

In this subcategory, the perception of the assistance provided by health professionals was identified from admission to the Obstetric Center to cesarean section.

> *The nurses said they were going to prepare her and that I had to put on a special outfit, cap, mask and they explained to me where I should stay.* (P6)

> *The doctors came and explained, then the nurses, then they gave me the clothes, mask, cap and explained that I could not move, I could only stay by her side.* (P8)

Analytical category 2: Emotional aspects in the process of birth by cesarean section at the Obstetric Center.

In this category, the feelings and their experience from the hospitalization at the Obstetric Center to the cesarean section with the birth of their child were addressed by the participating parents.

> *For me, seeing the baby being born was a very positive experience, I felt being born together with her, a new father was born when I saw her little face, we were very anxious.* (P4)

> *I was always there by her side giving emotional support and that was the most important thing. Having someone from the family close by provides comfort, security, and makes the woman calm.* (P10)

DISCUSSION

The environment of the obstetric surgical center is normally seen as a place of apprehension, due to its great technological arsenal and attention to birth that is not physiological, having its structure designed to meet regulatory norms and rigid and necessary standards of patient safety, which did not foresee the presence of the companion, hindering the entry and permanence of the same in this birth scenario.[16]

This inadequacy to the presence of the companion is perceived by the parents, in this research, when they highlighted as unfavorable conditions for their participation in the birth: the small area of the operating room, the large team, the sterile environment, and the lack of mobility in the operating room.

This environment, composed of surgical instruments, sterile fields, inadequate infrastructure and professionals unprepared to receive the companion, contributes to the distancing of the accompanying father in the birth process, since its construction and planning were developed exclusively to meet the needs of health professionals and not of the companions.[16]

The conformations in the surgical environment and the care philosophy of hospital institutions must allow hospital technologies, the physical structure and the practices of humanization of labor and birth established by health professionals to coexist harmoniously in order to provide quality care to the binomial and the accompanying father and the establishment of a bond between them and the health professionals.[17]

Florence Nightingale theorized that the physical environment must be favorable and welcoming and the nursing care given to the person being cared for, in this case, pregnant women and their psychosocial needs, must enable favorable circumstances, being fundamental for the adaptation to the new situation of birth experienced.[18]

In this sense, in the daily life of health services, in addition to an adequate physical environment, the welcoming is also necessary, being expressed in the relationship established be-

tween health professionals and users, mainly through guidance on the assistance provided, active listening and support to the demands presented.[19]

The reception of the team was a favorable condition highlighted in the experience of fathers, based on the guidance of professionals, the ambience of the sector, and the satisfaction with the care provided from hospitalization to cesarean section.

Thus, the study showed that for the effective insertion of the accompanying father in cesarean sections, besides structural changes that integrate him into the birth process, it is necessary to plan actions and sensitize health professionals, aiming at a greater interaction with him.

The insertion of the obstetric nurse in birth settings promotes the humanization of care with emphasis on the mother-child--family triad, because their training is based on scientific evidence and principles of respect for women and their particularities in the care of normal birth and cesarean section.[20]

However, in the assistance of the obstetric nurse in this scenario, the confrontation between the humanization of care performed by the nurse and the practices influenced by the biomedical model and the medicalization of care to the female body is still observed.[21]

The Nursing professionals, when performing the welcoming process, are faced with a plurality of feelings of women and accompanying parents, propitiated by the birth process.

High-risk pregnancy is configured by physiological, emotional, and social transformations that generate uncertainties and fears on the part of the pregnant woman and her companion related to the development of pregnancy and the consequences for the newborn, requiring integral health care and the support of health professionals.[22]

Parents reported experiencing a diversity of feelings in the process of their child's birth, such as excitement, anxiety, fear, and concern of an unfavorable outcome for their wife and child at birth.

These common feelings in the construction of parenthood require support from health professionals, family, and society so that the adaptation to psychological, emotional, and social changes is successful for parents, especially in high-risk pregnancy and delivery, which cause changes rooted in the risk to the pregnant woman and the fetus, generating repercussions throughout the family.[22,23]

In this sense, health professionals during the follow-up of high-risk pregnancy must have empathy to understand the feelings and emotions involved in this pregnancy, guiding women, their partners, and their families about the changes experienced, providing security, support, welcoming, and bonding, alleviating their fears and concerns.[23]

The presence of health professionals who support women, their health needs and singularities, and fathers during childbirth brings well-being and safety, and their care, bonding, and guidance are essential at this time in their lives.[10,24,25]

Accompanying fathers evaluated that their participation in the cesarean section occurred through physical and emotional support to their wives. Research corroborates this thought, stating that the presence of a companion provides the physical protection and emotional support the woman needs during the birth of her child and contributes to well-being, which reduces the possibility of future depression in the postpartum period.[11,26]

The presence of a companion of the woman's choice during birth provides a better experience for women in childbirth, even with the presence, involvement, and qualified assistance of health professionals.[27]

However, it is still notorious in the current Brazilian obstetric scenario a contradiction between what science and legislation recommend and the way practices are organized. It is perceived that scientific evidence, international recommendations and laws regulated by the government have not been sufficient to guarantee women the right to be accompanied during childbirth, especially in cesarean sections.[27]

In addition to this fact, the social imaginary still established that pregnancy, childbirth, and childcare belong to the female context represent the greatest challenges to men's involvement in the pregnancy-puerperium cyclel.[22]

CONCLUSION

The insertion of the companion in the cesarean scenario demands a new look for fathers, so that their presence is not only physical, but they can actually experience this moment, considering the countless feelings and meanings that contribute to the construction of the paternal role with profound results for their lives and their families.

In this sense, in addition to complying with the legislation and institutionalized prerogatives, the adaptation of the physical environment of the cesarean section to the accompanying father, the preparation and sensitization of the family since pregnancy for the moment of childbirth, and of the health professionals involved in the gravidic-puerperal cycle are substantial to enable a greater integration of fathers in the birth.

In this way, the creation of health education strategies such as groups and collective consultations since prenatal care is pointed out, in which health education practices of preparation for childbirth do not only include mothers, but also fathers, adapting them to their demands and allowing the sharing of feelings experienced.

Still as proposals, the creation of new programs, policies, and governmental actions are necessary, as well as changes in regulatory norms and in the management of institutions, besides the elaboration and implementation of care protocols that guarantee and stimulate not only the presence of the accompanying father, but also his effective participation.

Added to these, one can propose the sensitization of the multiprofessional team involved in the gravidic-puerperal cycle and the development of new flows, training, and standards of care so that teamwork and dialogue between health professionals and accompanying fathers can be established in order to encourage their presence.

Specifically, the inclusion of the obstetric nurse's role, since prenatal care, makes it possible, through its actions of bonding, welcoming, and health education with guidelines and qualified information, to encourage the presence of the accompanying father since pregnancy, generating beneficial implications for the moment of delivery, whether normal or cesarean.

Therefore, it is suggested that such actions should be widely disseminated from primary care in prenatal care to tertiary care in scenarios of labor and birth by cesarean section, breaking the barriers and institutional, cultural, historical and gender difficulties established aiming at a qualified and humanized assistance providing positive effects for the birth, for the construction of fatherhood and consequently for the new family formed.

The number of participants, the sample made up of fathers who participated for the first time in the birth of their children, and the unique setting may configure possible limitations of the study. However, the objectives and methodological aspects proposed by the research were reached, providing the elucidation and discussion of the conditions that involved the parents' experience of cesarean birth.

This research aimed to contribute to the praxis and thought of Nursing, especially Obstetric Nursing, from the reflection on the participation of the accompanying father in cesarean sections, offering data for the academia, for the improvement of Nursing care and of the multiprofessional team, as well as stimulating future research on the theme.

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