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RESEARCH

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Fatores que influenciam a escolha do tipo de parto na percepção das puérperas

Factors that influence the choice of birth type regarding the perception of puerperal women

Factores que influyen en la elección del tipo de nacimiento en la percepción de las puerperas

Rúbia Mara Maia Feitosa¹; Ruana Daniela Pereira²; Tamara Jéssica Costa de Paula Souza³; Rodrigo Jácob Moreira de Freitas⁴; Sarah Azevêdo Rodrigues Cabral⁵; Lázaro Fabrício de França Souza⁶

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ABSTRACT

Objective: To understand the factors that influence the process of choosing the type of delivery, from the perception of mothers. **Methods:** This is a qualitative and descriptive research, held at the Women's Hospital Midwife Maria Correia, Mossoró/RN. A total of 14 mothers were interviewed. Data were analyzed according to the Collective Subject Discourse technique. The study was submitted to the Ethics Committee in Research of Universidade Potiguar approved under the number CAAE: 38520214.0.0000.5296. **Results:** Women's desire a birth delivery without complications and fast recovery. The influences of the "fear of pain" and individual experiences and other women for choosing the type of delivery are significant. **Conclusion:** We emphasize the importance of access to prenatal quality actions that provide safe choices, clarifying doubts and future mother's wishes, reassuringly for delivery.

Descriptors: Women, Parturition, Hospitals.

¹ Nurse graduated by the State University of Rio Grande do Norte (UERN). Master degree in Clinical Care in Nursing and Health by the State University of Ceará (UECE). Specialist in Activation of Processes of Change in the Higher Education of Health Professionals by the National School of Public Health (ESNP/FIOCRUZ). Mossoró, Rio Grande do Norte, Brazil. E-mail: rubinhafeitosa@hotmail.com.

² Nurse graduated by the Potiguar University (UnP). Natal, Rio Grande do Norte, Brazil.

³ Nurse graduated by the Potiguar University (UnP). Mossoró, Rio Grande do Norte, Brazil.

⁴ Nurse graduated by the State University of Rio Grande do Norte (UERN). PhD in Clinical Care in Nursing and Health by the State University of Ceará (UECE). Mossoró, Rio Grande do Norte, Brazil.

⁵ Psychologist graduated by the University Center of João Pessoa (Unipê). Specialist in Public Health and Family Health by the Faculty of Patos (FIP). Specialist in Cognitive Behavioral Therapy. MBA in Management of People and Companies by the University Center of João Pessoa (Unipê). Master's Degree in Intensive Therapy by the Brazilian Institute of Intensive Care (Ibrati). Professor at the Nova Esperança Nursing School in Mossoró (FACENE/RN). Coordinator of the Psychopedagogical Support Nucleus (NAP/FACENE). Mossoró, Rio Grande do Norte, Brazil.

⁶ Social Scientist. Master in Social and Human Sciences from the State University of Rio Grande do Norte (UERN). Coordinator of Research and Teaching at the Faculty Nova Esperança (FACENE). Mossoró, Rio Grande do Norte, Brazil.

RESUMO

Objetivo: Compreender, a partir da percepção das puérperas, os fatores que influenciam na escolha ao tipo de parto. **Métodos:** Trata-se de uma pesquisa do tipo qualitativo e descritivo, realizado no Hospital da Mulher Parteira Maria Correia, município de Mossoró/RN. Foram entrevistadas 14 parturientes. Os dados foram analisados de acordo com a Técnica do Discurso do Sujeito Coletivo. A pesquisa foi submetida ao Comitê de Ética em Pesquisa da Universidade Potiguar, aprovado, sob o número do CAAE: 38520214.0.0000.5296. **Resultados:** As puérperas apontam o desejo de um parto sem intercorrências e com recuperação rápida. São significativas as influências do “medo da dor” e das experiências individuais e de outras mulheres para a escolha da via de parto. **Conclusão:** Ressalta-se a relevância do acesso ao pré-natal de qualidade, com ações que proporcionem escolhas seguras, esclarecendo dúvidas e anseios da futura mãe, tranquilizando-a para o momento do parto.

Descriptores: Mulheres, Parto, Hospital.

RESUMEN

Objetivo: Comprender, a partir de la percepción de las madres, los factores que influyen en la elección del tipo de parto. **Métodos:** Se trata de una investigación cualitativa y descriptiva, que tuvo lugar en el Hospital de la Mujer de la partera María Correia, en Mossoró/RN. Fueron entrevistadas 14 madres. Los datos fueron analizados de acuerdo a la técnica del Discurso del Sujeto Colectivo. El estudio fue presentado al Comité de Ética en Investigación de la Universidad Potiguar con número de autorización CAAE: 38520214.0.0000.5296. **Resultados:** Las mujeres apuntan al deseo de un nacimiento sin complicaciones y una recuperación rápida. Las influencias del “miedo al dolor” y las experiencias individuales y otras mujeres para elegir el tipo de parto son significativos. **Conclusión:** Destacamos la importancia del acceso a las acciones de calidad prenatales que proporcionan opciones seguras, aclarar dudas y deseos futuros de la madre, de modo tranquilizador para la entrega.

Descriptores: Mujeres, Parto, Hospitales.

INTRODUCTION

Pregnancy is the period in a woman's life in which occurs physiological changes that guarantee a propitious environment to the fetus' development and is a moment of psychological changes that generate expectations, emotions, fears and anxieties for the pregnant women, demanding during this phase, specific guidance and care. One example is related to choose the type of delivery.

Several factors, associated or not, involve the questions about choosing the most appropriate type of childbirth, ranging since the quality of obstetric care until the implications concerning mother and baby's health, and relate to the meaning of delivery assigned for each woman.¹

In this perspective, women should receive accurate information so they can enforce, as recommended by the Program for Humanization of Prenatal and Birth, the right of free choice of delivery type, which must be respected, especially when pregnant women are properly oriented and monitored throughout the process of pregnancy and childbirth.²

This decision may be influenced by several factors regarding the risks, benefits, possible complications and future repercussions. We know that choosing the type of delivery has to do with the knowledge that pregnant women have upon the subject through the guidelines given by health professionals.

It is essential for the delivery type decision a closer relation between the professional and the pregnant women, ensuring a comprehensive and quality care, clarifying their doubts and anxieties with regard to aspects of pregnancy, birth and postpartum. Thus, the professional role in the promotion of women's health during pregnancy and childbirth, in health education and assistance to the process giving birth/birth is a key instrument for the construction of pregnant women's autonomy.³

According to data presented at the 5th National Monitoring Report on the Millennium Development Goals (MDGs), launched in May 2014, Brazil obtained a reduction of 55% of the pregnant women death rate in two decades, from 1990 to 2011, corresponding to a drop of 141 to 64 deaths per 100,000 live births. This represents an improvement, even greater than the average reductions in Latin America and in the world, representing a total of 45%. Another fact also deserves attention: in Brazil, 99% of deliveries were performed in hospitals or other health facilities.⁴

On the other hand, about two decades ago, cesareans indicators have shown to be growing. By observing the data pointed by the “National Demographic and Children and Women Health” held in 2006, it is clear that cesareans numbers remained high, reaching proportions of 43.8%. After the release of the study, the cesareans levels increased almost 10% between 2000-2007, with respective rates of 38% to 47%. The same study shows that in 2007 the Southeast region was the one that showed a greater degree of cesarean deliveries with 54.2%, followed by the South and Midwest regions, technically tied with 52.8% and 52.9% each. The Northeast had 36.4% and, finally, the North region with 35.3%.²

In 2010, in Brazil, the percentage of cesarean deliveries was 52.34%, with the highest incidence in the state of Rio Grande do Sul, the seventh in the ranking among the units of the federation, reaching 58%, well above the Brazilian rate. The proportion of cesareans deliveries has shown increase over the period 2000 to 2011, reaching, in the aforementioned state, the proportion of 60.3% in 2011.⁵

In general, the Ministry of Health (MH) is concerned about the caesarean rate in Brazil, which far exceeds the 15% deemed appropriate by the World Health Organization (WHO). The highest concentration occurs in the private network, which makes 80% of deliveries via caesarean section nowadays. In public, births by surgery represent 40%.⁶

When performing an analysis of the high rates of operative deliveries, we wonder whether this fact stems from the “women desire”, or can occur by external influences such as medical convenience, lack of qualified professionals,

or even the search for tubal ligation during a cesarean.⁷ There are indications related to fetal distress and risks to the mother justifies the cesarean section, however, there is often a subjective assessment not related to clinical issues, which imposes the convenience of the doctor over the mother needs.⁶

This reflects the dimension of the problem, as the issues related to the choice of delivery, which should be limited to the status of women, is being often decided by the medical team. Thus, the maternal decision ends up being neglected and its condition of being a mother, unique moment in a woman's life, becomes traumatic.

In Mossoró, in 2012, 78.2% of 3,715 births were cesarean (2,904 births). Normal delivery represented 21.7% (805 births) of the total, while 0.2% (06 births) were classified as "not specified".⁸ Given the above, the following question was considered: In Mossoró/RN, which factors influence the choice of delivery type by the mothers?

In this scenario, it is observed that there are few discussions that give visibility to this issue and the main theoretical references found are from distant periods, 1996 to 2009. The majority part of the recent publications, 2014 and 2015, approaches the problem with further deepening, addressing research with pregnant women in primary health care.

A few articles discuss the factors related to the choice of childbirth type from the mother's point of view. Noteworthy is a publication with 25 women interned in the rooming of the University Hospital Maria Aparecida Pedrossian (HUMAP) Campo Grande/MS, in order to know the factors reported by mothers, which were considered in choosing the type of delivery.⁹

Thus, this study is justified as a contribution and renewal of scientific literature on the subject to be treated, bringing as a search scope from the perspective of mothers who, after delivery, are in the maternity ward of a hospital, reporting their reasons for the implementation or not of their choice to the type of delivery.

Health professionals need to participate in this discussion to ensure humane care from prenatal until the postpartum period. In this perspective, this work has the primary objective to analyze the factors influencing the choice of delivery type by the mothers of Mossoró/RN.

METHODS

This is a descriptive qualitative research conducted in the city of Mossoró/RN. This city is located at a distance of 295 km from the state capital, Natal. It is the second most populous city, according to 2011 data from the Brazilian Institute of Geography and Statistics (IBGE), with 262,344 inhabitants.

The study took place at the Women's Hospital Midwife Maria Correia (HMPMC). The state service, located in Mossoró/RN, being a reference to maternal and child care of low and high risk, offering care for pregnant women of

the West and the Açu Valley regions. The Women's Hospital performs an average of 300 births per month.

The study subjects were 14 puerperal women interned in rooming at HMPMC during the last 12 to 72 hours. The choice of mothers in hospitals was justified by the fact that these prenatal care have already been done by health professionals in Primary Care, getting information about the types of delivery, its risks, and benefits. In this perspective, researchers understand that the mothers were able to explain the type of delivery they wanted to have during pregnancy and whether this choice was in fact achieved, reaching their expectations.

To compose the subjects, the following inclusion criteria were used: women that, during their pregnancy, were registered in Humanization Programme Monitoring System in Prenatal and Birth (SISPRENATAL, in Portuguese) were attending prenatal service in Family Health Strategy (FHS), were, in the period of the survey, admitted in the sector of rooming, between 12 to 72 hours after the experience of normal or caesarean section and agreed to participate in this research beforehand signing the Written Informed Consent form (WIC).

As exclusion factors: mothers who were discharged from the hospital rooming sector, those at the time of the survey were unable to verbalize; under 18-year-old mothers, those diagnosed at high risk and those who did not have physical (pain, fatigue) and psychic conditions to participate.

Regarding data collection instrument, a semi-structured interview was used. This is a tool to guide a "conversation with purpose," it should be a facilitator of openness, expansion and deepening of communication.¹⁰ This instrument had questions prepared by researchers, so that ranged from the knowledge of mothers on the type of delivery, its risks and benefits, since the important factors for the realization of the choice of delivery type.

Data were collected in April and May 2015, only after the project has received approval from the Research Ethics Committee (REC). The researchers conducted the visit and they went in the morning to the hospital rooming sector to deliver a letter of invitation to the mothers that met the research inclusion criteria.

The women who agreed to participate in the study received, in the afternoon, the Written Informed Consent form and, along with researchers, scheduled the day and time to conduct the interview, still in the rooming facilities. It is important to emphasize that priority was given to schedule the interview in a time that does not prejudice the hospital routines, and the time was agreed with the health professionals.

This approach to interviewing them in the infirmary was adopted regarding their physical situation (pain and inability to walk) caused by caesarean or vaginal delivery. The interviews were recorded on an MP3 player. In transcripts of the speeches was taken into consideration the anonymity of mothers, identified in the study with reference to the letter

P1, P2, P3 etc. After collecting data, the first step was the analysis process of testimonials full transcription.

Data were analyzed according to the technique of the Collective Subject Discourse (CSD). This is a form of presentation for qualitative research results, which is based on testimonies. These statements will be presented in the form of one or more written speech-synthesis in the first person of singular, in order to express the thought of a community as if this community were the speaker.¹¹

To conduct the study were taken into account the assumptions of Resolution 466/2012 of the National Health Council/Ministry of Health that regulates research with human beings.¹² This resolution shows the ethical aspects of research involving human beings, the process of informed consent, the risks and benefits, among others. It states that the participant does not need to be identified and may give up the search anytime without being penalized.

The study was submitted to the evaluation of the Research Ethics Committee of the University Potiguar (UNP), supported by the respective resolution. It was approved by the statement number: 907,461 and in the number of CAAE: 38520214.0.0000.5296.

RESULTS AND DISCUSSION

Characterization of Research Subjects

This study included 14 mothers attended by the Maternity Hospital. The age of respondents ranged between 14 and 43 years old. Among them, four (28.57%) have completed high school, four (28.57%) have not completed high school, three (21.42%) have not completed primary school, two (14.28%) were graduated and one (7.14 %) was an undergrad student.

Regarding the social-demographic aspect related to pregnancy, it is known that the arrival of a child interferes in the academic career of women, which is reflected in high rates of low education among young mothers as a result of evasion, abandonment, and the difficulty in returning to school after the child's birth.¹³

Among the participants, five (35.71%) were from Mossoró and nine (64.28%) from the surrounding cities. Regarding the number of children, six (42.85%) had only one child, five (35.71%) had two children, one (7.14%) had three children, one (7.14%) had five children and one (7.14%) had six children. It is known that in families with more and older children, pregnant women tend to seek less health care, becoming important the location and active search of health services, so women can initiate the prenatal as early as possible.¹⁴

Regarding the number of prenatal consultations, nine women (64.28%) went to more than six consultations, the minimum considered by the Ministry of Health in order to have a healthy pregnancy.

Finally, asked about the type of birth they had, six women (42.8%) reported normal delivery; while five women (35.7%) reported cesarean and three women (21.4%) said that along

the maternal journey had more than one child, changing the nature of labor between normal and caesarean.

The results of operative delivery, especially for first pregnancy, are particularly concern data since they imply a high probability of repeating this type of delivery in future pregnancies. The medicalization of birth is opposed to the World Health Organization recommendations which, besides establishing as ideal rate of cesarean section the percentage of 15%, seeks to ensure a minimum supply of interventions in childbirth care.⁹

It is possible to evidence the profile of each participant in the following table:

Table 1 - Characterization of the Participants. Mossoró/RN, 2015

Participants	Age	Schooling	City	Children	Consultations	Childbirth
P1	28	Incom. Highschool	Mossoró	1	4	Normal
P2	35	Incom. Primary School	Martins	5	5	Normal
P3	23	Incom. Highschool	Baraúna	2	10	Normal/Cesarean
P4	18	Comp. Highschool	Mossoró	1	6	Normal
P5	43	Comp. Highschool	Carnaubais	6	4	Normal/Cesarean
P6	21	Incom. Primary School	Mossoró	2	3	Cesarean
P7	24	Comp. Highschool	Mossoró	1	6	Cesarean
P8	24	Comp. Highschool	Baraúna	2	6	Cesarean
P9	26	Graduated	Areia Branca	1	7	Cesarean
P10	16	Incom. Graduation	Mossoró	1	2	Normal
P11	14	Incom. Highschool	Jucuri	2	12	Normal/Cesarean
P12	21	Incom. Primary School	Baraúna	1	8	Cesarean
P13	27	Incom. Highschool	Areia Branca	3	8	Cesarean
P14	31	Graduated	Pau dos Ferros	2	7	Cesarean

Source: Information provided by the research participants.

For the analysis, the CSDs were grouped by topic. Each CSD was associated with the corresponding central idea so, in this way, it was possible to analyze the statements collected, using the current scientific literature on the subject.

Knowledge of mothers about normal and cesarean delivery

The mothers, when questioned about their respective knowledge of normal and caesarean delivery, answered it is a complex issue, according to the extent of tangents doubts about comfort and the mothers and newborn safety during the process of parturition. These questions were mainly related to the practices of normal delivery and the feeling for it: pain, suffering, fear.

Give voice to users of health services for the identification of their knowledge of the various factors that involve the delivery route is an important tool to (re) define the planning of health actions at the level of academic training, assistance, and management.

Therefore, in this category are contained the testimonials concerning the knowledge of mothers about the normal and caesarean section, it was possible to identify two main ideas: (1) Normal delivery hurts and cesarean delivery hurts less and (2) I do not know, but I heard that normal childbirth hurts, and cesarean recovery is worse, as shown in Table 2.

Table 2 - About the delivery type. Mossoró/RN, 2015

Central Idea	Collective Subject Discourse
(1) Normal delivery hurts and cesarean delivery hurts less	"[...] I know, normal delivery is better, the pain is just in time, recovery is immediate, when the baby is born, the pain is over, it is all right. It's just horrible pain [...] has no explanation, no name to define how much is bad [...] but it is the best choice of mode of delivery because is the time that the baby chooses to born when he knows it is ready and well formed." (ON NORMAL BIRTH).
	"I know, I liked cesarean delivery because we feel pain after the birth because is a surgery, but then it's ok. Not to mention that there we have anesthesia, the doctors, everything calm. I still didn't want to have a normal delivery, never had, do not want, even without experiencing one, but anyway I just wanted Cesarean why normal hurts a lot. Cesarean is even better because you do not feel anything during childbirth. Take anesthesia and that's it." (ON caesarean section).
(2) I do not know, but I heard that normal childbirth hurts, and cesarean recovery is worse	"I do not know for sure, I will not lie. I know what the others say, so I'm even afraid to speak in normal delivery because I'm afraid of unbearable pain [...] do not have much experience [...] just know that pain is abnormal. The other women who had normal regretted this decision." (NORMAL BIRTH).
	"I do not know anything thoroughly, do not know so much about each of them, but I know I there is the caesarean and by the experience I had, although painful, I think I would rather normal, with Cesarean we can't get up for a long time, the pains are horrible, the stitches, and the complications that may arise in the future (CESAREAN SECTION)."

Source: Information provided by the research participants.

In the central idea (1) you can see that the mothers list some biological characteristics to differentiate the type of delivery and subsequently use these arguments to justify their choices. Focus on pain as a key element to differentiate normal and cesarean delivery. Although both pathways present the painful sensation it is the intensity of pain that differentiates them. The normal delivery is associated with extremely unbearable pain.

Also in these speeches, there is the presence of behavioral patterns and values transmitted collectively, through culture, and are passed on through generations, outlining the perception of mothers on the delivery route. The socio-cultural dimension is able to interfere with the affinity that the woman will have to a respective kind of delivery, contributing to the formation of myths, beliefs, and opinions that reverberate in the unique experience of each pregnancy.¹⁴

It is noticed that most mothers who said knowing the delivery routes considered cesareans the best option to choose. Are determinants of preference: the fear of the pain of normal delivery; previous experience; security and flexibility in the process. It is in this direction that the obstetric practices have been promoting the growth of pharmacological methods used to provide a decrease in pain sensation, thus promoting greater comfort at the time of parturition. Because of the hospitalization process, women began to think that caesarean is more "natural" and comfortable.¹⁵

Fear of pain during vaginal delivery is considered one of the sociocultural factors that may also affect the woman's decision about the mode of delivery, leading to pregnant women to opt for elective caesarean section, which is decided in advance scheduling day and time and making possible for her to give birth without any pain, since she receives strong painkillers after the surgery.⁷

In addition, many women still feel afraid to give birth vaginally, mainly because they fear the consequences that may arise from this type of delivery, for example, the onset of urinary and fecal incontinence, genital dystopias and even perineal important lacerations.

The central idea (2) denotes that the women interviewed have obtained little information provided by health professionals during your pregnancy. A fact that contributes to curtail women's autonomy against the choice of the delivery type. It is noticed that these women do not even experience the dynamics of normal birth, but they associated it to pain. This perception can be influenced by ignorance or lack of dialogue with the health professionals who accompanies their prenatal and by not clarifying questions about the timing and the type of delivery.

It can be seen in the discourse of mothers that pain and suffering appear as inevitable aspects of normal delivery, an unknown and unpredictable experience. This perception is reflected in the comparison with previous deliveries and a preconceived attitude about the pain of childbirth, even for women who have never been pregnant. The woman's desire for a caesarean is sustained by fear, convenience, and

disinformation. Often the mother fears the consequences of a vaginal birth because they considered it a risky experience. The woman has the paradoxical idea that the surgery is a way to avoid pain.⁹

This fear, however, is not justified, since the discomfort experienced by mothers during labor and postpartum is not much different between the two delivery routes. So, the pain of childbirth, even though mitigated by the use of analgesics on the cesarean section, it is always present, from pre-birth to post-partum, varying in intensity as the physiological, physical and emotional conditions of woman in labor, as well with quality of care provided to them in these moments.¹⁶

The women who had a preference for cesarean section justified their choice from some previous experience with normal delivery that was not successful or even the fear of suffering and feeling pain in natural birth, believing that during the cesarean section women receive a more careful assistance.¹³

The knowledge of caesarean section revealed by the interviewed mothers is linked to the medicalized welfare model. Currently, the predominant in the parturition process is the choice of cesarean section, where you can have the convenience of a scheduled and painless intervention. Such predominance in medical professional choice for caesarean section shows a connection with the training of health professionals based on the technical-scientific and bound, in general, to the prospect of knowledge regulation, unidirectional and prescriptive. This practice is influenced and dominated by administrative and political power and driven ideologically by biomedical knowledge, hindering educational approaches that value knowledge, prudence, and critical analysis, by professionals and users in relation to integrative practices, alternatives and can disregard the perspective will and autonomy of patient.⁷

Reasons for choosing the delivery type

For the realization of this category, mothers were asked about the type of birth they wanted to have during pregnancy and whether this choice was, in fact, realized. It was possible to see that this decision reflected many feelings on their speeches, as anger, disappointment, happiness and satisfaction. The speeches underlined three central ideas: (1) No right to choose, (2) Medical indication and (3) Casualty.

Six women in this study had a preference for natural childbirth since the beginning, according to their views, this type of delivery would allow a faster recovery, favoring their rapid return to daily activities, and it avoids the inconveniences caused by cesarean section, for example, hospitalization, aches, and pains that usually occur after the child's birth.

For these mothers, normal childbirth made them more active, a feeling that is not perceived in the caesarean section, because the woman takes a passive stance, losing in parts the sense of their protagonism.⁹

In Table 3 are the mothers' speech:

Table 3 - Type of delivery choice. Mossoró/RN, 2015

Central Idea	Collective Subject Discourse
(1) No right to choose	"I had no choice, if I had I'd choose normal for sure. But the doctor had already opted for caesarean. I did not counteract him. The doctor decided. All my plans were dashed because of the doctor's choice."
(2) Medical Indication	"I did not have the expansion, during the consultations I had complications and I came here [...] was medical indication [...] because of the high pressure, she [the doctor] decided the type."
(3) Casualty	I had my baby inside the ambulance and did not have time not to come here. From Martins, I had to go to Pau dos Ferros, from there they took me here suffering. So much pain.

Source: Information provided by the research participants.

In the central idea (1), we note that the choice for the delivery type by mothers is curtailed by the conduct of health professionals who indiscriminately opt for a caesarean section. It is known that there are indications related to fetal distress and risks to the mother that justifies the operative delivery, however, in a considerable number of times, there is a subjective assessment not related to clinical issues, which puts the convenience of the doctor over the mothers' need.¹⁷

It is undeniable that there were numerous benefits from the institutionalization of birth, as the best asepsis, a problem that was a frequent cause of puerperal infection and maternal death, and ways of monitoring and resolution, such as emergency care to newborns at risk by a specialized medical team. However, with the overvaluation of birth technique and overemphasis on its physiology, psycho-emotional and social aspects are neglected; preventing women their right to choose it according to their meanings acquired culturally.⁷

The choice regarding the type of delivery is a right, but mothers need to receive accurate information about the delivery routes so they can make decisions independently and safely. In general, the notion of individual autonomy and freedom of choice presented here allude to the ethical principles that guide the life in the community. Autonomy enables every individual full freedom of information, decision, and action since the rights of others are respected.¹⁸ Thus, the dialogue between the health professional and the woman allows the exchange of information, enabling benefits in childbirth and facilitating the woman expression.¹³

Authors share concerns about the high caesarean section rates in the country for several reasons: a) unnecessary exposure to risks of surgery; b) increased spendings on health services, from the hospital and/or doctors point of view; c) increased maternal and fetal mortality; d) higher probability of birth of premature babies, low birth weight and respiratory and/or neurological disorders.¹⁷

Given the high rates of operative deliveries in Brazil and the discourse of the interviewees in the central idea (1) of this category, we question whether this fact stems from the "desire of women", or may occur for medical convenience, ease health system, lack of qualified professionals, or search

for tubal ligation during cesarean section. Although private hospitals do more cesarean than public hospitals, is not an option for every woman the preference for cesarean section.⁷

The vulnerability of women caused by fear and fear against the parturition process makes the mother value the opinion of the doctor, respect arising from the detention of scientific knowledge, making them submissive to the choices of professionals, usually uncontested.¹⁹

These factors show the importance of the role of women as having the right to decide about the delivery type of their choice. However, it is on the health team, especially those who carry out delivery, accept the decision of their patient or interfere when there is a risk for mother and/or fetus.

In the central idea (2) it is valid to point out that the opinion of the professional at the time of delivery should also be respected, as it can make the mistake of choosing a way of giving birth that is not indicated for the moment. The most frequent indications for cesarean section are: occurrence of previous cesarean section, fetal distress, and breech presentation.²⁰

The purpose of delivery care is to take care of women and their newborns, keeping them healthy, with minimal complications, thus ensuring the safety of both. Thus, it is important that interventions in the birth of a child are performed only when recommended and when appropriate.²

Thus, professionals and health teams have to guide and clarify about possible complications, making women active in the self-care process during pregnancy and making them feel secure regarding the process of giving birth.

In the central idea (3) "Casualty": there is the statement that during the time of parturition, complications can occur leading professionals to adopt emergency measures to not endanger the mother and baby. In this perspective, the discourse of the interviewee referred to the need for health professionals for conducting normal delivery in adverse circumstances.

In adverse situations it is also necessary to think if the conduct is not generating interventions and unnecessary violence during labor, because they transform what would

be a normal event in a dehumanized procedure, further increasing the painful feelings and fears.⁹

Reflecting on this fact reiterates the importance of the professional preparation when providing care to pregnant/parturient. It is essential that health professionals, regardless of the position they act, have the ability, technical competence and emotional control to provide assistance.

Technical capacity needs to be highly valued, however, it is also essential that health professionals act in a humane way, valuing all dimensions of care.

Influences for the choice of delivery type

It is evidenced by the speech of mothers that there was the participation of external influences on delivery type decision-making, while others decided themselves based on the success of previous deliveries.

About the influences are noticeable institutional, individual and collective mechanisms, previous experiences, the medical power and the family, the absence of dialogic action in the prenatal period, among others.

Given the above, two central ideas arise from collective discourses: (1) No influences; (2) Complications during pregnancy and (3) With professional influence.

Table 4 - Health professionals influence on choosing the delivery type. Mossoró/RN, 2015

Central Idea	Collective Subject Discourse
(1) No influences	<i>"There was no such thing as influence [...] because I didn't do prenatal correctly [...] just felt pain and was brought here [...] I think if I had to choose, I'd choose caesarean again, but no one influenced me, if it had occurred well I'd want it again, but the downside is I had an infection and I am still here [9 days after surgery] [...] despite all the doctor left me free to choose the delivery type since it was made in private hospital, around 3000 reais, UHS only for 'emergencies'."</i>
(2) Complications during pregnancy	<i>He [doctor] told me it was better Cesarean in my case, because of the high pressure and she [nurse] also said it because I was with hypertension after pregnancy [...] and said it was better because I Cesarean I would not have expansion."</i>
(3) With professional influence	<i>"I did not have conditions to choose. I told him I wanted normal. For me, it would be normal, since I got pregnant I had already decided I wanted normal, but it didn't happen [...]. The doctor had to travel, we needed to schedule the day and time for the baby to be born. It was a doctor choice, not mine. I had no choice."</i>

Source: Information provided by the research participants.

In the central idea (1) "No influence", it is possible to note security of some mothers about the choice of the delivery type. Especially those who had been mothers before, allowing them in different pregnancies several choices for mode of delivery.

Infers here that the previous experiences of the women themselves, successful or not, end up serving as a mirror and inducing the woman to choose their delivery type. Knowing that every pregnancy is different, what is suitable for an expectant mother or pregnancy is not always recommended to another.¹³

To pregnant woman accomplish their choice of delivery type, is necessary knowledge, information, and power that will enable the conscious and deliberate decision making. The speeches of the mothers of this study outlined similarity with other studies when showing that the mothers' decision-making was based on previous experiences and the possibility of repeating the same type of delivery would be possible both in normal as in cesarean.⁹

On the other hand, we also realize that the knowledge of a part of the mothers in relation to the delivery mode is related to how information on the subject is available to them. In this bias, prenatal exists as an educational tool of high potential but its importance is still not understood. The participation of a multidisciplinary team is necessary to perform activities and information about pregnancy and childbirth, attempting to decrease anxiety and insecurity of pregnant women, in addition, to providing greater interpersonal relationship between professional and patient.¹³

Regarding the central idea (2), over the past decades occurred advances in medicine that allowed cesareans become a safe and alternative method for vaginal delivery in situations involving maternal and fetal risk. The main maternal and fetal risks are hypertensive disorders and labor dystocia. Other medical factors are crucial for the C-section, such as the presence of meconium in the amniotic fluid and fetal macrosomia.²²⁻²³

The women in this study revealed that the information passed on prenatal were not satisfactory since the majority said they have never received any information on delivery routes during the consultation, and those who received, said it happened in inaccurate and insufficient way.

The realization of prenatal is a vital role in prevention and/or early detection of diseases, both maternal and fetal, consenting healthy development for the baby and minimizing the risk for the pregnant women. Information about the different experiences should be shared between women and health professionals.

The possibility of exchanging experiences and knowledge is considered the best way to promote understanding of the pregnancy process. Also reveals that prenatal care is responsible for taking care of the physical and mental health of mothers and babies, making doubts about the pregnancy and maternity to be solved in the clearest possible way.²⁴ It is up to professionals and health teams to guide and clarify these issues, making women more active in the self-care process during pregnancy and making them feel secure about the gestational process and delivery. It is noteworthy that the professional assistance practice, especially nursing staff, determines the degree of potential for the humanization of giving birth/birth process, surpassing even the right field, break resistance to their effective implementation in health services.

However, knowing that the delivery type should be changed if there is a risk for mother and child, it is also evident that the freedom of choice guaranteed to puerperal is withheld by the manipulation of information provided by health professionals who follow the pregnancy through prenatal. The choice regarding the delivery type is a right, but the mother needs to receive accurate information about delivery routes so they can make decisions independently and safely. Dialogue - it is reiterated - between the health professional and the woman allows the negotiation and exchange of information in order to guarantee benefits in childbirth and facilitating freedom of expression for the pregnant woman.⁵

Meanwhile, what is observed in the central idea (3), professional influence, is their interest in carrying out the caesarean section. Choosing the cesarean section, allows the obstetrician to handle the length of delivery and the time for its realization, earn higher financial gains, associate surgery Caesarean section with tubal ligation and still hide the lack of preparation in conducting normal deliveries.¹³

There are indications related to fetal distress and risks to the mother that justifies the cesarean section, however, the assessment is subjective and not related to clinical issues, which puts the convenience of the doctor over the mother need. Another factor in discussion about medical influence on the number of caesarean sections may be related to deficient training to conduct complicated deliveries and fear malpractice suits.⁶

A few decades ago, cesarean delivery was performed only in exceptional circumstances, i.e. in life-threatening situations for the mother and the fetus, and almost all women resisted to this method. Lately, the high incidence of caesarean sections is a worldwide phenomenon, and Brazil is recognized as one of the countries with the highest rates and

considered one of the clearest examples of this procedure even without indications.¹³

The insensitivity of professionals regarding the needs of women, lack of information, the conditions of the public or private health system, insecurity, fear, and fear for not achieving dreams end up producing frustrations in those women that are not always overcome.²⁵

CONCLUSION

The birth process is a phenomenon surrounded by myths and beliefs, involving cultural aspects such as values and opinions that are passed from generation to generation, with direct influence on the opinion and preference of women for a certain type of delivery.

The desire for natural childbirth was demonstrated by the mothers of the research, although this choice represented fewer rates than caesarean, but the mothers who opted for the normal delivery used the justification that it favors faster recovery and healing, allowing an early return to normal activities when compared with a caesarean postpartum.

It could be also perceived the fragility of the information passed on by health professionals at the time of realization of prenatal consultations, regarding the delivery routes. It is in the prenatal that the professional who performs the delivery presents important role as health educators, urging the autonomy of pregnant women for choosing the delivery type in which your child will be born.

However, in the current healthcare system in Brazil, their choices are not always respected. The discussion of the results found points to the need for constant revision and improvement of woman care programs for pregnancy and childbirth, as well as the training of the multidisciplinary team involved in this type of care to ensure safe motherhood. It is necessary to respect the choices of pregnant women on the delivery type when they have been properly oriented, helping to ensure information on reproductive health and women's rights, encouraging natural and humanized delivery.

It is expected, therefore, that this study will contribute to new research related to this topic. It is known that comparative studies in different health services and cities, using the same methodology, can find other results, which enables discussion and deepening of the different factors that influence the choice of delivery type.

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Author responsible for correspondence:

Rubia Mara Maia Feitosa
Rua Cícero Aires de Lima, Ap. 5, N° 52
Aeroporto, Mossoró/RN
ZIP-code: 59607-390
E-mail: rubinhafeitosa@hotmail.com