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Normal birth vs. cesarean: preferences of two groups of women in the Family Health Strategy

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Abstract: As childbirth is a significant event for women, this study aimed to know the preference and the factors that determine the choice of mode of delivery, considering normal and caesarean section, of two groups: primiparous and multiparous women. This is an exploratory and descriptive field survey with quantitative and qualitative approach. After approval by the Ethics Committee (Opinion nº 206.863/2013), the study was conducted in two health units of the municipality of Sinop-MT, in the period from April to June 2013, with two groups of women. The participants were 27 women; 15 (55.56%) primiparous and 12 (44.44%) multiparous women. The latter had experienced normal and cesarean birth. Primiparous women were younger (18-30 years) than multiparous, 40% had a family income of one minimum wage and 60% were common-law married. Multiparous women were older (25-61 years), many had not completed high school (58.33%), were married (58.33%) and had family income above one minimum wage. The median age of menarche in both groups of women was 12 years and the first sexual relationship of the primiparous occurred at younger age (16 years) than the multiparous (17 years). Among primiparous women, 33.33% (n: 5) had begun prenatal at eight weeks of pregnancy and 73.33% (n: 11) had attended five or more prenatal consultations. Among multiparous women, 83.33% (n: 10) had received prenatal care in all pregnancies, only seven women had more than six consultations, and these two groups were assisted by medical and nursing professionals. As for questions and information about pregnancy, women sought people close to them such as mothers, mothers-in-law, female friends, besides doctors, internet and few women sought nurses. The majority (n: 15) of women did not receive guidance on the signs of childbirth and the types of delivery. Among the women who received such information, this came from doctors or nursing teams. Regarding the time of hospitalization of the multiparous women, they were hospitalized for one day when they went through normal delivery and two days when they went through cesarean delivery. With regard to breastfeeding, children of multiparous women were breastfed within one hour after normal delivery and cesarean section, and 62.5% (n: 10) continued breast-feeding for more than six months. When asked about the type of delivery they wanted to have, 86.67% (n: 13) of primiparous women responded vaginal delivery. Among multiparous women, 58.5% (n: 24) chose normal delivery route for their pregnancies. Among deliveries (n: 12) of primiparous women, 58.33% had caesarean and 41.67% had normal deliveries, and among multiparous, there were 61% normal deliveries and 39% caesarean sections. On the incidence of births in the municipality from January to June 2013, there were 66.51% normal deliveries and 33.49% caesarean sections. Regarding the sensation of pain during childbirth between multiparous women, 58.33% said they felt more pain before and during vaginal delivery and 33.33% said after cesarean section. They described the pain of normal childbirth as a unique and difficult to explain, a painful experience, however, satisfactory after the birth of the child. The reasons cited by multiparous women for the preferring vaginal delivery were faster recovery and return to normal activities, and the absence of pain after vaginal delivery. It is concluded that caesarean section rates remain high despite the fact that there is a preference for normal delivery. It is observed that more nursing instructions are necessary during prenatal care.
Keywords: Nursing. Pregnancy. Childbirth.

Introduction

Pregnancy is a special process in the life of women and their families, a unique experience. Several changes and choices take place during pregnancy, and one of them is the choice of the type of delivery. Childbirth is an event that encompasses the whole process of pregnancy and postpartum. Chilbrirth is anticipated during pregnancy as expectations and continues to be mentioned later in the form of memories and feelings that mothers hold (LOPES *et al.* 2005).

The type of delivery has a number of implications in terms of need and indication, risks and benefits, depending on each situation, performance time, complications and future repercussions, with normal birth presenting more advantages than cesarean sections (BRASIL, 2001).

When searching the preference of pregnant women on the way of delivery, the preference is for by vaginal route instead of caesarean sections. The convenience of this procedure and the fear of suffering and pain after cesarean sections were the most frequently reported responses by women in the research carried out by Tedesco *et al.* (2004).

The decision by the indication of performing a caesarean section should be from the doctor with the active participation of women. Women should know that there are alternative ways to control pain possibly associated with labor and that there is no justification to perform a cesarean section just for this purpose. Women should also be informed that vaginal delivery after a cesarean section is not only safe but desirable, helping to avoid the problems potentially arising from repetitive cesareans (BRASIL, 2001).

The World Health Organization (WHO) advocates for any region of the world that there is no justification for cesarean delivery rates to be greater than 10-15% (BETRÁN, 2007 apud SANCHES; MAMEDE; VIVANCOS, 2012). It is observed that, in many places around the world, rates of this surgery are higher than those recommended 25 years ago by the WHO (PATAH; MALIK, 2011). In Brazil, the total rate of cesareans in the Health System and private services was 40% in 1996 and, in 2006, increased to 45% (BRASIL, 2009). When analyzing the incidence of cesarean sections in relation to socioeconomic level, it is observed that increased average income of the population is related to increased incidence of operative delivery (QUEIROZ *et al*. 2005).

It is necessary that health professionals, especially those related to nursing care, which are closer to patients, recognize and raise awareness on the importance of this moment for women, as for some of them this will be the most striking episode of their entire lives (LOPES *et al*. 2005).

The knowledge acquired in the course on woman health and expectations obtained through participation in outreach projects in this area have called attention to this area of activity.

The high rates of cesarean births are noteworthy and they rise the interest to research the women's preference for the mode of delivery in order to make sure that they are actually looking for such a route or if the circumstances really imply the need for indication of caesarean sections, as well as which are the reasons that lead to the choice of mode of delivery, since this event is very important and striking for women.

It was sought in this study to learn what is the preference of women on delivery route of two groups, primiparous and multiparous women, considering normal delivery and caesarean section, and to describe the reasons that led them to their choices. It is also sought to determine the incidence of normal deliveries and caesarean sections in the city in order to compare the reality found to other studies. And finally, this study was an attempt to assess whether these women received orientation in the course of pregnancy on the issues surrounding this process, especially birth signs, and the advantages and disadvantages of each route. It is extremely important that nurses know the real motivations that lead pregnant women to choose a specific delivery route in order to check if they know how the birth process takes place, if they have doubts, fears and insecurities. Knowing that guidance/information needs to be passed to these women, will help to make them aware and prepared for the experience of a positive childbirth, whether cesarean or normal.

Methods

This is an exploratory and descriptive field survey with quantitative and qualitative approach.

The research consisted of two groups of women: the first, a group of fifteen primiparous women (Group A) and the other, twelve women who have had previous experience of normal and caesarean section (Group B).

The inclusion criterion in both groups was that women had the age equal or superior to 18 years. Included in Group A, women who have had both delivery experiences and agreed to participate by signing the Informed Consent (IC); and in Group B, women in the first pregnancy, in the third trimester, or who had probable date of delivery within the data collection period, registered in the Sisprenatal, receiving prenatal care and who agreed to participate by signing the IC.

Exclusion criteria were: age under 18 years; pregnant women mentally impaired or under any condition that could impair their reasoning; and women who had only one type of birth experience.

Empirical data collection was performed using a semistructured interview. The guiding instrument was a form containing questions on identification of participants and questions on the researched subject.

Interviews were conducted individually in the period from April to July 2013, in two Family Health Units in the municipality of Sinop-MT.

Data from the Program for Humanization of Prenatal and Birth were accessed in the Municipal Council of Health in order to know the number of births occurred in the period from January to December 2012 and January to June 2013.

Before analysis and interpretation, data were selected, coded and tabulated. Data were analyzed using descriptive statistics, namely, absolute frequency, median and 25th and 75th percentiles for continuous variables and relative frequency for categorical variables are presented in tables created in Excel/2010 program. The proportion of cesarean section and vaginal deliveries were calculated using the number of deliveries by type of delivery as the numerator the total number of births as denominator.

To ensure anonymity, interviewees were given fictitious names through the speeches presented throughout the study, and M for multiparae and P to primiparae, following a numerical order of the interviews, for example, M1, M2 or P1, P2 and so on.

Ethical principles

This research was submitted to the Research Ethics Committee of the University Hospital Júlio Muller, Federal University of Mato Grosso (Opinion Number: 206.863/2013) and was approved within the ethical principles and the law.

Results and discussion

The participants were 27 women; 15 (55.56%) primiparous and 12 (44.44%) multiparous women. The latter had experienced normal birth and cesarean section. In the unit I, there were 12 women; four (33.33%) multiparous and eight (66.67%) primiparous. In the unit II, there were 15 women, eight (53.33%) multiparous and seven (46.67%) primiparous.

Table 01. Characteristics of women attending the Family Health Strategy, Sinop/MT, from April to July 2013.

VARIABLES	PRIMIPAROUS (N: 15)		MULTIPAROUS (N: 12)	
	n	%	n	%
Level of education				
Complete Higher Education	1	6.7	1	8.33
Incomplete higher education	1	6.7	1	8.33
Complete High school	6	40	3	25
Incomplete High school	1	6.7	1	8.33
Complete Elementary School	4	26.7	2	16.67
Incomplete elementary school	2	13.3	3	25
Literate	0	0	1	8.33
Marital Status				
Single	1	6.7	3	25
Stable union <1 year	3	20	0	0
Stable union > 1 year	9	60	1	8.33
Married	2	13.3	7	58.33
Divorced	0	0	1	8.33
Family income*				
< 1 minimum wage	1	6.7	1	8.33
1 minimum wage	6	40	2	16.67
2 minimum wages	4	26.7	4	33.33
3 to 4 minimum wages	4	26.7	4	33.33
5 minimum wages or more	0	0	1	8.33
Occupation				
Housewife	10	66.7	7	58.33
Unemployed	4	26.7	4	33.33
Student	1	6.7	0	0
Housekeeper	0	0	1	8.33
Menarche				
Median age	12 years	0	12 years	0
Percentile 25%	11 years	0	11 years	0
Percentile 75%	13 years	0	12 years	0
Does not remember	1	0	0	0
Age at 1^{rst} sexual relationship				
Median age	16 years	0	17 years	0
Percentile 25%	14 years	0	16 years	0
Percentile 75%	18 years	0	19 years	0

* Corresponds to the minimum wage in 2013, R$ 678.00.

Among the women studied (N: 27), the age of the primiparous (N: 15) ranged between 18 and 30 years, with a median of 20 years (P25%: 18; P75%: 23 years). In turn, multiparous women (N: 12) were between 25 and 61 years old, with median of 34.5 years (P25%: 31 years; P75%: 50). In the group of primiparous women, most had completed secondary education (40%), had stable marital relationship for longer than one year (60%), family income of one minimum wage (40%) and referred as occupation the housework (housewives), thus without personal income (66.7%). Most multiparous women had completed secondary education (25%) and did not complete primary education (25%), were

married (58.33%), had family income between 2 and 4 minimum wages (66.66%) and 58.33% had unpaid occupation (housewives). Table 01 shows the profile of interviewees in detail.

It is observed that the primiparous women are younger and most have low family income (one minimum wage) and are common-law married. In turn, multiparous women are older, many did not finish high school, are married and have family income above one minimum wage. This may be related to the participation of children in family income, and/or a higher income due to more years of work.

As for the age of menarche of the two groups, the median age of 12 years was found for both groups (P25% 11 years in both groups; P75%: 13 years among primiparous and 12 years among multiparous). The median age of first sexual intercourse among primiparous women was 16 years and among multiparous, 17 years (Table 01).

When comparing the two health units, most of the women are housewives [66.67% and 60% in Unit I (N: 12) and Unit II (N: 15), respectively] and have a family income between two and four minimum wages [50% and 66.66% in Unit I (N: 12) and Unit II (N: 15), respectively]. They differ in education and marital status; in Unit I, 33.33% (n: 4) had incomplete primary education and 58.33% (n: 7) had stable relationship for more than one year, while in Unit II, 40% (n: 6) had completed high school and 46.67% (n: 7) were married. As for the age of menarche of the interviewees from the two health units, a median age of 12 years was obtained. The age of first sexual intercourse for women in Unit I had a median of 16 years and in Unit II, a median of 17 years.

Data related to prenatal and pregnancies of the two groups surveyed

All primiparous women (N: 15) were experiencing the first pregnancy, so none had a history of abortion. In turn, among multiparous women, 41.67% (n: 5) had five or more pregnancies, and among these, only three women had experienced abortion, while the rest (n: 9) did not have this experience.

Primigravidae interviewed reported having initiated prenatal care between the fourth and 17th week of pregnancy; most started with eight weeks 33.33% (n: 5), two women (13.33%) began before completing eight weeks, two (13.33%) at 12 weeks, two (13.33%) at 13 weeks and only one (6.67%) started at 17 weeks.

Prenatal care should start as early as possible, preferably in the first 120 days of gestation in order to allow the previous detection and treatment of complications with pregnancy and detection of the need for specialized monitoring. At least six prenatal consultations shoul happen, ideally one in the first quarter, two in the second quarter and three in the third quarter (BRASIL, 2005). It would be appropriate to follow pregnant women through every month of pregnancy, either through consultations, health education groups or through home visits by community health workers.

Among the interviewed women, 80% (n: 12) were in the third trimester of pregnancy, while 20% (n: 3) were at the 26th gestational week. It is noteworthy that 73.33% (n: 11) of primiparous women had made five or more prenatal consultations until the time of the interview, confirming good adherence to prenatal care. Only one (6.67%) of the interviewees was not performing prenatal care in the Family Health Strategy, as she was being assisted by the particular network, and 80% (n: 12) of women were being monitored by medical professionals and nurses of the Health Unit.

Among multiparous women, 83.33% (n: 10) had performed prenatal care in all pregnancies. Of these, seven women (58.33%) had more than six consultations in all pregnancies; two women (16.67%) had less than six consultations in one of the pregnancies, and one (8.33%) held less than six consultations in all pregnancies. The two women who did not undergo prenatal care (16.67%), one had given birth to four children, where three were delivered vaginally at home with aid of a midwife and the last child was born in public health services, resulting in cesarean delivery. Another interviewee had three pregnancies; two happened in the public health service, resulting in normal birth, and the other ther pregnancy in the private network, resulting in cesarean delivery.

With respect to professional classes that performed prenatal care in multigestive women, in the case of gestations that resulted in normal delivery, five women (41.67%) were followed only by physicians and five (41.67%) were assisted concomitantly by physicians and nurses. In turn, among the pregnancies that ended in caesarean section, it was noted that 50% (6 women) were followed only by physicians, and four women (33.33%), by physicians and nurses. The other women (16.67%) did not receive prenatal care.

Araújo and Reis (2012) reinforce that it is the competence of nurses to monitor the prenatal care of low-risk pregnant women in basic health units and low-risk maternity hospitals. Nurses need to perform the nursing consultation, which specifically includes the follow up of low risk prenatal care and may require routine examinations as well as the prescription of medications previously established in public health programs and approved by the health institution, as supported by the Law of Professional Practice of Nursing in Brazil (Law nº 7,498/86) and the Decree nº 94.406/87.

A healthy pregnancy requires the awareness of the need for provision of guidance and information both for women experiencing pregnancy and for family members or friends who are around the pregnant woman, at any socioeconomic level. In this sense, nurses must provide comprehensive care to pregnant women, recognizing their basic needs

and promoting health education during pregnancy (ARAÚJO; REIS, 2012).

When asked about the possible doubts women had during pregnancy and how they managed to solve them, 80% (n: 12) of primiparous women said they had doubt, 58.33% (n: 7) sought information on pregnancy with their mothers, 83.33% (n: 10) also with the doctor, 50% (n: 6) sought information on the internet and/or books and 25% (n: 3) with other people like grandmothers, mothers-in-law, female friends. Only one woman answered that she sought the nurse to answer her questions.

The subset of multiparous women (N: 12), when asked if they sought information regarding the types of delivery, only 33.33% (n: 4) of patients sought this information. They sought information in the experience of other women close to their families (mother, sister, mother-in-law, aunt), during the consultation they sought the doctor, and they looked up in the internet. In the study carried out by Silva, Ribeiro and Costa (2011), pregnant women reported to seek information about the advantages and disadvantages of types of delivery in magazines, newspapers and on the internet.

The study of Melchiori *et al*. (2009) investigated the influences on the choice of delivery among thirty women who chose normal delivery, and 24 reported that they were influenced by mothers and other female relatives or friends. The same influences were reported by eight of the 11 women who chose caesarean section.

The women of the two groups surveyed were asked if they received guidance on the signs of labor and types of delivery, and 60% (n: 9) of primigravidae said they did not. Those who were instructed on the subject (n: 6), when asked which professional gave them information, 83.33% (n: 5) reported receiving information from physicians and 16.67% (n: 1) obtained guidance from nurses in the unit and nursing students. In turn, 50% (n: 6) of the multiparous women received information; of these, 66.66% (n: 4) were guided by the doctor, 16.67% (n: 1) by the nursing staff and 16.67% (n: 1) did not answer.

It is noteworthy that 83.33% (n: 10) of multiparous women did prenatal and 73.33% (n: 11) of the primiparous attended five or more queries. It is noted that most of the women interviewed did prenatal care, but not all received information about labor signs and types of delivery. In the case of primiparous women, they may still receive information, as they were still performing prenatal care at the moment of this study.

It is known that, during prenatal nursing consultations, nurses must provide comprehensive care to pregnant women, recognizing and meeting their basic needs, encouraging women's participation in self-care, seeking to promote uneventful childbirth and postpartum experiences (ARAÚJO; REIS, 2012). However, Rios and Vieira (2007) found that there is an encouragement of increased coverage at the expense of quality, which does not meet the regulatory guidelines of basic actions towards health promotion of simultaneity of these actions.

Regarding the length of stay, 48% (n: 12) of multiparous mothers who had normal birth remained one day at the hospital after delivery, 28% (n: 7), two days, 8% (n: 2), three days, and 16% (n: 4) did not report this information. As for cesarean delivery, the length of hospitalization ranged from 2 to 9 days, 43.75% (n: 7) and 6.25% (n: 1), respectively, 25% (n: 4) four days, 12.5% (N: 2) two days, 6.25% (n: 1) five days and 6.25% (n: 1) six days.

Multiparous women were also questioned about on breastfeeding, both pregnancies resulting in normal delivery and caesarean section. Of pregnancies that resulted in normal birth (n: 25), all the women said they breastfed immediately after birth, 16% did it immediately, and 44% did it up to an hour, 24% within two hours, 4% two days after delivery and 12% did not remember the time. As for duration of breastfeeding, 24% breastfed for 12 months, 20% for six months. It is notable that 84% (n: 21) breastfed for at least six months. Of pregnancies that resulted in cesarean section (n: 16), 68.75% of women said they breastfed soon after birth; only one (6.25%) reported that was immediate; 18.75%, within one hour; 12.5%, two hours; 6.25% three hours after delivery; and 25% did not remember the exact period of breastfeeding. When questioned on for how long continued breastfeeding, responses ranged from 01 week to 36 months, 18.75% breastfed for 12 months, 62.5% (n: 10) breastfed for more than six months.

The multiparous women were asked if they received, during pregnancies, guidance on breastfeeding prenatally and during hospitalization, in the prenatal: seven (58.33%) women received information about breastfeeding, four (33.33%) did not receive, and one (8.33%) did not answer. In turn, during hospitalization: eight (66.67%) women said they had been informed, three (25%) were not informed and one (8.33) was not hospitalized. Regarding the health professional that gave them guidance, 16.67% (n: 2) of women said they received information from physicians and nurses; 8.33% (n: 1) said only from physicians; 25% (n: 3) said from the nursing staff; and 50% (n: 6) did not report this.

Breastfeeding is critical at the first 24 hours after birth. It is observed that mothers need more attention when undergoing cesarean delivery than normal delivery. In both cases, normal birth as cesarean section, mothers get better over the time, after delivery. This variation in the performance of breastfeeding suggests greater attention from nurses within 12 hours after delivery (ROCHA; SIMPIONATO; MELLO, 2003).

Multiparous women were asked about sexual intercourse during gestations and 41.67% (n: 5) said that it was normal, but 25% (n: 3) reported

having difficulties, 16.67% (n: 2) mentioned pain, 8.33% (n: 1) mentioned discomfort and one (8.33%) did not respond.

Data related to childbirth

Primiparous women were questioned on which mode of delivery they preferred, and 86.67% (n: 13) said they would like to have normal delivery, and 13.33% (n: 2), cesarean delivery. However, births (n: 12) were 58.33% (n: 7) cesarean deliveries and 41.67% (n: 5) normal deliveries (Table 02). The contact with three participants after the interview, to know which type of delivery was performed, was not possible. It is noteworthy that 13 women would like to have normal delivery. However, only five pregnant women underwent this type of delivery. As for the indications for cesarean sections, the reasons reported were improper fetal position for birth through normal delivery (n: 2), childbirth complications or emergencies (n: 3), and two cases of unsuccessful evolution to normal delivery.

Among multiparous mothers (N: 12), there were 41 deliveries out of 50 pregnancies, and the difference is due to abortions. It is observed that 25 deliveries (61%) were normal and 16 (39%), cesareans. As for the choices of delivery of multiparous women, 58.5% (n: 24) chose the route of normal delivery, while 29.3% (n: 12) wanted cesarean section, as can be seen in Table 02. During the interviews, they demonstrated the desire of caesarean section to then perform tubal ligation because they did not want to have more children. This justification was also found by Oliveira *et al.* (2002) in their investigation.

Table 02. Data related to the choice of type of delivery of the two groups of women attending the Family Health Strategy, Sinop/MT, from April to July, 2013.

VARIABLES	PRIMIPAROUS (N: 15)		MULTIPAROUS (C: 12)	
	n	%	n	%
Choice on way of delivery	**15**	**100**	**41**	**100**
Nº normal delivery	13	86.67	24	58.5
Nº cesarean section	2	13.33	12	29.3
No choice	0	0	5	12.2
Nº of births occurred	**12**	**100**	**41**	**100**
Nº normal delivery	5	41.67	25	60.98
Nº cesarean section	7	58.33	16	39.02

Table 03. Number of normal deliveries and caesarean sections carried out in the public network in the city of Sinop/MT for the periods from January to December 2012 and from January to June 2013.

HEALTH UNIT	PERIODS									
	2012					2013				
	PN		PC		TOTAL	PN		PC		TOTAL
	N	%	N	%		N	%	N	%	
All Units	935	59.5	635	40.5	1570	282	66.51	142	33.49	424
Unit I	156	64.46	86	35.54	242	28	56	22	44	50
Unit II	60	61.85	37	38.15	97	11	55	9	45	20

On the incidence of vaginal delivery and cesarean section, it is observed in Table 03 that, in the year 2012, 59.5% of births were normal and 40.5% were cesarean sections. Then, from January to June 2013, there were 66.51% normal deliveries and 33.49% caesarean sections. Although the percentage of normal delivery is higher in relation to cesarean section, cesarean section rate is well above the average (10-15%) accepted by the WHO (BETRÁN, 2007 apud SANCHES; MAMEDE; VIVANCOS, 2012). When the units studied were analyzed, the percentage of caesarean sections was almost equal to normal delivery (45% and 55% respectively) in the unit II in 2013. When comparing the percentage of normal deliveries (59.5%) and caesarean sections (40.5%) that took place in 2012 in all health units, the values were similar in the unit I in 2013; 56 % normal deliveries and 44% caesarean sections. Multiparous women (n: 12) were asked about the feel of labor pain, before, during and after delivery. In normal delivery, 58.33% (n: 7) of the multiparous patients answered that they experienced pain before and during delivery, 25% (n: 3), only during delivery, and 16.67% (n: 2), before, during and after childbirth. In caesarean section, 33.33% (n: 4) reported that they felt pain just after delivery, 25% (n: 3) said they felt pain before delivery only, 16.67% (n: 2), before and after, and 16.67% (n: 2), before, during and after delivery. Only one woman said she had no pain. Thus, women feel more pain before and during vaginal delivery and after cesarean delivery.

In order to organize the presentation of speeches about the advantages and disadvantages of each type of delivery, description of pain during labor, as well as the preference of multiparous women on route of delivery and the rationale that

guided the choices of primiparous, the following categories were established:

Multiparous women (n: 12) were asked about the feel of labor pain, before, during and after delivery. In normal delivery, 58.33% (n: 7) of the multiparous patients answered that they experienced pain before and during delivery, 25% (n: 3), only during delivery, and 16.67% (n: 2), before, during and after childbirth. In caesarean section, 33.33% (n: 4) reported that they felt pain just after delivery, 25% (n: 3) said they felt pain before delivery only, 16.67% (n: 2), before and after, and 16.67% (n: 2), before, during and after delivery. Only one woman said she had no pain. Thus, women feel more pain before and during vaginal delivery and after cesarean delivery.

In order to organize the presentation of speeches about the advantages and disadvantages of each type of delivery, description of pain during labor, as well as the preference of multiparous women on route of delivery and the rationale that guided the choices of primiparous, the following categories were established:

Advantages of normal birth

When questioned as to the advantages of normal delivery, 83.33% (n: 10) of multiparous women reported faster recovery and return to normal activities (n: 9), no pain after delivery (n: 4), possibility to care for the newborn and to perform self-care (n: 1), and because they consider this type of delivery natural, satisfying and better for the child (n: 2). The percentage of 8.33% (n: 1) did not answer the question, stating that they had no idea/knowledge of what were the advantages and 8.33% (n: 1) reported that there are no advantages in normal birth. The last woman had a negative experience with normal birth:

> Two days after delivery you can walk, take care of the baby and of yourself, go back to normal life, there is no increased belly, it's not pale, the body goes back to normal faster, the health is other thing. It is a great joy, because you take part of all, you can breastfeed soon after delivery. (M1).
>
> No, I had none. (M4)
>
> Faster recovery, I think for the baby is better, is natural for the baby" M11.
>
> We feel pain at that moment, but afterwards we feel no pain" M12.

Disadvantages of normal birth

As for disadvantages, the most frequent reports of multiparous women were feeling terrible pain (n: 4), there are no disadvantages in normal birth (n: 2), and the other women answered other disadvantages such as risk of developing to surgery and hemorrhage (n: 1), that episiotomy is painful (n: 1) and two women did not answer, as it appears in the lines below:

> *The pike, because it is painful. (M1)*
>
> *I do not think there are disadvantages, even if it takes the pike. (M5)*
>
> *The pain is too much, it seems that at that time you will die. (M7)*
>
> *You go through the pain, besides, the area becomes relaxed, it is not like before. (M8)*

Advantages of cesarean delivery

Multiparous women mostly stated that the caesarean section brings no pain due to anesthesia (n: 10) and they also cite as an advantage the possibility of planning the delivery, faster labor and also that this surgery can even save lives, as can be seen in the words:

> *It saved my daughter's life, it saved a life. (M1)*
>
> *You enter in the room feeling no pain, the procedure is scheduled, you know the time that the child will be born, for me the recovery was fast. (M4)*
>
> *When you apply anesthesia, the pain goes away. (M7)*
>
> *It's faster than labor, we just schedule and that's all. (M10)*

Disadvantages of cesarean delivery

The most frequently reported statements about disadvantages were: slow recovery (n: 4), pain after the effect of anesthetic medication (n: 3), risk of complications and hospital infection (n: 2), there is greater need for care after birth (n: 4), the child may be born premature (n: 1) and two participants reported that cesarean section does not have disadvantages:

> *You run the risk of getting hospital infections; the person is not born at the right time, the pain after anesthesia. (M2)*
>
> *There was no disadvantage in my cesarean section, I had no medication allergy. (M4)*
>
> *We cannot cough, walk, you have to ask others to do things for you. (M7)*
>
> *Everything takes time, it takes time to the body return to normal, lose weight, to recover. Go through the anesthesia, I'm afraid of the needle. (M10)*

Description labor pain

On the description of the pain of natural childbirth, women's testimonies resulted in words such as difficult to explain, satisfactory, unique experience, unbearable, bearable, it can be experienced at other times, as evidenced in the statements below:

> *It's a satisfying experience, after the child is born you don't even remember the pain. (M1)*
>
> *Abnormal labor pain, deadly pain, terrible pain, it is like you will not resist. (M4)*
>
> *I cannot describe, it's a pain so crazy. (M5)*
>
> *It's a pain that comes slowly and goes increasing, it seems like it goes destroying everything. Labor pain is forgotten afterwards, it doesn't even seem like you went through it, because in the second pregnancy I did not even remember the pain, because otherwise, we would not have other children. (M9)*

Preference of multiparous women on the way of delivery

Regarding the preference for mode of delivery, multiparous women (N: 12) were questioned on which mode of delivery they would prefer if they had a future pregnancy, as they passed through both cesarean section and normal

delivery experiences. 66.67% (n: 8) women prefer vaginal delivery and 33.33% (n: 4), cesarean delivery. Reports of preference for vaginal delivery are due to the rapid recovery and delivery, the possibility to care of the child and perform self-care soon after birth, shorter exposure time in the hospital thus avoiding complications, because this type of delivery is natural for women and children, the satisfactory experiences and because it is a unique experience for women, as shown in the statements:

> *Of course it is normal because the recovery is faster, milk comes out soon after delivery, we can take care of the baby. In the following day you can stand up, walk, take care of yourself, you can feed soon after birth. The skin is different, is more beautiful, is not pale. The body comes back faster. After delivery, the hip and breast increase, it makes women more beautiful, more feminine. It's healthy, satisfactory. Everything is good in normal birth, the intestine works best. Normal birth is an accomplishment in women's lives, is biblical, is an experience, a unique joy to the woman. (M1)*
>
> *I would prefer normal again, because the person avoids catching diseases and stays less time in the hospital. (M2)*
>
> *The health of the woman is different in normal birth, because there is no need for anesthesia, because it is natural. (M6)*
>
> *Because of the speed of labor, I prefer cesareans. But for recovery, I would rather choose normal. But to choose, I prefer normal because of the experience, and because the body goes back faster. (M10)*

Reasons that guided the choice of primiparous women

Primiparous women were questioned regarding the delivery route they wanted, 86.67% (N: 13) responded that they wanted vaginal birth. The motivations presented were rapid recovery, pain only at the moment of delivery, as opposite to cesarean section, being able to take care of the child and of the house right after delivery, as the lines below show:

> *They say vaginal delivery is better than cesarean, you do not feel much pain after having a baby. (P3)*
>
> *Because I die to do it, because the next day the mother can bathe her child. (P4)*
>
> *It hurts a lot, but then is past. In cesarean section recovery takes longer, then I would not be able to take care of her. (P7)*
>
> *Cesarean section is a procedure, there is risk, I am afraid they forget something inside me. I know I will feel pain, but I think positive and everything will be OK. (P15)*

Those women who intended to have cesarean delivery (N: 2) justified their preference by the fear of vaginal birth, fear of complications and for not wanting to experience the pain of normal delivery as it appears in the statements below:

> *Fear of normal delivery, delivery by forceps. (P9)*
>
> *Less pain, you do not feel the child being born. (P13)*

Final considerations

It is observed that the primiparous women are younger and most have low family income (one minimum wage) and are common-law married. In turn, multiparous women are older, many did not finish high school, are married and have family income above one minimum wage.

The median age of the first intercourse of primiparous women is lower than the multiparous, 16 and 17, respectively. Women surveyed of the two institutions differ in education and marital status. In the unit I, located in a poorest neighborhood, most of women had not completed elementary school and most had stable relationships. In the other unit, located in a more central neighborhood, women were married and had completed high school.

Primigravidae mostly initiated prenatal care in the eighth week of gestation, with five or more prenatal consultations until the time of the interview. They were in the third trimester of pregnancy and were followed by medical professionals and nurses of the health unit. Of the 10 multiparous women who underwent prenatal care in all their pregnancies, only seven had more than six prenatal consultations. They were also followed by doctors and nurses.

Primiparous women seek to solve any doubts related to pregnancy with physicians, mothers and other people close to them, as well as in books and on the internet, and few seek nurses. It is essential that nurses create a bond with the patients, in order to be seen by pregnant women as an ally where they can seek guidance and support when they think it is necessary. When health professionals are the source of information used by pregnant women, this is a guarantee that the guidelines received are reliable and will really benefit the women.

It is observed that dissemination of information on issues involving pregnancy during prenatal care is still needed. In both groups, there are women who had not received information regarding labor signs, types of delivery and their advantages and disadvantages, as well as breastfeeding. This lack of knowledge contributes to difficulties in having more participation in their bodily events and making decisions and informed choices about them, says Gama *et al.* (2009).

To comparison, it was sought to know the incidence of normal deliveries and caesarean sections of the municipality made in the public health system, during the whole period of the year 2012 and January-June 2013. There were high rates of cesarean sections in both periods, despite the fact that the public system encourages normal delivery. It would be opportune to research the actual indications for caesarean section in public hospitals. The high incidence of caesarean section has led to the increase of maternal and neonatal morbidity and mortality, especially puerperal infection and prematurity, featuring a major public health problem (MANDARIN, 2009).

Analyzing the reasons for the preference of multiparous women for normal delivery, after passing by the two childbirth experiences, it is observed in the testimonials that this preference is due its advantages and due to the disadvantages of cesarean sections. These are also the reasons mentioned by primiparous women to choose normal delivery.

Regarding the sensation of pain, multiparous women said they feel more pain before and during vaginal delivery and after cesarean delivery. They described the pain of normal childbirth as a unique and difficult to explain, a painful experience, however, satisfactory after the birth of the child. This information and exchange of past experiences passed to pregnant women, especially to primiparous women, in a group of pregnant women, can make them more confident and prepared for delivery. This function must be developed by nurses in basic health units.

It is possible to observe that some women had negative experiences in both types of delivery, which led them to prefer the type of delivery that caused less suffering. This may suggest a failure in health care in the public network (basic health units), which still lacks preparation through guidance and information, and in the hospital area, where humanization of childbirth care is missing, as well as the guarantee of rights of pregnant women. According to the Ministry of Health, in order that women can experience motherhood with safety and well-being, proper care at delivery is needed, and it is a right essential for every woman. The health team must be prepared to host pregnant women, their partners and their families, respecting all the anguish of that moment, creating a deeper bond, passing them confidence and tranquility in order to ensure the desire to reach the end of the pregnancy, a healthy newborn, as well as a healthy woman/mother, free from any trauma caused by the process of birth (BRASIL, 2001).

The Ministry of Health created the Program for Humanization of Prenatal and Birth (PHPB) through Ordinance nº 569/GM of June 01, 2000, with the purpose of developing promotion, prevention and assistance to the health of pregnant women and newborns, promoting increased access to these actions, increased quality and capacity of obstetric and neonatal healthcare as well as its organization and regulation under the Unified Health System. However, although many professionals want to provide qualified care, they face obstacles such as lack of investment in infrastructure, materials and equipment, among other instruments (BRASIL, 2000).

Despite the difficulties in the workplace, nurses need to know the anxieties, feelings, doubts, fears of pregnant women and understand the factors that influence important decisions and assist them in better choices in order to ensure their quality of life.

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