REVISTA ONLINE DE PESQUISA

CUIDADO É FUNDAMENTAL

Universidade Federal do Estado do Rio de Janeiro • Escola de Enfermagem Alfredo Pinto

RESEARCH DOI: 10.9789/2175-5361.rpcfo.v13.7114

ROUTES OF WOMEN SUBMITTED TO CESARIANA IN THE PUBLIC HEALTH CARE SECTOR

Percursos de mulheres submetidas à cesariana no setor público de atenção à saúde

Percursos de mujeres submetidas a la cesariana en el sector público de atención a la salud

Sarah Dias Silva[1]; Andreza Rodrigues Nakano[2]; Cláudia Bonan[3]

How to quote this article:
Silva SD, Nakano AR, Bonan C. Routes of women submitted to cesariana in the public health care sector. Rev Fund Care Online. 2021 jan/dez; 13:8-16. DOI: http://dx.doi.org/10.9789/2175-5361.rpcfo.v13.7114

RESUMO

Objetivo: explorar os itinerários de cuidados à gestação e ao parto de mulheres submetidas à cesariana no setor público de saúde e analisar os elementos dos itinerários que colaboram para este desfecho. Métodos: estudo qualitativo no qual foram analisadas 16 entrevistas com usuárias do setor público, de municípios do Rio de Janeiro, entre os anos de 2011 e 2012, com intervalo de 6 a 18 meses pós-parto. Resultados: realizar o pré-natal em serviços de saúde, fazer exames laboratoriais e ultrassonográficos são cuidados presentes nos itinerários de todas as entrevistadas, e a participação da família reforça estes cuidados. A maioria sabia qual maternidade procurar para o parto e entendia que a via seria definida por indicações médicas. Conclusão: Prevalece o cuidado à dimensão biológica da gestação e do parto, e a cesariana aparece como parte do acervo de cuidados e não como uma escolha.

Descritores: Cesárea; Parto; Sistema único de saúde.

[1] Graduated in Nursing from UFRJ, Obstetric Nurse Certified by IFF / FIOCRUZ, Specialist in Women's Health Nursing from IFF / FIOCRUZ, First Lieutenant in the Brazilian Navy.

[2] Graduated in Nursing from Universidade Federal de Juiz de Fora (UFJF), Master's Degree from IFF / FIOCRUZ, PhD from IFF / FIOCRUZ, Assistant Professor at UFRJ.

[3] Graduated in Medicine from Universidade do Estado do Rio de Janeiro (UERJ), Master's Degree from UFRJ, PhD from UFRJ, Professor at IFF / FIOCRUZ.

ABSTRACT

Objective: to explore the routes of gestation and delivery care of women undergoing cesarean sections in the public health sector and to analyze the elements of the itineraries that collaborate for this outcome. **Methods:** a qualitative study in which 16 interviews with public sector users from Rio de Janeiro municipalities between 2011 and 2012 were analyzed, ranging from 6 to 18 months postpartum. **Results:** performing prenatal care in health services, performing laboratory and ultrasound examinations are all present in the itineraries of all the interviewees, and the participation of the family reinforces these care. Most knew which maternity to look for in childbirth and understood that the pathway would be defined by medical indications. **Conclusion:** care for the biological dimension of gestation and delivery prevails, and cesarean delivery appears as part of the collection of care and not as a choice.

Descriptors: Cesarean section; Parturition; Unified health system.

RESUMEN

Objetivo: explorar los itinerarios de cuidados a la gestación y al parto de mujeres sometidas a la cesárea en el sector público de salud y analizar los elementos de los itinerarios que colaboran para este desenlace. **Métodos:** estudio cualitativo. Analizadas 16 entrevistas con usuarias del sector público, de municipios de Río de Janeiro, entre los años 2011 y 2012, con intervalo de 6 a 18 meses post-parto. **Resultados:** realizar prenatal en servicios de salud, hacer exámenes de laboratorio y ultrasonográficos son cuidados presentes en los itinerarios de todas entrevistadas, y la participación de la familia refuerza estos cuidados. La mayoría sabía qué maternidad buscar para el parto y entendía que la vía sería definida por indicaciones médicas. **Conclusión:** Prevalece el cuidado a la dimensión biológica de la gestación y del parto. La cesárea aparece como parte del acervo de cuidados, no como una elección.

Descriptores: Cesárea; Parto; Sistema único de salud.

INTRODUCTION

Brazil is one of the countries with the highest incidence of cesarean sections in the world. According to data from the *Sistema de Nascidos Vivos* (*SINASC*) [Live Birth Information System], 55.5% of the infants in 2015 were born by cesarean section in Brazil.[1] The *Inquérito Nacional sobre Parto e Nascimento* [National Enquiry into Labor and Birth] showed that 45.5% of the habitual obstetric risk women had a cesarean section.[2] These rates express a high incidence of surgery in both private and public hospitals. According to the World Health Organization (WHO), these values are not justifiable, as there is no evidence that a cesarean section will bring benefits to women who do not need it.[3]

In the private health sector, the proportion of cesarean section reached 84.6% in 2015,[4] and have raised questions and interventions from health authorities. A type of material culture that develops itself and normalizes cesarean sections as a way to be born[5] and the influence of medical power and health mercantilism[6] are results of research on what the cause of cesarean section rates in private hospitals.

In the public sector, cesarean sections have also been gradually increasing, attracting attention and mobilizing actions to face this scenario.[5] About 70% of all births in Brazil are performed in public hospitals, of which 46% are cesarean sections; in the Southeast Region, 61% of infants were born by cesarean section.[7]

Studies carried out in Brazil with women who had a cesarean section in private hospitals or hospitals of the *Sistema Único de Saúde* (*SUS*) [Brazilian Unified Health System] highlighted factors and aspects related to this procedure and the women's right to choose the delivery route.[8,9,10] Other studies aimed at the women's opinions, social representations and experiences about childbirth.[11,12]

Thus, this study is aimed at exploring the pregnancy and childbirth care itineraries for women who had cesarean sections in public hospitals and analyzing the social, personal and care factors associated with these itineraries that contribute to the incidence of cesarean sections among these women.

Care itinerary is a type of therapeutic itinerary, which is a theoretical reference involving events, interaction, negotiation, and decision making throughout the experience of illness and health; it also includes the search for treatment and cure of diseases.[13] Despite being used more frequently in studies related to diseases, therapeutic itineraries can be applied to analyze the process of pregnancy and delivery.[14,15] Also, it can be useful for exploring the route chose by women who had a cesarean section. Since these are reproductive life events, we will assume that the term "care route"[16] is not related to the idea of illness, making clear our understanding of the process of pregnancy and labor.

METHODS

This qualitative research was carried out with women who had a cesarean section and employed the method of studying oral reports[17]. The inclusion criteria were: (1) women who had cesarean section between January and December 2011 in maternity hospitals of the metropolitan region of *Rio de Janeiro* and *São Paulo* city, Brazil, (2) belonged to one of the groups with the lowest expected cesarean section rates according to Robson's criteria,[3] and (3) aged from 18 to 35 years old at the time of delivery. Considering the total of 79 interviews, 16 with women who had a cesarean section in public sector hospitals of *Rio de Janeiro* State, Brazil, were analyzed.

The oral reports were submitted to thematic content analysis in order to extract implicit information from them.[18] First, the interviewees' statements were analyzed by performing a floating reading. This process produced thematic units, and four categories emerged from them. In order to safeguard the anonymity of the research participants, we used a code to refer to them.

This research was approved by the Research Ethics Committee of the *Instituto Nacional de Saúde da Mulher, da Criança e do Adolescente Fernandes Figueira (IFF)* at *Fundação Oswaldo Cruz* (FIOCRUZ) under the *Certificado de Apresentação para Apreciação Ética* (CAAE)

[Certificate of Presentation for Ethical Appreciation] No. 60909616.3.0000.5269 on November 2016. Furthermore, this study complied with the ethical standards of research involving human participants.

RESULTS AND DISCUSSION

Characterization of the participants

The study participants were young and adult women aged from 18 to 33. Almost all of them reported living with their partner and being housewives. As for parity, seven women were primiparous, five were secundiparous, and four were multiparous.

The participants' statements along with study results are presented below. The statements were labeled according to the woman's parity because sometimes it determines the features of care itineraries.

Prenatal routines

For most of the women interviewed, prenatal care was initiated as soon as possible after confirming pregnancy. This indicates that monitoring pregnancy by using biomedical resources is seen as something necessary and urgent, as pointed out in the following statement: "*As soon as I did the test. I did the test there and I went straight to the health care unit to start receiving prenatal care.*" *(P8, primiparous woman).* Because there is no guarantee that the woman's body will naturally change during pregnancy, it is necessary external evaluation preferably by a specialist in order to monitor pregnancy and make important decisions about labor. Even those participants who have had previous pregnancy experiences assume the importance of seeking prenatal care immediately.

Prenatal care provided by professionals in public hospitals was part of the participants' routine care. Laboratory and ultrasound exams complemented the prenatal routine and revealed the need for monitoring the fetus' development. Ultrasonography was often performed in private sector clinics without referral by a physician. The participants stated that they could afford these exams. The importance of the biological aspects of prenatal care was highlighted by the following testimonials:

> *Ah! I was told that I had to do several exams [...] I had to pay for the ultrasound exams because it took too long. Then I got scared, you know? I did only one exam in a public clinic [...] Then the girl made an appointment, and I paid for the appointment and went in.* (P7, primiparous woman)

Regarding the care and resources used throughout prenatal care, there is no difference between women who had one delivery (primiparous women) and those who had two or more (secundiparous and multiparous women, respectively). Prenatal care had similar relevance among women belonging to both groups.

The Ordinance that established the *Rede Cegonha* [Stork Network] in Brazil defined at least seven prenatal appointments as a care indicator. On the other hand, the WHO already states that six prenatal appointments are sufficient to guarantee the quality of care. The main indicator of birth prognosis is to receive prenatal care and doing it early is considered essential for adequate care. The adherence of women ≤ 12 weeks pregnant has been the target of public policies, as well as performing all recommended prenatal exams, such as serological tests for HIV and syphilis, hemogram, urine culture, among others.[19,20]

A nationwide study revealed that prenatal care in Brazil has reached values close to 99% and the onset of prenatal care before sixteen weeks of pregnancy has occurred with more than 75.0% of women.[21] Another study, which was conducted in public health care institutions of the *Rio de Janeiro* city, *Rio de Janeiro* State, Brazil, found that the percentage of pregnant women who started receiving prenatal care before sixteen weeks was 74.4%.[22] In contrast, both studies concluded that although the increase in prenatal care coverage has been successful in Brazil, the quality of care needs to be improved according to the standards recommended by the *Programa de Humanização do Pré-natal e Nascimento* [Prenatal and Birth Humanization Program].[21,22]

Public policies have aimed at ensuring perinatal care for all pregnant women through access to services, appointments, and exams, thus strengthening the understanding of pregnant women and the general population that biomedical care is a priority and essential for routine care. One study showed that biomedicine care is also delivered in the supplementary health care system. The monitoring of the parturition process and clinical-laboratory evaluation were the most predominant actions in this case.[15]

The family participates throughout the prenatal care itinerary, especially by reinforcing the importance of biomedical care in health care services already valued by women. The presence of a relative during an appointment goes beyond simple follow-up: they ask health care professionals to make sure that the pregnancy is being monitored effectively for the safety of both woman and fetus.

> *Then when my mother came here [...] she went with me. [...] Then my mother asked the doctor during the days she stayed here.* (P2, secundiparous woman)

The results of the study *Nascer no Brasil: inquérito nacional sobre parto e nascimento* [Being born in Brazil: national inquiry into labor and delivery] showed that 98.2% of women reported having ultrasonography during pregnancy, which was predominant among the exams considered essential for prenatal care according to the Brazilian Health Ministry, such as blood sugar and urine tests, for example.[21] This corroborates the idea that women and their families value image exams since it provides a "visualization" of the fetus and consequently the feeling that

its development is "under control". This value attributed to ultrasonography is corroborated by a study that shows that the fetus image is identified as an important record of the child's own image, even if the interpretation is limited and different from the one provided by professionals.[23]

Few participants reported receiving special care throughout pregnancy. They were instructed, for example, to perform physical activities or change the diet, but not always adhered to these instructions: *"[...] she instructed me to take* a *walk to help in childbirth, things like that"* (P3, primiparous woman).

A study conducted with women who had cesarean sections in private sector hospitals identified them as "people who care for themselves very much" because they were concerned about exercising, controlling their diet, using vitamin supplements, receiving lymphatic drainage, etc.[7] Receiving care other than prenatal care may then be related to the socioeconomic factors.

Few care itineraries included the preparation of women for delivery by health care professionals during prenatal care. Only two women were guided through this process and reported that they considered normal delivery as the best option. Guidelines on the benefits of normal delivery are known by these women, but cesarean sections, which leads to complications during labor, are presented without mentioning their risks and.

> *And they didn't explain the cesarean section very much because until then I was going to have a normal delivery, according to the doctor too, it was going to be normal delivery, do you understand? [...] they said it would probably be a normal delivery unless there was some complication, but I was prepared, they prepared me for normal delivery.* (P6, primiparous woman)

A study showed that half of the interviewed women said they had not received information about each type of delivery.[24] Another study, which was carried out more recently, reported that this problem remains. Its findings revealed that a small proportion of women using the public health care system in *Rio de Janeiro* city, even those who were 37 weeks pregnant, reported not being guided through childbirth.[22] Furthermore, other study demonstrated that the low proportion of women receiving guidance during prenatal care resulted in their insufficient preparation for childbirth.[21]

The study results, which are in line with the literature, suggest that one of the consequences of the lack of preparation for childbirth is women having little information about cesarean sections at the end of pregnancy. Consequently, the risks arising from cesarean sections diminish after this procedure is performed successfully.

Ideas concerning childbirth

In general, the women's view on normal delivery and cesarean section did not vary. All participants, regardless of parity, pointed out the same characteristics (good and bad) for each type of delivery and talked about their respective advantages and disadvantages. The idea of normal delivery as a natural process associated with rapid recovery was predominant. Nonetheless, the multiparous women described it as painful. The cesarean section has been described as something unnatural, causing slow recovery and dependence on relatives for the day-to-day activities during the postpartum period. Despite these disadvantages, they pointed out that the absence of pain until delivery is the great advantage of cesarean sections.

> *[...] the advantage is that then you can do everything normally. [...] And the disadvantage of the cesarean section is that you can't do anything. [...] It's really bad there, got it? Staying dependent.* (P4, primiparous woman)

One study found that the vast majority of women considered rapid recovery as the main advantage of normal delivery and strong contractions as the main disadvantage. Regarding cesarean sections, this study showed that most of the interviewed women reported that the main advantage of cesarean sections was that they felt no pain during delivery; however, the main disadvantage was the late recovery.[25] These same findings are similar to those found in other studies on the obstetric field.[9,26,27]

The women's care itineraries in this study relied upon the opinion and experience of their relatives and friends about normal delivery and cesarean section. The characteristics, advantages, and disadvantages of each delivery type described by the interviewees, their relatives, and their friends were essentially the same. This demonstrates that opinions on delivery shared by people of the women's social circle only corroborate their ideas and have no effect on their care itineraries.

> *All my grandmother's children were born by normal delivery. She says it's much better than a cesarean section. Because there's pain during normal delivery, right? And there's no pain during the cesarean section. You keep feeling pain.* (P16, secundiparous woman)

Among the Brazilian health care services, the family sector is described as the one that most influences therapeutic itineraries.[28] A study showed that the peoples' opinions have an influence on the possible feelings women may have regarding childbirth.[29] The relatives' opinions, who value and favor cesarean sections, solidify the women's ideas about surgical intervention. In this way, the women's itineraries tend not to change, since they and their relatives share the same opinions. Most of the women interviewed, after having a cesarean section, described it as quiet or good; therefore, even though there are relatives that solidify the idea of normal delivery being the most advantageous one, a successful experience with surgery can transform the understanding about it, and can even make it an alternative. Cesarean sections are always

seen as a solution for some adverse situations that may occur during vaginal delivery.

> *You know what? Cut it, I don't feel pain at that time. Even if I feel pain later, I'll take medicine, and it's over. I'm fine today! Oh! After one month I started to work again, you know? [...] It got no swelling. There was nothing. It's awesome!* (P16, secundiparous woman)

The findings of a study showed that more than 40% of women who had a cesarean section in a public sector hospital said they would choose this type of delivery again.[9]

It is highlighted that not all women looked for information on pregnancy and childbirth on the Internet, in books or magazines. The minority of primiparous women, which had no experience in parturition, discussed what information they sought and its sources. For the women who sought information, the Internet, magazines and mobile applications were important sources of information. Despite describing the source of information, they did not discuss its content and quality.

On the other hand, a multiparous woman stated that the search for information by means of reading material was unnecessary since previous experiences were already enough. The low demand for information may favor a change of opinion in relation to the processes of pregnancy and childbirth.

> *The name of the site I don't know. All I know is it's "mommy and baby" or something like that. [...] I know I even saw children's names; I saw how to care.* (P15, secundiparous woman)

> *No way, right? I have a lot [of kids] [...] Read what? I already know.* (P5, multiparous woman)

A review of literature on birth-related decision-making pointed out that contemporary women are subject to information about health and childbirth from the media, thus influencing preferences and decisions. Nevertheless, many authors question the conditions of women's autonomy in the face of decisions about childbirth and the asymmetries of power and knowledge exhibited by medical professionals.[30] The limitation of women's autonomy, which results from health professionals' authority, was also highlighted in another study. Its findings showed that even women exhibiting resistance to the biomedical model regarding childbirth care, for example by questioning the use of exogenous oxytocin, were submitted to these interventions because they had no power to change the situation.[26]

In this way, it is highlighted the fact that the interviewees had little influence upon decisions in relation to cesarean sections and their rights at the time of childbirth were not respected. Thus, it is necessary to guarantee the rights of these women throughout and childbirth.

Besides the low demand for information, it is important to consider the relevance of previous experience with pregnancies. Caring for pregnant women seems to employ the same steps and do what is already known, as one woman said.

It is worth noting that, in addition to the women's search for information, it is relevant and indispensable for health care services to provide information. One of the objectives of prenatal care is to carry out educational and preventive activities, and it is of utmost importance to create health education spaces for women as a way of consolidating important information about pregnancy. Furthermore, it is necessary that health care services fulfill their role in promoting education and health, focusing not only on pregnant women but also on their partners and relatives since they are also part of this process and share doubts and experiences.[19]

Past pregnancy and childbirth experiences influenced the statements of multiparous and secundiparous women. These women' experiences can contribute in a positive or negative way to the preferences and decisions about pregnancy and childbirth.[10,29]

Two women described their experiences with previous deliveries in different ways. While one had the best experience with vaginal deliveries and rejected cesarean sections, the other stated that she could have another cesarean section because the first one she had was performed successfully.

> *For me, it was totally... normal delivery was good. I did not like the cesarean section. [...] I prayed that it would be normal, but then it wasn't...* (P11, multiparous woman)

> *No! I said it because I'd had the first cesarean section before, so... I already knew what would happen.* (P16, secundiparous woman)

Going to the maternity hospital

A variety of reasons made the participants go to a maternity hospital due to labor. Few of them were guided through the criteria used to decide whether they should go to a maternity hospital. In general, they went to maternity hospitals because of referrals made during prenatal care, changes seen during an ultrasound exam, and clinical changes. Real signs of labor (rupture of the amniotic sac, frequent uterine contractions, etc.) were ignored.

Even without guidance on the signs of labor, some pregnancy-related events, such as the rupture of the amniotic sac, are widespread in society and when they happen, women understand that they need to seek a health care service. This is mentioned by a participant who, even without receiving instructions, sought to go to a maternity hospital due to the rupture of her amniotic sac.

> *My water broke at 7:00 am. Then I went to the maternity hospital, got there and the doctor saw me and said that it wasn't a break but a rupture.* (P10, primiparous woman)

A study concluded that more than two-thirds of pregnant women were admitted early in public maternity hospitals due to pre-labor and had cesarean sections.[31] Another study carried out with pregnant women seeking maternity hospitals early showed that most of them were admitted without any uterine activity or cervix dilation.[32] Two studies indicated that less than 51.0% of the interviewed women received guidance on labor signs during prenatal care.[21,22] The study findings, which were corroborated by the literature, showed that guidance on the true signs of labor may not be effective within the health care services.

According to the study results, few primiparous women reported knowing where to go in case of intercurrences or beginning of labor. Two women knew which maternity hospital to go to and received prenatal care and guidance on the signs from a professional nurse.

> *And during prenatal care, I learned that if I feel something, I should go to X maternity hospital. And they always explained to me what normal delivery and contractions and everything would be like. How I'd get to the hospital, what they'd do.* (P6, primiparous woman)

Studies showed that the lack of guidance on which reference maternity hospital pregnant women should seek at the beginning of labor hinders the quality of care. This is caused by the lack of coordination between the services that provide prenatal and childbirth care. One study revealed that less than 60.0% of pregnant women were instructed to seek a reference maternity hospital. Furthermore, another study pointed out that 40.0% of pregnant women in the last trimester of pregnancy received no information about this.[21,22]

The secundiparous and multiparous women were referred to a maternity hospital during prenatal care, which was facilitated by connections between their relatives and physicians. These referrals were made due to clinical changes or according to the schedule as described by the following testimonial:

> *"Since the first time I receive prenatal care here, the doctor said immediately: 'Your baby will be born by cesarean'. So, I was scheduled for the cesarean section."* (P2, secundiparous woman)

Most of them already knew which maternity hospital they should go because they had a delivery in the same hospital or received prenatal care in a hospital environment.

The cesarean section

The circumstances that led primiparous women to undergo a cesarean section were different from those that led secundiparous and multiparous women to undergo it. The primiparous women were aware that they would have a vaginal delivery unless some situation could prevent it. For them, cesarean sections were just a type of delivery and not a choice. They understood that the clinical conditions established by a physician during labor determine the type of delivery as stated by one participant: *"they scheduled it, they said it would probably be a normal delivery unless there was some complication"*.

Some of the clinical reasons that led primiparous women to have a cesarean section were: abnormal presentation, no dilation or passage, and low amniotic fluid levels. Besides these, other indications were described only as a medical decision with no further details. The physicians decided in favor of cesarean sections without asking for the women's opinion, except in two cases. Thus, the women assumed that the decisions made by these professionals were definitive without questioning.

> *Then the doctor asked me, "What do you prefer? Normal delivery or a cesarean section?" I said I'd prefer a normal delivery. [...] Because at that time I tried normal delivery with the help of the doctor, but she [the baby] was in a sitting position. Then he said, "No, we're not going to make it. Because the girl is in a sitting position and it's dangerous, got it?* (P7, primiparous woman)

The participants' statements pointed out that the physicians, despite observing certain clinical events that indicate the need for a cesarean section, subtly allow the women to take responsibility for the decision about the delivery route even though these women did not decide anything.

According to the literature, the cesarean section has been chosen as the default delivery route by medical professionals regardless of scientific evidence. Nevertheless, for the study participants and their relatives, cesarean sections may be linked to the idea of better care combined with biomedical interventions, since we are part of a society continuously concerned with health, aesthetics, productivity, and sexual and social performance.[30,33]

It is important to stress that, as already described in the literature, cesarean section rates among primiparous women are concerning because having a prior cesarean section increases the probability of having another one in the future as seen in the obstetric practice.

In the case of secundiparous and multiparous women, the following factors were taken into account when the medical professionals decided in favor of cesarean sections: prior cesarean section, risks detected during pregnancy, and tubal ligation due to family planning. The women who underwent tubal ligation through the cesarean section discussed their care itinerary and stated that both surgeries were scheduled for this purpose. For some of these women, the cesarean section was already a certainty; for the rest of them, it was as a possibility at the professional's discretion who provided care for them.

> *I was already scheduled for tubal ligation. [...] I've only received family planning counseling before. [...] So I took it to the doctor and I did it.* (P1, multiparous woman)

Although there are legal restrictions to scheduling cesarean sections in order to undergo tubal ligation,[34] this was used by the study participants. A study showed that more than 40.0% of the interviewed women stated that this was the reason that made them choose a cesarean section.[24]

Regarding scheduling cesarean sections, there are clinical events that justify it as stated by Participant 2. One study showed that maternal complications such as hypertension, diabetes, and depression during pregnancy increase the cesarean section rates in public sector medical institutions.[35] It also concluded that having a prior cesarean section is a factor associated with cesarean sections in this sector.[35] In another study, there was an association between having had a prior cesarean section and having the same procedure during the current pregnancy.[36]

Scientific evidence suggests that there is no longer an absolute need for women who have had a prior cesarean section to undergo this surgery again. Having had a prior cesarean section, which is the case of the vast majority of participants, are situations that allow labor and vaginal delivery. The maternal mortality rates are higher among the women who have had a prior cesarean section and had a cesarean section again compared with those who have had a vaginal delivery. In general, in addition to its high success rate, having vaginal delivery after having had a cesarean section presents low health risks. The risk of uterine rupture during vaginal delivery after having had a prior cesarean section is approximately 1%. New cesarean sections are recommended to women who had three or more prior cesarean sections or have a cesarean section scar.[37]

Some secundiparous/multiparous women pointed out having a connection with the institution in which they had the last cesarean section. For most participants, this connection was built with prior satisfactory childbirth experiences in these institutions, as evidenced in the following statement:

> *All the three of them. I received prenatal care and they were born there. [...] Yeah, because my chart was there... My medical history was there and they accepted me.* (P1, multiparous woman)

According to the study results, it is highlighted the connection between the participants and public sector hospitals to which they were previously admitted. However, is already known that women receiving private-sector care are connected with gynecologists and obstetricians. In a study carried out with women receiving private-sector care, it was found that they received prenatal care from trusted gynecologists with whom they established a long friendship, which can be contacted by telephone or the Internet in case of doubts or possible gestational changes.[7] A similar finding was described in another study, in which women who received private sector prenatal care reported having a relationship with the physician who performed it.[21]

Many women referred to cesarean section not as surgery but as "delivery". Some of them used the terms "cesarean section" or equivalent ones, which reinforces, as already described in the literature, the hypothesis of normalization of cesarean sections as a way to be born and not as a surgical event.[7] Despite not being a choice for women in public hospitals, cesarean sections are one of the options that can be considered during childbirth, as can be seen in the following statement:

> *"[...] I hoped it would be a normal delivery too, but since it was a cesarean section [...]".* (P8, primiparous woman)

CONCLUSIONS

By analyzing the care itineraries of women who have undergone cesarean sections in public sector institutions, it was possible to understand that receiving a better prenatal care and knowing to which maternity hospital to go at the beginning of labor are associated with a greater value attributed to biomedical care. The investigated itineraries involved biomedicine care with monitoring. This makes cesarean sections, which are surgeries, procedures that need to be viewed with more attention during parturition, especially by medical professionals.

In most cases, the delivery route was determined by medical professionals without asking for the woman's opinion. Even if they had the chance to choose the delivery route, it is implicit that medical professionals make them bear the responsibility for undergoing the surgery.

According to the analyzed itineraries, the women had little interest in seeking information on pregnancy and childbirth on Internet, books or magazines, which makes them vulnerable and not likely to question any decisions made during parturition. Also, the health care services' failure to promote health education were highlighted. The following questions remain: (1) *"If all women receiving public sector care were to be informed and participate in educational groups about pregnancy and childbirth, would they have autonomy over decision-making about the birth route?"*; (2) *"Would they have the power to negotiate with professionals about the birth route?";* and (3) *"Would that be enough to decrease cesarean section rates?"* These questions may not be answered even if new studies would be carried out. Nonetheless, they indicate that there are dimensions with regard to the care itineraries that need to be considered so that all health care services could be improved.

Brazil has been experiencing high rates of cesarean. This practice has been deemed to be necessary and is little questioned by women. Although care within the professional sector predominates, the analyzed itineraries revealed that the family sector's influence in reaffirming the importance of the pregnancy biological dimension. Also, public sector care needs to be considered, which involves religious and

alternative practices. Thus, surgery is not the only solution for childbirth.

Although the concept of therapeutic itineraries is more used in studies on diseases, it offered new perspectives on analyzing the itineraries of pregnant women undergoing cesarean section.

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Received on: 19/12/2017
Reviews required: 19/04/2018
Approved on: 29/06/2018
Published on: 05/01/2021

Corresponding author:
Sarah Dias Silva
Address: Rua Capanema, nº 134, apto 103, Tauá, Rio de Janeiro, Rio de Janeiro, Brasil.
Zip code: 21.920-070
E-mail: diassarah93@gmail.com
Telephone number: +55 (21) 97578-7988

Disclosure: The authors claim to have no conflict of interest.