Original Article

Preference for type of childbirth, factors associated with expectation and satisfaction with childbirth

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ABSTRACT

This study aimed to analyze women's preference and satisfaction regarding the type of delivery and the association with the sociodemographic and obstetric characteristics. This is a cross-sectional study, carried out in three stages, with a sample of 190 puerperal women. The results showed that 68.9% wished natural childbirth and 31.1% wanted Cesarean section. The preference for natural childbirth was associated with first pregnancy (p=0.042) and previous natural childbirth experience (p<0.001); among women who had Cesarean section previously, the preference prevailed for Cesarean section (p<0.001). There were no statistical differences associated with other variables, as well as the puerperae's satisfaction. Binary logistic regression indicated association between previous experience and expectation by type of childbirth. The experience with previous childbirth influenced the preference for the type of childbirth; however, there were no differences in the puerperae's satisfaction, regardless of whether the outcome corresponded to the expectation.

Descriptors: Cesarean Section; Natural Childbirth; Personal Satisfaction; Nursing.

INTRODUCTION

The indication of the type of childbirth should base on consistent clinical reasons and specific situations. Cesarean section is a surgical procedure intended to intervene when risks are greater in the face of the natural childbirth benefits, and should be indicated only in necessary cases(1). There is an expressive increase in Cesarean section rates

practically all over the world, exceeding the percentage from 10% to 15% of births, which is considered acceptable and justifiable by the World Health Organization (WHO)[1].

In Brazil, Cesarean section is currently the most common way of birth, accounting for 56% of childbirths, an index that contributed to the creation of a protocol with guidelines for Cesarean sections, which aims to reduce these numbers, since inadequate indication may favor maternal and infant morbidity and mortality[2]. A national-based study entitled 'Birth in Brazil' indicated a rate of 51.9% of Cesarean sections, 45.5% of which occurred in low-risk pregnancies, 80% were indicated because the first birth was a Cesarean section, and 88% of the women did not even go into labor[3].

According to the American College of Obstetricians and Gynecologists, elective Cesarean section indicated before 40 gestational weeks does not allow full brain development of the fetus, which is estimated to last between 35 and 39 weeks. Therefore, the newborn may show respiratory problems, thermal control difficulties, sucking/feeding difficulties, jaundice due to excess bilirubin, hearing, visual, learning and behavior problems. In addition, newborns are at greater risk of: death, need for hospitalization in Intensive Care Centers, prolonged hospitalization, and greater demand for health services in the first year of life. In addition to the risks inherent in the surgical procedure, women undergoing Cesarean section are at risk of developing infections and hemorrhages, and in future pregnancies may be at increased risk for placenta praevia, placental accretion, postpartum hemorrhage and hysterectomy. Therefore, it is recommended that in the absence of maternal or fetal indication, vaginal childbirth is always the safest and most appropriate[4].

Thus, among the indications for Cesarean sections are justifiable: dystocia or failure in the progression of labor after delivery, cephalopelvic disproportion, interpartal interval less than two years after Cesarean section, anomalous fetal presentations, acute fetal distress, thick meconium (fetal distress) and changes in fetal heart rate[5].

After a previous Cesarean section, risks should always be evaluated by objective scores to indicate the next Cesarean section, since vaginal childbirth may be possible and is not contraindicated in these cases. Surgery is indicated only after two Cesarean sections or an interpartal interval of less than two years[6].

Although increasing the risk of morbidity and mortality for both the mother and the newborn, many pregnant women decide to have a Cesarean section. Fear is one of the reasons that can influence the expectation and choice of the pregnant woman. This is one of the most stressful agents reported for different reasons: fear of pain, fear of not being able to give birth, fear of how it will be conducted by professionals, as the main reasons for the preference for Cesarean section, as it is seen by many as painless, fast and safe[7-8].

Information on types of childbirth, risks and benefits are universal rights of pregnant women provided by the Global Alliance for Safe Motherhood, and the preference and choice of the woman for the type of delivery should always be considered with this knowledge[9].

Given the reality of high rates of Cesarean section in Brazil and its possible complications, the importance of identifying preferences and indications and outcomes of women submitted to Cesarean

section is justified, in order to elucidate the subject and to analyze how assistance has been provided, making it possible to draw up strategies to favor the quality of care and safety of the mother-child binomial.

Thus, this study aimed to analyze women's preference and satisfaction regarding the type of childbirth and the association with the sociodemographic and obstetric characteristics.

METHOD

This is a cross-sectional, quantitative study performed at the Hospital de Clínicas of the Federal University of Triângulo Mineiro (HCUFTM).

The Research Ethics Committee of the Federal University of Triângulo Mineiro approved this research under opinion No. 862.636 of October 24, 2014, in compliance with the guidelines inherent in the research protocol contained in Resolution No. 466/2012 of the National Health Council. After clarification, all participants signed the Free and Clarified Consent Term (FCCT), and those under the age of 18 had the consent of their legal guardians associated with their consent.

Data collection occurred in three stages. The first aimed to identify the preference for the type of childbirth among pregnant women; the second, after the delivery, to analyze the outcome between the puerperae, and the third stage sought to evaluate their satisfaction with the childbirth.

Participants in the first stage of the study were pregnant women at normal risk and at high risk, who were hemodynamically stable and in good clinical condition, from the 30th gestational week assisted at the hospital outpatient clinic (HCUFTM). We excluded pregnant women with fetal malformations incompatible with life (detected by medical evaluation and diagnosis); who had cognitive deficits and/or whose outcome was abortion, fetal death or stillbirth, and those who had deliveries performed in other institutions or municipalities.

The sample was non-probabilistic with data collection by convenience, in which 211 pregnant women were included from December 2014 to February 2015. Between the first and second stage, 21 participants were excluded because their childbirth was not in the institution. Losses were taken from the study analysis, so that the final sample consisted only of the participants of the two stages, totaling 190 participants.

In the first stage, interviews were carried out using a structured instrument built by the authors and submitted to a pilot study with 10 pregnant women, who were excluded from the analysis.

The instrument included the following variables: sociodemographic information (age; origin, self-referenced color, partner, occupation and schooling); health conditions (family history, smoking, alcohol use, illicit drug use and pathologies); current and past obstetric history (number of pregnancies, previous deliveries, abortions, number of prenatal visits, and gestational age at the time of the interview). Two more questions were made after this block of questions. One was a closed question regarding the type of delivery desired and one was open, in which the participant justified the reason for the preference. In the case of ignored information, it was removed from the statistical analysis. In addition to the interviews, we collected information from the prenatal card and the medical records. The pregnant women were approached during

waiting or after consultation, oriented on the objectives and invited to participate. The interview took place in the office, respecting principles of secrecy and privacy.

To carry out the second stage, the researchers opted for the list of patients hospitalized in the Gynecology and Obstetrics Ward of the hospital, the record of the women who participated in the first stage, based on the calculation of the probable date of childbirth or the childbirth scheduling. At this stage, information was collected on the type of childbirth and justification, in case of Cesarean section. The collection occurred in the medical records and, if the puerperae were not found, information was collected from the medical archive section of the hospital.

The third stage occurred within seven to 15 days after discharge. The women were contacted by telephone and asked to give their opinion on the childbirth, only answering if they were pleased or not with the experience; and what was the reason(s), if not. This method avoided response bias, since they would be allocated in the institution's wards during the second stage. There were three attempts to contact them from the provided number; however, it was not possible to contact 19 puerperae, and 171 puerperae were questioned about their satisfaction.

For the analysis, we used the technique of double typing with later validation, using Microsoft Excel®. The Statistical Package for the Social Sciences® version 20.0 was used in the statistical analysis. The descriptive analysis of the data on sociodemographic and obstetric variables was performed. The chi-square statistical test verified the association between preference for type of childbirth and variables of interest. To assess the associations magnitude, prevalence ratios (PR), odds ratios (OR) and their respective confidence intervals (95%) were used. To ratify associations, binary logistic regression was performed. The level of significance was set at 0.05.

RESULTS

Women's mean age was 26.2±6.4, ranging from 14 to 41 years. Of these, 6.3% were adolescents and 10.9% were 35 years or older; the majority had a partner (83.2%) and did not exercise paid activity (54.2%).

Regarding clinical conditions, family history and habits, 26.3% had no family history of pathologies and 16.3% had a family history of arterial hypertension; 6.3% consumed alcoholic beverages; 7.4% were smokers and only one woman reported using illicit drugs. When questioned about previous or ongoing diseases, 24.2% mentioned at least one disease, with hypertensive syndromes (21.3%), hypothyroidism (12.8%) and epilepsy (8.5%) being more frequent.

Regarding obstetric history, the number of pregnancies ranged from one to nine, with an average of 2.56 (±1.5), more frequent second (35.8%); mean number of alive children of 1.18 (±1.3), ranging from zero to six, and 24.7% had suffered abortion as a result of previous gestation. The gestational age during the interview ranged from 30 to 40 weeks, with a mean of 33.8 (±3.4) gestational weeks.

When questioned about expectation regarding the type of childbirth, 68.9% desired natural childbirth, of these, 55.7% believed that this delivery would provide faster maternal recovery; 14.5% mentioned that it

was the most natural and healthy birth for mother and newborn; 8.4% reported pain at natural childbirth as momentary, and 8.4% wanted to have natural childbirth again, since the previous one was successful.

Among women who had expected Cesarean section, 30.5% referred to iterativity (more than two Cesarean sections) as cause; 23.7% attributed to fear of pain and 15.3% to safety of surgery.

Data from the medical records indicated that 50.9% of childbirths were completed by Cesarean section; 48.1% of natural childbirth and 0.9% for forceps delivery. To justify Cesarean sections, in the medical records of puerperal women 18.9% were classified as emergency and among the reasons for indication were iterativity (23.2%), fetal distress (16.8%); macrosomia (10.5%), induction failure (10.5%) and maternal complications (10.5%).

In the analysis between the sociodemographic characteristics and the preference for the type of natural childbirth, there was no association (Table 1).

Table 1: Association of preference for natural childbirth with sociodemographic characteristics. Uberaba, MG, Brazil, 2015.

Variable	Natural		Cesarean		Total		PR	OR	p
	n	%	n	%	n	%			
Age (n = 190)									
< 26	70	72.9	26	27.1	96	50.5	1.12	1.46	0.232
> 26	61	64.9	33	35.1	94	49.5	(0.93 – 1.36)	(0.78 – 2.70)	
Occupational activities (n = 188)									
Not paid	72	66.1	37	33.9	109	58.0	0.92	0.75	0.374
Paid activities	57	72.2	22	27.8	79	42.0	(0.76 – 1.11)	0.40 – 1.41)	
Schooling (n = 190)									
No schooling up to primary education	84	67.7	40	32.3	124	65.3	0.95	0.85	0.623
Secondary or higher education	47	71.2	19	28.8	66	34.7	(0.78 – 1.16)	(0.44 – 1.63)	
Partner (n = 190)									
With a partner	108	68.4	50	31.6	158	83.2	0.95	0.85	0.695
With no partner	23	71.9	9	28.1	32	16.8	(0.75 – 1.21)	(0.37 – 1.96)	
Self-referenced color (n = 190)									
White	40	69.0	18	31.0	58	30.5	1.00	1.00	0.997
Not white	91	68.9	41	31.1	132	69.5	(0.41-1.20)	(0.51 – 1.95)	
Income (n= 190)									
< 1 minimum wage	105	67.3	51	32.7	156	82.1	0.89	0.63	0.295
> 1 minimum wage	26	76.5	8	23.5	34	17.9	(0.71 – 1.09)	(0.27 – 1.50)	

In the analysis between the obstetric characteristics and the preference for natural childbirth, there was an association with the first gestation (p=0.042) and the previous experience of natural childbirth (p<0.001); and among women who had previous Cesarean section, there was a greater preference for a new Cesarean section (p < 0.001) (Table 2).

In the binary logistic regression model, the variable previous experience of natural childbirth remained associated with this pathway and the experience of previous Cesarean section associated with the preference for a new Cesarean section (Table 3), indicating that the previous experience influences expectation.

Among the 171 puerperae contacted, there were no significant differences (p=0.407) in satisfaction with the type childbirth, regardless of whether the outcome met the expectation (Table 4).

Table 2: Association of preference for natural childbirth with obstetric variables. Uberaba, MG, Brazil, 2015.

Variable	Natural		Cesarean		PR	OR	p
	N	%	n	%			
Prenatal Consultations (n = 190)							
≥ 6	84	70.0	36	30.0	1.04	1.14	0.681
< 6	47	67.1	23	32.9	(0.85-1.28)	(0.61-2.15)	
Number of pregnancies (n = 190)							
One pregnancy	38	80.9	9	19.1	1.24	2.27	0.042
Two or more pregnancies	93	65.0	50	35.0	(1.03-1.50)	(1.02-5.07)	
Previous natural childbirth (n = 190)							
Previous experience	62	83.8	12	16.2	1.41	3.52	<0.001
No experience	69	59.5	47	40.5	(1.18-1.69)	(1.71-7.24)	
Previous Cesarean section (n=190)							
Previous experience	24	35.8	43	64.2	0.41	0.08	<0.001
No experience	107	87.0	16	13.0	(0.30-0.57)	(0.40-0.17)	
Information on types of childbirth during pregnancy (n = 187)							
Received information	53	63.1	31	36.9	0.87	0.64	0.155
Did not receive information	75	72.8	28	27.2	(0.71-1.06)	(0.34-1.19)	

Table 3: Binary logistic regression model between the expectation outcome for vaginal childbirth associated with obstetric variables (n = 190). Uberaba, MG, Brazil, 2015.

Variable	n	%	RCP	p
Number of pregnancies				
One pregnancy	67	35.3	1.236	0.729
Two or more pregnancies	123	64.7	(0.37-4.10)	
Previous natural childbirth				
Previous experience	74	38.9	0.388	**0.044**
No experience	116	61.1	(0.16-0.97)	
Previous Cesarean section				
Previous experience	47	24.7	12.113	**<0.001**
No experience	143	75.3	(4.56-32.16)	

Table 4: Satisfaction of puerperal with type of childbirth and correspondence between outcome and expectation (n=171). Uberaba, MG, Brazil, 2015.

Outcome and expectation	Satisfied		Not satisfied		PR	OR	p
	n	%	n	%			
Yes	111	94.1	7	5.9	1.04	1.66	0.407
No	48	90.6	5	9.4	(0.94-1.15)	(0.50-5.47)	

DISCUSSION

This study pointed out that the majority of interviewed pregnant women reported a preference for natural childbirth. Similarly, other Brazilian studies corroborate this preference, with frequencies varying from 58% to 80%[10-11].

The decision by type of childbirth generates doubts, insecurity and fear. Women who experienced natural childbirth have positive perceptions, are more tranquil, fast, simple and practical. The previous experience plays a fundamental role in the decision, thus, women who had natural childbirth continue to opt for it. Primiparous women who have doubts end up being influenced by the media, family members and those who have already experienced childbirth[9].

The reasons that led the participants to prefer natural childbirth are reinforced by other studies that have also found faster maternal recovery, more natural and healthy delivery for mother and newborn, and

momentary pain at delivery[8,10-11]; in addition to these reasons, the authors point out: faster procedures, easier breastfeeding and previous experience of natural childbirth[8,10-11].

Less than half of the interviewed pregnant women reported expecting Cesarean section, similar to other Brazilian studies in which the percentage of Cesarean preference ranged from 20 to 42%[10-11]. Research on aspects related to Cesarean preference found that the motivations are fear of vaginal delivery pain, insecurity in local care, negative experience in natural childbirth, desire to perform a tubal ligation and previous positive experience[10-11].

In contrast, one study found that 60% of the pregnant women reported prefering for Cesarean section during pregnancy and the Cesarean rate in the sample was 59.2%. When Cesarean-associated factors were analyzed, there was a higher number of Cesareans when the same physician who assisted prenatal care assisted in the childbirth (92.3%, p<0.001); maternal age higher than 30 years old (69.6%, p=0.005), with higher schooling level (63.4%, p=0.004), planned pregnancies (67.7%, p=0.003) of previous Cesarean section (63.6%, p<0.001). Of the Cesareans performed, 80% of the women did not even go into labor and 70% were assisted by the same physician in prenatal care and delivery, through the supplementary health system (p<0.001) and private care (p<0.001), with a significant Cesarean occurrence in these cases[12].

Although most pregnant mothers wanted natural childbirth, most births occurred by Caesarean section. A study carried out with 81 pregnant women in Rio Grande do Sul confirmed the alarming rates of Cesarean sections in Brazil, showing that their preference did not interfere in the performed childbirth, since the majority wanted natural childbirth (75%); however, the rate of cesarean section in the studied city was 89%[13].

A study carried out in a public hospital in Picos (PI) showed a similar rate of Cesarean sections (54.5%), according to this study results[14]. A Chinese study points to the main justifications for Cesarean indications: cephalopelvic disproportion, previous Cesarean section, secondary stop of descent and dilatation, fetal distress, macrosomia and anomalous fetal presentation[15]; in the study sample, the main indications were iterativity (previous cesarean section) and fetal distress and cephalopelvic disproportion was an infrequent justification.

A study in the city of São Paulo found that Cesarean section was more prevalent in women with advanced age, in cases of iterativity and gestational age over 40 weeks[16]. One study also pointed out an association between elective Cesarean section and age over 18 years, having finished at least secondary education; income/paid work; having a partner and performing prenatal care in the supplementary network[18]. Preventing the first Cesarean section is fundamental for the long-term decrease in the rate of cesarean delivery, since natural childbirth after Cesarean section is still questioned by many physicians due to the risk of uterine rupture[17].

Literature review from seven clinical trials that assessed whether active childbirth management (artificial amniotomy, intravenous oxytocin use, continuous support with doula and/or obstetrician nurse, use of partograph and review of ducts) impacted Cesarean section rates, indicated a small reduction in the

rate and it was not possible to determine the effect of each of the management components in this decrease. However, satisfaction was assessed in only one trial, and 75% of participants reported being pleased with childbirth regardless of birth route[18].

Regarding satisfaction with childbirth, a survey with 200 puerperae, using a scale from zero to 10, the child-related average was equal to nine, demonstrating a high satisfaction degree[19]. In contrast, a study found relevant dissatisfaction percentages in which 67% of nulliparous were not satisfied and 64% attributed that to care quality[20]. A qualitative study showed that women who had natural childbirth had a higher satisfaction rate, while those submitted to Cesarean section showed frustration in their speech[21]. Among those who declared that they were pleased with the Cesarean section, positive aspects were fear of pain and the medical indication for this delivery during pregnancy[21].

Similarly to the results, individual and previous experiences of women and their family members were factors that influenced the woman by choosing the type of childbirth[21]. They considered the influence of closer people, but they point out the importance of being guided by the professionals during prenatal care and/or childbirth, and cited in order of frequency: medical, nurse and doula guidance[21]. Among those who did not receive information, they sought opinions and publications on the Internet as their source[21] to support their choice.

Given the high rates of Cesarean sections, the reasons associated with preference and their justifications, it is necessary to reassess the organization of obstetric practices, with the purpose of proceeding with changes in childbirth care, respecting the physiology of women and favoring the interests of all involved. It is worth reflecting that "good childbirth", be it vaginal or Cesarean, should be one that provides maternal and neonatal well-being[22]. Decisions by type of childbirth and preferences of pregnant women should be guaranteed, if they are able to choose the one that suits them best.

When assessing the effects of professional support on decision by type of childbirth, especially after a previous Cesarean section, women who received the support showed less decision conflicts regarding the planning and type of delivery. In addition, greater knowledge about the different types of childbirth and their results can be verified among the assisted women. However, in a similar way to this study, regardless of the support, women were pleased with the delivery[23].

It is worth reflecting on the traditional midwifery/obstetrician nurses influence on birth assistance. A review study, after analysis of 15 clinical trials, found that women assisted by midwives/obstetricians showed lower rates of analgesia/anesthesia; forceps deliveries; amniotomy; episiotomy and preterm births and fetal/neonatal losses, and higher rates of spontaneous natural childbirths. Thus, women assisted by these professionals showed a reduction in the number of interventions during labor and delivery, which influenced satisfaction regarding the experience, since all were pleased about the process[24].

A study with 232 women in an Australian maternity ward aimed to present an overview of the care model performed by a midwifery/obstetricians group. When assisted by these professionals, 87% of the pregnancies resulted in vaginal delivery, 97% of satisfaction with childbirth, and they would recommend the

service to friends and relatives[25].

Likewise, professional follow-up/assistance can and should be a strategy to reduce Cesarean rates and maternal and child complications, in addition to improving the psychological and emotional aspects of pregnant women in the childbirth process.

The importance of the nurse, especially the obstetrician nurse in the educational pregnant process, is emphasized. This should be responsible for the guidelines on different types of childbirth, warning signs and labor (to avoid early hospitalizations and unnecessary interventions) and clarify doubts. Some of the women who preferred Cesarean section chose it for fear of pain and for believing in the procedure safety. Thus, it is up to the nurse, through health education, to reduce the 'fear' of the unknown, to promote dialogue with the women, with the team and with other women, helping them to have more conscious choices and expectations and, consequently, reach satisfaction with childbirth. This professional must be present in the services, with a proactive stance and establish a link with the clientele and other institution professionals[21].

The authors understand this study limitation with respect to external validity, since the data reflect an institutional and local reality and, perhaps, cannot be generalized to other populations and in different contexts.

FINAL REMARKS

Cesarean section had the greatest prevalence, although natural childbirth was the most preferred by most pregnant women. First-time mother and women who had previous natural childbirth showed greater desire for the natural outcome. Binary logistic regression identified that previous experience influenced preference for type of delivery.

There were no significant differences associated with other variables, nor were there significant differences in the satisfaction of puerperal women, regardless of whether the outcome corresponded to the expectation.

Previous childbirth experience may influence on the expectation and choice for a particular way of delivery, but this expectation did not influence the satisfaction with the childbirth regardless of the outcome.

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