

## Choice of type of delivery: factors reported by puerperal woman

*Escolha do tipo de parto: fatores relatados por puérperas*

*La elección del tipo de parto: factores relatados por puérperas*



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### ABSTRACT

**Objective:** To know the factors listed by puerperal woman that influenced the choice in type of delivery.

**Methods:** Qualitative research, developed with 25 puerperal women in a University Hospital of Mato Grosso do Sul, between September and November 2014. A semi-structured interview was used for data collection and the Collective Subject Discourse was used to organize and tabulate the data collected.

**Results:** The Collective Subject Discourses resulted in the following categories: Desire for the type of delivery; Respect for the chosen type of delivery and Factors that influenced the choice. Most of the women interviewed (76%) expressed a preference for normal birth due to rapid recovery, less pain and suffering.

**Conclusions:** The influence of family members, previous experience with childbirth, professional-customer interaction and internet information influenced the type of delivery chosen, which reinforces the importance of health education since the pre-natal stage, highlighting the need to equip women to perform a conscious choice.

**Keywords:** Vaginal delivery. Cesarean section. Decision-making. Women's health. Millennium Development Goals.

### RESUMO

**Objetivo:** Conhecer os fatores relatados por puérperas que concorreram na escolha do tipo de parto.

**Métodos:** Pesquisa qualitativa, desenvolvida com 25 puérperas em um Hospital Universitário de Mato Grosso do Sul, entre setembro e novembro de 2014. Utilizou-se a entrevista semiestruturada para a coleta de dados e o Discurso do Sujeito Coletivo para organizar e tabular os depoimentos.

**Resultados:** Os Discursos dos Sujeitos Coletivos resultaram nas categorias: Desejo pelo tipo de parto realizado; Respeito pelo tipo de parto escolhido e Fatores que influenciaram a escolha. A maioria das mulheres entrevistadas (76%) manifestou preferência pelo parto normal devido à recuperação rápida, menor dor e sofrimento.

**Conclusões:** Concorreram na escolha do tipo de parto: influência da família, experiências prévias com parto, interação profissional — cliente e informações via internet, o que reforça a importância da educação em saúde desde o pré-natal, destacando a necessidade de instrumentalizar a mulher para realizar uma escolha consciente.

**Palavras-chave:** Parto normal. Cesárea. Tomada de decisões. Saúde da mulher. Objetivos de Desenvolvimento do Milênio.

### RESUMEN

**Objetivos:** Conocer los factores relatados por puérperas que concurren en la elección del tipo de parto.

**Métodos:** Investigación cualitativa, desarrollada con 25 parturientas que se encontraban en un Hospital Universitario de Mato Grosso do Sul, entre septiembre y noviembre de 2014. Se utilizó la encuesta semiestruturada para la recolección de datos y el Discurso del Sujeto Colectivo (DSC) para organizar y tabular las informaciones.

**Resultados:** Los DSCs resultaron en las categorías: Deseo por el tipo de parto realizado; Respeto por el tipo de parto elegido y Factores que influyeron en la elección. La mayoría de las mujeres encuestadas (76%) prefirieron el parto vaginal debido a la recuperación rápida, menos dolor y sufrimiento.

**Conclusiones:** Concurrieron en la elección por la vía de nacimiento fueron: influencia de la familia, experiencia previa con parto, interacción profesional — cliente e información vía internet, lo que refuerza la importancia de la educación en salud desde el prenatal, destacando la necesidad de instrumentalizar a la mujer para realizar una decisión consciente.

**Palabras clave:** Parto normal. Cesárea. Toma de decisiones. Salud de la mujer. Objetivos de Desarrollo del Milenio.

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## ■ INTRODUCTION

Among the eight Millennium Development Goals (MDGs), the fifth (improving maternal health) presents a major challenge for Brazil and the world. For Brazil in particular, the challenge is to overcome the medicalization of delivery<sup>(1)</sup>, facilitate the access of women to the means and health services, allowing for communication and expression of health matters that regard them, adequate assistance and equal opportunities in the use of healthcare, which reflect in the degree of development of the public healthcare systems.

According to the fifth national MDG follow-up report, released in May 2014, Brazil reduced its mortality rates in pregnant women in 55% throughout two decades (1990 to 2011), meaning that these rates fell from 141 to 64 deaths per 100,000 live births, a more significant advancement than the average reductions in Latin America and the world, which were of 45%. The percentage of deliveries assisted by trained health professionals - one of its main indicators - in 2011 was of approximately 66% within the countries in development. In Brazil, 99% of births were performed in hospitals or other health care facilities<sup>(2)</sup>.

But, there are aspects related to birth care assistance that still need to be discussed. The birth care assistance model in Brazil is characterized by excess prevention, which has contributed to the increase in cesarean sections and maternal and childhood morbidity and mortality<sup>(3)</sup>. The ratio of maternal mortality related to surgical births continues to be one of the indicators that most contributes to this increase<sup>(2)</sup>. The Brazilian rate of cesarean sections corresponds to 52%, reaching 88% in private healthcare, numbers that are much higher than the maximum limit of 15% proposed by the World Health Organization (WHO)<sup>(4)</sup>. A study performed in 24 countries and 372 delivery assistance institutions in the African, Asian and Latin American continents puts the rates of the cesarean section, without medical recommendation, between 0.01 and 2.10%<sup>(5)</sup>.

The results of another study performed in Paraná, where the source of funding related to the type of delivery was considered, pointed to the fact that even in Brazil's Unified Public Health System (SUS), the cesarean sections exceeded vaginal deliveries in the 11 years of monitoring the phenomena, which allowed to draw the conclusion that the increase in surgical deliveries does not depend on the funding being public or private<sup>(6)</sup>.

Regarding vaginal births, Brazil has a rate of 68.5% and appears in second place within the American countries while Nicaragua occupies first place with a 69.1% rate. The study considered sociodemographic conditions of wom-

en, the structure of the assistance institutions, clinical aspects of pregnancy and delivery and women's options<sup>(5)</sup> to determine types of delivery.

The Brazilian government has established actions with the intention of transforming this reality, thus improving the quality of obstetric and neonatal assistance in order to achieve the fifth MDG. In 2012, the ministries of health and education launched the National Residency Program in Obstetric Nursing (PRONAENF)<sup>(7)</sup>, qualifying nurses to assist in deliveries of usual risk in order to stimulate and regularize the obstetric assistance provided by non-doctors, thus reducing the volume of unnecessary cesarean sections and interventions during this assistance.

The professional training of nurses as a strategy of the Stork Network qualifies them to provide humanized quality service, and gives them the capacity to act in different moments of the pregnancy cycle: prenatal, labor, birth and post labor<sup>(7)</sup>.

The non-doctors that can perform vaginal deliveries are nurses and obstetric nurses, and doulas (or midwives)<sup>(8)</sup>. Evidence shows that the assistance models involving these professionals are associated to smaller rates of interventions and greater satisfaction among women<sup>(8)</sup>.

Respect for the woman transforms birth into a unique and special moment. She has the right to participate in decisions about her health and actions related to her own body, including the type of delivery to which she will be submitted.

The cesarean and vaginal deliveries are the alternatives available. Because of this, it is expected that the pregnant woman are given the right to analyze the risk and benefit in order to choose freely<sup>(9)</sup>.

This implies in giving women the opportunity to participate in decisions related to what was informed as an ethical and legal obligation of health professionals to provide clear and complete information regarding care, treatment and alternatives<sup>(10)</sup>.

In this aspect, supervised internships of the Obstetric Nursing Residency in obstetric centers gave the interns the opportunity to know that, in order to achieve the fifth MDG and the goal to guarantee reproductive health right and the presence of a qualified person during delivery, the participation of the woman in the choice of delivery for their baby must also be contemplated.

Therefore, the guiding question of this article, extracted from the monograph: "Types of delivery: factors related to the choice of the pregnant woman"<sup>(11)</sup> was: How do you feel about the type of delivery you experienced? The objective was to know the factors listed by pregnant women that contributed in the choice of type of delivery.

## ■ METHODS

This is an analytical cross-sectional study with a qualitative approach in the theoretical perspective of Safe Motherhood, adopting the methodological framework of Lefèvre and Lefèvre<sup>(12)</sup>, the Collective Subject Discourse (CSD), produced as a requirement for obtaining the Obstetric Nursing Specialist title, in the Residency modality (CCA), offered by the Federal University of Mato Grosso do Sul.

The CSD is a proposal for the organization and tabulation of qualitative data obtained from testimonies<sup>(12)</sup>, capturing the factors that influence the choice of types of delivery by the subjects.

The study subjects were 25 puerperal women admitted to the Joint Accommodations of the University Hospital Maria Aparecida Pedrossian (HUMAP) of Campo Grande – Mato Grosso do Sul, who met the inclusion criteria that follows: puerperal women with vaginal or cesarean delivery experience in the last 12 to 72 hours. The acceptance to participate was documented through the signing of the Free and Informed Consent Form. Children under 18 years of age, those with a high risk diagnosis, those who had multiple births or stillbirths, women deprived of their freedom, indigenous woman and those who were hearing impaired were excluded.

HUMAP is a public institution that functions as a teaching hospital, receives usual risk and high-risk pregnancies, because it is a reference institution in this specialty. The team of Gynecology and Obstetrics is comprised of physicians, residents and medical students from Medical school. It also counts with obstetric nurses and residents of the Obstetric Nursing program. The current health care model is centered on the doctor, and the Obstetric Nursing service has adopted humanized practices.

Data were collected between September and November 2014. The semi-structured interviews were conducted by the guiding question: *How do you feel about the type of delivery you experienced?* and preceded by prior continuous analysis of the contents and stopped when there was a repetition of the discourse. The subjects received the letter P (parturient) and a sequenced entry number according to their entrance in the group.

For the organization and tabulation of the data, three of the four methodological figures of the Collective Subject Discourse (CSD) were used: the key Expressions (ECH), which are excerpts from individual speech highlighted by the researcher and that reveal the essence of the content of speech; the Central Ideas (CI), ie names or linguistic expressions that describe and name, in a more succinct way and as accurately as possible, the direction(s) present in the

homogeneous set of ECHs; and the Collective Subject Discourse, which corresponds to a speech synthesis, prepared with cutouts of individual speeches and similar meaning, always in the first person singular. Therefore, the collective subject discourse consists of the key expressions that have the same Central Idea<sup>(12)</sup>.

All phases of the study have been developed respecting the ethical standards for research involving human subjects, and data collection was preceded by the approval of the research project by the Ethics Committee of the Federal University of Mato Grosso do Sul, Opinion No. 789 863 / 2014 with Presentation Certificate for Ethics Assessment (CAAE) No. 3148.0114.3.0000.0021.

## ■ RESULTS AND DISCUSSION

The age of the subjects ranged from 18 to 37 years old, with predominance of the range between 20 to 30 years old, considered ideal for the reproductive process; the experience was between three and four deliveries (28%) each, one (24%), two (16%) and five (4%). As for the type of delivery, 14 (56%) interviewees underwent cesarean section; of these, six had previous cesarean section, five girls used this type of delivery in their childbirth experience, and 11 (44%) underwent vaginal delivery, and 10 (40%) repeated the experience of previous pregnancies.

The results of operative delivery in this study, especially in first-time pregnancies, are of particular concern, since they imply a high probability of the repetition of this type of delivery in future pregnancies. The medicalization of childbirth is opposed to the World Health Organization recommendations that advocate an ideal rate of cesarean sections up to 15% and minimal interventions in childbirth care<sup>(1)</sup>.

The high percentage of cesarean deliveries is a major challenge for health policies, given the unnecessary risks for both the mother and the child, in addition to its association with maternal mortality and additional costs to the health system; especially when the reduction of maternal mortality is associated with skilled assistance during birth, emergency obstetric care and to Brazil's inability to achieve the goal of a 75% reduction in maternal mortality by 2015<sup>(6)</sup>.

From the analysis of interviews with the subjects, the speeches were organized and tabulated in three categories: Desire for the type of delivery; Respect for the chosen type of delivery and Factors that influenced the choice.

### Desire for the type of delivery

In this category, strengths and weaknesses of the range of the desired type of delivery were cited. There was em-

phasis on the satisfaction with the rightful choosing of a vaginal delivery, reflected in positive terms, starting from a wide variety of sensations that only the experience of vaginal birth provides<sup>(13)</sup>. Sensations that were also perceived with the choice of operative delivery, elected to not feel pain or not infringe risk to the fetus/neonate, or disappointment for having failed in the attempt of a vaginal delivery.

For interviewees who have succeeded in vaginal delivery as per their wish, the feeling of relief, ecstasy and fulfillment exceeded expectations.

*I had a vaginal birth. That's what I wanted, I'm feeling great, it went as planned [...]. It was the best thing that happened to me, it was God's wish. I thought it would be a vaginal delivery, not the way I thought, it was better [...]. I'm feeling good, that's why vaginal delivery is great (P4, P7, P8, P9, P10, P13, P15, P16, P18, P22, P24).*

Vaginal delivery is active, healthier and natural, transforming the laboring woman into the protagonist, a fact that is not perceived in a cesarean section, because in that case, the woman adopts a passive posture, losing her role as a protagonist to a certain extent<sup>(14)</sup>.

For some women who underwent cesarean section, the study showed the frustration, loss of control and loss of the protagonist role, because the women had wanted a vaginal delivery and had to be subjected to a cesarean section.

*I expected a vaginal delivery but had to undergo a cesarean section [...]. I tried to have a vaginal delivery, but wasn't able to. My delivery was pretty difficult (P1, P2, P3, P5, P6, P11, P12, P14, P17, P19, P20, P21, P23, P25).*

There are conditions justifying the appointment and performance of CS (cesarean section). But, there are also frequent difficulties imposed on women against exercising autonomy over their bodies and being protagonists of the birthing process. When fully handing themselves to the care professionals, women progressively remove themselves from the decision-making process of pregnancy and its ending<sup>(15)</sup>. The sensation of not being able to give birth is a frequent anguish during delivery, making women most vulnerable to medical interventions during this period<sup>(1)</sup>.

On the other hand, a minority comes in the defense of the CS. In our study, among the factors that contributed to the realization of this desire is the fear of pain and the medical recommendation, as can be seen in the following speech:

*I prefer cesarean section to vaginal delivery because I'm afraid of the pain [...]. I hate feeling pain [...]. I came prepared to have a cesarean section. I mentalized that I did not want to feel pain [...]. I feel good, I had a cesarean section, it was what I wanted (P2, P5, P14, P21, P22).*

The woman's desire for a cesarean is sustained by fear, convenience and misinformation. The mother often fears the consequences of vaginal birth because she considers it a risky experience. The woman has the paradoxical idea that surgery is a way to avoid pain<sup>(16)</sup>. In addition to the misinformation, unnecessary interventions during labor and obstetric violence turn what would be a normal event in a dehumanized procedure, further increasing the painful feelings and fears, which contribute to the acceptance and request for a cesarean<sup>(1)</sup>.

Fear of the pain experienced in vaginal birth was also listed as a contributing factor for choosing a cesarean, according to some studies<sup>(1,9,17-18)</sup>.

Certain criteria for the desire and the choice of cesarean section are related to expectations and beliefs that may compromise the birth process. This type of birth seems to be understood by women as painless and safe.

When there was a recommendation for a cesarean section, it was found that some women demonstrated passivity, submission and complicity.

*The cesarean was the doctor's decision [...]. I did not expect to have complications during childbirth. I wish it had been vaginal [...]. For her sake (baby) I submitted myself to a cesarean section. My husband and my mother told us that, for her, anything was worth it (P1, P2, P3, P6, P11, P17).*

By declaring they "did not expect to have complications", the CSD makes it evident that the desire of the woman was annulled in favor of not exposing themselves to any risk. Desires are not met, especially when some complication presents itself and begins to justify the interventions, which, when not properly shared through dialog, leave an impression of imposition due to the risk<sup>(15)</sup>.

The vulnerability of women, triggered by the birthing process, coupled with the doctor's medical knowledge make the mother value the opinion of health professionals at the expense of their own, not intending, however, to invade their power of decision in face of medical evidence that is indisputable<sup>(9)</sup>.

The training of the obstetrician, concentration on complications and high-risk pregnancies, as is the case of HUMAP, sculpts their preference for technology and intervention.

## Respect for the chosen type of delivery

As for the principle of autonomy, understood as a person's ability to decide what is "good", what is suitable for them, according to their values, their needs and their interests, most of the subjects, 19 (76%) expressed a preference for vaginal delivery. Of these, ten women (40%) preferred vaginal delivery, but underwent cesarean sections, nine (36%) chose and were able to have a vaginal delivery, and five (20%) had chosen and had an operative delivery. Only one (4%) had no preference, but believed that vaginal delivery would be best.

Contrary to the predominant hospital and medicalized model, women signaled their preference for vaginal, natural and humanized birth, in contrast, of course, to the operative delivery, highly practiced in Brazil and, in many cases, without meeting the criteria and/or recommended classifications in national and international medical literature.

The medicalization of childbirth also contributed to the rising rates of cesarean sections<sup>(1)</sup>, but some pregnant women have a birth plan, which is vaginal delivery, and, therefore, some of them act with the intention of achieving it<sup>(10)</sup>.

The speeches that follow describe and name feelings and satisfaction, freedom, autonomy and respect for the physiology of delivery.

*Vaginal delivery is better, due to the recovery being faster [...]. When labor ends, we are ready and well and taking care of the baby, we do not need much help [...]. You can get up, take your shower [...]. I see them (mothers) walking everywhere and with a cesarean there isn't that much freedom, you have to be more cautious [...]. With a vaginal delivery you do not depend on anybody [...]. You have your baby and, in a few hours, you're okay, everything is fine and it's not like that with a CS (P1, P2, P3, P4, P5, P6, P8, P9, P10, P11, P12, P14, P15, P16, P20, P22, P24, P25).*

Some of the reasons cited by women who preferred vaginal delivery express a common belief and are also found in several studies<sup>(9,14,16)</sup>.

Whereas the physiology of labor involves an intense body experience, you can approach it with pleasure and joy. Active labor is instinctive, it is giving birth naturally and spontaneously through the will and determination of the mother, and her complete freedom to use her body and be the protagonist of this process. The woman gives her baby the best way to start life through a secure transition be-

tween the uterus and the world, regaining her fundamental power as a woman in labor, a mother and woman<sup>(13)</sup>.

*Vaginal delivery is smoother [...]. It is better for the women and the child [...]. The baby is born on that date in the most natural way [...]. It has a full preparation to know it's coming into the world, so it seems like it comes out more prepared [...]. Its facilitates breastfeeding [...]. It is natural, right [...]. You have to wait for contractions to have the baby [...]. My delivery was underwater, it was in a tub, it was different [...]. Vaginal childbirth is a good experience and it is healthier (P4, P5, P6, P10, P11, P13, P16, P18, P19, P22, P25).*

Vaginal delivery is a characteristic of human physiology, its benefits are numerous, given that the woman's body was prepared for it. Most mothers and newborns are able to cross the critical moment of birth healthily, without medical intervention<sup>(16)</sup>.

## Factors that influenced the choice

In this category, many factors are listed and reveal that the choice of type of delivery by the interviewed mothers is influenced by different institutional, individual and collective mechanisms of previous experiences, the medical and family power, the lack of dialogic action in the pre-birth period, interest, curiosity and cultural background, among others.

Preliminarily, in order for a woman to be able choose her type of delivery, knowledge, information and power in order to make a decision are needed. The speeches of the mothers showed that decision-making was based on previous experience and the possibility of repeating the same kind of labor was equal both in vaginally and operative deliveries.

*My previous births were vaginal [...]. The experience of the first delivery was wonderful. My other births went so smoothly that I could not believe they were vaginal deliveries [...]. I insisted in having a vaginal delivery, although it had been suggested I have a cesarean section (P1, P4, P7, P8, P15, P16, P20, P22).*

*All of my deliveries were cesarean sections [...]. The doctor said my body wasn't able to undergo vaginal delivery [...]. I already knew how it would happen (P2, P5, P25).*

Certain socioeconomic conditions, the choice of the obstetrician or the mother, the institutional conditions and ce-

sarean background, are factors associated with the recommendation of type of delivery. However, vaginal birth after a C-section is safe, desirable, and helps prevent problems that could potentially arise from repeated cesareans<sup>(15)</sup>.

The preference for vaginal delivery was related, among other factors, to the cultural background of women, in which personal and family experiences and stories are considered<sup>(17)</sup>. But, the previous experiences by mothers regarding the moment and type of delivery is decisive in choosing the route of birth in future pregnancies<sup>(19)</sup>.

In both existing birth routes, the speeches of the subjects revealed that the actors that operate in this scenario influenced their choice, highlighting those of their daily life (family, acquaintances and friends) and professionals (doctor, nurse and doula).

*I was influenced by my family: mother, sisters, aunts [...]. My mother always explained everything to me [...]. My sister and I were born vaginally and my brother, through a cesarean. She always said it was better to have a vaginal delivery [...]. Despite science, we're more guided by what parents and grandparents say [...]. I listened to advice from acquaintances, friends, my mother's experiences, my mother in law [...]. Experiences of women who had vaginal deliveries and women who have had caesarean sections (P1, P2, P4, P5, P7, P8, P9, P12, P14, P16, P18, P19).*

*I clarified any doubts during prenatal appointments [...]. I attended lectures and workshops for pregnant women with doctors and nurses at the health center [...]. I received guidance from obstetric nursing residents [...]. Doulas [...]. Through the prenatal staff and here at the time I arrived; everyone from start to finish. It was my wish, but there was influence from the team (P2, P9, P11, P13, P14, P16, P17, P19, P20, P21, P24, P25).*

In a study conducted in the city of Juiz de Fora (state of Minas Gerais), it was confirmed by the reports of the participants that the woman who were closest to the mothers, their family or friends, played a fundamental role in forming their opinions<sup>(19)</sup>. Such influences are modulated by family stories that reveal positive and negative aspects of experiences and the experiences of each person of the family group, and the family as a whole<sup>(17)</sup>. Family interference in deciding the type of delivery comes from grandparents, sisters-in-law, husbands, and especially mothers, and the type of delivery is chosen according to these influences<sup>(20)</sup>.

Other variables were reported in speeches such as the transfer of professional information and/or guidance, good

interpersonal relationships established during prenatal care and/or labor.

However, the speeches also revealed that the subjects had human weaknesses such as fear of pain and complications that immobilized and weakened a heteronomic relationship.

The insensitivity of professionals to women's needs, lack of information, the conditions of the public or private health system, the insecurity and fear revealed and the dreams that were not achieved that end up frustrating these women are not always overcome<sup>(10)</sup>.

In this research, the testimonies also showed that the professional - patient communication is unilateral, not providing dialogue, depriving women of clear explanations. The subjects had no prior access to clear and sufficient information to make choices.

*I had no guidance during my pre-natal period [...]. The doctor said almost nothing [...]. They never explained how delivering a baby would be [...]. I questioned the doctor because it was my first pregnancy [...]. I had no idea how it was. I was inexperienced and he only told me the what I needed to know when it was time to deliver (P11, P18).*

The educational activities during prenatal care are extremely important because it is then that both the physical and psychological preparation of women for the act of motherhood occurs. The quality of prenatal influences in the chain of beliefs and opinions on the types of delivery, and consequently on the final choice. The health care provider in the role of educator has to be attentive to such assistance<sup>(19)</sup>.

When information is scarce, or the person knows they are entitled to more information, they seek this information through electronic means and sources (internet). For this group of subjects, even for those who reported having received information during their consultations and through social and family life, the Internet has proved to be an important instrument as a source of information, also used to grasp concepts on the subject<sup>(10)</sup> and enable decision making.

*The largest source of information I have is the internet. I read everything I found interesting [...]. It's what motivated my vaginal delivery (P1, P2, P6, P9, P12, P14, P17, P18, P21, P23).*

One study showed the existence of ambiguous postures in regards to seeking information about the types of delivery. While some considered themselves informed,

seeking knowledge through magazines, newspapers and the internet, other women have shown no such interest <sup>(20)</sup>.

The availability of information on pregnancy and childbirth favors the inclusion of pregnant women in decision-making, providing opportunities for the manifestation of their autonomy in relation to the type of delivery <sup>(9)</sup>.

## ■ CONCLUSION

The study found that 76% of subjects preferred vaginal delivery. This preference was justified by the fact that it is a natural process, has a faster postpartum recovery, facilitating movement and work, and the possibility of providing care for the baby without restrictions.

It was shown that previous experiences with childbirth, family interference, professional-client interaction in prenatal consultations and electronic sources of information influenced the choice of type of delivery.

Therefore, the participation of the obstetric nurse/doula in the attention to the pregnancy and postpartum cycle is indispensable, for this professional holds a strategic role in the educative process, besides assisting the woman with quality, and in a more humanized way.

Women should be given the opportunity to rescue their protagonist roles in the birth process, allowing them to decide about the type of birth based on information consistent with scientific evidence. The actions described in the MDG and related to the quality of attention given to reduce mortality of mothers is part of the competencies and abilities essential to these professionals.

Some elements from the study can be considered, such as the necessity to participate more efficiently in the presence of an obstetric nurse during the phase of dilation, as a way of strengthening the connection with the woman and sharing the conscious choice in the type of birth based on individual questions and clinical evidence.

Among the limitations of this study, little participation and action on part of the nurse in the direct attention to the expulsion period as a new activity in the institution researched, the characterization of the institution itself as a reference for high risk in the context of the municipality, and the biomedical model culture and our scenario of practice can be cited.

Some actions can be performed by the obstetrician nurse during Primary Health Attention, and as a contribution of the study to the practice and deregulation, it is suggested that: the autonomy of the woman in the choice of delivery type and the valuing of their history, inheritances and choices be promoted. Advice on the best moment for admission during labor should be given, avoiding early

hospitalization, as should advice on beneficial practices to be adopted during labor, the promotion of clarifications, the distancing of fears that may arise during the process of pregnancy and labor, and the fostering of dialogic experiences between women and the health professionals.

It is recommended that the results of the study be taken beyond the scenario for which they were developed, considering the social determinants of the individual and collective subjects as a foundation for the development and execution of public health policies according to the precepts of Safe Maternity.

The comparative studies in different institutions and municipalities, based on the same methodology, can find other results, with emancipatory care during childbirth, a more appropriate assistance-based approach to women, and elucidation of the various factors that influence the choice of the birth, so that more women are heard and able to exercise their right to decide how they prefer to give birth.

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