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Original Article

ASPECTS INFLUENCING WOMEN'S DECISION MAKING ABOUT THE MODE OF DELIVERY

ASPECTOS QUE INFLUENCIAM A TOMADA DE DECISÃO DA MULHER SOBRE O TIPO DE PARTO

ASPECTOS QUE INFLUYEN EN LA TOMA DE DECISIÓN DE LA MUJER ACERCA DEL TIPO DE PARTO

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Objective: get to know the aspects that influence decision making about the mode of delivery among women in the third term of pregnancy. Method: descriptive and qualitative study, developed in 2015 involving 15 pregnant women. Semistructured interviews were undertaken and the data were submitted to content analysis. Results: vaginal birth was the preferred delivery route among the pregnant women. The experiences by relatives, close persons and the pregnant woman herself, feelings and sensations experienced and the prenatal care received were the aspects that influenced the women's decisions. Conclusion: the choice of the mode of delivery was not influenced by a single aspect, but by a series of inextricable factors that, when analyzed separately, perhaps would not be able to influence the decision.

Descriptors: Pregnant Women. Parturition. Decision Making.

Objetivo: conhecer os aspectos que influenciam na tomada de decisão sobre o tipo de parto, por gestantes no terceiro trimestre de gestação. Método: estudo descritivo, qualitativo, realizado em 2015, com 15 grávidas. Realizaram-se entrevistas semiestruturadas e os dados foram posteriormente submetidos à análise de conteúdo. Resultados: o parto vaginal foi apontado como a via de preferência entre as gestantes. As experiências vivenciadas por familiares, por pessoas próximas e pela própria gestante, bem como sentimentos e sensações experimentadas, e a assistência pré-natal recebida foram os aspectos influenciadores na decisão da mulher. Conclusão: compreendeu-se que a escolha do tipo de parto não foi influenciada por um aspecto apenas, mas por uma série de fatores indissociáveis que, quando analisados separadamente, talvez não fossem capazes de influenciar a decisão.

Descritores: Gestantes. Parto. Tomada de decisão.

Objetivo: conocer los aspectos que influyen en la toma de decisión acerca del tipo de parto, por embarazadas en el tercer trimestre de gestación. Método: estudio descriptivo, cualitativo, en 2015, con 15 embarazadas. Se realizaron

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entrevistas semiestructuradas, cuyos datos fueron posteriormente sometidos al análisis de contenido. Resultados: parto vaginal señalado como la vía de preferencia entre las embarazadas. Experiencias vivenciadas por familiares, personas cercanas y la propia embarazadas, así como sentimientos y sensaciones experimentadas, y asistencia prenatal recibida fueron los aspectos influyentes en la decisión de las mujeres participantes. Conclusión: se comprendió que la elección del tipo de parto no fue influenciada por un aspecto sólo, sino por una serie de factores indisociables que, cuando analizados separadamente, tal vez no fueran capaces de influir en la decisión.

Descriptores: Mujeres Embarazadas. Parto. Toma de decisiones.

Introduction

Pregnancy is associated with a period of bodily and emotional transformations for women and is experienced individually. Several aspects, such as fears, anxieties, doubts and joys permeate this experience and, when associated with physical, cultural and personal factors, these influence the women's attitudes during pregnancy, childbirth and birth[1]. Thus, to understand the complexity of this phenomenon from a comprehensive care perspective, one needs to consider, in addition to biological events, how women act in the process of pregnancy, parturition and maternal care, particularly with regard to the choice of the type of delivery.

Motherhood is a transforming and impactful experience. Therefore, the woman needs to be respected in her decisions. Her protagonist role throughout the process, including during labor and delivery, is important for an active and participatory experience[2]. Being a protagonist in childbirth involves, among other factors, having the appropriate knowledge necessary to make decisions and choices. Initially mentioned in the Adelaide Recommendations in 1998, the proposal to create public policies that value the right to choose in relation to the form of giving birth was put in practice in the Prenatal and Birth Humanization Program[3-4]. The woman is entitled to decide on her preferred mode of delivery, being a female right and an exercise of autonomy[3]. Therefore, the need to strengthen women's empowerment is emphasized with a view to ensuring that women participate actively in decisions about the birth process, establishing autonomy as a fundamental right[5].

The institutionalization and medicalization of childbirth have transformed this moment into a pathological process, mediated by unnecessary interventions. Influenced directly by this trend, the woman increasingly turns into an object of action, in addition to having lost, at various moments, the control over her body and the process of motherhood[2]. In Brazil, most deliveries are performed in hospitals or health institutions[6]. In addition, the proportion of cesarean deliveries in the country was 55.4% in 2014, including public and private services[7], which is well above the 15% indicated by the World Health Organization[8].

The mode of delivery is distributed unevenly across the country. Cesarean delivery rates are lower in public services and in the Southeast. Inverse inequality was verified though, showing that women with more years of education, better socioeconomic conditions and users of the private health sector figure among those with higher rates of cesarean sections and lower chances of natural birth. On the other hand, only one-fifth of pregnant women have an initial caesarean section. This percentage increases at the end of the pregnancy, especially in the private sector[7].

Given this scenario, it is observed that the high rates of surgical deliveries do not always reflect the woman's final or initial desire. Results of the aforementioned studies, associated with the experiences in the area of Women's Health, mainly in pregnancy, prepartum, childbirth and postpartum care at all levels, motivated the development of this study about the factors influencing pregnant women's choice of the

delivery mode. Although the focus adopted here, i.e. the choice of the delivery type, brings about very complex issues that make it difficult to understand, external influences may be responsible for these changes and may occur at the convenience of doctors, health services or the system itself[9].

The clinical evaluation is largely subjective, in which the professional's comfort prevails over the woman's need[7]. It is important to give voice to women in order to know how they choose the delivery route and to understand that non-clinical determinants are related to their decision[10-11]. Therefore, a series of factors, including the aforementioned sociocultural aspects[10], previous experiences[12], medical and prenatal care[11], family and friends[13], influence the woman's decision making, inserted in a social environment and against the background of personal experiences. Most of the studies involved postpartum or pregnant women though, regardless of the pregnancy period. As it has already been shown that the women's desire changes at different moments during the pregnancy[7], the following question is raised: Which aspects influence pregnancy women's decision making on the type of delivery during the third trimester of pregnancy? The main influence of aspects related to the professionals and services the pregnant women are submitted to are assumed as premises[9].

Knowing the range of aspects related to women's decision making about the mode of delivery allows health professionals to help them to experience the pregnancy-postpartum period healthily, with autonomy and empowerment, offering care based on the principles of humanization, comprehensive care and respect for their rights. Thus, the goal was to get to know the aspects that influence pregnant women's decision making about the mode of delivery in the third term of pregnancy.

Method

This descriptive study with a qualitative approach was carried out in a city in the region of Zona da Mata in the state of Minas Gerais, Brazil. This type of study was chosen because it is believed that, in order to provide qualified care, it is essential to understand the individual's experiences, contextualizing and involving the person in the culture (s)he is inserted in in a singular way[14].

The city in the state of Minas Gerais where the research was carried out is located at 240 km from the state capital. According to data from the Brazilian Institute of Geography and Statistics (IBGE), a population of almost 80 thousand inhabitants was estimated in 2016. The study took place in the Primary Health Care service network, composed mainly of Family Health Strategy Units (FHS), where 17 family health teams are distributed, prioritizing the most vulnerable areas. Also, this network includes a polyclinic, responsible for attending to the population not covered by the FHS. The city's service network includes specialized and hospital care institutions, also for care to pregnant, parturient and postpartum women.

The population selected for the study consisted of pregnant women living in the city, enrolled in the Monitoring System of the Prenatal and Birth Humanization Program (SISPRENATAL) and in one of the municipal health care teams during the data collection period. Another inclusion criterion was being in the third term of pregnancy (28th week of gestational age or more) during the collection period. These criteria are justified by the fact that they are receiving prenatal care from health professionals, thus supposing that they get information on the types of delivery. In this perspective, we considered that this would favor the dialogue about the decision on the mode of delivery, also due to the greater proximity of the event. Exclusion criteria were: high-risk pregnant women with clinical conditions that could interfere in the choice of delivery.

A semistructured interview script was used as a data collection instrument. In this instrument, five guiding questions ranged from the sociodemographic characteristics of the interviewees to expectations related to the

decision on the type of delivery and reasons for the choice.

The data collection period was between September and October 2015. Participants were chosen using non-probabilistic convenience sampling, based on the list of pregnant women enrolled in the seventeen family health teams, considering the abovementioned inclusion and exclusion criteria. After contact with the health service, each pregnant woman was initially selected, also considering the ease of access. Subsequently, a home visit took place to invite her to participate in the study. For the pregnant women who agreed to participate, the interviews were scheduled according to their availability and preference. At the end of the study, 15 pregnant women had been interviewed.

All the interviewees were informed about the study objectives and the need to sign the Informed Consent Form after reading and agreeing to participate in the research. All interviews took place at the women's homes to preserve the privacy of the information. The statements were recorded individually and then fully transcribed for analysis. During the transcripts of the statements and analyses, the pregnant women were identified with the letter "P" (Pregnant), followed by the Arabic numerals corresponding to the order of the interview (P1, P2, P3, etc.). The data saturation criterion was used to limit the sample. The information provided by new participants would add little to the research due to redundancy and repetition in the discourse[15].

Data were analyzed according to the content analysis technique. This analysis is performed by categorizing units of text (words or phrases) that are repeated in a single theme, following the steps of pre-analysis, material exploration, treatment of results and, finally, inference and interpretation of data[16].

The research received approval from the Human Research Ethics Committee of the Federal University of Viçosa, on June 8, 2015, under Opinion 1,147,440. According to the assumptions of National Health Council Resolution 466/2012 on research involving human beings, the objectives of the study, the risks involved and the guarantee of anonymity were informed and clarified.

Results and Discussion

Fifteen pregnant women participated in the study, in the third trimester of pregnancy, between the 28th and 38th weeks of gestation, aged between 16 and 41 old. Six pregnant women were adolescents, eight were between 20 and 40 and one was over 40 years old. Most reported unplanned pregnancies and two of them also took part in prenatal care in the private network, besides the public network. Two-thirds were primiparous. Among the multiparous women, four had previous experience with vaginal delivery. In relation to the level of education, only one pregnant woman had completed higher education; one had incomplete higher education; three completed high school; four, incomplete high school; and six, incomplete elementary school. Care of the home and family was the main activity for nine of them.

In order to respond to the study objectives, the categories that emerged in the data analysis, and which will be discussed next, were: the type of delivery desired, the factors that influenced their decision process and, finally, questions about the guidelines received during prenatal care regarding the types of delivery.

Type of delivery the pregnant women desired

The pregnant women appointed vaginal delivery as the preferred route, although the preference for cesarean section has increased in Brazil in recent years. The interviewees' profile may be related with these findings though. In the results of another study, we noticed differences in the desired mode of delivery, with the predominance of vaginal delivery among primiparous women with childbirth financed by the public sector[7]. This profile is similar to that found in the pregnant women interviewed. The justifications were mainly related to the quicker and easier recovery, not interfering with the routine, besides the belief that vaginal delivery is natural and physiological, bringing fewer risks for the mother and the baby. These choices were expressed in the following statements:

> *I want natural. My first child was natural and it was great. I got out of there walking, I got home cooking, I took care of the house, normal* [...] *It did not even seem that I had given birth [laughs].* (P2).

> *I prefer natural birth. We see many cases saying that natural birth is good for the baby, for the mother, I'm aiming for both my wellbeing and my baby's. The recovery is much better and the risk for the baby is much lower than the cesarean birth.* (P10).

These results corroborate findings from other studies[7,10-13,17]. In one, the initial preference for vaginal birth was 66%; more than half of the women had a cesarean section as the final delivery route though. The proportion of surgical delivery as the final route was about three times higher than the initial preference for this same type of delivery[7]. This is perhaps one of the reasons for the high rates of cesarean sections registered in Brazil, suggesting that there is a gap between the choice of the pregnant woman and the fulfillment of this desire, as already seen in a previous study[7]. Moreover, there is a difference between what doctors say is the women's opinion and what they express as preferences and motives[18]. Current-day obstetric practice, marked preferentially by surgical delivery, can make health professionals seek justifications for their conduct.

During the analysis of the reports, the pregnant women were relatively passive, mainly towards the doctor's decision-making power. The final decision on the type of delivery was attributed to this professional. This may be due to trust, but also to the imposition and posture of power, which is very common in these relationships, in view of the persistence of the biomedical model in health institutions[10,19].

> *I prefer it, right? [natural birth]. But as I'm already 39 years old, I do not know what my conditions are. The doctor has not informed me yet. I hope they'll say I can have natural birth.* (P3).

> *But the doctor said like, he will do his best for me to have the natural birth. But it's no good at all to want and not be able to. You have to see what it's going to be like.* (P10).

> *But I do not know what it's going to be like. I even asked the doctor, but she said she has to wait and see what's going to happen. How will the process move ahead. I may not have passage.* (P6).

The determinism of cesarean section as a mode of delivery may be influenced by biological issues[13], in a minority of cases, or by the physician's influences and interventions during childbirth[12]. The women accept the change in the option initially made, motivated by the concern to guarantee well-being, not to feel pain and to have a calm evolution. The medical decision prevails in the process of choosing the delivery route, on behalf of the woman and the baby's safety[20]. The woman's protagonist role in this choice is hidden by the emblematic figure of medical power.

Due to the women's lack of empowerment, fear and insecurity, they transfer the responsibility to the doctor, give up their autonomy and accept technical interference, preventing them from acting actively in this process. The woman, who should be the protagonist, distances herself and becomes a collaborator, which can also justify the high rates of caesarean sections in recent decades. Thus, the discourse of normal childbirth is perceived as an ideal that moves away from the real[19-21].

The doctor's responsibility for the decision on the birth route confirms the current obstetric model, characterized by the women's low participation and by the care practices in which the physician drives the parturition process. The physician is considered to possess privileged formation and to be able to "help" the mother in the decision process during the pregnancy and postpartum cycle, influencing her opinions[19].

Increasing the autonomy of women in this decision-making process is a possibility to cope with the epidemic scenario of unnecessary and unwanted cesarean sections in Brazil. The idea of autonomy means acknowledging the right for them to make their choices and to act freely according to their values. It also refers to the need to provide the capacity to decide on the aspects that influence their life in a responsible and informed way[5]. Autonomy is extremely important in the Brazilian obstetric scenario, being pointed out as one of the objectives[22] in the Humanization Program of Prenatal and Birth Care[3].

In this perspective, the resumption of female prominence in childbirth is necessary and is related to the reformulation in the current care

model for delivery and birth[22]. The Ministry of Health points out that obstetric care needs to be based on the humanization of care, respecting the natural process and avoiding unnecessary interventions[3]. In addition, the decision of the woman in her parturition process is essential for the sake of a humanized and physiological delivery, allowing her to take an active stance and assume her decision-making power during the process[22].

Influences in the pregnant woman's choice of the delivery route

The decision on the delivery route is influenced by multiple factors, some easily identified in discourse, others related in such an intrinsic and intertwined way that it does not permit knowing and outlining each of them in detail[4]. It was evidenced that the pregnant women start from previous experiences to assist in their decision making process on the way of delivery. These women associate their current choice with previously experienced events, especially the delivery route in a previous pregnancy:

> [...] *natural. I dread cesarean section. Ah ... says that women have to stay in bed. All my children were born natural [childbirth], I dread cesarean section.* (P7).

> [...] *I prefer [natural birth]. I've never been operated on and I do not even want to mess with it. All my other births were natural, were very quiet and God willing this one will be too.* (P4).

Previous experiences are important because they determine how the woman experienced the pregnancy period. And they differ between primiparous and multiparous women[7,10-11,13]. In addition, the woman carries along the entire experience gained during her life during the delivery. It is of fundamental importance to know the experiences and the cultural baggage she brings[4]. Women who underwent a cesarean section after vaginal delivery do not wish to have another one because of post-operative pain, scarring and risk of maternal mortality[23]. Therefore, vaginal delivery becomes a priority, in the belief that it is the best way to give birth[11]. The previous experience, however, can interfere positively or negatively, setting expectations for the next delivery; if it was a successful experience, it becomes the woman's desire[19]. Positive memories in women who gave birth at home guaranteed their trust in the birthing process, making them want to repeat the experience[4]. If the experience was negative or traumatic, however, it leaves behind feelings of fear and concerns and can influence the opposite choice on the next occasion[7,19,23].

> *Cesarean section. My first fetus was suffering, the time was running out. The water broke, I had no passage. None, nothing, two centimeters of dilation; then it was taking long, I was worried and it was a cesarean section* [...] *I do not think it will be good to have a natural birth, because nothing's going to come out of here.* (P9).

In nulliparous women, experiences of close or acquainted people may be determinant in choosing the delivery route, not taking into account that pregnancies are unique[11]. Although they sometimes refer to the experiences of other people, it is noticed that they prefer to use relatives' discourse for guidance. From this perspective, it is observed that the cultural influences passed on by the social group they are part of affect the decisions. Thus, it is perceived that the delivery and birth process is seen as a phenomenon that extends beyond giving birth. It receives cultural contributions, especially from the family and close people, and is associated with personal values, beliefs and experiences[13]. Women often bring references from childbirth stories they have heard or experienced close to a family member or friend[4]. In the case under study, most subjects addressed positive experiences associated with rapid recovery in vaginal delivery. Others referred to negative stories associated with cesarean section.

> *I do not want cesarean section. My sister-in-law had one. She was barely getting out of bed, her belly ached, she needed help all the time.* (P2).

> *Here everyone wants cesarean section, right? Just my grandmother does not. My mother, my aunt, everyone. My mother even said that if I wanted to do it naturally it's possible, but I do not want not to.* (P5).

> *Oh, my mother, my mother-in-law, my grandmother, all talked about the recovery, right? Which is better. All of them had natural birth, and they told me to try it.* (P11).

The interactions that take place in the family environment modulate the feelings and help in the interpretation and the meanings the women carry during the pregnancy. This is because it is in the family that one first learns to perceive the world and be part of it, being an important element in the ethical and moral values of the woman and, consequently, in her choices[13]. In addition, there is a relation between how the woman was born and how she will give birth[4]. Therefore, it is clear that the experiences of women belonging to their family group, especially the mother, and of other subjects, in addition to previous experiences in multiparous women, influence the pregnant women's decision making.

Some feelings and sensations were also perceived as influencers in the decision-making process of pregnant women. These include pain, fear and insecurity. The women can perceive these sensations in different ways, so that their intensity varies according to the threshold of each, the degree of relaxation, environment, support received during labor, whether from the professional or her companion, preparation during prenatal care and others[1,20]. Fear of pain related to vaginal delivery is indicated as an obstacle for the choice of this delivery route[10,12-13,21]. At times, surgical delivery is seen as a solution for the pain, making it advantageous. The pain of vaginal delivery is understood as unnecessary suffering, not as part of the physiological process. In cesarean section, on the other hand, pain can easily be avoided by anesthesia during delivery and by analgesics afterwards[19,21].

> *Because I'm so afraid of natural birth. Not fear, it's dread really* [...] *Fear of everything. Fear of pain, fear of suffering really, of staying there suffering. In short: it is fear. In fact, I'm afraid of both, but you need to do one* [...] *I always wanted cesarean section. I'm less afraid, the pain is less, there is medication to help.* (P5).

The pregnant women did not mention, in any of the statements, the use of non-pharmacological methods for pain relief, such as relaxation techniques, freedom of positioning, walking and presence of a companion. This implies that the quality of care offered[17] may also influence the fear of natural birth. Some obstetric practices commonly used during labor, such as episiotomy, episiorrhaphy, oxytocin misuse and bed restriction, are able to amplify pain and are unnecessary in most cases[12].

Pain is recognized in many cultures as an inherent event in the parturition process. When associated with suffering, however, it distances the delivery from its natural and physiological nature and can be considered as one of the motivating factors for the increase of cesarean sections in the country[12,21].

Fear was also present in the discourse of pregnant women who chose the cesarean delivery method though. These feelings are mainly related to recovery during the postpartum and to the risks associated with a surgical procedure, which corroborates the findings in another study[19]. This indicates that fear is a common feeling among pregnant women and influences, in different ways, the decision as to the type of delivery, be it vaginal or cesarean.

> *I'm really scared of the C-section, right? Of the anesthesia, the pain you feel afterwards. I prefer the natural birth.* (P6).

> *I dread cesarean section. The way the women get after leaving the birth room, right? I do not want to.* (P7).

Feelings of insecurity related to the evolution of vaginal delivery and to medical care were observed, especially in pregnant women who opted for cesarean section, leading them to choose elective cesarean section, a fact that can be decisive when combined with cultural and social issues[13]. Feelings like this lead one to think that there is a lack of conversations about labor with the professionals responsible for prenatal care, in view of a trend towards greater insecurity when it comes to an unknown subject. In some statements, it is noted that the influence of the suffering is also related to the delay in labor, generating a diversity of bad feelings and sensations about the evolution of labor.

Therefore, women's continuous lack of knowledge about the physiology of parturition and the importance of uterine contractions for maternal and fetal well-being is highlighted[19]. This deficiency needs to be corrected in the pregnant woman's monitoring. The fear

generated by the ignorance of how the delivery will evolve and the impossibility of control over the situation influences this woman's decision, as she believes that the delay in labor can cause harm to the baby. This understanding reinforces the unpreparedness to go through the moment[13].

Finally, the convenience of planning and scheduling surgical delivery also influenced the pregnant women's decisions. Sometimes, it increases the possibility of being assisted by a known professional and safety for mother and child binomial[7].

Guidance on the type of delivery in prenatal care

Some women's expectations of childbirth result from a combination of factors related to knowledge about the pregnancy-puerperal period. In this sense, the information and guidance received during prenatal care plays a fundamental role. There are several types of activities that can be used for this purpose during care. These moments prepare the woman physical and psychologically and also promote the exchange of knowledge and interaction among the health professional, the pregnant woman and the family, and may also minimize anxieties and fears in relation to childbirth and the pregnancy period[11].

The results of this study showed that the pregnant women did not receive or received few guidelines regarding the types of delivery and their characteristics. This issue was covered superficially during the consultations and the women did not ask further questions either. Perhaps due to the existence of common-sense knowledge, which is able to satisfy, or there is such a degree of impropriety that the woman does not consider this matter important within her decision-making power. In only one discourse, the interviewee affirmed that she had received guidance on the delivery route, but it was clearly incomplete. Being women in the third term, the lack of information on these aspects emerged as a cause for concern, as childbirth was approaching and reflection was due.

> *The doctors here at the service asked me which birth I wanted. He did not explain much, but he asked.* (P1).

> *No. They did not discuss anything with me at all, but I did not ask either.* (P12).

> *My doctor always talked to me that natural birth is better. She explained these things there, the thing about the baby breathing better when it is natural.* (P14).

Another study had already found little reference to information about the delivery routes[7]. When information is provided, this occurs in a limiting way, without permitting reflections, questions and discussion on the subject[21]. One can think that this type of information does not provide for the clarification of doubts and is not effective for the woman to experience pregnancy and delivery with safety and empowerment.

The Ministry of Health[3] recommends that prenatal care should associate individual and group education activities, favoring the preparation for childbirth and postpartum, clarifying doubts and allowing the woman to choose the best type of delivery and the exercise of her autonomy. Three pregnant women appointed the educational groups as important means of information for the woman about the pregnancy, the delivery and the postpartum. They are related to feelings of satisfaction and serve as a means of bringing the new practices and methods established by the Ministry of Health in care for vaginal delivery to the pregnant women.

> *There was the woman from the group who talked to us. She said there in a group that happened, that natural birth is better, for us, for my baby. She said that it is better for everything* [...] *She talks about pregnancy with us and talked about this. It's pretty cool. People who are young like this* [...] *learn some things.* (P1).

> *It's because, in the group of pregnant women that the girls do, they said it. There at the service. They told me that recovery is faster [natural delivery], the baby can be born healthier. Talk about delivery, breastfeeding for me and the baby, breastfeeding* [...] *I like it, it's important, right? We learn some things, there are other women too, and it's important for us to know these things. I like it a lot!* (P11).

> *There in the group, they say it there, when we arrive, you know? There's a meeting and they say it. They explain how the delivery happens, they said there's a ball to sit on and that the delivery gets easier. Those things* [...] *That we can choose what delivery we want, they said lots of things, that it's better for the baby and for us to have natural birth* [...] *It's good. We find out about some new things, which they don't say during the consult. I didn't even know these ball things, right miss? I found out there.* (P13).

The obstetric care model leaves gaps. One of them is related to the appropriate guidelines on the whole process. This type of failure generates doubts, insecurities and dissatisfaction among pregnant women and their families. Therefore, bonding and communication are needed between the pregnant woman and the health professionals[21].

Nurses consider that health education activities are essential for the achievement of women's autonomy, and that actions based on listening, dialogue and counseling facilitate women's better understanding in the pregnancy-postpartum period. Thus, it should be emphasized that this professional category needs to use the workplace and orientation strategies to provide comprehensive and humanized prenatal care, considering the woman as an active subject of the process.

Conclusion

These study results point to the diversity of aspects that permeate the woman's decision about the type of delivery. The pregnant woman, in turn, inserted in a social context, has values, feelings, beliefs and experiences that intermingle to shape her representations and decisions about the birthing process. Therefore, they show the complexity of the decision-making process on the delivery route during pregnancy. It is clear that no single aspect, but a series of inseparable factors influence this choice. Analyzed separately, these might not be able to influence the decision.

The experiences of relatives, close people and the pregnant woman herself, as well as feelings and sensations experienced, and prenatal care received during the process were some of the aspects found and discussed in this study as influences in the woman's decision. It is emphasized, however, that there is a range of other factors that may also be associated with the choice of the birth route. Given the limitations of the method chosen, the collection instrument and the analysis method, however, these were not identified. Particularly in view of the possibility of finding complementary results, the need to further investigate the particularities related to the choice process during pregnancy and labor itself is reinforced.

It is important to note that the preferential route of delivery was vaginal, contradicting the high cesarean rates recorded in Brazil. This fact arouses reflections on studies that get deeper into the subject decision and autonomous power of women in view of the choices throughout the pregnancy-postpartum process, including the pregnancy, birth and maternal care. Even though it is not the focus of this study, the results lead one to think that the interference of the health professional in the delivery route does not occur during prenatal care in most cases, but it is crucial at the moment of giving birth.

In a scenario that evidenced the ineffectiveness of the preparation form for childbirth, it is timely and necessary that nurses working in prenatal care assume their role with quality, a responsibility already established and reinforced by protocols and official documents. Given the dynamism and capacity of the nurse, it is possible to improve prenatal care, as well as the related indicators, besides enabling and promoting women's autonomy and role during the period.

Therefore, the results are expected to provide reflections among the FHS professionals about the gaps in prenatal care, enabling them to provide qualified care.

Collaborations:

1. conception, design, analysis and interpretation of data: Andressa Paula de Castro Martins and Camila Mendes dos Passos;

2. writing of the article and relevant critical review of the intellectual content: Andressa Paula de Castro Martins, Mariana Véo Nery de Jesus, Pedro Paulo do Prado Júnior and Camila Mendes dos Passos;

3. final approval of the version to be published: Andressa Paula de Castro Martins, Mariana Véo Nery de Jesus, Pedro Paulo do Prado Júnior and Camila Mendes dos Passos.

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