

## Every birth is a story: process of choosing the route of delivery

*Cada parto é uma história: processo de escolha da via de parto*  
*Cada parto es una historia: proceso de decisión de la vía del parto*

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### ABSTRACT

**Objective:** To analyze the discourses on the choice of the route of delivery from the perspective of women and health professionals in a public network. **Method:** The methodological approach is the discourse analysis. The data collection was through interviews and the treatment of the data was based on discourse analysis. **Results:** The categories were: 1- Between the preference and the decision there is no choice; 2- The complexity of the choice of the route of delivery; 3- It is necessary to legitimize the choice of the woman. **Final considerations:** From the perspective of women in labor the route of delivery is determined by the physician and women are not proactive. The nurses' performance is timid, although their presence is fundamental for stimulating the physiological delivery and promoting the autonomy of women. It identifies the need for the physician to adopt a welcoming attitude, informing the women about the pros and cons involved in choosing the route of delivery.

**Descriptors:** Delivery Assistance; Women's Health; Speech; Normal Labor; Cesarean Section.

### RESUMO

**Objetivo:** Analisar os discursos sobre escolha da via de parto na perspectiva de mulheres e profissionais de saúde de uma rede pública. **Método:** A abordagem metodológica é a análise do discurso. A coleta de dados foi mediante entrevistas e o tratamento dos dados foi a partir da análise do discurso. **Resultados:** Constituíram-se as categorias: 1- Entre a preferência e a decisão não há escolha; 2- A complexidade da escolha da via de parto; 3- É preciso legitimar a escolha da mulher.

**Considerações finais:** Na perspectiva das parturientes o tipo de parto é determinado pelo médico e as mulheres não são pró-ativas. A atuação do enfermeiro é tímida, embora sua presença seja fundamental para o estímulo ao parto fisiológico e promoção da autonomia das mulheres. Identifica-se a necessidade do médico adotar uma conduta acolhedora, informando as mulheres sobre os benefícios e prejuízos implicados na escolha do modo de nascer.

**Descritores:** Assistência ao Parto; Saúde da Mulher; Discurso; Parto Normal; Cesárea.

### RESUMEN

**Objetivo:** Analizar los discursos sobre la decisión de la vía de parto en la perspectiva de mujeres y profesionales de la salud de una red pública. **Método:** El abordaje metodológico es el análisis del discurso. La recolección de datos fue mediante entrevistas y el tratamiento de los datos fue a partir del análisis del discurso. **Resultados:** Se constituyeron las categorías: 1- Entre la preferencia y la decisión no hay decisión; 2- La complejidad de la decisión de la vía de parto; 3- Es necesario legitimar la decisión de la mujer. **Consideraciones finales:** En la perspectiva de las parturientas el tipo de parto es determinado por el médico y las mujeres no son proactivas. La actuación del enfermero es tímida, aunque su presencia sea fundamental para el estímulo al parto fisiológico y promoción de la autonomía de las mujeres. Se identifica la necesidad del médico de adoptar una conducta acogedora, informando a las mujeres sobre los beneficios y perjuicios implicados en la decisión del modo de nacer.

**Descriptorios:** Asistencia al Parto; Salud de la Mujer; Discurso; Parto Normal; Cesárea.

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## INTRODUCTION

In childbirth care, the improvement of new techniques, as well as the respect for women's autonomy and correct clinical indications, directly implied the choice of the route of delivery. However, there was an increase in the number of non-evidence-based cesarean operations, which added morbidities to the mother/child binomial and costs to health services, becoming a public health problem<sup>(1)</sup>.

Worldwide there is an increase in the number of cesarean sections. Countries such as Iran and the Dominican Republic cesarean rates are on average 41.9%, followed by Italy and Mexico, which have an incidence of 38.2% and 37.8%, respectively<sup>(2)</sup>.

In the model of childbirth care in force in Brazil, more than half of all Brazilian children are born by the abdominal route, an index that reaches approximately 80% in the supplementary health network, reaching proportions above that recommended by the World Health Organization, which is 10 to 15%<sup>(3)</sup>.

In an attempt to reduce this epidemic of caesarean section and to raise awareness among the population, WHO proposes that different countries and health institutions use Robson's classification system as a tool to monitor cesarean rates; a strategy that allows comparisons with their determinants the different cesarean rates among hospitals, cities and countries<sup>(4)</sup>.

In obstetric care, issues related to the route of delivery polarize the discourse of women and health professionals. The choice between 'cesarean section and normal labor' causes controversies in different discursive fields, mobilizes activists, persistent advocates and divergent opinions that end up creating false indications and compromising the safety of the mother/newborn/parent triad.

In this context, it is important to emphasize that the majority of cesarean indications are relative, and not based on scientific evidence<sup>(5)</sup>. During the course of pregnancy, many health professionals attending prenatal care and childbirth use different devices to justify intervention in childbirth care. There are more supposed than real risks as: large baby, baby circled by the umbilical cord, being the woman's decision weakened by the power of persuasion in medical discourse<sup>(6)</sup>.

It is understood that the decision by the route of delivery comprises a phenomenon that accompanies the entire pregnancy process, since this initiative creates innumerable expectations in the pregnant woman from the beginning, and continues to be mentioned even after the final outcome, persisting in the form of memories and feelings, or even consequences for health, which become part of its history<sup>(7)</sup>.

Sociocultural factors and allusions to the delivery model, besides underestimating the risks associated with the cesarean operation, are worrisome. It is known that, when compared to normal delivery, the chance of severe maternal morbidity rises 2-fold among women submitted to intrapartum cesarean section and 2.3 times in the case of elective cesarean section<sup>(8)</sup>.

There is evidence that babies born by the abdominal route have an increased risk of problems related to the characteristics of immunity and metabolism. Causes of maternal death due to hypertensive syndrome and infection may be associated with cesarean section<sup>(2)</sup>.

In stating the route of delivery, different arguments are used, both by health professionals and women, to justify or ponder their choices, so that personal desires and preferences stand out in relation to technical and scientific knowledge as determinants in the incidence of high cesarean rates.

Faced with this problem, this article aims to analyze the discourses on the choice of the route of delivery from the perspective of women and health professionals of a public network. This article prioritizes the participants' expectations regarding the route of delivery.

## OBJECTIVE

To analyze the discourses on the choice of the route of delivery from the perspective of women and health professionals of a public network.

## METHOD

### Ethical aspects

The fieldwork began after approval of the Ethics and Research Committee of *Universidade Federal de Minas Gerais* and its construction was done in compliance with the requirements of Resolutions 196/96 and Resolution No. 466/2012 of the National Health Council, which regulates the guidelines and norms of research involving human beings.

### Theoretical-methodological reference

The methodological approach used is Discourse Analysis<sup>(9)</sup> from the perspective of Foucault and Pêcheux, considering that, in this study, the fundamental question is to analyze the discourse constructed in the relationship between obstetricians, obstetrical nurses and women in childbirth care. Since in this discursive interaction there may be times when the woman's discourse is opposed to that of the health professional, or the participants' attempt to appropriate the internal logic of the dominant discourse in the field of health.

It is understood that discourse is socially constitutive. Language is positioned in social practice, and discourse is a moment of this practice that is faced with other moments, such as discursive and non-discursive. Foucault reveals the connection between discourse, desire, and power. And it points out that in this imbricated relationship not everything can be said, it depends on the circumstances and from who says, there are those who can and those who cannot speak<sup>(9)</sup>.

This is an interpretive and qualitative approach. The choice of the qualitative method is due to the complexity of the studied situation and the nature of the research problem. This methodological way allows analyzing situations that extrapolate the quantitative data, besides considering the subjectivity, complexity and dynamism of the phenomena<sup>(10)</sup>.

### Hypothesis

This research is based on the assumption that the discourse on the way of delivery is dissymmetric, essentially marked by an institutionalized medical knowledge, which determines an interventionist model of childbirth care and does not promote

the active participation of women in the process of choosing the route of delivery.

### Study scenario

The investigation's research scenarios were seven public maternity hospitals in the municipalities of the Central-West macroregion of Minas Gerais State. Being a medium-sized maternity hospital, with approximately 250 deliveries/month and six small ones, between 65 and 80 deliveries/month. The choice was purposeful, considering the fact that research of this magnitude is usually carried out in large centers and little is known about childbirth care in small maternity hospitals.

### Collection and data organization

Data collection was performed through interviews between September 2014 and March 2015, with a guideline and field diary, to record the observations made during labor and delivery, aiming to emphasize the discourse established among health professionals and women. Then the individual interviews were recorded in digital apparatus and transcribed in full for analysis and interpretation of the speeches from the authors' statements, in order to guarantee the integrity and reliability of the information.

Thirty-six women, 10 obstetrician nurses and 14 obstetrician physicians participated in this study. Because it was a qualitative study, it was not intended to be concerned with the quantification of participants, but with their representativeness, a priori. The final sampling was done by theoretical saturation, when it was noticed that there was no further increase in the information obtained. However, at least one medical professional and one nurse from each setting were respected.

The inclusion criteria for health professionals were: to be included in the maternity staff and to provide direct assistance to women in childbirth; be a nurse or obstetrician. In relation to women: having been parturient in one of the maternity wards, scenarios of this study; had a normal delivery or cesarean section, hospital stay in the institution of at least 6 hours, be in the puerperium and be between 15 and 45 years old.

### Data analysis

The analysis comprised a three-step process: 1<sup>st</sup>- Organization, transcription and arrangement of speeches in full. 2<sup>nd</sup>- Vertical reading comprehending the exhaustive reading of each individual discourse for apprehension of the central ideas. 3<sup>rd</sup>- Horizontal readings to determine the ideas or meanings that resemble or not the organization of the convergent data in common themes, determining the categories.

The anonymity of the participants was guaranteed by alphanumeric identification, according to the segment to which they belong: W for women, Phy for Physicians and Nur for Nurses, followed by number according to the approximation for the interviews.

## RESULTS

### Participants characteristics

The age of the women participating in the study ranged from 16 to 38 years. The results showed that of the 36 participants, ten did not finish elementary school, thirteen did not finish high school, eleven completed high school and only two entered university.

In terms of religiosity, sixteen women reported being Evangelicals, nineteen Catholics, and one black, belonging to any cult or religion.

With regard to family income, twenty-four women reported living with less than two minimum wages<sup>1</sup>, four had a family income of up to three minimum wages, and only two women had a family income of up to five minimum wages, the rest did not know how to report.

With regard to the route of delivery, it is verified that twenty-four parturient had normal deliveries, nine with episiotomy and twelve pregnant women underwent a cesarean section. The analysis of the testimonies allowed identifying that, for seventeen women, the physician chose the route of delivery; eighteen women report having participated in the choice of delivery route and only one woman delegates the choice of delivery route to the nurse.

All nurses who met the inclusion criteria accepted to participate in the study. Of the ten obstetrician nurses who collaborated with the study, nine are of the female gender and only one is of the male gender. When questioned about the time of training these present two to six years of professional experience as specialists.

Of the fourteen obstetrician physicians interviewed, eleven were of the masculine gender and five of the feminine gender. All have declared themselves to be specialists with medical residency and work in both the public and private networks. With regard to work experience, most have a significant trajectory in maternal and child care, with between 15 and 37 years of training.

The analysis raises reflections on the expectations and specificities in the choice of the route of delivery, what are the determinants of this choice, what is the real capacity of women to exercise autonomy during the whole process, inserted in a context of care marked by excessive cesarean delivery. The results were organized in three categories that refer to the discourse of each type of specific participant, who manifest and express different representations.

### 1<sup>st</sup> Category – Between preference and decision there is no choice

The narratives indicate that the parturient of this study did not participate effectively in the choice of the type of delivery. For some women this option was determined by the health professional or attributed to a spiritual force, to God, to chance or to an eventuality or fatality.

*For me it was God, because at the time, everything was indicating that it was going to be normal. (W6)*

1 The value of the reference minimum wage 724.00 reais

*The moment I decided that I did not know what it was going to be I came all the way asking God to be normal, recovery is faster. (W7)*

*Ah, it was an eventuality, I wanted normal, but it was not possible, there had to be C-section. (W11)*

*It was God, surely my gestation was supposed to be normal, and my purse burst and I did not dilate, I had to have a C-section anyway, it was past the time the baby was born, I was 9 months straight. (W13)*

*I was asking God to be normal, then they even said it was going to be normal. (M18)*

*I was sure it was going to be a C-section, but God said, "My daughter, you do not deserve to go through this, I'll give you something better" so the normal birth was at the last minute. (W23)*

Many women point out that the definition of the type of delivery was the decision of the health professional. In the speech, one perceives a passivity and conformity with the determination of the professional, which signals the desire for a quiet, quick, pain-free delivery, regardless of the route of delivery. Seventeen women claim that the physician who chose the birth route. The thematic phrases illustrate the finding:

*"The physician himself chose," I also wanted cesarean, I'm afraid the delivery to be normal. (W10)*

*"There was no choice," is the physician accompanying the prenatal care, who made the call and said it was normal. (W20)*

Fear of pain emerges in speech initially as the main reason for wanting to have a cesarean section or to justify the fact that women change their opinion about the route of delivery during pregnancy.

*I'm afraid the delivery to be normal, so I chose cesarean, but the physician also chose cesarean section. (W10)*

*I wanted normal, but when you're there feeling the pain, whatever you want, just so you do not feel pain to do even a cesarean section. (W17)*

*It's a lot of pain, childbirth is not a pleasurable experience, it's very difficult, but the cesarean section is not indicated, we go through a normal birth. (W19)*

*I wanted normal, only that later I saw the girl delivering. (W26)*

In an argumentative discourse, women point to various justifications, ranging from fear of pain to explaining the choice of the route of delivery.

*The physician decided it was going to be the cesarean delivery, because it was not dilating and losing plenty of liquid. (W12)*

*There was no way for me because I had little dilation and the child was already on the way. (W14)*

*The physician, because she touched four times and there was no dilation, I did not even go into labor, and it has been already past hour. (W21)*

*He said that I could not have normal possibility because I already have two cesarean sections and another one would hurt my womb. (W25)*

*At the time I had to undergo cesarean because of the umbilical cord that started to come out. (W18)*

*For my age, the pregnancy to be a risk, infection, anemia, had no passage, began to dilate more did not go ahead, then there was no way and she wanted to be born anyway, I did not want to wait any longer, so the cesarean section was the best. (W24)*

*I was afraid I could not make it because on ultrasound the baby was very large. (W28)*

These findings demonstrate that parturient incorporate technical arguments from the field of health in their speech, such as stopping the dilation, uterine rupture, infection and loss of fluid to justify the need for intervention. Some indications for caesarean section, such as large baby and risky pregnancy, still emerge in the speech.

It can be seen from the narratives of the women that, although they participated in the choice of the way of delivery, this decision seems not to have been based on consistent data. They show regret and a sense of disappointment with the outcome of childbirth.

*I thought it was better, it was going to be easier, but I concluded that it is not, it was unpleasant, if I had to choose now I would choose cesarean section. (W3)*

*I thought normal birth was more normal, but then it passes by. (W31)*

*But I already came here knowing that they were going to try normal birth until the last case. (W28)*

The parturient express that they already wanted the normal birth and signaled some reasons for choosing the natural way of delivery, twelve women affirm that they always wanted normal birth; the following thematic phrases illustrate this finding:

*His recovery is faster, with the cesarean you feel pain and recovers, but I was opting for the normal. (W28)*

*I have always been afraid of cesarean, of anesthesia, normal people suffer, but a suffering that the baby was born is over. (P2)*

*Because my first child was already normal, then the baby, who was sitting, turned and fit, had everything to be normal. (P30)*

It is identified in the parturient's discourse that the choice of the way of delivery is much more than desired, depends on access to the guidelines during the prenatal period and involves familiar and cultural aspects.

*I chose, I did the birth plan, I studied, no one induced me to anything, and no one said "you have to do so". Of course in doula's case, she gives you the tips. She asks what you want and says "so you have to read about it, it gives you the way, but the choices who will make it is you". (W35)*

*I convinced everyone, my husband, my family; I had a lot of trouble, because here in the county it is rare for anyone to want a normal birth. I've heard every kind of comment you can think of, "Oh, it's vanity!", "Oh, it's expensive to have a C-section!" "Not because I know it's better for me and my daughter, and that's why I want it." "Time was passing and the baby did not want to be born, and I waited a week and the people say a lot of things like "it will pass the hour, ah it is stirring, ah how is it". (W36)*

Immersed in a cultural context that adopts cesarean as a rule, women have to affirm for themselves and for society the reason for choosing the natural way of giving birth. It is observed that there was an inversion of values and meanings in relation to the form of birth in Brazil.

## **2<sup>nd</sup> Category - The complexity of choosing the route of delivery**

The option for delivery route is a complex issue from the perspective of the medical professional. Initially it is stated as an essentially technical criterion, with indications described in the manuals and books of obstetrics and in the evolution of labor, according to the limits defined by the partogram.

*It is the classic criteria that are in the books, if the patient is on labor and if we let her go to normal birth it is because she is able to. (Phy 12)*

*The indication is purely and simply Obstetric; we observe if the patient has conditions of childbirth, if she wants to deliver, if the companion is sensitive to the guidelines and if the delivery is progressing according to the partogram. (Phy 3)*

*The criteria are mainly technical. (Phy 5)*

As the narratives evolve, questions emerge about the subjects' subjectivity, which deviate from these technical criteria established by assistance protocols in relation to the determination of the type of delivery.

*Looking at it is complex, it involves a lot. There are conditions for the birth that is the mother's; there are the conditions of the fetus and the conditions of the obstetrician and the staff. (Phy 2)*

*It has several situations, the answer is very individual, and sometimes even not having an absolute indication of cesarean section you opt for the cesarean, because of this situation. Every birth is a story, every patient is a story and every obstetrician is a story. (Phy 6)*

*I've been more technical, because it has very theoretical criteria, and it has to be based on the partograph. (Phy11)*

From a physician's point of view, the woman in labor requires care and other skills that are not just technical, her behavior is unpredictable, and she escapes the rules of maternity protocols.

*A good labor to me is the one that is fast, I do not like that much dragged, suffered thing. I prefer a normal and quiet delivery, which evolves as it should evolve. But we have to think too, because if you look only at what women think, we will have a caesarean in everyone. (Phy 1)*

*If you do not have any contraindications to normal delivery, that's right. Now, you have to think also about the patient, about her receptivity. If the woman decides that she does not want a normal birth, it is very complicated. (Phy 9)*

*You have a patient that you do not want to force her to have a normal delivery. She may even labor, but she does not cooperate. If you do not have a structure to offer, analgesia, a doula, you will not be able to offer a proper delivery for her. So it cannot be too strict with the criteria. (Phy11)*

It identifies an inversion of cultural and social values of both women and health professionals in relation to the way of delivery. Many women choose surgical delivery before they even get pregnant or go into labor as a non-painful way to have children. And the health professional, faced with this phenomenon and the difficulty of sustaining his speech, ends up making decisions, influenced by financial issues, comfort and time.

*The woman already comes thinking "I want a cesarean", we tried to convince her, we failed, then we said, "let's go then, your problem". (Phy 8)*

*Nowadays it has almost become a trade, the patient wants to demand a lot, but she herself gives nothing. (Phy 6)*

*The criteria are mostly technical, but women find that having normal birth is suffering unnecessarily. (Phy 5)*

*The cesarean is already a culture in the city, there are lots of unstructured people, coming and thinking that showing off with the baby in the belly is beautiful. And at the time of childbirth they do not let them to be touched, do not help and start asking for a C-section before entering the hospital. (Phy 7)*

Without arguments to convince the woman, the physician says she is persuaded by the parturient and in a discourse of victimization transfers the fault of the excessive number of cesarean sections to the woman who in his perspective does not want to feel pain, does not collaborate during the process, which causes a certain intolerance and embarrassment.

*Today the patient does not want to feel any pain; she does not want to have any work. We see that the patient wants a normal birth, but it hurts, they are not prepared for childbirth. (Phy 10)*

*What makes people upset is a patient who is about to labor and begins to speak: "I have to do cesarean, I have that" this situation constrains the physician; the user comes thinking that cesarean is the salvation of the world. (Phy 13)*

*I am not part of the class that makes deliveries on demand, if it is able to be born in normal birth, it will be born in normal. (Phy 4)*

In medical discourse, a cesarean is presented as a safe and predictable procedure represents a tranquil procedure and within its control.

*In that same intimate, I would make a cesarean in everyone, because thirty years of profession, tired, normal childbirth stresses, is that it has to follow the rules, if it depended on me would make cesarean in everybody. I tell you this because here in the region what is most talked about is that in the hospital people kill a boy, there is no compliment, it is only criticism. And the woman in fear is hard to deal with. (Phy 7)*

*I like to give birth, but I like to have cesarean too. (Phy10)*

From a physician's perspective, a cesarean section is a very simple and innocuous procedure, which becomes a very serious problem. The average time spent in a surgical delivery is around 40 to 50 minutes and after the obstetrician delivers the baby to the pediatrician he does not feel more responsible. What is important is that the mother and the child leave the birth alive, even if the experience was traumatic as he says in his speech:

*There is no other way, if there was another way I would, it was not I who invented the birth, it was God. (Phy 7)*

It is hoped that the delivery will evolve and happen as soon as possible for the child to be born soon and the medical team follow up with the care of other women or to carry out other activities. And this way of understanding the evolution of labor contributes greatly to increasing cesarean rates and perpetuating the interventionist model.

*For example, it comes from above that can have only thirty percent cesarean, so we should educate these patients, because they think normal birth is humiliating, if they had money and paid for it, they would have a cesarean section. (Med 4)*

*In 2012 our cesarean rate was 80.4 %, but I'll explain: a new physician who comes to operate here may do 6.7 cesareans. Every Wednesday the cesarean indexes go to one thousand in the municipality. There is another physician who works here who is another crazy one and does not have the patience to evolve. (Phy 14)*

*I warn the patient that delivery is only normal from the vagina after it is born. I already prepare the patient by saying that I can make an effort, which can turn into a cesarean, in the worst case. (Phy 8)*

It is identified in the narrative the concern expressed in the discourse with the goals to be fulfilled. Sensitized with this issue, WHO emphasizes the importance of focusing actions on the needs of each patient<sup>(3)</sup> and discourages the focus on trying to reach certain indicators.

### **3<sup>rd</sup> Category - It is necessary to legitimize the choice of women**

In the speeches of the nursing professionals, it was evidenced that the performance of this professional category is still timid regarding the choice of the way of delivery. This definition is still physician-centered, although the nurse participates in the discussions.

*The definition of the type of delivery is even made by the physician. (Nur 3)*

*We discuss the criteria for choosing the type of delivery, but for now, here, these routines are turning around the physician, but we have the freedom given by them to discuss the cases. (Nur 10)*

Childbirth care is perceived as vertical, the desire and choices of women recorded in the birth plan are disregarded. In many moments of the process the physician's determinations are made, in the sense of order to be fulfilled:

*Assistance is often imposed, the woman is not comfortable choosing. She comes imagining how the delivery will be and all, and the professional imposes, directs the woman on his way, it had to be the opposite. (Nur 5)*

*We have a high cesarean rate due to the impatience to wait for the labor; there is no adhesion to the birth plan chosen by the pregnant woman. There is more that medical imposition, than it is going to be done there at that moment. It is a little distant from what is planned, does not have the support and the incentive to the natural childbirth. (Nur 6)*

The speech of childbirth as a natural and physiological event is emphasized in the narratives. Obstetric care should incorporate the principles of care and stimulation into the physiology of giving birth.

*The delivery is a very natural thing, even if there is anybody, it happens, in my opinion everything is normal childbirth. (Nur 4)*

*I think the best route is normal birth, for the mother and for the baby; we have less maternal death, less neonatal complication. Today we talk a lot about cesarean, so I'm afraid to say like this: "I'm not in favor of a cesarean on demand" and it seems like I'm very strict, but I'm not, I think that to choose cesarean on demand has to be very oriented and usually is not. (Nur 8)*

It is necessary to legitimize the choices of women, granting them autonomy as a way of being and acting throughout the process.

*Even if it is a choice that did not work, regardless of whether it is normal delivery or cesarean delivery, but that you have the opportunity to experience, at least try, not to be*

*depressed. Because, sometimes, the patient's dream is to have a normal birth, in the first examination that the physician says "I will not expect normal delivery" and is already in caesarean section, there is a woman who cries, it is important to validate this choice. (Nur 9)*

In the current scenario of childbirth care, the nurse practitioner has difficulty sustaining a speech in defense of normal delivery. Faced with cultural factors, the limits of the parturient and the unfavorable conduct of the evolution of labor, it ends up joining a predominant discourse in the field of health.

*I think they are the criteria and also the initiative of the mother. The upper middle class will always choose cesarean section. (Nur 2)*

*The criteria are several, but in my eyes, sometimes she has the condition of normal delivery, but she is very tired, exhausted and she tells you "I do not give a damn" you help, but there has to be a limit". (Nur 7)*

*The cesarean is a surgery like any other, it has the indications, but I think if I cannot follow the labor up, have a good experience or if the woman leaves here unhappy, traumatized and if she has a normal interventional delivery, she better has cesarean section. (Nur 8)*

Medical professionals often set up a scenario of clinical need for cesarean section, creating a limiting and hostile situation, with the purpose of persuading and convincing the parturient, the companions and even the obstetrician nurse, who come to believe that there are no more conditions to perform labor.

## DISCUSSION

The analysis of the results of the present study allows us to consider that the choice of the delivery method is closely related to the cultural and social factors and to a model of assistance to interventional delivery, which influences the autonomous coping capacity of women, to give birth C-section is culturally perceived as more practical and more reliable, creating a paradox between individual desire and collective thinking<sup>(11)</sup>.

Women are conditioned to think that they do not have the right to the option programmed by elective cesarean in the SUS, due to the normatization of public policies; discourse that is contrary to the social condition of women who claim to have this privilege of choosing the way of delivery, because they have a supplementary health plan<sup>(12)</sup>.

The expectation of many women regarding delivery is based on this interventionist assistance, which has come to be considered as natural or traditional<sup>(13)</sup>. Inheritance of a technocratic model of childbirth care, which spread the idea of passivity of the immobilized woman during childbirth, while undergoing interventions by unknown professionals to shorten the time until birth. Educational practices are not capable of transposing the socially constructed cesarean culture.

The discourses of women and health professionals reveal that the decision of the type of delivery implies an excessive

dependence on the determination of the medical professional, on actions not based on scientific evidence and on an inversion of values in the social and health field, in which the cesarean section became the rule.

The situations related to the choice of the way of delivery are conflicting and asymmetrical, physicians and nurses have different values<sup>(1)</sup> in essence and nevertheless in appearance. The medical discourse is said to be persuaded by the woman who wants the cesarean or who does not tolerate the pain, contradicting the nurse's statement that the woman chooses the cesarean delivery for fear of her pain being neglected or being disrespected during labor.

This problem regarding the choice of delivery method is not recent, and it is necessary to look for new ways of understanding the factors involved in this process<sup>(14)</sup>. It is known that the mode of birth may have long-term repercussions for mother and child, the risk of developing chronic and autoimmune diseases according to the type of delivery<sup>(15)</sup>. And in addition to these risks, the way of delivery, according to its indication and driving can be configured in a form of obstetric violence.

It is believed that the prospects of women in relation to the way of delivery are consequences of the access and availability of information during prenatal care. These guidelines are interpreted according to the life history of each woman. In this sense, the approach to the delivery route during prenatal care includes an educational action, as it enables the pregnant woman to know about alternatives of care during labor and delivery and to learn how to deal with the diversities that may arise at this moment<sup>(16)</sup>.

In the care setting of the small maternity hospitals investigated in this research, obstetrical nursing still has a timid performance, especially regarding the type of delivery, although it is recognized that the presence of obstetrician nurse is essential to support the woman in the conduct of work labor and delivery, and to increase her knowledge about this moment, reducing the external influences that lead to a labor with intervention<sup>(17-18)</sup>.

The fear of pain, the speed and the improvement of surgical techniques appear in the speeches as the main arguments used by both obstetricians and parturient to justify their choices. Another reason that emerges in the narratives as a possible determinant in the increase of cesarean sections are the personal preferences of obstetricians and women. This result is similar to a study on this same subject, carried out in a municipality in the South of the Country<sup>(19)</sup>.

Another important consideration to be made regarding childbirth care is that, because they are unaware of their rights, for fear of being reprimanded, or because they do not know that they can claim better care, women surrender their bodies, their lives and their babies care of health professionals<sup>(20)</sup>. Many parturient assume an attitude of passivity and conformity to the determinations and impositions of health professionals. Little is questioned, the imperative seems to be silent before a hostile and disrespectful treatment.

Continuing this line of thought, by directing our gaze towards childbirth as the outcome of pregnancy and unnecessary cesarean sections, with negative implications for the health of parturient and babies, it can be concluded that, although some women assume the cesarean section as an initial choice, they are not being

guided by the advantages and disadvantages of the birth route<sup>(21)</sup> and are not aware of the risks of prematurity and its consequences.

The evaluation of care received at the time of delivery does not depend exclusively on the way of delivery, the dissatisfaction or satisfaction of women with the experience of childbirth is closely related to the attention and availability of the team<sup>(17)</sup>.

It is understood that building a relationship of respect and trust between health professionals and women is an essential strategy of care and should be prioritized. And it can be deduced that in order to achieve this goal, it is necessary to consider the subjectivity and the needs of each woman, to validate their choices, so that they have a critical attitude towards the orientations received, being able to recognize the benefits and the related to the option chosen as the way of delivery.

## FINAL CONSIDERATIONS

The results reveal the complexity involved in the choice of delivery method. From the perspective of women, this choice is determined by the professional during the prenatal visit or at the time of the examination, and the number of women who participate autonomously and consciously in this process is small. The nurses' performance, especially in the small maternity units investigated, is still restricted, although their presence is fundamental for stimulating physiological delivery and for promoting the active participation of women. The option

on the way of delivery is very focused on the power of the physician, even if this decision contradicts the desire and the birth plan previously performed by women.

## Study limitations

It should be noted that the study has limitations because it was developed in small maternity hospitals in the interior of Minas Gerais, where the obstetrical nurse's role is still timid and the scenarios investigated do not offer care technology such as water delivery, analgesia for normal delivery, which may have interfered in the results found, not allowing generalizations.

Despite these limitations, the results pointed out may support new research on the quality of delivery care in the public and private network and on the expectations of women and professionals regarding the choice of the way of delivery and its implications on the health of mothers and babies, seeking interface with existing public health policies.

## Contributions to the area of nursing, health or public policy

The results show that it is necessary to adopt measures that seek to make health professionals have a more active role in guiding women and their families about the benefits and prejudices involved in choosing the mode of birth. In order to combat abusive cesarean rates in the country, a phenomenon that has had negative and persistent repercussions on the health of women and children.

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