

WOMEN'S PREFERENCES REGARDING TYPES OF DELIVERY: THE MEDIATION OF CULTURAL ASPECTS

A CULTURA MEDIANDO PREFERÊNCIAS PELO TIPO DE PARTO:
ENTRELAÇAMENTO DE FIOS PESSOAIS, FAMILIARES E SOCIAIS

INTERFERENCIA CULTURAL EN LA PREFERENCIA POR EL TIPO DE PARTO:
ENTRELAZAMIENTO DE HILOS PERSONALES, FAMILIARES Y SOCIALES

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ABSTRACT

This is a qualitative and descriptive study that aims at identifying the cultural aspects influencing on women's preferences regarding type of delivery as well as the influence of family and personal experiences. Data was collected through semi-structured interviews with women participating in a group meeting of pregnant women. Two categories emerged from the thematic content analysis. Results revealed that women are inserted in a cultural context, surrounded by experiences, values and beliefs, which shape their preferences regarding delivery method. Current tendency to medicalize childbirth care threatens women's knowledge about, appropriation of and ownership over their own body, and contributes to cement the idea that a vaginal birth is dangerous, increasing sense of fear over this type of delivery.

Keywords: Parturition; Culture; Family; Nursing.

RESUMO

Estudo qualitativo e descritivo, visando conhecer as mediações da cultura sobre as preferências de mulheres relativas à via de parto e a influência da família e das vivências pessoais sobre essas preferências e na determinação da via de parto. Para a produção dos dados aplicaram-se entrevistas semiestruturadas a mulheres que participaram de um grupo de gestantes. Da análise de conteúdo temática emergiram duas categorias. Dos resultados apreende-se que as mulheres inseridas em sua cultura, no interior da qual está sua família, são cercadas de vivências, experiências, valores e crenças que dão forma às histórias que modelam preferências e as escolhas no nascimento de um filho. A cultura medicalizada de atenção ao parto pode comprometer a possibilidade de a mulher conhecer, apropriar-se e dominar as manifestações do corpo, contribuindo para crenças de que o parto vaginal é perigoso e potencializando sentimentos de insegurança e medo em relação a qualquer decisão em prol desse parto.

Palavras-chave: Parto; Cultura; Família; Enfermagem.

RESUMEN

Estudio cualitativo y descriptivo que busca identificar la interferencia de la cultura en las preferencias de las mujeres por el tipo de parto y conocer la influencia de la familia y de las vivencias personales en dichas preferencias y en la determinación del tipo de parto. Para la recogida de datos se realizaron encuestas semiestructuradas con mujeres que participaron de un grupo de embarazadas. Del análisis de contenido temático emergieron dos categorías. De los resultados se deduce que las mujeres insertadas en su cultura, en cuyo seno se encuentra la familia, están rodeadas de vivencias, experiencias, valores y creencias que construyen historias que a su vez modelan las preferencias y elecciones en el nacimiento de un hijo. La cultura de medicalización del parto puede comprometer la posibilidad de que la mujer conozca, se adueñe y domine las manifestaciones de su cuerpo. Además, contribuye a la creencia de que el parto vaginal es peligroso, lo cual potencia sentimientos de inseguridad y miedo con relación a cualquier decisión a favor de esta elección.

Palabras clave: Parto; Cultura; Família; Enfermería.

INTRODUCTION

Childbirth is unpredictable and unknown to many women; the momentous event is full of expectations, hopes, worries, fears, anxieties and anguish.¹ It is a complex phenomenon and subject of study of various specialties, including nursing. Several studies characterize the rates of caesarean sections as a problem. Such high rates grant to it the status of an established cultural phenomenon reason why many national and international studies are interested in identifying the factors that influence the preference and/or choice of that mode of delivery.²⁻⁵ The belief that vaginal birth is natural and therefore more humane, uneventful and resulting in quicker recovery is recurrent. Furthermore, fear of anaesthetics and the fact that this mode of delivery it is the most usual in the family can explain such preference. On the other hand, fear of labour pain, vaginal problems, previous personal or other women's experiences, safety and agility as well as medical recommendations are factors that lead to caesarean section²⁻⁵ preference.

The right to choose the type of delivery was mentioned in the II International Conference on Health Promotion, in 1988, and recommended in the Adelaide Declaration. This document proposed the creation of public policies for childbirth based on the preferences and needs of women. It also highlighted the importance of allowing them to control the process which involves, among others, search for information regarding the right to healthcare and an active stance next to the health team.⁶

Women's right to control their own body was, somehow, appropriated by medical knowledge to justify caesarean sections, not always clinically recommended. From a medical perspective, elective caesarean sections reflect pregnant women's choice, often supported by the family.²

In this study, culture is understood as a complex web of meanings woven by man to which he is, paradoxically, tied up.⁷ The concept of culture as total phenomenon – with a certain-worldview shared by people that guide their practices and attitudes – encompasses health/disease related issues and, thus, the birthing process.⁸

Regarding childbirth, literature reveals that family stories contribute to shape several aspects, such as pain, which is ambiguously perceived as suffering or as natural consequence of the process.⁹

It is within the family group – set in a particular cultural context – that an individual first perceives the world and learns how to situate himself in it, through constant negotiation. The family group moulds cultural, ethical and moral values transmitted intergenerationally through beliefs, rites and myths with meanings and signifiers, contributing to the structuring of the psychological universe of its members and their choices.¹⁰ According to scholars of family groups it is necessary to increase studies in the area so as to qualify knowledge production in family nursing.¹¹

Considering that birthing choices should be based on women's preferences and needs, high rates of caesarean births in an upcountry city of the state of Rio Grande do Sul are striking: in 2008, out of 452 births, approximately 82.7% were caesarean sections. This is a much higher rate than that of the whole state (53.7%)¹² and well above the 15% recommended by the World Health Organization (WHO).²

Since cultural aspects, especially those shared within the family, and personal experiences influence decision making on childbirth, the following questions are posed: "According to women living in urban areas of an upcountry city in the state of Rio Grande do Sul, what is the influence of cultural aspects on their birthing choice?"; "What is the influence of family and personal experiences on these preferences?".

Given the above questions, the current study aims at identifying the cultural aspects influencing on childbirth preferences of women living in urban areas of a municipality of Rio Grande do Sul; it also aims at investigating the influence of family and personal experiences on such preferences.

METHOD

This is a descriptive, qualitative and cultural study.^{13,14}

Field research was conducted in a municipality at the north of the state of Rio Grande do Sul; six women participated in the study; they were located from medical records of two groups of pregnant women attended at a Family Health Strategy unit (FHS) in the 12 months previous to the study. Inclusion criteria were: to be delivered of a child in the previous six months, to reside in the referred municipality, to be over 18 years of age.

Women that met the above criteria were selected and randomly contacted by telephone. They were explained about the study's objectives and the possibility of a domiciliary interview at a date and time of their choice. All women contacted agreed to participate in the research; the number of participants was defined by saturation criterium.¹⁵

The research was approved by the Ethical Considerations Certificate No 0120.0.243.000-11, issued by the Research Ethics Committee of the Federal University of Santa Maria. All participants signed the Free, Prior and Informed Consent form. Data was collected in July and August 2011 through semi structured interviews with the following questions: "What have you heard about childbirth?"; "Which type of delivery would you choose?"; "Why would you prefer such type of delivery?"; "What have you heard about delivery of women in your family?" In order to preserve the anonymity of research subjects, participants were identified as C1, C2... to C6. Institutions and names of people were replaced by nicknames.

Data was analysed by thematic content analysis, summarized in three steps: pre-analysis, data exploration and interpretation of results.¹⁵ Firstly, the material produced was exhaus-

tively read, data was categorized, text was edited and the units were grouped according to themes; finally, data was interpreted and integrated to referential anchor – culture – and collated with other authors' studies on the same subject.

RESULTS

Six women – four pregnant and two postnatal – aged between 25 and 41 years, participated in the study. Three of them were married, two were in a stable relationship and one was single. One worked outside the home. As per level of education, two had primary education (one complete and the other incomplete), three had completed secondary education, and one was university-educated. The average monthly family income was, at the time of the study, about three times the minimum wage. On average, each participant shared the house with other three people. As for previous pregnancies, the two postnatal women had one and two children, respectively; among the pregnant ones, one had a son, two two children and one three children.

Data analysis revealed two categories, which demonstrated the influences of family and personal experiences on the birthing choice. The first category identified reasons for the group preferring a certain type of delivery; the second, despite personal preferences, reasons for the delivery they had actually experienced.

THE EXPERIENCES AND THE STORIES: YARNS THAT WEAVE BIRTHING PREFERENCES

By analysing contents of interviews, researchers found out that initially most participants wanted a vaginal delivery because they thought it the best option for mother and baby.

If I could choose, I would have a natural childbirth, because everyone says it's a very good delivery. You feel pain but then, they say it's the same as nothing (C2)

Data revealed that reasons for not having a vaginal delivery were lack of hospital infrastructure in the municipality and fear that this type of delivery may bring complications or sequels to mother and child.

At the beginning I wanted a natural birth. I'd try it, if the hospital's infrastructure was better (C1)

Apart from the above, two participants said they had sustained their choice of natural birth until they reached hospital at the onset of labour. One of them reported having insufficient dilatation and a hypertensive crisis, leading to a caesarean section. The other, after vaginally delivery of a child, wanted a natural birth as well but had changed her mind at hospital after

considering that the health team was not up to delivering the care and attention she thought necessary.

I went to hospital sure of having a natural delivery, but blood pressure was too high (...) (C2)

I was three fingers dilated by the time I went to hospital. After they examined me I came home and decided to call another doctor, to have a caesarean. Then I decided to have a caesarean. It was taking too long; I thought they were winding me up. (C4).

Another interfering factor was family interactions, many of which were processed during pregnancy and with significant participation of the pregnant woman's parents.

I talked with my in-laws and with my mother. My mother influenced me a little. She didn't want me to wait for a normal delivery if I was going to have it in (bigger city) because I didn't know what was going to happen. She said it would be better to have a caesarean, that normal delivery is a struggle, that one suffers a lot (C1)

With the first one, my parents influenced me; they feared caesarean, the cutting, recovery. I was very young, they did the examination, it was time and I had it. I was in labour and there was no time for anything else. But it was because of my parents (C4).

Two participants mentioned that their choice of a vaginal delivery was respected and there were no opinions to the contrary amongst their social relations.

It was my choice! No one was against it (C5).

Besides the family, the participants also mentioned advice from people outside their families.

Some people scare you and tell you a lot of things. So people end up being afraid and I think that is why they choose a caesarean (C2).

Women that give birth by vaginal delivery are often praised.

My mother and my grandmother used to say you had to be a great woman for a normal delivery; for a caesarean you didn't need to be so brave (C4).

It should be noted that all the participants were born vaginally and that most of them came from large families.

My brother and I were born by normal delivery. My mother's last child was a caesarean so she could have a tubal ligation. She said it was ok (C5).

My adoptive mother always said that my mother had had eleven children. She used to say that Tulipa, my biological mother, had no time to feel pain, that the baby came out in a jiff (C2).

The participants had many stories (from within the family group or out) that emphasized both positive and negative aspects of a vaginal delivery. Despite the stories' content – some of them full of negative experiences – they reported an initial preference for a normal delivery, not always materialized due to psychological, clinical or obstetric reasons.

My mother always said Tulipa was like a rabbit. That's why I always thought a normal delivery would be better (C2).

I have a sister-in-law that had three babies through natural delivery. She got there, and had them. It was easy to her (C5).

When the participants' talked about their family birthing history, they mentioned easy delivery and women's faster recovery as positive aspects of normal delivery. However, some participants recalled stories of a negative nature.

My mother had ten children, all naturally. The first one was more difficult, with forceps. Child birth was difficult, with a midwife. Where she lived most of them were vaginal deliveries; few caesareans[...] (C3).

The first two ones were normal. With Begônia, my little sister, it was terrible. My mother had induced labour; a lot of suffering because she was not dilated. The baby didn't come down, there was no way (C4).

This category data reveals that the preferences for a certain type of delivery are determined by the interpretation and meanings that women give to other women's experiences in their family group and to the stories originated from them, as well as to their previous experiences.

EXPERIENCES AND PERSPECTIVES: THE INTERTWINING OF REASONS FOR A CAESAREAN SECTION

From the experiences and attitudes towards childbirth, some interconnected reasons were identified as being deter-

minant factors for an elective caesarean delivery. It is significant that, even reporting a preference for a vaginal delivery, five of the six study subjects had a C-section.

In the context of pregnancy and childbirth, unexpected situations may frustrate the preference of women and/or families for a certain type of delivery. Biological circumstances (e.g. foetal distress, arrest of cervical dilation, placental abruption, and hypertension) were related as reasons for caesarean section.

I had a contraction, before having the first child; it was very quick: I felt pain and then it was gone; I was not dilated. At the end, the baby's heart stopped beating and I had a caesarean (C2).

I had placental abruption when I was pregnant with my last daughter. I was in the first month of pregnancy and I spent the whole pregnancy in bed (C3).

I had one contraction after the other but was always three fingers dilated and the baby was going up. In the second pregnancy was the same thing (C5).

It should be emphasized that beyond these determinants, psycho-emotional manifestations – depending on the cultural environment of the pregnant woman – can be produced and potentiated according to the meanings assigned to events related to childbirth and delivery. If the birth process is recognized as threatening, anxiogenic experiences could be elicited and, consequently, somatised – thus, the influence of cultural aspects over these manifestations is characterized. Therefore, the anxiety preceding birth triggered, according to one of the participants, a series of adverse physical events that culminated in a caesarean section.

Up to a point I was doing fine. Nearing my due date, my blood pressure went up; I think I was too anxious (C2).

Another determining fact was difficulties of previous deliveries, which they deemed unnecessary. Therefore, with the prospect of reissuing that experience surgical delivery is regarded as the possibility of warding off the suffering.

That is why I said I wanted a caesarean. I didn't want to go through that again. I suffered a lot to have my last child. It seems that at that moment you lose all your strength (C6).

Fear of the unpredictability and uncontrollability of the labour process is associated with a vaginal delivery that could potentially harm the baby. Such aspects can influence the participants' choice.

I said I didn't want a normal delivery anymore. I feared the baby would pass its due date, I thought about Margarida's experience (C4).

In this sense, fear and insecurity connected to childbirth refer to conjectures, commonly developed within the family and other social groups, about its possible outcome. Even if they are not expressed, situations that may endanger the safety of mother and baby influence the decision regarding type of delivery.

One of the study participants classified the local hospital's infrastructure as inadequate. Therefore, she went to another city for a safer caesarean section, a more complex procedure. However, physicians' influence can also take part, which demonstrates how far health professionals (and the culture they represent), intervene in issues relating to labour and birth.

Here the hospital doesn't have good infrastructure, so I went to another city. The main factor was the organization here. The other doctor arranged everything so all would be safer. This made me chose the caesarean section. The doctor from the other city said that if I wanted a normal delivery I would have to go there at least a month before due date. As I didn't have where to stay we decided to schedule the caesarean, so things would be easier (C1).

The possibility of tubal ligation at the time of C-section indicates further influences of the health care system over pregnant women. Experiences shared within the family group and the community in which they live reinforce and feed back into the culture of health system.

I wanted a ligation as well. So I had to go for a caesarean, like my sister-in-law had (C2).

The study demonstrates that caesarean delivery was predominant among research participants. At the time of data collection, only one woman had had a different method of labour. Being inserted into a medicalized method of childbirth process, a C-section is considered safer and more beneficial than a vaginal delivery. The study participants related that even if a normal delivery were possible, they might still have not done it because they associated it with negative experiences – obstetric and neonatal complications, pain and suffering, – which gives a traumatic connotation to the process.

DISCUSSION

The study results indicate that the participants' initial preference for a vaginal delivery was related, among other factors, to their cultural background, personal experiences and family histo-

ry. The world of each social group is organized by cultural aspects according to its own logic. It is an integrative and formative experience that preserves social groups who share and communicate their systems, principles and cultural values.⁸ Thus, beliefs, values, feelings, perceptions and representations about childbirth result from the influence of psychological, social and cultural factors.^{16,17}

The influence of family and other social groups related to the study participants features prominently when they talk about their preferences regarding the method of delivery. It is generally originated during pregnancy, which is consistent with findings of similar studies.^{18,19} In this sense, it is important to highlight that family and other social groups which women belong to are a part of a cultural structure that shapes them and, at the same time, will be shaped by them.

Culture is not dissociated from nature, since biological issues contribute to produce and consolidate beliefs, such as that a C-section could prevent possible complications to the baby and minimize the mother's suffering. This belief arises from the interpretation of meanings resulting from previous childbirth experiences. The birthing process involves many aspects transmitted by the family, especially parents that shape women's emotional responses to it.³

The cultural content that permeates the social group's narratives need to be addressed by health care professionals in a context that goes beyond pregnancy. Consequently, the pregnant woman, her family and the health professional, can critically think and interpret the set of beliefs that inform those individuals' worldview, maintaining, accommodating or reorganizing decisions about health, specifically those relating to childbirth. Health care professionals need to establish a link between scientific knowledge and family wisdom as well as to consider the pregnant woman and her family's previous experiences.^{2,20}

According to the above recommendations, nurses should consider pregnant women and their families as a whole, taking into account their values, beliefs and perceptions. In doing so, the professional can identify what guides their decisions, what gives meaning to their thoughts and, along with them, interpret the possibilities of each health care subsystem they use, taking advantage of what is best in each one of them. Therefore, the nurse will contribute to the strengthening of family ties and their decisions regarding childbirth.²⁰

Given the family's influence on the preferences and versions about the birth process, it is important to consider health professionals relationship with the family, whose dynamics and affective ties are forever changed by the baby's arrival.²¹ The birth of a new family, along with the new baby, strengthens relationships to face changes involving birth and women's adaptation to motherhood.

Amongst the reasons of the participants, the researchers identified others that went beyond the clinical and obstetric: the C-section, specifically, is the birthing method favoured by the

health care system. The process should be considered, beyond the birthing process itself and in the light of notions such as self-management – understood as the right of choosing the ideal place for giving birth or deciding whether or not to have more children.

The study findings corroborate, to a certain extent, other investigations that found out that fear of childbirth, pain and ignorance about the benefits of natural childbirth influence the preference for a caesarean delivery.^{9,18}

Regarding childbirth pain, a study of pregnant women in their last quarter of pregnancy sought, among others, to understand pain and its cultural dimension. The results of such investigation are confirmed by the present study – both consider that fear of labour pain summarises all of pregnant women's fears and concerns; figuratively speaking, the process materializes itself as a monster that contaminates a process that is basically physiological. The current study concludes that fear of childbirth, present in the narratives, is due to misinformation and to the hospital's maternity care organization.²²

The notion of unnecessary pain contributes to the representation that a C-section is the only possible alternative to overcome pain. Eventual difficulties brought about by a caesarean section are considered minor issues for, in this study scenario, the procedure was sold as the only available alternative to the sufferings of the birthing process.

It is important to point out that pregnancy and birth are periods of big changes – physical, affective and emotional – not only to women but to the family group as a whole. The process generates expectations that can turn into a source of anxiety and stress. As a consequence, the C-section may be seen as a way out of an experience that, in the view of some women, is synonym with bodily suffering.

The study suggests that the main reason for choosing a certain type of delivery is the removal of pain. The representations created about the process are translated in fear and such result is, probably, due to ignorance about the process or to the cultural context of pregnant women.^{19,22} Such assumption is in consonance with the present study findings and indicates that different theoretical perspectives are useful to understand the level of complexity of the subject in question.

Data acquired from this study allowed researchers to determine to which extent the family group and other people within the pregnant women's social circle influence their choices. Such preferences are shaped by family stories of positive and negative birthing experiences and information about the process and health care delivered during pregnancy.

FINAL CONSIDERATIONS

The study results reveal that the participants are inserted in a particular cultural universe surrounded by experiences, val-

ues and beliefs that shape their preferences regarding various life stances, including the birth of a child. The influence of the pregnant woman's mother is felt in the preference manifested for a determined type of delivery.

A medicalized approach to the birthing process restricts women's right to control and take ownership of her own body as well as endorses the belief that a vaginal delivery is dangerous to mother and child. Consequently, insecurity and fear of that delivery method are enhanced.

The results and the theoretical framework of the current study demonstrate that a "culturalist" approach has to be avoided as it tends to conduct to stereotypes such as "women living in certain places prefer that given type of delivery": data collected enables researchers to detect different preferences amongst the study participants and even, from the same women depending on the moment and on her experience.

Therefore, researchers expect that this study will signify a contribution to the nursing profession since it will spark reflections on pregnancy care considering the background of the leading roles – the pregnant woman and her family. Such purpose is based on the principle that the thinking mechanism, beliefs and worldview guide the individuals and social groups' actions and decisions. Understanding them is essential to the harmony between carer and patient, avoiding value judgments and prioritizing a practice based on cultural relativism.

The research recommends further studies applying interpretive ethnography that could contribute to investigate how much cultural aspects influence the preference on types of delivery.

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