







Original article

## Women's choice of birth method: autonomy or imposition?

Escolha da via de nascimento pela mulher: autonomia ou imposição?

*La elección del método de parto por parte de la mujer: ¿autonomía o imposición?*

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### Abstract

**Objective:** To describe women's knowledge, experiences, and expectations regarding birth methods, in order to verify whether they represent feminine choices or professional impositions. **Method:** A qualitative, descriptive, and exploratory study was conducted with 14 women from a municipality in the Western Border region of Rio Grande do Sul, between February and June 2022, using semi-structured interviews. Participants were interviewed on two occasions, during pregnancy and after the birth of their babies. The data were subjected to thematic content analysis. **Results:** most of the women showed a preference for vaginal delivery. However, it was observed that, after the experience of giving birth, many reported that the choice of delivery method had been imposed, with their wishes not taken into consideration. **Conclusion:** It was found that women do not have autonomy in decision-making, nor can they discuss what they consider best for themselves and their babies.

**Descriptors:** Women; Natural childbirth; Cesarean section; Personal autonomy; Physician-patient relation

### Resumo

**Objetivo:** descrever os conhecimentos, as experiências e as expectativas de mulheres em relação às vias de nascimento, a fim de verificar se representam escolhas femininas ou imposições profissionais. **Método:** estudo qualitativo, descritivo e exploratório, desenvolvido com 14 mulheres de um município da Fronteira Oeste do Rio Grande do Sul, entre fevereiro e junho de 2022, por meio de entrevistas semiestruturadas. As participantes foram entrevistadas em duas ocasiões, durante a gestação e após o nascimento do bebê. Os dados foram submetidos à análise de conteúdo temática. **Resultados:** a maioria das mulheres demonstrou preferência pelo parto vaginal. No entanto, foi observado que, após a experiência da parturição, muitas relataram que a escolha da via de nascimento foi imposta, sem que seus desejos fossem

levados em consideração. **Conclusão:** constatou-se que as mulheres não têm autonomia para tomada de decisão, tampouco podem dialogar sobre o que consideram melhor para si e para seus bebês.

**Descritores:** Mulheres; Parto normal; Cesárea; Autonomia pessoal; Relações médico-paciente

## Resumen

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**Objetivo:** Describir los conocimientos, experiencias y expectativas de las mujeres respecto a los métodos de parto, para verificar si representan elecciones femeninas o imposiciones profesionales. **Método:** Se realizó un estudio cualitativo, descriptivo y exploratorio con 14 mujeres de un municipio de la región fronteriza oeste de Rio Grande do Sul, entre febrero y junio de 2022, mediante entrevistas semiestructuradas. Las participantes fueron entrevistadas en dos ocasiones: durante el embarazo y después del nacimiento de su bebé. Los datos se sometieron a un análisis de contenido temático. **Resultados:** La mayoría de las mujeres expresaron su preferencia por el parto vaginal. Sin embargo, se observó que, tras la experiencia del parto, muchas contaron que la elección del método de parto fue impuesta, sin que se tomaran en cuenta sus deseos. **Conclusión:** Se constató que las mujeres no tienen autonomía en la toma de decisiones ni pueden hablar sobre lo que consideran mejor para ellas y sus bebés.

**Descriptorios:** Mujeres; Parto normal; Cesárea; Autonomía personal; Relaciones médico-paciente

## Introduction

Over the past few decades, the healthcare model has undergone reformulations, which have also affected women's healthcare during the pregnancy and postpartum period. In this context, birth has gone from a natural event, carried out within the family and with the assistance of midwives, to a hospital-based and medicalized practice, marked by an epidemic of cesarean sections.<sup>1</sup>

The objective of delivery care is to ensure that both the woman and the newborn remain safe and healthy. Vaginal delivery, being a physiological event, is beneficial for both mother and baby, and is the recommended method of delivery for women with low-risk pregnancies as well as for those with high-risk pregnancies, provided they receive appropriate care.<sup>2</sup>

However, from a capitalist perspective, cesarean section has become an idealized procedure because it is relatively quick and generates high productivity and greater profit for institutions and healthcare professionals. As a result, some healthcare providers influence women in their choice, claiming it to be the pregnant woman's own wish.<sup>1</sup>

Lack of knowledge about the physiology of delivery makes women vulnerable to external influences. Consequently, they assume a passive role, and the birth

process becomes centered on the healthcare professional, who often conducts the experience through unnecessary and harmful interventions.<sup>3</sup> Thus, it is considered that, in addition to the need to reduce cesarean rates without real indications, it is necessary to rethink the model of care for delivery and birth, in order to ensure the preferences and choices of pregnant women.<sup>4</sup>

It is important to highlight that cesarean rates remain at high levels in Brazil. According to the Live Birth Information System, there has been a rise in cesarean rates nationwide, reaching 59.5% in 2023.<sup>6</sup> This information was confirmed by preliminary data from the Born in Brazil II Survey, which indicates rates above 50% in the country.<sup>7</sup> Although the global trend also suggests an increase, with projections of reaching nearly one-third of births by 2030 in international contexts, Brazil is already among the countries with the highest cesarean rates, reinforcing the urgency of understanding the determinants of this method of birth.<sup>8</sup>

Cesarean section is recognized as contributing to the reduction of maternal and neonatal deaths by ensuring effective intervention in situations of imminent risk, constituting a vital measure in specific and clinically indicated circumstances. However, it is a major surgery and should therefore be performed only when the risks of vaginal delivery outweigh its benefits. When performed without proper indication, cesarean section may be associated with short- and long-term negative outcomes for the mother–baby dyad.<sup>8–9</sup> Furthermore, in some cases, choosing a cesarean section without a real indication may compromise women’s protagonism and autonomy, resulting in negative birth experiences and increased unnecessary interventions.

This study is justified by the need to deepen the understanding of the subjective, cultural, and institutional dimensions that permeate the choice of method of birth. Despite advances in public policies for the humanization of delivery, many women still have their decisions influenced by power asymmetries in the professional–pregnant woman relationship. Understanding how women’s knowledge, expectations, and experiences affect this process is essential to support strategies for health education, female empowerment, and the improvement of obstetric care. Additionally, the results of this study may contribute to critical

reflection on the hegemonic model of delivery care, fostering safer, more humanized, and woman-centered practices, in line with the guidelines of the Unified Health System. Thus, the objective was to describe women's knowledge, experiences, and expectations regarding methods of birth, in order to determine whether they represent women's choices or professional impositions.

## **Method**

This is a qualitative, descriptive, and exploratory study.<sup>10</sup> The Consolidated Criteria for Reporting Qualitative Research (COREQ) criteria were used to guide the writing of the research.

The research was conducted in the municipality of Uruguaiiana, located on the Western Border of Rio Grande do Sul, between February and June 2022. This municipality has approximately 117,210 inhabitants with 17 Family Health Strategies (FHS) units.

Pregnant women with usual risk pregnancies, with a gestational age equal to or greater than 32 weeks, who were receiving prenatal care at any FHS in the municipality, regardless of parity, were included. The justification for including pregnant women from 32 weeks onwards was based on the attempt to capture participants who had experienced most of their prenatal care and formed their expectations about the birth methods. The inclusion of first-time mothers was intentional, since, in addition to their lived experiences, the study sought to analyze knowledge and expectations about birth methods, socially constructed throughout the pregnancy-puerperium cycle. No exclusion criteria were used, since the qualitative design adopted sought to encompass the heterogeneity of maternal experiences, allowing for the capture of different subjective constructions about the process of choosing the birth method.

For the operationalization of data collection, the researcher asked the Family Health Strategy (FHS) nurses for access to the data of pregnant women undergoing prenatal care. Afterwards, two pregnant women from each FHS unit in the municipality were conveniently selected and invited via WhatsApp® to participate in the study. This invitation presented the theme and the objective of the research.

Upon agreeing to participate, a date and time for the interviews were scheduled according to the participant's availability.

Data collection was carried out in two stages through individual semi-structured interviews, with both open and closed questions. It is noteworthy that no pilot tests were conducted and that the main researcher had received prior training for the development of the data collection.

In the first stage, participants were interviewed during pregnancy. Initially, sociodemographic and obstetric data were collected. Then, a semi-structured interview was conducted, guided by the triggering question: "Before starting prenatal care, what did you know about vaginal delivery and cesarean section?" Eight complementary questions were included to deepen previous knowledge, sources of information, planning, and expectations regarding the methods of birth.

The second stage took place until the 15<sup>th</sup> day postpartum, respecting the initial postpartum recovery period. In this phase, the aim was to understand the experiences lived during the baby's birth, using the following question as a starting point: "How was the experience of your baby's birth for you?" The interview included ten additional questions, adapted according to the method of birth (vaginal or cesarean section), investigating the presence of a companion, care procedures, autonomy in decision-making, and situations of disrespect or perceived obstetric violence.

In the first stage of data collection, the focus was to investigate pregnant women's knowledge and expectations regarding the methods of birth. In the second stage, the experiences actually lived during birth and the postpartum period were explored.

Both stages took place via conventional audio call through the WhatsApp® social network or via video call on the Google Meet® platform, according to the participant's preference. The data production process was audio-recorded upon authorization and lasted a mean of 30 minutes. The main researcher, who had experience with interviewing techniques, conducted data collection.

Fifty-five (55) pregnant women were invited. However, 14 formally declined and 27 did not return the researcher's contact, despite two attempts with each of them. Thus, the study included 14 participants, who underwent prenatal care in ten different FHS units in the municipality. Recruitment of new participants was concluded once the data saturation criterion was reached.<sup>10</sup>

The interviews were fully transcribed and subjected to thematic content analysis.<sup>10</sup> During the pre-analysis stage the interviews were transcribed into Microsoft Word® to use available tools to highlight words with text color and shading for significant terms and/or expressions. From this, it was possible to organize the corpus. The material was then explored, leading to the identification of 70 recording units (significant excerpts from participants' statements), which were later grouped into 21 initial meaning units. From these, through semantic approximation and convergence of meaning, seven provisional meaning nuclei were formed. After successive re-readings and analytical refinement, the nuclei were condensed, resulting in three final thematic categories. Finally, the results obtained were processed and interpreted based on theoretical frameworks in the field of obstetrics.

The Ethics Committee of the Educational Institution under opinion number 5.071.694, dated October 29, 2021, approved the research project. It complies with the ethical principles established by Resolutions. 466/2012, number 510/2016, and number 580/2018 of the Ministry of Health. For anonymity purposes, participants were identified by the letter P for "Participant," followed by a number. All participants signed the Informed Consent Form (ICF).

## **Results**

The characterization of the participants regarding social characteristics and obstetric profile is shown in Box 1.

**Box 1** – Categorization of participants. Uruguaiiana, 2022

Codename	Age (years)	Color / race	Marital status	Education	Occupation	Who do you live with?	Obstetric profile
P1	28	W	CLM	CHS	Housewife	Partner and children	PRG4 P2 CS1 A0
P2	22	W	S	CHS	Housewife	Alone	PRG1 P0 CS0 A0
P3	26	W	S	IHE	Student	Partner	PRG1 VD0 CS0 A0
P4	31	W	CLM	CHE	Veterinarian	Partner and mother	PRG1 VD0 CS0 A0
P5	31	B	M	IHE	Student	Partner	PRG2 VD0 CS1 A0
P6	25	W	CLM	CHS	Self-employed worker	Partner and daughter	PRG2 VD0 CS1 A0
P7	27	W	M	CHE	Self-employed worker	Partner	PRG2 VD0 CS0 A1
P8	35	W	S	CHE	Nutritionist	Partner and son	PRG4 VD0 CS1 A2
P9	34	B	S	CHS	Housewife	Grandmother and partner	PRG1 VD0 CS0 A0
P10	34	B	S	IES	Housewife	Sister, brother-in-law, nephew and partner	PRG2 VD1 CS0 A0
P11	34	W	M	IHS	Housewife	Partner and daughter	PRG3 VD1 CS0 A1
P12	19	W	CLM	IHS	Student	Partner and brother	PRG1 VD0 CS0 A0
P13	20	W	CLM	CHE	Housewife	Partner and mother	PRG1 VD0 CS0 A0
P14	23	W	CLM	IHE	Trainee	Partner	PRG1 VD0 CS0 A0

Legend: Race/color W - white; B - brown. Marital status: M - married; S - single; CLM - common-law marriage. Education: IES - incomplete elementary school; IHS - incomplete high school; CHS - complete high school; CHE - complete higher education; IHE - incomplete higher education. Obstetric profile: PRG - number of pregnancies; VG - number of vaginal deliveries; CS - number of cesarean sections; A - number of abortions.

In the first stage, the women were between 32 weeks and 39 weeks and six days pregnant. Only six participants planned their pregnancies. However, all of them came to desire them after discovering they were pregnant. In the second stage of the research, it

was found that of the ten pregnant women who preferred vaginal delivery, five underwent this method of birth and five underwent cesarean section. Among the four participants who preferred cesarean section, one had a vaginal delivery and the others had cesarean sections. It is observed that all women with a previous cesarean section again had births via surgery.

Through the analysis, three categories emerged: *"I heard that"*: pregnant women's knowledge about the methods of birth; *"It's very relative"*: pregnant women's expectations about the birth of the baby; and Women's experiences with delivery and cesarean section: from the denial of autonomy to practices of obstetric violence.

#### *"I heard that"*: pregnant women's knowledge about birth methods

The pregnant women mentioned the benefits and risks of birth methods. Regarding vaginal delivery, they indicated rapid postpartum recovery, improved breathing of the baby after birth, increased immunity, and early contact between mother and baby. They mentioned risks involving fainting, lack of strength during the expulsive phase, heart problems, hemorrhages, lack of dilation, episiotomy, and the Kristeller maneuver. For the baby, they considered that vaginal delivery could lead to fetal distress and neonatal death.

*Natural delivery, I think, has several benefits, even for the child; you can have contact much faster. (P3).*

*Natural delivery is better for both the woman and the child [...] Recovery is better. (P8).*

*I think natural delivery helps in the development of the baby's body. (P12).*

*The risk in delivery is that if the woman doesn't dilate, the baby won't be born and could die. (P5).*

*One of the risks of delivery is not having the strength to push the baby out or fainting. (P2).*

*The risk of natural delivery is having to push too hard and fainting, or having heart problems. (P10).*

*There are some natural deliveries that involve episiotomy, and this cut greatly alters the woman's body. I think that is one of the risks, because it cannot happen, not even pushing the woman's belly for the baby to be born. (P14).*

Regarding cesarean sections, the women indicated that it is a painless procedure that could save the lives of the mother and/or baby if vaginal delivery were not possible. However, they stated that cesarean sections could involve risks of infection, suture rupture, postoperative pain, delayed breast milk production, the need for assistance

with newborn care, and fear of anesthesia. For the baby, there may be a risk of premature birth and delayed contact between mother and baby.

*In a cesarean section, the mother doesn't feel pain [...] I believe it's less traumatic for the woman. (P4).*

*I believe that a cesarean section serves to save the life of the baby or the mother, because if it didn't have benefits it wouldn't exist [...], but it's riskier because it's surgery. I know that it interferes with the woman's entire gynecological life afterward and reduces the chances of the woman having a normal delivery in future pregnancies. (P7).*

*The post-cesarean period is bad, there's a lot of pain. (P5).*

*They say the anesthesia is bad after a cesarean section, I'm afraid. (P2).*

*In a cesarean section, recovery is slower, the milk may take longer to come in, the woman needs to take better care of herself because of the incision and can't take care of the baby alone in the first few days. (P8).*

*You have to be careful after a cesarean section because of the infection that can occur, or rupture of the stitches. (P10).*

Some participants indicated that they received information during prenatal consultations from primary health care professionals, in which they were instructed on the characteristics of birth routes and on recovery.

*They talked about the risk of me having a vaginal delivery after having a cesarean section, that it could rupture the uterus during delivery. (P1).*

*I am quite afraid of delivery, I thought about having a cesarean section and asked about the recovery, but they told me that normal delivery is healthier for me and the baby. (P12).*

Birth routes were also a topic discussed in interpersonal relationships. Women stated they talked about the subject with their partners, family, and friends, sharing their fears and doubts.

*I talk a lot with my mother and my boss, because they already have children. [...] I ask, "Oh, is it very painful?", "What does it feel like?" But they said that each body reacts in a different way, that just as my mother felt pain, I may not feel it. My sister says that during a cesarean section you don't feel anything because you're under anesthesia, but that afterwards you start to feel the pain in your stomach and the stitches pulling. (P3).*

*I talk to my mother and my mother-in-law. I tell them that I wanted to have a cesarean section, but I have to wait, we are looking into the possibility of having a cesarean section outside the clinic, but I can't afford it. (P4).*

*My husband asked if I wanted a natural delivery or a cesarean section, I told him that I prefer natural and he said that's great, that it's better for me, for me to recover better and take care of the baby. I talk to him because he is part of this process, it is our decision. (P9).*

In short, it was observed that the participants demonstrated knowledge about birth methods based primarily on the experiences of others and information from family and social life, in addition to specific guidance received during prenatal care. This knowledge included both benefits and risks attributed to vaginal delivery and cesarean section, although, in some cases, it was associated with inaccurate or incomplete information.

*"It's very relative":* Expectations of pregnant women about the birth of their baby

Ten participants stated a preference for vaginal delivery. They justified this by saying that this method of birth allows for faster recovery and has benefits related to the baby. The four participants who expressed a preference for cesarean section explained that they did not want to go through the pain and suffering of labor. They also reported fear of delivery.

*I want a cesarean section because I already know what it's like and because I don't have much information about delivery [...] nowadays, those who have a doula are the ones who benefit from having a normal delivery [...] I'm sad to know that there's no one available to do this through the public health system (SUS). (P6).*

*If the physician says I need a cesarean section, I want to understand [...]. But I intend to go there and say that I prefer a normal delivery, that I prefer not to be on an oxytocin drip, because I want to wait for it to progress naturally [...] I just hope the physician does what's right for me. (P7).*

*I think the greatest fear of a pregnant woman isn't even the delivery itself, but the person who is there performing the delivery—especially in the public health system (SUS), where you don't know who the medical team will be or whether they will perform any unnecessary intervention [...]. I would like them to consider my preferences; I am going to say that I want to try for a vaginal delivery. (P13).*

*I want a cesarean section because I think it would be less painful. (P3).*

It was found that, for some, the choice of birth method was linked to previous experiences related to labor and/or delivery, as well as the advantage of choosing the date of birth.

*I wanted a cesarean section because I'm tired, I don't want that pain and suffering again [...] the physician used oxytocin because I didn't have enough contractions and performed an episiotomy. It was very traumatic. (P11).*

*I want a cesarean section. Because I suffered a lot during the delivery of my first daughter and I'm afraid of suffering again [...] I also intend to schedule the cesarean section because I'm alone with my daughter in the city, my husband lives in another city, so I need to know the birth date so he can come and stay with me. (P5).*

When asked about discussing their preferred method of delivery with the healthcare professionals providing them with prenatal care, they stated that they would not bring it up because, since they would be admitted through the Brazilian public healthcare system (SUS), they felt their wishes would not affect the outcome.

*When I go to have my baby, if it's not the physician who does my prenatal care who's on duty, he won't be the one to deliver my baby, so it's a stalemate, because I depend on others, that's how it works in the SUS (Brazilian public healthcare system) (P4).*

*It's very relative, since it's through the SUS, if I go there now and say I want a cesarean section and they don't want to, I know they won't do it. (P11).*

*I didn't say anything because when I go to prenatal appointments it's very quick, they don't have time to sit down and talk, they just look at my exams and that's it (P13).*

*Through the SUS it depends a lot on who the physician is, because I know they give preference to those who are paying, so whether I say anything or not, it won't change anything (P14).*

In general, pregnant women's expectations regarding delivery were influenced by fears, previous experiences, and access to healthcare services. Most expressed a preference for vaginal delivery during pregnancy, although they also expressed insecurities about the care received and little confidence that their choices would be respected during delivery.

Women's experiences with vaginal delivery and cesarean section: from the denial of autonomy to practices of obstetric violence

Pregnant women who only had the SUS (Brazilian public healthcare system) as health insurance were not asked about their preferred method of delivery. All women in labor had a companion of their choice during the birth of their baby.

*Nobody asked anything, they just said that if a cesarean section was needed they would do it, but since everything was going well it was supposed to be a normal delivery. (P2).*

*The physician saw that she was head down, then said it was going to be a normal delivery. Nobody asked what I preferred. (P9).*

*Nobody asked my opinion. The physician was even going to wait for a normal delivery, but when she saw the fluid with meconium, she took me straight to a cesarean section. (P4).*

*Nobody gave me a choice, especially since I wanted a normal delivery, so if they had given me the option to try for a normal delivery I would have tried. (P8).*

*The private physician even gave me the option of a normal delivery, but she said that inducing labor wouldn't help because it would be past the due date and that the best option would be a cesarean section. (P3).*

One of the participants, who underwent a cesarean section, reported being offended by a physician. According to her, this professional advised her to wait at home until labor began, but she was worried due to the lack of fetal movement. The participants' testimonies reveal instances of obstetric violence, including the Kristeller maneuver, directed pushing, and induction of labor without the woman's prior consent.

*When I was in the cesarean room, the physician came in, saw me, and yelled at me, saying that she had told me to wait for a normal delivery at home, that I had no business having a cesarean section. In the room after the cesarean, she came in and mocked me again [...] during the cesarean section, the physician asked the anesthesiologist to push on my belly, I felt very uncomfortable. (P14).*

*What bothered me the most was the directed pushing. When I was there on the stretcher and the physician kept telling me to push, I knew when to push, I didn't need him to tell me. (P7).*

*The on-call physician tried to force me to have a normal delivery, using oxytocin, but she didn't ask if I wanted induction. At that moment, I preferred a cesarean section to inducing labor. (P13).*

When questioned about their experiences and opinions regarding birth, the women mentioned the benefits of vaginal delivery. It is noteworthy that the participants who experienced vaginal delivery did not have an episiotomy, were able to move around during labor, and none used non-pharmacological methods for pain relief.

*I think most of the stories we hear about bad things regarding delivery are due to a lack of information, and that's something prenatal care can help with; information will be the game-changer. (P7).*

*Delivery is wonderful. My first delivery was difficult, [...] and that made me nervous for my second delivery. That's why, before, I wanted my baby to be born via cesarean section, but I'm grateful that he was born via vaginal delivery; it helped me overcome past traumas. It was a peaceful delivery. I think that because I stayed home for the whole process, it helped it be faster and less painful. It was pleasurable to give birth to my son. (P11).*

*Cesarean section is a beneficial procedure when necessary. I think people need to stop romanticizing cesarean sections, saying that women don't feel pain, because we do feel pain and have several limitations after a cesarean section, in addition to all the risks. (P8).*

Among the participants who had a cesarean section, four mentioned that the team indicated this delivery method due to lack of dilation. For the other participants, the following indications were mentioned: amniotic fluid with the presence of meconium, previous cesarean section, and macrosomic baby. In the latter case, the baby's weight was assessed by obstetric ultrasound. However, at birth, the child weighed 3375 grams.

Furthermore, the women reported postoperative complications such as: suture dehiscence, vomiting due to anesthesia, abdominal and uterine pain due to the Kristeller maneuver, delayed milk let-down, and a drop in blood pressure.

*I thought pushing on a woman's belly only happened during normal delivery. I had a lot of abdominal pain due to the procedure. (P14).*

*When I was at home, 10 days post-surgery, the cesarean incision opened a little; it's healing now, but the outer layer of skin remained open for a few days. (P8).*

*The post-operative period was quite bad; I had a lot of low blood pressure. (P3).*

*I wish someone had told me that it takes a while for milk to come in after a cesarean section, because mine did. (P1).*

*I didn't know I could feel so bad during the cesarean section and post-surgery; I felt unwell, vomited a lot, and the stitches hurt when I vomited. (P4).*

In the set of experiences reported, it was found that the method of delivery was frequently determined by the healthcare team without dialogue or shared decision-making. Participants reported situations of professional imposition, lack of clarity about procedures, and episodes of obstetric violence during vaginal deliveries and cesarean sections, as well as postpartum complications that affected maternal well-being.

## **Discussion**

It was observed that, although most pregnant women (n=13) began prenatal care early, nine participants did not receive any type of guidance on delivery and birth during their prenatal consultations. Among the participants who did receive information, it appears that this guidance was superficial, focusing primarily on the woman's quick recovery after a vaginal delivery, since it is a less invasive and healthier process for both mother and baby. However, this information did not include specific points about the physiology and stages of labor and delivery.

It is considered that prenatal care is a moment when women should be prepared for the birth process, receiving guidance related to physiological aspects, as well as the risks and benefits of the different methods of delivery. Such guidance is believed to reduce anxiety and fear surrounding this experience.<sup>11-12</sup> However, it was found that the professionals who accompanied the study participants during prenatal care did not adopt these practices.

Thus, it is necessary to reflect that the training of professionals working in Primary Health Care (PHC) may affect the delivery of guidance during prenatal monitoring. It is noted that professionals working in PHC have generalist training and do not always possess in-depth knowledge about the pregnancy and postpartum periods.<sup>13</sup>

From the testimonies, it is possible to see that the pregnant women demonstrated knowledge about the methods of delivery, recognizing both the benefits and risks associated with vaginal delivery and cesarean section. Their preference for vaginal delivery—often based on considerations related to recovery and the positive effects for the baby—contrasts with the perception that cesarean section, although a safe alternative in high-risk situations, brings additional postoperative challenges. Furthermore, the testimonies reveal that sharing experiences and information with family members, friends, and health professionals was essential for them to form their opinions and make informed decisions about the method of birth.

The participants indicated that vaginal delivery enables rapid recovery of the maternal body. They mentioned that this method of delivery contributes to the baby's breathing, increases immunity, and promotes early mother-child contact.

The benefits of vaginal delivery include faster maternal recovery, with lower rates of hemorrhage, puerperal infection, and pain when compared to cesarean section. Moreover, vaginal delivery contributes to shorter hospital stays and lower prematurity rates. Women who experience vaginal delivery also tend to have faster milk let-down, showing greater ease in initiating and maintaining breastfeeding.<sup>13-15</sup> It is also worth noting that vaginal delivery generates lower costs for the health system compared with cesarean section. Although surgical delivery is indispensable when clinically indicated, its indiscriminate use has been associated with increased short- and long-term maternal and neonatal complications, a higher risk of chronic and immunological diseases in childhood, and significantly higher costs for health systems.<sup>16-17</sup>

Most of the participants' knowledge about delivery was linked to the risks associated with this method of birth. They mentioned that delivery could lead to cardiac problems, hemorrhage, and interventions such as episiotomy and the Kristeller maneuver. Regarding the first association, it is important to highlight that there are no studies proving a link between vaginal delivery and the development of cardiac problems.

Authors state that vaginal delivery may pose a risk of hemorrhage when interventions such as episiotomy or vaginal trauma occur. In contrast, cesarean section may lead to the need for blood transfusions and hysterectomy. Therefore, there is a recognized need for studies that associate the risk of hemorrhage with the method of birth.<sup>18-19</sup>

With respect to episiotomy and the Kristeller maneuver, although they are routinely performed in many institutions, they are contraindicated interventions. It is important to note that these procedures offer no benefits to maternal or infant health.<sup>18</sup>

Additionally, the participants believed that vaginal delivery is associated with a higher risk of fetal death. However, it is worth mentioning that fetal well-being must be assessed throughout the entire labor and delivery process. Therefore, there is no scientific evidence linking vaginal delivery to the risk of fetal death, as long as monitoring is carried out appropriately during labor and, when alterations are detected, interventions are performed to avoid fetal distress and intrauterine fetal death.<sup>18</sup>

Women who demonstrated knowledge about the methods of birth indicated that their information came from people in their family and/or social circles. However, many of these pieces of information proved to be inaccurate, especially those related to the risks of vaginal delivery. Thus, it is recognized that these individuals may influence women's preferences and decisions. Nevertheless, it is important to consider that, very often, the knowledge conveyed by the support network is not grounded in scientific evidence.<sup>20-21</sup>

From this perspective, it can be observed that the absence of guidance or the presence of inaccurate information about delivery can generate fear in women. This feeling, in turn, can influence their preference for cesarean section.<sup>2</sup> Therefore, it is understood that health professionals and services must promote the dissemination of information, encouraging discussions on the topic and fostering women's autonomy.<sup>13-14</sup>

Among the various available tools, the delivery plan stands out as an effective resource that can be developed during prenatal care. This instrument helps pregnant women understand the processes involved in delivery and promotes more effective communication with the multiprofessional team at the time of delivery. The delivery plan supports women's decision-making process by allowing them to express their

preferences and expectations regarding the method of birth, strengthening their autonomy and the exercise of informed choices.<sup>22</sup>

Health education associated with the use of educational technologies plays a crucial role, as it contributes to clarifying doubts, reducing anxiety, and empowering pregnant women, ensuring their autonomy and a positive delivery experience.<sup>22</sup> In this context, it is essential that health professionals act as facilitators of this process, encouraging women to take an active role in their delivery experiences and to exercise their rights in a more informed manner.<sup>23</sup>

It is possible to observe a complex panorama of preferences, fears, and perceptions among pregnant women. While many highlight the benefits of vaginal delivery, others express the insecurity and pain associated with this experience, leading them to consider cesarean section as a less painful and more controlled alternative. In addition, the dynamics of care provided by the SUS (Brazilian Public Health System) generate a feeling of powerlessness, revealing that pregnant women feel that their preferences may not be respected.

In the study in question, it was identified that most pregnant women, even demonstrating little knowledge about the benefits of vaginal delivery, preferred this route because they understood it to be a natural and physiological process. Despite the preference for vaginal delivery, manifested during pregnancy, it was found that not all had their choice respected. It is considered that, in some cases, there was medical imposition on the method of delivery, as another study points out, indicating that the obstetrician's discourse redirects pregnant women's choices about their bodies.<sup>24</sup>

Therefore, despite the preference of many women for vaginal delivery, reality often prevails, whether due to a lack of dialogue or the approach of the medical team during delivery assistance, generating negative experiences. The experiences of pain, discomfort, and the feeling of helplessness during cesarean section are contrasted by accounts of vaginal deliveries that, although challenging, were described as positive experiences.

Furthermore, it was found that the choice between cesarean section and vaginal delivery was not a shared decision between professionals and pregnant women. Participants also reported that their preferences for the method of delivery were not

valued. They felt they should not share their wishes with the professionals who assisted them at birth. Research reinforces that, often, women tend to delegate the decision to the obstetrician. This, in turn, can demonstrate imposition regarding the method of birth, disregarding the woman's wishes.<sup>21-22</sup>

It was also observed that among the participants who mentioned a preference for vaginal delivery, fear of pain was a recurring aspect in their statements. However, it is important to remember that labor pain varies for each woman and can be influenced by physiological, psychological, environmental, and cultural factors. Pain may be intensified in situations in which the woman experiences anxiety, insecurity, fear, or helplessness. Other factors that can exacerbate the painful sensation involve a lack of knowledge about the physiology of delivery and the absence of a bond with the healthcare team.<sup>25-26</sup>

Some women reported a preference for cesarean section due to previous traumatic experiences during labor and/or delivery. The choice of cesarean section is generally associated with procedures routinely performed during delivery without scientific evidence to justify them.<sup>26</sup> The choice for cesarean section was related to multiple factors. Among these were the fear of labor pain, concerns about possible maternal or fetal risks, previous traumatic experiences of their own or of people close to them, the desire to maintain control over the birth process, and the lack of knowledge about the risks and benefits of this method of birth.<sup>26</sup>

The participants' statements reveal situations of obstetric violence, including the performance of interventions and medicalized care, verbal or physical aggression, lack of adequate facilities for proper care of pregnant women, and economic, racial, and sociocultural discrimination. It can be inferred that both the medical imposition regarding the method of birth and the violence reported by the women occur due to the prevailing model of obstetric care.

A study conducted in Sweden showed that physical and psychological abuse during delivery is a reality even in contexts with broad healthcare coverage and advanced medical technology, and is recognized by women as a form of obstetric

violence. This violence manifests through experiences marked by a lack of information and consent regarding performed procedures, absence of adequate pain relief, and disrespectful attitudes on the part of professionals.<sup>27</sup>

Professionals—largely physicians—use power relations grounded in biomedical knowledge to impose their will over women's wishes. The women, in turn, submit without resistance to the professionals' decisions, whether out of fear or lack of knowledge.<sup>24,27</sup>

Another aspect highlighted in the findings is that none of the participants reported the use of pharmacological or non-pharmacological methods for pain relief during labor and delivery. It is recognized that such measures increase comfort, promote relaxation, calmness, and body self-awareness, and restore women's autonomy.<sup>28</sup> Lack of knowledge about pain relief methods is common among pregnant women, making it essential to provide adequate information so they can actively participate in decisions regarding their care and pain management during delivery.<sup>28-29</sup>

It is important to emphasize that the reasons given by the participants for undergoing cesarean section do not represent real indications. Therefore, it is necessary to reinforce that performing cesarean section unnecessarily increases the risk of complications for maternal and infant health, and may lead to maternal and neonatal death.<sup>29-30</sup> In the present study, participants who underwent cesarean section reported suture dehiscence, vomiting due to reaction to anesthetics, postoperative pain, difficulty breastfeeding, and fluctuating blood pressure. In this sense, it is necessary to consider that, in situations of risk to the life of the mother and/or fetus, cesarean section represents a fundamental resource. In addition, it can and should be an alternative for women who demonstrate a preference and desire for this method of delivery.<sup>21</sup> However, it is essential that they have access to information about the procedure, with emphasis also on the risks of this intervention.

It is considered that recruiting only pregnant women with access to the internet or cell phones may represent a limitation of this study, since this approach restricted the participation of women who did not have such resources. This situation prevented a broader and more diverse sample from being obtained, which may have compromised the representativeness of the data collected.

Regarding data collection, although the alternation between audio and video calls may be considered a limitation of the study, it is considered that this did not compromise methodological standardization or data quality. All interviews followed the same script, were conducted by the same researcher, and audio-recorded with the participants' permission, ensuring consistency and reliability. The choice of interview format was defined according to the participants' preference, respecting the ethical principle of autonomy. The quality of qualitative data is linked to the depth of the narratives and the relationship of trust established between researcher and participant, and not to the technological resource used; thus, it is understood that the absence of facial expressions did not interfere with the understanding of women's experiences and expectations regarding the method of birth.

Regarding inclusion and exclusion criteria, it was decided not to establish exclusion criteria, as the objective of the study was to understand the social and subjective construction of choices about the method of birth, which includes not only lived experiences, but also expectations and prior knowledge. In this sense, the inclusion of primiparous women was intentional, as it allowed for a comparison of perceptions between women with and without previous delivery experiences, broadening the understanding of the phenomenon investigated.

We believe that the findings reveal important aspects of delivery and birth care. In this sense, it is considered that the results can contribute to the reflection of primary health care professionals and the hospital context on the conduct adopted and the need to rethink the model of women's health care, aiming for more humanized and respectful care that allows for greater autonomy and female protagonism. In addition, the evidence obtained can guide women in the decision-making process regarding the birth process, strengthening their ability to actively participate in decisions related to care. These findings can also contribute to improving professional practice, encouraging the adoption of woman-centered approaches, enhancing communication between the team and the pregnant woman, and promoting the use of educational technologies that foster more positive and satisfying delivery experiences.

## Conclusion

The study made it possible to observe that women show a preference for vaginal delivery but do not have autonomy in decision-making. They are unable to express their preferences, nor can they engage in dialogue about what they consider best for themselves and their babies. It was also found that the women were not adequately informed about the methods of birth during prenatal care, and most of their knowledge consists of popular beliefs, often associated with precarious and interventionist care provided by health professionals. Such information can associate vaginal delivery with pain and suffering, overshadowing the benefits of this method of birth for the mother-child dyad.

Therefore, it is essential to make a joint effort to promote more effective and comprehensive education on the methods of birth, one that values women's wishes and their personal and family experiences. This change must include the training of health professionals so they can offer more humanized, woman-centered care, allowing women to have space to discuss their preferences and actively participate in the decision-making process. By ensuring that women are informed and supported in their choices, the birth experience can become more positive and satisfying for the woman, the baby, and the family.

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