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DECIDING THE ROUTE OF DELIVERY IN BRAZIL: THEMES AND TRENDS IN PUBLIC HEALTH PRODUCTION

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ABSTRACT: This study addresses the production of knowledge in the public health field regarding the “decision” on the route of delivery. This is an integrative literature review that discusses uses, potentials and limits of this category in analyses of the practice of cesarean sections in Brazil. We used a combination of thematic and discourse analysis techniques. The literature on cesarean sections in Brazil has advanced from the narrow focus on the individual choice to a deeper contextualization. However, literature still needs to progress, since there are few discussions on socio-cultural, political, and economic issues, and on the role of medical and non-medical technologies.

DESCRIPTORS: Parturition. Cesarean section. Choice behavior.

A DECISÃO PELA VIA DE PARTO NO BRASIL: TEMAS E TENDÊNCIAS NA PRODUÇÃO DA SAÚDE COLETIVA

RESUMO: O artigo estuda a produção de conhecimento no campo da saúde coletiva sobre a “decisão” relacionada à via de parto. Trata-se de um estudo de revisão integrativa da literatura que discute usos, potencialidades e limites dessa categoria nas análises sobre a prática da cesariana no Brasil. Utilizou-se uma combinação de técnicas de análise temática e de discurso. Considera-se que a literatura sobre cesariana no Brasil tem avançado ao sair do foco estreito de escolha individual para uma contextualização mais profunda. Acredita-se, porém, que a literatura ainda precisa progredir, pois há poucas discussões de questões socioculturais, políticas, econômicas e sobre o papel das tecnologias médicas e não médicas.

DESCRITORES: Parto. Cesárea. Comportamento de escolha.

LA DECISIÓN POR EL TIPO DE PARTO EN BRASIL: TEMAS Y TENDENCIAS EN LA PRODUCCIÓN DE SALUD COLECTIVA

RESUMEN: El artículo estudia la producción de conocimiento en el ámbito de la salud colectiva sobre la “decisión” en relación al tipo de parto. Se trata de un estudio de la revisión integradora de la literatura que trata sobre los usos, las posibilidades y límites de esta categoría en los análisis sobre la práctica de la cesárea en Brasil. Utilizamos una combinación de técnicas de análisis temática y del discurso. Se considera que la literatura sobre la cesárea en Brasil ha avanzado de la limitada visión de la elección individual a una contextualización más profunda. Se cree, sin embargo, que la literatura aún tiene que progresar, porque hay pocas discusiones de temas socio-culturales, políticos, económicos y acerca del papel de las tecnologías médicas y no médicas.

DESCRIPTORES: Parto. Cesárea. Conducta de elección.

INTRODUCTION

With the rise of biomedicine, labor and delivery practices suffered deep changes during the 20th century. From private events assisted by traditional midwives, these practices were gradually transferred to the hospital environment and centered in the physician's image, becoming progressively dependent on technological interventions, spreading a technocratic birthing model.¹ The growing use of cesarean sections is part of this process.

Brazil was not immune to these changes. Labor care has been increasingly marked by technical and technological interventions as well as by a broad use of cesarean sections as a mode of delivery.² For nearly two decades, the Brazilian Ministry of Health (MH) has intervened with policies to humanize labor and delivery, and to reduce the number of cesarean sections, based on recommendations of the World Health Organization (WHO) and following scientific evidences that point to the disadvantages of surgery compared to vaginal delivery, in terms of maternal and perinatal morbidity and mortality as well as expenses for the healthcaresystem.³⁻⁵ Social movements involving women and health professionals have also raised the flag of labor and delivery practices transformation under the perspective of humanization and reproductive rights. Nevertheless, the country still stands out in the world scenario for having over half of all deliveries being surgical, mostly elective.⁶

Due to the prevalence and controversies around their meaning and consequences, cesarean deliveries are considered a public health issue, and, thus, have also been the object of interest of academic studies. In search of understanding this phenomenon, recent studies have scrutinized factors associated with cesarean deliveries, such as, type of institution (public or private), geographical region, socioeconomic level of women or characteristics of professionals and medical care.⁷⁻¹³ A part of the literature analyzes maternal and perinatal outcomes, comparing cesarean with vaginal deliveries, and demonstrated worse results for the surgery, in terms of morbidity and mortality, mainly among women living in less privileged social and health-conditions.¹⁴⁻¹⁶ Some studies used a clinical and/or surgical approach and address the use of medication, evaluation of the pelvic floor, postpartum depression, among other clinical issues.¹⁷⁻¹⁹

Another set of studies, discuss more sociological and anthropological concerns, such as the

“decision”, “choice”, “preference” or “opinion” of women and professionals regarding the route of delivery.²⁰⁻³⁵ Most studies point to the preference of women for the vaginal delivery in the initial phases of pregnancy, which contrasts with the growing number of cesarean deliveries in Brazil. In contrast, studies with professionals reveal their belief in the female preference for cesarean delivery and in the safety of the surgery.^{31,36} Women who make use of the private health sector, and who hypothetically would have better access to information and quality services, are those who mostly undergo surgeries. These are some of the issues that suggest that knowledge on the cesarean practice and on the issue of “decision”, “choice” or “preference” for the mode of delivery in Brazil still has many gaps.

The object of analysis of the present study is the production of knowledge and academic debate in the field of collective health on the “decision” – and its variants “choice” and “preference” – related to the route of delivery. The purpose is to discuss uses, potentialities and limits of these categories in analyses about cesarean section practices in the Brazilian reality.

METHODOLOGY

This is an integrative literature review.³⁷ Studies published in scientific journals and indexed in LILACS and MEDLINE data bases on the subject of cesarean delivery in Brazil, between 2000 and 2013, were gathered from the Virtual Health Library (VHL) portal. First, the following keywords were used separately: “cesarean”, “route of delivery”, and “delivery”. With the keyword “delivery”, the criterion “main subject” of publication was applied, to select only studies that had “cesarean”, “delivery”, “natural delivery”, “obstetric delivery”, and “humanized labor” as central subject. Then, the following combinations of keywords were used: “cesarean” and “choice”, “cesarean” and “decision”, “route of delivery” and “choice”, “route of delivery” and “decision”, “delivery” and “choice”, “delivery” and “decision”. With the aid of specific filters available at the VHL search tools, we opted to include only publications in the form of articles in the study, whose full texts were available, and which had Brazil as the “country/region” of subject. Following application of the inclusion criteria, lists were produced for each keyword or combination of keywords. When the lists were compared and the repeated productions excluded, a total of 239

studies were gathered. This collection was carried out between February 4th and 6th of 2014.

The treatment of this material started with organization of the studies according to the year of publication and reading of abstracts. After examination of the problems and objectives, the 239 studies were rearranged according to the following thematic fields: 1) "decision", "choice", or "preference" related to route of delivery (28 studies); 2) factors associated with route of delivery (30 studies); 3) perinatal and maternal outcomes related to route of delivery (24 studies); 4) care practices, indicators and policies related to delivery (79 studies); 5)

clinical and/or surgical studies related to delivery (22 studies); 6) cesarean delivery and labor as peripheral subjects (52 studies); 7) veterinary studies (four studies).

The 28 publications^{20-36,38-48} having "decision", "choice", or "preference" for the route of delivery as central category were selected for analysis, as presented in Table 1, and used as written sources. Although one of the filtered studies was not an article, but an editorial,³⁴ it was included in the analysis, since it belongs to important authors in this field who have other publications on the subject being analyzed in the present review.^{29,35}

Table 1 - Analyzed publications

Author	Title of production	Journal	Year of publication
Leão MRC, Riesco MLG, Schneck CA, Angelo M. ²⁰	<i>Reflexões sobre o excesso de cesariana no Brasil e a autonomia das mulheres.</i>	Ciênc Saúde Coletiva	2013
Cardoso JE, Barbosa RHS. ²¹	<i>O desencontro entre desejo e realidade: a "indústria" da cesariana entre mulheres de camadas médias no Rio de Janeiro, Brasil.</i>	Physis	2012
Haddad SMT, Cecatti JG. ²²	<i>Estratégias dirigidas aos profissionais para a redução das cesáreas desnecessárias no Brasil.</i>	Rev Bras Ginecol Obstet	2011
Ferrari J. ²³	<i>Preferência pela via de parto nas parturientes atendidas em hospital público na cidade de Porto Velho, Rondônia.</i>	Rev Bras Saúde Mater. Infant	2010
Kasai KE, Nomura RMY, Benute GRG, Lucia MCS, Zugaib M. ²⁴	<i>Women's opinions about mode of birth in Brazil: a qualitative study in a public teaching hospital.</i>	Midwifery	2010
Pires D, Fertoni HP, Conill EM, Matos TA, Cordova FP, Mazur CS. ²⁵	<i>A influência da assistência profissional em saúde na escolha do tipo de parto: um olhar socioantropológico na saúde suplementar brasileira.</i>	Rev Bras Saúde Mater Infant	2010
Sodré TM, Bonadio IC, Jesus MCP, Merighi MAB. ²⁶	<i>Necessidade de cuidado e desejo de participação no parto de gestantes residentes em Londrina-Paraná.</i>	Texto Contexto Enferm	2010
Conill EM, Pires D, Sisson MC, Oliveira MC, Boing AF, Fertoni HP. ²⁷	<i>O mix público-privado na utilização de serviços de saúde: um estudo dos itinerários terapêuticos de beneficiários do segmento de saúde suplementar brasileiro.</i>	Ciênc Saúde Coletiva	2008
Dias MAB, Domingues RMSM, Pereira APE, Fonseca SC, Gama SGN, Theme Filha MM et al. ²⁸	<i>Trajetória das mulheres na definição do parto cesáreo: estudo de caso em duas unidades do sistema de saúde suplementar do estado do Rio de Janeiro.</i>	Ciênc Saúde Coletiva	2008
Potter JE, Hopkins K, Faúndes A, Perpétuo I. ²⁹	<i>Women's autonomy and scheduled cesarean sections in Brazil: a cautionary tale.</i>	Birth	2008
Faisal-Cury A, Menezes, PR. ³⁰	<i>Fatores associados à preferência por cesariana.</i>	Rev Saúde Pública	2006
Faúndes A, Pádua KS, Osis MJD, Cecatti JG, Sousa MH. ³¹	<i>Opinião de mulheres e médicos brasileiros sobre a preferência pela via de parto.</i>	Rev Saúde Pública	2004
Barbosa GP, Giffin K, Angulo-Tuesta A, Gama AS, Chor D, D'Orsi E, et al. ³²	<i>Parto cesáreo? Quem o deseja e em quais circunstâncias?</i>	Cad Saúde Pública	2003
Hotimsky S N, Rattner D, Venancio SI, Bógus CM, Miranda MM. ³³	<i>O parto como eu vejo...ou o parto como eu desejo? Expectativas de gestantes, usuárias do SUS, acerca do parto e da assistência obstétrica.</i>	Cad Saúde Pública	2002
Potter JE, Hopkins K. ³⁴	<i>Consumer demand for caesarean sections in Brazil. Demand should be assessed rather than inferred</i>	BMJ	2002
Potter JE, Berquó E, Perpétuo IHO, Leal OF, Hopkins K, Souza MR et al. ³⁵	<i>Unwanted caesarean sections among public and private patients in Brazil: prospective study.</i>	BMJ	2001

Author	Title of production	Journal	Year of publication
Dias MAB, Deslandes S F. ³⁶	<i>Cesarianas: percepção de risco e a sua indicação pelo obstetra em uma maternidade pública no município do Rio de Janeiro.</i>	Cad Saúde Pública	2004
Teixeira C, Correia S, Victora CG, Barros H. ³⁸	The Brazilian Preference: Cesarean Delivery among Immigrants in Portugal.	PLoS One	2013
Mandarino NR, Chein MBC, Monteiro Júnior FC, Brito LMO, Lamy ZC, Nina VJS et al. ³⁹	<i>Aspectos relacionados à escolha do tipo de parto: um estudo comparativo entre uma maternidade pública, outra privada, em São Luís Maranhão, Brasil.</i>	Cad Saúde Pública	2009
Osís MJD, Ceccati JG, Pádua KS, Faúndes A. ⁴⁰	Brazilian doctors' perspective on the second opinion strategy before a C-section.	Rev Saúde Pública	2006
Ferrari J, Lima NM de. ⁴¹	The obstetricians' attitudes regarding the labor choice of delivery in Porto Velho, Rondonia, Brazil	Rev Bioét	2010
Watanabe T, Knobel R, Suchard G, Franco MJ, d'Orsi E, Consonni EB et al. ⁴²	Medical students' personal choice for mode of delivery in Santa Catarina, Brazil: a cross-sectional, quantitative study.	BMC Medical Education	2012
O'dougherty M. ⁴³	Plot and irony in childbirth narratives of middle-class.	Medical Anthropology Quarterly	2013
Ferreira LA, Silva JAJ, Zuffi FB, Mauzalto ACM, Leite CP, Nunes JS. ⁴⁴	<i>Expectativas de gestantes em relação ao parto.</i>	Rev Pesq: Cuid Fundam Online	2013
Pimenta LF, Ressel LB, Stumm KE. ⁴⁵	The cultural construction of the birth process.	J Res: Fundam Care Online	2013
Béhaque DP, Victora CG, Barros FC. ⁴⁶	Consumer demand for caesarean sections in Brazil: informed decision making, patient choice or social inequality? A population based birth cohort study linking ethnographic and epidemiological methods.	BMJ	2002
Chiavegatto Filho ADP. ⁴⁷	<i>Partos cesáreos e a escolha da data de nascimento no município de São Paulo.</i>	Ciênc Saúde Coletiva	2013
Torloni MR, Daher S, Betrán AP, Widmer M, Montilla P, Souza JP, et al. ⁴⁸	Portrayal of caesarean section in Brazilian women's magazines: 20 year review.	BMJ	2011

A combination of thematic and discourse analysis techniques was then used,⁴⁹ both for understanding the thematic cores used in the construction of study problems, and for discursive articulation of scientific arguments. The analytical work was performed in two stages. Firstly, multiple readings of the publications were carried out. Next, tables for analysis of the following aspects were built: method of presentation and development of study problems; delineation of objects and purposes of study; used methodologies; results, discussions, and conclusions. After these procedures, studies were categorized into five thematic cores, which subsidized the interpretation and presentation of results of this review.

RESULTS AND DISCUSSION

The "decision", "choice", or "preference" for the route of delivery was an object of growing interest in the literature in the analyzed period. Between 2000 and 2004, production on the subject included seven publications; between 2005 and

2009, six publications; and between 2010 and 2013, 15 publications were found. The authors are affiliated to different knowledge fields, such as medicine, nursing, social sciences, and psychology. Most publications (19) were found in Brazilian journals; however, there is significant production of studies (nine) in foreign journals. Nearly all publications (24) were found in journals classified as A1, A2, B1, or B2 by the Qualis scientific journal ranking system, of the Coordination for the Improvement of Higher Education Personnel (CAPES, as per its acronym in Portuguese) of the Ministry of Education, in 2012. A total of 12 publications were found in journals classified as A1 and A2, and 12 in journals classified as B1 and B2, which indicates an acknowledgment of the production quality. As regards methodology, 12 productions were quantitative studies, 10 were qualitative studies, three combined quantitative and qualitative methods, two productions were reviews and one was an editorial.

The themes that stood out in this set of publications were: cesarean sections as a "public health

issue"; the "medical factor" in the cesarean practice; the "women's preference" question; "free choice" vs. "women empowerment"; inequalities in health provision, and the "commercialization" of labor care; the socio cultural context: status, safety and planning ideals.

Cesarean sections as a "public health issue"

In the analyzed studies, with few exceptions, the rates of cesareans in Brazil are presented as "abusive", "alarming", and "worrying", and conform a real "outbreak", "a public health issue".^{32,36,38-40} The divergence of cesarean delivery rates in the country with those considered acceptable by the WHO, which recommend from 10% to 15% surgeries in the total number of births, are frequently addressed.^{21-22,25-26,33,36,39-40}

The generalization of surgery is seen as a sanitary issue for presenting higher morbidity and mortality risks for the mother and newborn, as well as for affecting breastfeeding.^{20,32-33,36,38-39} In defense of a more rational use of cesarean sections, "scientific evidences" are emphasized: good medical practices must be based on specific parameters, balancing benefits and risks and trying to avoid iatrogenies.^{20,28-29,32,40} The economic impact of the rise of caesarian deliveries on the health system must be considered, since indiscriminate use of surgery increases expenses.^{33,36,38}

In contrast to the literature trend, two studies criticize the initiatives for reducing the number of cesarean deliveries, based on rates recommended by the WHO, which were proposed in 1985, therefore authors believe them to be outdated.^{23,41} The authors argue that obstetric practices must accompany the changes in the dynamics of reproductive life, such as the increase of mother age, lower number of children, and greater weight gain during pregnancy. The authors also report that, over the last decades, there has been great advancement of medical technologies, making cesarean sections safer. For them, the results of studies referring to risks inherent to each type of delivery - vaginal and surgical - are debatable, thus further studies are needed.

The "medical factor" in the cesarean delivery practice

For many authors,³⁵ the rise of cesarean rates would be a consequence of factors such as the belief of physicians that the surgery is safer, lack of

professional skill to assist vaginal delivery, greater convenience and profitability for these professionals, as well as the fact that physicians assume women prefer surgery. It has been argued that physicians of the private sector believe that women are mistaken when they express their wish for a vaginal birth and, with a paternalistic posture, they "convince" their patients that surgical delivery provides more protection to the mother and the baby.²⁹ It is advocated that, in the private sector, the "option" of women for cesarean delivery is a consequence of a type of dialog with the doctor in which there is little motivation towards the vaginal delivery and "guidance" (explicit or not) towards the cesarean-delivery.^{21,25,27-28} In a study carried out in the Brazilian Unified Health System (SUS), the authors also concluded that the high rates of cesarean deliveries mainly reflect convenience and lack of training of professionals who, to justify their practice, affirm that women prefer surgery.³¹

A study carried out in a teaching hospital with medical students showed how university education and medical residence focus on training caesarian delivery and inculcating the idea of practicality, convenience and safety of the procedure.⁴³ In line with this, another study argues that, in public maternity hospitals, rates of surgery are also increased, conveying a professional culture based on the belief of procedure safety and biases of obstetric medical training.³⁶ The study calls attention to a generation of obstetricians who are lacking familiarity with techniques and maneuvers of the vaginal delivery. In face of any difficulty during labor, they go for surgery, assuming that besides having more experience with this type of birth, they feel less exposed to future lawsuits.

When asking doctors about the strategy of obtaining a second opinion before performing the cesarean section, a survey showed that professionals did not find it feasible in the private system, since they assume that the obstetric practice should not be controlled in this sector.⁴⁰ Another study advocates that physicians and hospitals are mostly responsible for the growing rate of cesarean sections and that the main strategies to avoid unnecessary caesarians should be directed to professionals.²²

The "women's preference" issue

The other side of the coin in the subject of convenience/interest/physician power is the decision/preference/choice of women. Sixteen articles

worked with the idea, or found it in their results, that most women initially prefer the vaginal birth.²⁰⁻³⁵ Observing that a great number of these pregnancies ended in caesarian deliveries, many authors discuss women's autonomy in decision making around birth and the asymmetries of power and knowledge of physicians. Many authors notice that, along the pregnancy, physicians create a scenario of supposed rather than real risks which justifies intervention during prenatal care visits: "big baby", "narrow hip", "nuchal cord", are said to women, who "choose" cesarean delivery in face of the fear of being held responsible for any negative outcome, and their decision is jeopardized as a result of the "power of persuasion" of physicians.^{21,25-29,35,40,43}

A study found that in the private sector, finding a physician willing to assist a vaginal delivery using the health plan is not always easy, and paying directly to a physician is very costly, even for middle-class women.²¹ The idea that middle- and upper-class women prefer cesarean to vaginal birth and that they request surgery is criticized.^{29,34-35} For these authors, a great number of these surgeries are "unwanted cesarean deliveries": women are "persuaded" at the end of pregnancy, especially by the presentation of risk situations that are not in agreement with scientific evidences. It is emphasized that, with the "banalization" of surgery, women are not surprised at the surgical indication and opt for the cesarean, resigning their initial wish for the vaginal birth.²⁸

Unlike most of the literature, preference for the cesarean was found among women in a private maternity hospital.³⁹ In contrast, in the public maternity hospital studied, the authors found that the vaginal route was preferred. However, it was noticed that all women who wanted to have a cesarean delivery in the private sector had their wish met, something that did not occur among those who wanted vaginal birth in the same sector.

Women's preference for a cesarean delivery, the "cesarean delivery upon maternal request", as responsible for the increase of surgery, is questioned by authors who observed, in a study with pregnant women of low socio economic level, a demand for cesarean deliveries associated with the fear of the attitudes of professionals during the service and also with the wish for tubal ligation.³³ In a study with women using the SUS, it was advocated that "cesarean deliveries upon maternal request" is more of a consequence of a medical and institutional

culture than a "real preference" of women.³² The authors affirm that these are situations that involve the obstetrician's presence - absence of the partner, delay in admission time, bad previous experiences, absence of techniques for pain relief, which would be associated with the request for surgery.

In the reviewed literature, the preference for caesarian delivery - its authenticity, legitimacy, and even the ability of choice - is questioned or relativized, differently from the preference for vaginal delivery, which does not appear as an object of study itself. The causes for the "cesarean delivery upon maternal request" need further understanding, at times, even to talk women out of this preference. Thus, the need for greater attention at psychological aspects, more dialog between women and professionals, as well as more information during prenatal care are often discussed.^{24,26,44} In line with this, it is argued that medical advising in favor of vaginal delivery may have a positive consequence, as well as educational studies directed to the population.²⁸ A study pointed out the nurse as a strategic professional for the humanization of childbirth and for supporting women in believing in their birthing ability.⁴⁵ Thus, it states it is important that women be informed and that other professionals participate to reduce the rates of cesarean deliveries.

It has been argued that women's preference for a type of birth, both for cesarean and vaginal delivery, seems to be associated with satisfaction with a previous childbirth, influenced by maternal and especially neonatal outcomes.³⁰ Another study also emphasized the relevance of previous experiences, as well as of family relationships.²⁵ In line with this, a group of authors refer to the importance of the experience transmitted by close women regarding the preference for cesarean or vaginal delivery.⁴⁴⁻⁴⁵

"Free choice" versus "women empowerment"

The discussion on autonomy, as regards the parturition process, follows two diverging views: when it is a matter of defending women's prerogative of requesting a cesarean delivery, autonomy seems to be associated with the idea of "free decisions" and the right of "choice";^{23,41} on the other hand, autonomy seems to be associated with the idea of "women empowerment" when vaginal birth is advocated, which is seen as an emotionally significant event for women.^{20-21,24-26,45} The last trend, prevalent in studies, incorporates a critical glance at gender inequalities and the medicalization of the

female body and childbirth.³² The rise of cesarean deliveries means, thus, to disempower women and center the event of birth on the physician.

In the revised literature, there are discursive formulations stating that childbirth belonged to women in the past; however it is not under women's power anymore, but under the physicians' power. Studies discuss the medicalization of childbirth (as part of the social medicalization process), which made women incompetent in dealing with the event, due to its unpredictability and pain, transferring childbirth care from midwives to physicians.^{20-21,25} Childbirth is now surrounded by an interventionist practice in which women, by losing their leading role, have also "[...]gradually lost their right of choice".^{45:592} According to a previous study, the development of women's autonomy would be a strategy to deal with "[...] an epidemic scenario of unnecessary and unwanted cesarean deliveries",^{20:2399} having social networks and social movements as the most important promoters of this autonomy.

On the other hand, it is argued that users of the Brazilian public healthcare system do not have the "right of choice" on the route of delivery.^{23,41} The authors question the authenticity of the preference for vaginal delivery in the public sector, since women receive prenatal care in health units where they are assisted by nurses who follow programs of the MH directed to vaginal delivery. For the authors, the "non-right of choice" falls back on the most fragile women, belonging to suburban layers. Fulfilling the request of users for cesarean deliveries is advocated by these authors as an ethical question.

In general, the literature on the choice for the route of delivery criticizes the above mentioned. It has been argued that, in fact, the rise of justifications for cesarean delivery has increased the chance of women not having the desired vaginal delivery.²⁹ It has also been pointed that even middle-class women are not free from social and gender contradictions, in which the interests of physicians prevail, in a commercial, iatrogenic, and dehumanized biomedical model that dismisses women from their central role.²¹

Inequalities in health care provision and the "commercialization" of child birth care

Studies show that women with higher socioeconomic level, schooling and users of the private sector have more caesariandeliveries.^{22,40} In theory, these women would have greater access

to healthcare and lower gestational risk; thus, the rates of cesarean deliveries in this group could not simply be explained by medical indication. Part of the analyzed texts associates the growth of surgery with the dynamics of the private system,^{25,27-28} considering that two studies, explicitly develop a criticism towards the commercialization of labor and delivery.^{21,46}

Labor and delivery have become, thus, a "business" in which economic interests prevail and are part of a "commercialized model" of healthcare.²¹ In a capitalist society, cesarean delivery means greater productivity, since it can be performed in less time, and higher profitability, due to higher hospital expenses for the patient. Scientific and technical knowledge has become a tool of the childbirth "business", as the medical discourse disguises the commercial interests behind the cesarean delivery practice. A study that investigated the preference for cesarean delivery between groups of women of low socioeconomic level discussed the problematic of the excess of cesarean sections as part of a market of unnecessary interventions, created from inequalities in healthcare provision.⁴⁶ The authors advocate that the request for cesarean delivery among women who feel marginalized from the access to medical technology is the form of avoiding poor and negligent service. It is not only a matter of lack of information, but a real and concrete situation of inequality in the service where requesting intervention means asking for quality service. Technology becomes, thus, a synonym of good care.

Socio-cultural context: status, safety and planning ideals

Some authors discuss how personal and family values interfere in the decision making regarding the route of delivery, developed during prenatal care.^{25,27} For these authors, the expectations regarding childbirth are passed on by cultural characteristics such as fear and unnecessary pain, idea of vaginal delivery as risky for the life of mother and baby, as well as attempt of planning daily family life around the event of birth. The safety of the cesarean delivery is little questioned in a biomedical culture that spreads the technological advancements of surgeries. A study advocated the hypothesis that the decision for cesarean delivery, in the initial stage of pregnancy, is related both to previous self or other women of the family's reproductive experiences, and to the socio-cultural context, which is marked by

the fear of pain of the vaginal delivery.²⁸ Conversely, the decision at a later period of pregnancy and during labor would be more influenced by physicians and assisting practices.

The cultural issue of childbirth planning is highlighted in a study that showed how the diffusion of the cesarean practice, while allowing the choice of the date, has altered the dynamics of many maternity hospitals.⁴⁷ As demonstrated in the study, scheduled cesarean deliveries have led to a reduction of births in some days and to an increase in others, for instance, rejection of some families for certain dates such as Christmas or day of the dead, and the increase of surgeries at more convenient times and days of the week for physicians.

In a study carried out in Portugal, it was verified that Brazilian immigrants presented significantly higher prevalence of cesarean deliveries than Portuguese women.³⁸ It discussed how the cultural origin of women influences their perceptions of safety and risks involving childbirth, as well as the decision of professionals regarding the route of delivery in Portuguese public facilities. The study concluded that cesarean delivery is a safer mode of delivery and a symbol of social status for Brazilian women.

Another study advocated that contemporary women are exposed to information on health - including childbirth - in the most varied forms of media, and this exposure can influence preferences and decisions.⁴⁸ The authors performed a review of articles published in the best-selling female magazines in Brazil, between 1988 and 2008, and found that the advantages of the cesarean delivery are more frequently mentioned than the risks, strengthening the idea of safety of the surgical procedure, which may lead women to pay less attention to the possible ominous effects of the surgery.

A study with middle- and upper-class women in a private maternity hospital with high rates of cesarean deliveries proposed that, even when the decision for the surgery suffers great influence from the medical factor, women "negotiate" the birth of their children.⁴³ This turns the event into a significant celebration of the moment of transition into motherhood, with the family presence, photography, filming, among other things.

FINAL CONSIDERATIONS

Production of knowledge and academic discussion in the collective health field on "decision", "choice", or "preference" related to the route of

delivery in Brazil present high rates of cesarean delivery as a serious "public health issue" and a situation that must be reverted. The idea that the responsibility for the increase of cesarean deliveries belongs to professionals and that most Brazilian women prefer vaginal delivery prevails. There is a strong discussion that associates vaginal delivery and "women empowerment" affirming that, historically, childbirth was an event that belonged to women; and that now, they have been expropriated from the right of decision, and childbirth has become a medical event, with many "unwanted cesarean deliveries" being performed.

In this literature, it is argued that there is no "real preference" of women for cesarean deliveries. This expression - "real preference" is problematic, as there is no such thing as "free" choice or preference; therefore it is assumed to be disconnected from a macro-cultural and macro-social context. It is not our purpose to deny the advancements in the literature dedicated to the analysis of the cesarean delivery practice in Brazil, and there are studies attempting to leave behind the narrow focus on individual choice and go for a deeper contextualization of the route of delivery. However, it is believed that further understanding of the phenomenon is still necessary, since the discussion over the question "who decides" on the route of delivery or whether women "prefer" the vaginal or caesarian route still prevails.

There is a broad range of social processes that can be associated with the phenomenon of the growing number of cesareans and which are poorly discussed in the literature. Scheduled cesarean deliveries can be seen as a new type of birth in which unpredictability is removed, allowing for a rearrangement of the social dimension of the event, bringing together relatives and friends, besides better planning of the postpartum life routine. In addition, body care and permeability to technological interventions, being cesarean delivery an exemplary case, characterize a society with a constant concern with health, esthetics, social and sexual performance, and productivity. Thus, cesarean deliveries may mean, in the view of many women, relatives, and professionals, an idea of body care associated with a naturalization of biomedical interventions.

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