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PERCEPTIONS OF PREGNANT WOMEN REGARDING THE CHOICE OF THE ROUTE OF DELIVERY

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ABSTRACT: This study aimed to know the perceptions of pregnant women regarding the choice of the route of delivery. Descriptive study with a qualitative approach was conducted with pregnant women from a municipality in the Northwest region of the State of Paraná. Data were collected through semi-structured, audio-recorded interviews. For data treatment, the discourse of the collective subject was adopted. Participants were twenty pregnant women, 13 of whom undergoing cesarean delivery. According to the responses to the interviews, 25 key expressions were generated and five central ideas were originated: A – "Preference for vaginal childbirth", in which half of the pregnant women initially opted for this route of delivery; B – "Indication for cesarean section", with nine pregnant women (45%) with medical indication, despite the previous preference for vaginal delivery; C – "Choice for cesarean section", with four (20%) women who chose this route due to fear of labor pain; D – "Satisfaction with the route of delivery performed", in which all women (35%) undergoing vaginal delivery expressed satisfaction with this route; E – "Duality between satisfaction and suffering with the childbirth performed", in which all women who underwent cesarean section experienced this mixed feeling. This study concluded that half of the pregnant women have a preference for vaginal delivery, but the majority had a cesarean delivery. In the perception of pregnant women, the choices for cesarean delivery were due to medical indication, fear, insecurity and desire for sterilization. Educational actions are suggested to reduce insecurities in the decisions of pregnant women and enable autonomy in the conscious choice regarding the route of delivery.

KEY WORDS: Pregnancy; Cesarean section; Obstetric delivery; Natural childbirth; Nursing.

PERCEPÇÕES DAS GESTANTES QUANTO À ESCOLHA DA VIA DE PARTO

RESUMO: Esta pesquisa teve como objetivo conhecer as percepções das gestantes quanto à escolha da via de parto. Trata-se de um estudo descritivo com abordagem qualitativa, realizado com gestantes de um município da região noroeste do Estado do Paraná. Os dados foram coletados por meio de entrevistas semiestruturadas, audiogravadas. Para o tratamento dos dados, adotou-se o discurso do sujeito coletivo. Participaram 20 gestantes, das quais 13 realizaram o parto cesárea. De acordo com as respostas das entrevistas foram geradas 25 expressões-chaves e delas originaram-se cinco ideias centrais: A – "Preferência pelo parto normal", na qual metade das gestantes optou inicialmente por essa via de parto; B – "Indicação da via de parto cesárea", escolhida por nove gestantes (45%) com indicação médica, a despeito da preferência prévia pelo parto normal; C – "Escolha de via de parto cesárea", com quatro (20%) mulheres que escolheram essa via por medo da dor; D – "Satisfação

com via de parto realizada", via pela qual todas as mulheres (35%) que realizaram parto normal expressaram satisfação; e E – "Dualidade entre satisfação e sofrimento com a via de parto realizada", misto de sentimento vivenciado por todas mulheres que realizaram cesárea. Concluiu-se que metade das gestantes tem preferência pelo parto normal, mas a maioria acabou por realizar o parto cesárea. Na percepção das entrevistadas, as escolhas da via de parto cesáreo foram decorrentes de indicação médica, medo, insegurança e desejo pela laqueadura. Sugerem-se ações educativas esclarecedoras para diminuir inseguranças nas decisões das gestantes e possibilitar autonomia na escolha consciente quanto à via de parto.

PALAVRAS-CHAVE: Gravidez; Cesárea; Parto obstétrico; Parto normal; Enfermagem.

INTRODUCTION

Vaginal delivery is the route of delivery recommended by the World Health Organization (WHO) due to its benefits and the reduction in maternal and neonatal risks. In turn, cesarean section, without medical indication, represents an unnecessary risk to the health of the woman and the baby, since it increases the probability of respiratory problems for the newborn by 120 times and triples the risk of maternal death.[1]

The WHO recommends that the total number of deliveries by cesarean section in relation to the total number of those delivered in a health service does not exceed 15%, which must have a precise indication. However, cesarean sections become increasingly frequent in both developed and developing countries.[2,3]

In reference to this, the WHO highlights the increase in deliveries by cesarean section, which reached 18.6% in 2016. In Europe, the rate rose, in 20 years, from 15% to 25%, and in the United States, it reached about 33%. Brazil, together with Nicaragua, has the highest statistics on a world scale in terms of cesarean interventions. The cesarean delivery, which should be an exception, seems to be assuming the indication of a general rule.[4] In the south of the country, cesarean sections correspond to 61.7% deliveries, and in the public network of the State of Paraná they reached 63.5% in 2013.[5]

It is necessary to consider that three out of ten women start pregnancy with preference for cesarean delivery, but at the end of pregnancy this number rises to eight. This proportion increases due to the influence of prenatal counseling that overestimates the risks of vaginal delivery and stimulates fear and insecurity of the pregnant woman.[6]

In addition, it is known that women with higher socioeconomic status, higher education and users of the private sector are those undergoing more cesarean sections. They usually have greater access to health services and consequently less pregnancy risk, which leads to questions about the high rates of cesarean sections in this group, devoid of a reductionist look when simply pointing out medical indications.[7]

Primary Health Care is the gateway for pregnant women into the Unified Health System (UHS), and with the implementation of the Rede Cegonha, it aims to provide comprehensive care and monitoring by health professionals involved in pregnancy and postpartum care. Thus, the strengthening of health promotion actions, disease prevention and qualified listening to the needs of pregnant women, puerperal women and newborns, made possible by the establishment of the network, provides humanized care and the creation of bonds between professionals and family members.[8]

Allied to this, advances in the medical sciences area have contributed to safer pregnancies, since the monitoring of prenatal care with psychosocial approaches and educational and preventive activities allowed risk factors during pregnancy to be reduced or controlled. Nevertheless, there are still others that can influence maternal and neonatal health outcomes, such as sociodemographic conditions - unsafe marital status, low income and education, among other unfavorable environmental and clinical aspects.[8]

Furthermore, it is imperative to shift the established social paradigm, which has strongly influenced the "culture of cesarean sections" among Brazilian women. In this regard, the Theory of Social Representations (TSR) meets this need, as such representations are seen as a specific way of understanding and communicating what is already known. They occupy a position, at some point, among concepts that aim to abstract the meaning of the world and introduce in it order and perceptions that reproduce the world in a meaningful way.[9]

Seeking awareness of pregnant women and also of professionals who provide childbirth assistance about the possible negative impacts of surgical intervention for the mother and baby is still the best way to reduce rates of cesarean delivery. Once the probable reasons why women prefer cesarean to vaginal delivery are known, it is up to the medical society, managers and other health professionals to demystify misconceptions.[6,10]

It should be noted that this issue has been widely discussed in the literature for years. However, there is a need to know the aspects related to the choice of the route of delivery with a view to creating efficient educational actions, with effective responses, including socio-cultural changes.

With a view to expanding knowledge on the theme, the question is: what are the factors that influence the choice of the route of delivery by pregnant women? Thus, the present study aimed to know the perception of pregnant women regarding the theme.

METHOD

This was an exploratory, descriptive qualitative study, carried out in a municipality in the northwest region of the State of Paraná, which at the time had 17 Basic Health Units (BHU). Of these, the six with the highest number of registered pregnant women were selected.

The study included pregnant women in the 3rd trimester undergoing prenatal care through the UHS. In turn, those who were not found at home and/or reached by telephone and those who had given birth before the start of data collection in Phase 1 were excluded. The addresses and telephone contacts of the women were provided by the teams of the BHU.

Data collection took place from April to August 2018 through individual interviews recorded from a semi-structured questionnaire prepared by the researchers, with sociodemographic data and four guiding questions: 1) If you have a choice, which route of delivery do you prefer? Why?; 2) What was the route of delivery indicated by your doctor?; 3) Do you know why the route of delivery was indicated by your doctor?; and 4) Were you satisfied with the route of delivery?

The study was developed in two phases:

Phase 1 - prepartum period: in this phase, we applied the first interview with the pregnant woman, with a questionnaire composed of sociodemographic, clinical data and those related to the previous delivery and the current pregnancy; as well as an audio-recorded interview based on the first three guiding questions of the study, in order to identify the possible factors that influenced the choice of the route of delivery.

Phase 2 - postpartum period: phase characterized by the second moment of the audio-recorded interview in order to identify the route of delivery and the satisfaction felt by the pregnant women, as well as to gather other information, such as maternal and/or neonatal complications.

The Phase 1 and Phase 2 interviews lasted an average of 15 and 20 minutes, respectively, and took place at the interviewee's home, without the presence of other individuals and/or family members. It is noteworthy that all meetings were held by one of the researchers, a nursing student, who received guidance and training from two professors at a Higher Education Institution (HEI), who have experience in qualitative research with interviews.

She had no connection with the BHU and no bond with the participants before the study started. Therefore, when approaching and inviting to take part in the research, she made the questionnaire available to the participant, clarified the objectives, the technique of data collection and the ethical aspects that involve research with human beings. After contact and inclusion of the participants, there were no dropouts. New inclusions occurred until the objective has been achieved and the information became repeated.

To systematize and treat the data, the Collective Subject Discourse (CSD) was used, based on Lefèvre methodological framework.[11] In turn, the discussion of data was based on the conceptual theoretical framework of social representations.[9]

TSR is part of the sense that the social actor gives to the world in which he/she lives, present in a position, manifestation and/or opinion, characterized by the fact of seeking to reconstruct such representation that preserves its individual dimension articulated with the collective. Thus, CSD is a way of retrieving and presenting Social Representation, in which individual opinions or

expressions that are similar are grouped into semantic categories, and the contents or testimonies, written in the first-person singular, as if it were a collective speaking in the person of an individual.[11] To that end, the analysis of the participants' testimonies was composed of Key Expressions (KEs), Central Ideas (CIs), Anchorages (ACs) and the CSD.

After recorded and registered, the narratives were transcribed in a box prepared by the researchers and typed in Microsoft Word; this box was divided into four columns composed of KEs, CIs, ACs and CSDs. For technical procedures, testimonies were first obtained, using literally the spoken words, and then the reduction of discourses began with the individual reading and analysis of each discourse and the capture of its essential content. In general, the discourses were short, so the most significant strata of the text were organized with the KEs.

Based on the KEs, the meanings of the statements made up by CIs and ACs were sought. The CIs corresponded to the synthetic formulation of the discourse given by the subject, it was a description of the meaning of the testimony, that is, a semantic tag; from this, provisional central ideas and their respective KEs were grouped around the same theme.

There is a type of CI that appears sometimes in the testimonies, which is the AC, and was only used when the statement contained some value, a theory, an ideology, an explicit belief in the discourse that is professed by the subject, soon supporting the CIs.

Then, new readings were performed to confirm the permanent CIs and arranged according to the major themes analyzed in the study. Thus, CIs and ACs were identified, those that expressed and had the same meaning, equivalent or even complementary meaning in the best possible way, and grouped and categorized with the letters A, B, C, D and E with a synthesis-CI in order to avoid redundancies.

The construction of the CSD consisted of gathering the KEs organized according to CIs that had a similar meaning. Therefore, it is a synthesis-discourse made in the first-person singular. In the selection process of the KEs, the discourse that was not relevant to the research question was removed.

This study was approved by the Research Ethics Committee of the State University of Maringá, under opinion 2.539.313 in 2018. All information was clarified to the participants, respecting all ethical precepts, as well as the reading and signing the Free and Informed Consent in two copies (one to the participant, the other to the researcher).

RESULTS

Of the 73 pregnant women registered in the six BHU, 20 participated in the study, since the others were excluded according to the exclusion criteria - 50 were not found at home and/or reached by telephone and 3 who had already given birth before the onset of data collection. Among the participants, 19 were over 18 years old, 13 were brown, 8 were married, 11 had a family income of up to two minimum wages and 11 had completed high school.

Regarding the previous pregnancy, 12 women were multigravida, 11 had undergone prenatal care by UHS, 7 had had a vaginal delivery, 3 reported gestational diabetes and anemia and one, polycystic ovary. Two pregnant women reported that they had complications during the previous delivery, but were unable to explain what happened.

Regarding the current pregnancy, all the participants said they had effective prenatal care, 13 underwent cesarean delivery, one reported being treated for anemia, one for depression, one for thyroid dysfunction and one for polycystic ovary. There were three complications, two neonatal - one was due to respiratory failure and hypoglycemia, and the other, due to cardiorespiratory arrest without a definite cause - and the neonates stayed in the Intensive Care Unit (ICU) for 15 and 18 days, respectively; and a maternal complication due to infection at the surgical site, which resulted in the use of antimicrobials.

According to the responses of the participants, the interviews generated 25 KEs, of which five CIs were identified:

A – Preference for vaginal delivery
B – Indication for cesarean section
C – Choice for cesarean section
D – Satisfaction with the route of delivery performed
E – Duality between satisfaction and suffering with the childbirth performed

The CIs and CSD referring to the route of delivery chosen and performed by the pregnant women are described in Chart 1.

Chart 1. Central Idea (CI) and Collective Subject Discourse (CSD) regarding the route of delivery chosen and performed by pregnant women

CI	CSD	Representativeness – n (%)
A – Preference for vaginal delivery	**CSD 1:** *For me it's vaginal delivery, because they say it's better, I've heard a lot, they say recovery is faster, more comfortable, easier, the pain is just one; it was painful, it took a long time, but I took a shower, I was going to the bathroom normally [...]. They say that cesarean section is complicated because it is a surgery and has anesthesia, so I am very afraid.*	10 (50%)
B – Indication for cesarean section	**CSD 2**: *My choice was vaginal delivery, but the doctor indicated a cesarean section because my pregnancy was at risk, I had complications and changes in the baby's heartbeat and mine too, and then it was urgent [...]. At the time, I had no dilation and I even waited a few hours, then as I had no dilation, there was no way, I had a cesarean section.*	9 (45%)
C – Choice for cesarean section	**CSD 3:** *I wanted to have a cesarean, it was on my own, because I am very afraid of the pain of vaginal birth [...]. So, as I was going to have to wait longer and I had no dilation, I got scared and really asked for a cesarean section.*	4 (20%)
D – Satisfaction with the route of delivery performed	**CSD 4:** *I am satisfied with the vaginal delivery, it had to be the same as another, everything went well and my recovery was very fast.*	7 (35%)
E – Duality between satisfaction and suffering with the childbirth performed	**CSD 5:** *I am satisfied with the cesarean section, but vaginal delivery seems to be better because of the recovery, which is very good [...]. Only when you have to wait a long time, then you are afraid of being late, then you have to have a cesarean section and sometimes we take advantage of it and do the tubal ligation [...]. I think the pain you feel after the cesarean section is bad, to get up, to sit, to breastfeed the baby like that is complicated, in addition, the cut of the cesarean section is ugly and the pain is unbearable.*	13 (65%)

DISCUSSION

In the present study, the presence and effective monitoring of pregnant women in prenatal care was highlighted, which may explain the low number of comorbidities and complications, reducing the risk of maternal and neonatal morbidity and mortality. On the other hand, it was demonstrated that health teams that perform high-risk prenatal care need to review their educational practices: data showed points to be worked on in the organization and in the assistance provided to these pregnant women, highlighted by the lack of guidance and the need for qualification improvements during the monitoring of these women.[12]

Thus, studies indicate that prenatal care should be performed in a humanized, welcoming and qualified manner. The nurse, together with the multiprofessional team, plays a key role in assisting these women, with qualified listening, necessary guidelines for health education, monitoring during pregnancy, clarifying doubts and supporting concerns. In addition, it early identifies changes and risks in pregnancy, key points to consolidate the planning and development of pregnancy.[13,14]

Normally, most births evolve without problems, but there is a part of births in which complications complications occur.[15] This strengthens the findings of this study, in which two neonates evolved with complications. The professionals involved in the assistance must identify the critical cases that need more complex and specialized care in order to direct the most appropriate and specific care to this condition.[15]. One of the tools used for this - and which was introduced from the Rede Cegonha - is the risk stratification, which directs the pregnant woman to the point of care according to the risk.[8]

In the last three decades, Brazil has increased access to prenatal care for most pregnant women with a positive impact on health indicators, especially regarding child health, in addition to reductions in social and regional inequalities. Even so, there are still concerns about the unjustifiable practice of cesarean sections, which reach more than 50% in the country. This can be attributed, in a way, to preterm births, partially associated with unnecessary cesarean delivery and weaknesses in primary health care.[16]

However, despite the expansion of this access, not all Brazilian regions have a consolidated network or have favorable results in relation to its implementation. Therefore, it is necessary to have more explicit and explanatory policy formulations, assigning physiological programs of pregnancy, childbirth and the puerperium under the care of the entire health team, with incentives in interdisciplinary promotion and cooperation in the care of pregnant women, focusing on the needs and choices about pregnancy[17].

In the discourse of half of the pregnant women, we observed the preference for vaginal childbirth due to the fast recovery, comfort and ease, even if it provides pain and/or delay at the time of delivery. And when commented on cesarean delivery, some reported fear because it contained surgical and anesthetic interventions. Similar results have shown that most pregnant women prefer the vaginal delivery, as it is a natural process with rapid recovery when compared to cesarean delivery. Additionally, these women stated little suffering, less painful postpartum, ease in resuming daily activities and care for the newborn without restrictions, which showed benefits provided by choosing this route of delivery.[18]

The decision and desire for vaginal childbirth was presented in a study, and the choice of the route was based on social interactions that favor an interest and search to know this type of childbirth. The importance in the searches and reflections about social notes was highlighted when comparing vaginal and cesarean deliveries, as experiences of vaginal delivery value the representativeness for being a woman.[19]

Professionals commonly suggest vaginal childbirth, but some situations lead to the recommendation of cesarean section, as evidenced in the disclose referring to the indication for cesarean section. This is because they should only indicate cesarean delivery when there is some risk of morbidity and mortality and the probability of unexpected events, such as the baby's position and reasons related to neonatal and/or maternal health.[20] This result meets the prescriptive function of social representation, imposed on individuals with irresistible force. This is a combination of a structure that is present even before we begin to think and a tradition that decrees what should be thought.[9]

Thus, cesarean section must be decided through careful evaluations, as it can cause complications such as puerperal infections, hemorrhages, anesthetic risks and/or maternal and neonatal mortality or morbidity, thus being an important tool, but if used in a controllable way.[21]

It was noticed in the reports of nine participants in the present study that the indication of delivery was made by the doctor, associated with complications and risks for the mother and child. Despite this, it is necessary to reflect what still leads to high numbers of cesarean sections, since this scenario raises the concern that Brazil remains as one of the countries with a high rate and above that indicated by the WHO.[20]

Data from 2018 from England's national health service showed that, although the prevalence in spontaneous vaginal deliveries is 58%, 11% had instrumental assistance during delivery, 13% were elective cesarean sections and 16% were emergency cesarean section.[22]

In general, understanding these rates goes beyond the decision on the route of delivery, as one must take into account the needs for medical indication and also respect for the preferences of women. This includes perceiving the relationship between the nature and culture of these pregnant women so that the event of childbirth can be seen as a possibility of the woman's self-determination over her body.[23]

Parallel to this, the discourse on the choice for cesarean section was evidenced by the fear of pain, as it is known that, in addition to the convenience of scheduling the birth of the child, it is intended to avoid this discomfort during delivery. For this reason, many women opt for cesarean section and several times ignore or are not

informed about the possibility of receiving pain relief care also during vaginal delivery.[23]

The choice for cesarean section can, in many situations, be influenced by fear, convenience and misinformation. This is because, due to social and cultural influences, the woman considers the consequences of normal childbirth as if it were risky or that the surgery will avoid pain. In addition to the information not being adequate, unnecessary interventions during delivery transform what would be a normal event into a dehumanized procedure, further increasing painful sensations and fears, which contributes to the acceptance and request for cesarean section.[10]

A study carried out in southern Brazil shows worrying rates of cesarean sections, with 55% cesarean deliveries by UHS and 93.8% by the private system. The occurrence of this route in the private system is expressed by the woman's desire for cesarean section at the beginning of pregnancy; in the case of UHS, the associated factors were those related to family income greater than one minimum wage in Brazil, having had a previous cesarean section, pre-gestational overweight or obesity and desire for cesarean delivery at the beginning of pregnancy.[6]

Compared to developed countries, such as the United States, the incidence of cesarean section by maternal request and its contribution to the general increase in the cesarean section rate are not well known, but it is known that cesarean delivery on maternal request has increased there. Therefore, the American College of Gynecology and Obstetrics, in order to incorporate additional data on the results and information on maternal counseling and to link to existing resources, recommends that, in the absence of maternal or fetal indications for cesarean section, a plan for vaginal delivery is safe and appropriate, and when a woman wants a cesarean section, the doctor must consider her specific risk factors such as age, body mass index, accuracy of estimated gestational age, reproductive plans, personal values and sociocultural context.[24]

From this perspective, social representation is an unfinished cognitive and affective process of apprehending the world, in which communication and thought can only be understood as transformations of previous structures, cultural relativizations, materializations of meaning that surpass society in its historical context.[9] With this, the importance of communication and the provision of specific guidelines that clarify the risks and benefits of the route of delivery are reiterated, when there is a possibility for the woman to choose.

In Brazil, there is still an aesthetic concern, associated with the myth that the cesarean section keeps the anatomy and physiology of the vagina and perineum intact.[23] Therefore, providing the opportunity for dialogue during this prenatal period is an important care for conscious choice of the woman regarding the route of delivery.

In this way, the nurse can perform some actions in primary health care during care practices, demystifying some beliefs and resolving questions about childbirth, and thus promoting women's autonomy in choosing the route of delivery and valuing her life history and decisions. The dialogue during prenatal care, through information about hospitalization and childbirth, and the clarification of doubts that dispel fears are important points that humanize and respect the choices of pregnant women; consequently, they bring better maternal and child health and safety results to health professionals.[18]

A study in Germany reinforces the importance of preparing obstetric nurses about some primary care in which women face deficits and needs, particularly during pregnancy. In general, they talk about actions that can be implemented in such a way that pregnant women are empowered and welcome to clearly declare their preferences for care with obstetrics and motherhood in a safe way.[17]

When researched about satisfaction, vaginal delivery showed satisfaction with the route of delivery performed; on the other hand, there was a duality between satisfaction and suffering with the childbirth performed when it came to cesarean section. Thus, the discourses revealed opinions on how they feel and what these women think about the routes of delivery, and this shows the importance of respecting each one's choices, beliefs and individualities; when this occurs in a humanized way, it can reflect on the adherence and approximation of the mother-child binomial to the necessary health care.

A study conducted in a municipality in the Southeast Region showed the feeling of satisfaction of women in the decision for normal childbirth expressed in the statements about the essence of the experience of

giving birth with satisfaction in the encounter with herself, revealing her full potential and capacity as a woman.[19]

In contrast, another study carried out in a high complexity hospital in a city in the northeastern region of Brazil revealed that 44% assisted women had a low degree of satisfaction with labor and delivery. It can also be observed that most of them said they had no guidance on labor and delivery, and what they were told did not lessen the fears and anxieties related to this event.[25]

A qualitative study showed that women undergoing vaginal birth as an outcome reported higher levels of satisfaction, while those undergoing cesarean section showed frustration, pain and suffering in their speech. Among those who declared themselves satisfied with cesarean section, positive aspects highlighted were the fear of pain and the medical indication for this delivery during pregnancy.[18]

In the present study, the puerperal women undergoing cesarean delivery due to failure to achieve dilation or even with a view to performing the tubal ligation proved to be satisfied with the choice, as for some of them it would be absence of pain and a method for not getting pregnant again. Nevertheless, among those who did not get satisfied, it was due to failure to perform tubal ligation and/or hysterectomy, or to the dissatisfaction with their surgical scar. Therefore, the vast majority of the puerperal women were satisfied with the chosen and performed route of delivery.

Finally, one of the problems of social representation in modernity is to reconcile intuition and experience, heterogeneity and homogeneity, faith and reason. Common sense needs to be reinvigorated, "rehabilitated", because it reveals how we think and are, the way we communicate and their local and global implications. To endorse the constructive character of these representations - not as distortions of thought, but as a different and "hybrid" way of thinking in groups and apprehending social innovation.[9] - it is necessary for conscious choices regarding the route of delivery in fact be effective.

It is emphasized in this study the difficulty of access to pregnant women registered in the BHU, due to unsuccessful telephone contact, absence at home during attempts to visit and outdated addresses. Furthermore, the research is restricted to the context of a distinct group of pregnant women, which limits the generalization of the results obtained. However, the importance of the findings for the planning of actions that favor the conscious choice of the route of delivery by the pregnant women is emphasized. It is suggested to produce new research that broadens the understanding about the choice of the route of delivery of women in other public and private settings.

CONCLUSION

This study allowed to know the perception of pregnant women regarding the choice of a safe route of delivery to the mother/baby binomial and the challenges related to this conscious choice. Half of the women chose to have a normal delivery, and even though empowered with knowledge during prenatal care about the benefits of this route and despite the options, they were influenced to opt for cesarean delivery due to medical indication, fear, insecurity and opportunity for tubal ligation. Women undergoing cesarean section experienced a mixed feeling that permeates satisfaction and suffering with this route of delivery.

It is suggested that educational actions still need to be implemented by the maternal health care network in order to allow autonomy in the conscious choices of the route of delivery to be made by pregnant women during prenatal care.

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