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The perceptions of women about the choice of delivery modes: a descriptive study

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ABSTRACT

Aim: Discuss the perceptions of women when choosing a mode of delivery.

Method: A qualitative study done in a teaching hospital and health clinic, from January to March 2011, which interviewed 8 non-pregnant women at reproductive age. The data was analyzed and interpreted based on the thematic analysis of the material.

Results and discussion: The findings show the perceptions women have when choosing the mode of delivery, and the relevance of how they feel about the decision-making power of doctors concerning the mode of delivery. Some disagree with this attitude and feel they should have more say in the matter**.**

Conclusion: Some women do not agree with a unilateral doctor decision and argue that their involvement is vital, since they feel the effects firsthand.

Keywords: Birth; Women's Health; Culture; Nursing

INTRODUCTION

The organizational models of public and private services vary, as do work relationships between healthcare professionals and treatment, which results in different hospital experiences for pregnant women[1]. Most women still prefer to have natural deliveries at public maternity hospitals, and cesareans at private maternity clinics[2].

This decreases the scope of available assistance and does not grant much decision-making power to users of the private healthcare sector. As cesarean operations result in higher physician fees and hospital bills than natural deliveries, it is to be expected that most cesareans are performed on Caucasian women with higher incomes[3].

The way which obstetrical assistance is organized, the academic background of healthcare professionals, and the demand for cesareans from women who fear the impositions of hospital staff on the mode of delivery, are all factors that have influenced the increase of cesareans in our healthcare system[4].

Pain during childbirth is considered to be one of the main reasons that influence women's choice for cesareans and is deeply rooted in the popular imagination as an event associated with feminine purging. It this sense, it has its roots in the Biblical book of Genesis, which depicts Eve as the first human to sin and thus responsible for the corruption of all humanity with her transgression, as in the book of Genesis God states: "in pain shall you bring forth children"[5].

The idea that a woman must pay for her sins during childbirth, spread by hegemonic religion and medicine, counters the view of childbirth as a moment of pleasure. This view is considered heretical and a threat to the beliefs defining childbirth as a painful process, damaging to health and female sexuality, and which must be controlled by medical means[6].

Pain and its voluntary aspects are influenced by social, cultural and psychological factors. This is interwoven with the personal meaning women attribute to childbirth pain in their life context, and the relevant cultural definitions of body image, structure and functions[7].

The choice for a cesarean may be influenced by the mode of delivery previously experienced by women from higher social classes and income. Likewise, there is an urgent need for qualitative research to evaluate women's and doctors' preferences for cesareans, in addition to the complex interactions between them. Research can provide the basis for effective and safe obstetrical intervention with the aim of reducing the currently increasing rates of cesarean operations[8].

In a study that analyzed women's expectations concerning the method of delivery, the main reason given by women for choosing natural childbirth was faster post-delivery recovery, whereas for cesareans it was that the previous delivery had been a cesarean. However, the reasons given by these women for choosing cesareans did not coincide with medical recommendations in 47.5% of the cases in the study[9].

Changes in the model for delivery assistance may be a promising strategy for reversing this situation, since - regardless of the pregnant woman's initial choice - subsequent interaction with the hospital staff usually results in cesareans being the final mode of delivery[10].

To obtain autonomy, a woman's opinion should be included in the decision about which mode of delivery is appropriate and this happens more frequently as she is informed about the available scientific evidence to indicate the best course of action for a certain situation[11].

This humanistic approach embraces a line of thinking which adopts and proposes unconventional attitudes to guide obstetrical assistance, and questions the biomedical model. This approach is greatly influenced by the feminist movement that has played a fundamental role at the center of debates surrounding health issues and their relation to quality of life and citizenship[12].

In light of the context shown above, our interest in the topic led to the development of this study, with the aim of discussing women's perceptions when choosing a mode of delivery. After verifying scientific literature, we noted the lack of cultural research with non-pregnant women, outside a hospital or maternity context.

Consequently, this recent study offers insights that can have an impact on the nursing assistance offered to women during the delivery period, since it increases understanding of their treatment needs based on their perceptions of labor and childbirth.

METHOD

This current study consists of both qualitative and descriptive research, which is commonly used by social researchers concerned with practical application[13]. Semi-structured interviews were used as an instrument to collect the necessary data, and this data was investigated according to a Minayo thematic analysis[14].

This research was done in the municipality of Santa Maria – RS, Brazil, at the Kennedy Sanitary Unit (USK) and at the University Hospital of Santa Maria (HUSM). USK was chosen since it is used for the practical training and supervised internships of students from the Nursing Course at the Federal University of Santa Maria (USFM).

HUSM is a hospital school, founded in 1970, and a base for primary healthcare assistance in its surrounding districts, secondary assistance to the residents of Santa Maria, and additional assistance to the central region of the Gaúcho interior. This hospital is a center for teaching, research and Health Sciences extension courses, as well as for scheduling and maintaining healthcare activities for the local and regional communities.

This study involved 8 women in their fertile period who had previously given birth naturally or via cesarean; 4 were from USK and the other 4 from HUSM. The women chosen for the interviews had either requested assistance from the USK family planning program, or were seeking gynecological and obstetrical services from HUSM. The participants were given the designation M for women (from the Portuguese word for woman -*mulher*), and a number based on the interview order (M1 – M8). They were also classified by sociocultural aspects such as age, marital status, level of schooling, place of residence, number of children, occupation and previously-experienced method of delivery.

Special attention was given to ethical criteria and the bioethical principles of voluntarism during all the research activities, which are based on Resolution nº. 196/96 from the National Health Counsel, which enforces ethics during research with humans[15].

The project was approved by the Research Ethics Committee at the Federal University of Santa Maria, under the registration number 0317.0.243.000-10.

RESULTS

Concerning the profile of the interviewees, the following could be determined: the women were aged between 22 and 35; the majority were married (n=6), one was a divorcee and one was single (in a steady relationship at the time of the interview); in terms of level of education: 3 women had elementary schooling, 3 others finished high school, one dropped out of high school, and only one had a college degree; all of the women live in the urban area of the Santa Maria Municipality – RS; concerning the number of children, the group had an average of 2 children, with at least one and at most 4; as for occupation, 2 are housewives, 2 are nursing technicians, 1 is a nurse, 2 are maids, and 1 works at a supermarket.

Based on the description and analysis of the women's interviews, the perceptions of women when choosing the mode of delivery were put into categories, whose main results were then discussed based on an established dialogue with theoretical references, in order to understand how culture influences the childbirth process.

Perceptions of women when choosing a mode of delivery

To understand childbirth as an event in women's lives, specific questions were asked during the interview about the decision concerning the mode of delivery. The opinions of the interviewed women suggest a unilateral decision by doctors, as can be seen below:

> *The doctor makes the final decision on whether the delivery will be vaginal or C-section*. (M2)

> *I think it should be the woman's choice, but it's the doctor that decides. They say it's protocol, and this and that, but I know that's not how it works. That doesn't actually happen, right?* (M3)

> *Doctors usually decide on cesareans. I actually wanted a natural delivery but the doctor said he would do a C-section and that's what he ended up doing.* (M8)

According to another interviewee, women have no right to decide on the mode of delivery during the prenatal period in the private medical care system. Their autonomy is usually overlooked when they prefer a natural delivery.

> *In the private health sector, the doctor decides. We have no choice at all.* (M6)

Despite this centralized decision-making by the doctors, some women feel the need to be included in the mode of delivery decision, since they will experience all the effects of childbirth firsthand, unlike the doctor.

> *A woman should have more say in the matter than the doctor, since she feels all the effects and really knows what's happening*. (M1)

DISCUSSION

Women fully understand the decision-making power doctors have when choosing the mode of delivery. Nevertheless, some women disagree with the idea that this professional should unilaterally decide and make it clear that they want to be included in the decision.

This perspective points to women's wish for autonomy and participation in the decision about the mode of delivery, although what we see is the prevalence of the doctor's opinion on how the delivery should proceed.

When we refer to the autonomy of a woman going into labor, we are referring to a process in which the scientific/technical lexicon gradually begins to be broken up, so that the women and her family can be brought into the center of the decision.

However, for this to happen, it is important to provide a woman with all the information she needs to become an effective member of the medical team, and as such, have complete knowledge and ability to make the best decisions for all involved, especially herself and the child. This is undoubtedly a complex process, but when applied, it shows healthcare workers that respecting a woman's autonomy does not diminish their own professional autonomy, but instead increases quality, participation and ethical correctness[16].

Perhaps this is difficult to understand for healthcare professionals, whose work practices are rooted in a biomedical culture based on the ideology of technological progress, which, in a childbirth context, began after its institutionalization at the onset of the industrial era[12].

In the first decades of the 20th century, when childbirth began to be considered a pathological process that had to be controlled in order to prevent maternal and prenatal fatalities, it was characterized by episiotomies, unnecessary cesareans and the prophylactic use of forceps[17]. The result of this interventionist behavior is a discrepancy between what women want and what actually happens[18].

One of the reasons doctors give for these practices is the change in risk profiles for pregnant women. However, a study conducted in the United States that linked the increase in cesarean rates to changes in risk profiles, also found that the chances of a woman undergoing a cesarean during her first pregnancy have increased by 50% compared to 1996, even if she is not at risk.

It is believed that the risk assessment and indications for performing a cesarean are the responsibility of the medical team. Nevertheless, a woman should receive all the necessary information about the risks and benefits of this procedure so she can actively participate in the process.

This issue emphasizes a woman's right to information and their decision-making ability, meaning that they have the right to demand what is suitable for the child and themselves.

Healthcare professionals and women can reach a decision in advance regarding the mode of delivery, but this decision cannot be simply considered a matter of preference, as in the case of an early or elective cesarean without medical recommendation, because it may imply future risks and complications for both mother and child[11].

A woman's choice regarding the mode of delivery is regarded by medical literature as a contributing factor to the currently high rates of cesareans[20]. Cesareans give doctors the maximum amount of direction and control during delivery, and require minimum effort from the woman and uterus, which has resulted in the view that this procedure provides the best "products"; that is, it produces perfect babies, using some kind of industrial production metaphor[3].

Consequently, this has triggered the belief that cesareans are a protective measure in childbirth. This may be related to the notion that natural deliveries are traumatic for the fetus, and thus the professionals "ally" themselves with the child against the potential damage caused by the mother's body during labor. This notion ignores what may be most important for the woman and her child – the very nature of their experiences during delivery and birth[3].

Among obstetrical doctors, there appears to be a pro-cesarean culture, and consequently, some of them do not have the motivation and capability to control a natural delivery. On the other hand, in this situation women have a difficult time enforcing their decisions about the mode of delivery, as they feel less sure of their decision-making due to technical issues put forth by hospital staff.

CONCLUSION

Regarding the decision-making power that both the doctor and woman have when choosing the mode of delivery, the opinions from interviewees vary. Some stated that the decision regarding the mode of delivery should be the doctor's, while others said they did not totally agree with this and argued that a woman's decision should be considered, since she feels the effects firsthand.

Unfortunately, this culture has gone unnoticed by most of the women who find themselves in a vulnerable and unequal situation when faced with the doctor's sovereign decision, which in turn disregards the pregnant woman's choice.

As the interviewees stated, they accepted the hospital staff's attitude but felt that they should have made a different decision. They support changes in attitudes that put women at a disadvantage during delivery.

It is the duty of healthcare professionals to guarantee a woman's autonomy by respecting her choice for delivery. By reinstating this autonomy during delivery, we will return the central role in childbirth to the person to whom it rightfully belongs.

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