revista de pesquisa ISSN 2175-5361

CUIDADO É FUNDAMENTAL

Escola de Enfermagem Alfredo Pinto – UNIRIO

RESEARCH DOI: 10.9789/2175-5361.rpcfo.v15.11972

FACTORS RELATED TO PREGNANCY IN ADOLESCENCE: REPRODUCTIVE PROFILE OF A GROUP OF PREGNANT WOMEN

Fatores relacionados a gravidez na adolescência: perfil reprodutivo de um grupo de gestantes

Factores relacionados con el embarazo en la adolescencia: perfil reproductivo de un grupo de mujeres embarazadas

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ABSTRACT

Objective: to describe the reproductive profile of adolescent women participating in a group of pregnant women. **Method:** descriptive, cross-sectional, documentary and retrospective study carried out through the registration form of participants of a group of pregnant women linked to the nursing office of a federal public university in Rio de Janeiro in 2018. **Results:** 59 records were analyzed. there was a predominance of women, young people (71.2%); single (72.3%); multiparous (56%); who had previously had a cesarean section (39%); in the second trimester of pregnancy (61%); type of public prenatal care (86.4%); desiring vaginal delivery (45.8%) and postpartum tubal ligation as a contraceptive method (30.5%), participated in the group without companions (79.7%) and desired postpartum home visit (78%). **Conclusion:** the need, related factors and vulnerabilities in reproductive health were identified with a view to implementing primary care aimed at health promotion, disease prevention and early detection.

DESCRIPTORS: Women's health; Pregnancy in adolescence; Prenatal care; Health education; Nursing.

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Received: 07/06/2022; Accepted: 08/26/2022; Published online: 02/10/2023

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How cited: Pontes BF, Quitete JB, Castro RC, Fernandes GC, Jesus L, Teixeira RC. Factors related to pregnancy in adolescence: reproductive profile of a group of pregnant women. *R Pesq Cuid Fundam* [Internet]. 2023 [cited year mouth day];15:e11972. Available from: https://doi.org/10.9789/2175-5361.rpcfo.v15.11972

RESUMO

Objetivo: descrever o perfil reprodutivo de mulheres adolescentes participantes de um grupo de gestantes. **Método:** estudo descritivo, transversal, documental e retrospectivo realizado através da ficha de cadastro de participantes de um grupo de gestante vinculado ao consultório de enfermagem de uma universidade pública federal do rio de janeiro em 2018. **Resultados:** analisou-se 59 cadastros. houve predominância de mulheres, jovens (71,2%); solteiras (72,3%); multíparas (56%); que tiveram cesárea como via de parto anteriormente (39%); no segundo trimestre de gestação (61%); tipo de pré-natal público (86,4%); desejando a via de parto vaginal (45,8%) e laqueadura pós-parto como método contraceptivo (30,5%), participaram do grupo sem acompanhantes (79,7%) e desejam visita domiciliar pós-parto (78%). **Conclusão:** identificou-se a necessidade, fatores relacionados e vulnerabilidades em saúde reprodutiva com vistas a implementação de cuidados primários voltados à promoção da saúde, prevenção de agravos e detecção precoce.

DESCRITORES: Saúde da mulher; Gravidez na adolescência; Cuidado pré-natal; Educação em saúde; Enfermagem.

RESUMEN

Objetivo: describir el perfil reproductivo de mujeres adolescentes participantes de un grupo de gestantes. **Método:** estudio descriptivo, transversal, documental y retrospectivo realizado a través del formulario de registro de participantes de un grupo de gestantes vinculadas al consultorio de enfermería de una universidad pública federal de Río de Janeiro en 2018. **Resultados:** se analizaron 59 registros. hubo predominio de mujeres, jóvenes (71,2%); soltero (72,3%); multíparas (56%); que previamente había tenido una cesárea (39%); en el segundo trimestre del embarazo (61%); tipo de atención prenatal pública (86,4%); deseando parto vaginal (45,8%) y ligadura de trompas posparto como método anticonceptivo (30,5%), participaron del grupo sin acompañantes (79,7%) y desearon visita domiciliaria posparto (78%). **Conclusión:** se identificaron la necesidad, los factores relacionados y las vulnerabilidades en salud reproductiva para la implementación de la atención primaria dirigida a la promoción de la salud, la prevención de enfermedades y la detección temprana.

DESCRIPTORES: Salud de la Mujer; Embarazo en adolescencia; Atención prenatal; Educación para la salud; Enfermería.

INTRODUCTION

Adolescent pregnancy has represented a serious public health problem worldwide for almost half a century. This problem has biological, psychological, economic, educational, and family consequences that influence the socioeconomic and health indicators of countries. The millennium goal was to reduce by 70% the world maternal mortality and one of the reasons for not reaching the goal was teenage pregnancy. Thus, the Sustainable Development Goal and world health authorities have reinforced the need to improve health care practices for this population.[1]

Physiological and psychosocial changes and adolescent pregnancy carry mortality risks due to factors such as unsafe abortion and sexually transmitted infections. The gap in educational strategies, precariousness in public policies and priority actions related to teenage pregnancy in neglected populations represent vulnerabilities in the right to life, social class is linked to teenage pregnancy in which marginalized girls are disproportionately affected. The United Nations fund describes that the distribution of modern contraceptives to adolescents aged 15 to 19 years would prevent more than 2 million unplanned live births, 3 million abortions, and 5,600 maternal deaths per year worldwide. Adolescent pregnancy represents a problem of individual crisis and social risk.[2]

Education is a tool for promoting bioethical concepts and is a factor in preventing teenage pregnancy. Pregnancy due to sexual violence is a reality experienced by young mothers and intensified in low socioeconomic conditions, it is complex and produces persistent marks in the lives of women, institutional shelter is essential. The necessary support offered to women who need legal interruption for reasons of sexual violence depends on information from different professionals and society in general regarding public policies. Induced abortion is one of the main factors of conflict in bioethical dilemmas, bringing a reflection of health professionals regarding education and training seeking to protect and ensure the full realization of sexual and reproductive rights of adolescent mothers. Sexual education, a favorable environment for gender equality, the offer of health and sexual and reproductive rights are of utmost relevance, in addition to the promotion of actions and public policies and the guarantee of rights.[3]

Adolescent pregnancy is a social problem. Most victims of sexual violence are children, adolescents, and women in developing countries. Sexual violence is associated with social determinants such as poor governance, cultural, social, and gender norms, unemployment, low income, gender inequality, and limited educational opportunities. Factors such as the absence of one or both parents or being raised by a stepfather, parental conflicts, family adversity, lack of parental control have been associated with an increased risk of adolescent sexual abuse. Rape results in approximately 32,000 unwanted pregnancies each year.[4]

Universal access to reproductive health is an indeclinable human right recognized in international and national documents. Reproductive health is an integral state of physical, mental and social well-being, encompassing all aspects related to the reproductive system and its functions and processes, and not

merely the absence of disease. It requires a positive and respectful approach to sexuality and sexual relations, and aims at enabling women and men to enjoy and express their sexuality in a pleasurable and safe way without risk of sexually transmitted diseases, unwanted pregnancies, coercion, violence, and discrimination. It covers information and access to efficient, safe, permissible, and acceptable methods of family planning and other methods of fertility regulation, the right to access appropriate health services that ensure that women are able to safely go through pregnancy and childbirth.[5]

The World Health Organization (WHO) recommends, as prevention of teenage pregnancy, educational interventions that actively involve women in planning for childbirth, such as childbirth preparation workshops and participation in groups for pregnant women, which play an essential role in the empowerment of pregnant women, covering the way they will manage their labor, delivery, and puerperium. Favoring and providing a qualified prenatal care. Through educational activities, the woman becomes active in the process. Besides the benefits that the knowledge, exchange, and construction of information, knowledge, and practices, the transformation of perception and confrontation of the events of the pregnancy cycle brings to pregnant women, promoting an extremely rich dialogue. It is a highly relevant means of providing complete assistance to women during pregnancy. Health education is a democratic way to build a comprehensive conception of health, promoting self-care and improving health indicators.[6]

Based on these assumptions, the question is: How is the reproductive health of the users of the Gestante de Vida Group? Are there vulnerabilities for pregnant women regarding reproductive health? What are the main problems related to the reproductive health of pregnant women linked to the Nursing Office?

Thus, this study aimed to describe the reproductive profile of adolescent women participating in a group for pregnant women.

METHODS

This is a descriptive ecological time-series study with a quantitative approach using the retrospective documentary technique and cross-sectional design, developed with data contained in the registration form of pregnant women participating in a group of pregnant women linked to the Nursing Office of a Federal Public University in the coastal lowlands of the state of Rio de Janeiro in the year 2018.

Created in 2017, the group Gestante de Vida: space for female empowerment has the partnership of the Undergraduate Nursing Course of the Universidade Federal Fluminense Campus Rio das Ostras and the Parish of Nossa Senhora da Conceição in Rio das Ostras through the project "Obra do Berço" conceived with the Pastoral da Criança. In order to help pregnant women of socioeconomic vulnerability during prenatal care with health education actions, this extension and teaching project has engaged students and teachers in educational practices related to Women's and Children's Health as well as their families in the academic environment.

The convenience sample of this study corresponds to 59 (100%) registration forms, which was reached based on the following inclusion criteria: fully completed forms containing legible data.

The following variables were used: age, marital status, gestational age, parity, previous route of delivery, neighborhood, type of prenatal care (public/private/mixed), desired route of delivery, postpartum contraceptive method, presence of a companion in the meetings of the pregnant women's group, and whether postpartum home visits were desired. The data collected were entered into an Excel spreadsheet and processed in the R Program. Proportions and measures of central tendency were calculated.

In compliance with the ethical standards for research with human beings, this research was approved by the Research Ethics Committee of the Antônio Pedro University Hospital in December 2017, opinion nº 2.887.801 CAAE nº 93546617.3.0000.5243.

RESULTS

We considered a sample of 59 registration forms of pregnant women. There was a predominance of women, young 42(71.2%); single 45(72.3%); multiparous 33(56%); who had had cesarean section as birth route previously 23(39%); in the second trimester of pregnancy 36(61%); type of public prenatal 51(86.4%); wanting vaginal birth route (50.17%) and postpartum sterilization as contraceptive method 18(30.5%), who participated in the unaccompanied group 47(79.7%) and who want postpartum home visit 46(78%). As shown in Table 1.

DISCUSSION

The findings of this study showed a higher prevalence of adolescent and young participants. Adolescent pregnancy represents negative consequences to the health of adolescents and their children, complications during pregnancy and childbirth are the leading cause of mortality in girls aged 15 to 19 years in the world, occurs due to higher risks of eclampsia, puerperal endometritis, systemic infections and prematurity, due to social stigmas, Due to social stigma, lack of psychological and social support, low socioeconomic status, biological factors such as inadequate maternal weight gain, smoking, and biological immaturity that have a substantial impact on the health of the woman and her baby, there are also social and economic consequences such as rejection, violence, and interruption of studies that compromise their future. In underdeveloped countries annually 21 million adolescents become pregnant between the ages of 15 and 19, and 12 million give birth. 777,000 births occur to girls under the age of 15. According to Ministry of Health data collected by the United Nations Population Fund (UNFPA), more than 19,000 live births per year occur to mothers who are between the ages of 10 and 14.[7]

Table 1 – Distribution of variables of the study participants. Rio das Ostras, RJ, Brazil, 2022

Variables	N	%
Age	**16**	**27,1**
15 to 19 years old (teenager)	42	71,2
20 to 39 years old (young adult)	0	0
40 to 59 years old (middle aged)	1	1,7
Undeclared	0	0
TOTAL	**59**	**100**
Marital status		
Single	45	72,3
Married	14	23,7
Stable Union	0	0
Divorced	0	0
Widow	0	0
Undeclared	0	0
TOTAL	**59**	**100**
Gestational Age		
1 week to 3 weeks	0	0
4 weeks to 6 weeks	0	0
8 weeks to 10 weeks	1	1,7
12 weeks to 14 weeks	1	1,7
16 weeks to 18 weeks	6	10,2
20 weeks to 22 weeks	8	13,5
24 weeks to 26 weeks	5	8,5
28 weeks to 30 weeks	16	27,1
32 weeks to 34 weeks	16	27,1
36 weeks to 38 weeks	4	6,8
40 weeks to 42 weeks	0	0
Undeclared	2	3,4
TOTAL	**59**	**100**
Parity		
Nulliparous	19	32,2
Multiparous	33	56
Undeclared	7	11,9
TOTAL	**59**	**100**
Previous births route		
Vaginal Delivery	20	33,9
Cesarean Delivery	23	39
Undeclared	16	27,1
TOTAL	**59**	**100**
Type of Prenatal Care		
Public	51	86,4
Private	1	1,7
Mixed	1	1,7
Undeclared	7	11,6
TOTAL	**59**	**100**
Desired delivery route		
Vaginal Delivery	27	45,8
Cesarean Delivery	24	40,7
Undeclared	8	13,5
TOTAL	**59**	**100**
Contraceptive method Desired postpartum		
IUD	3	5
Placing a sterilization	18	30,5
Hormonal Injectable	9	15,2
Oral Hormonal	10	17

Table 1 – Cont.

Condom	5	8,5
Undeclared	14	23,7
TOTAL	**59**	**100**
Presence of a companion in the meetings of the Gestant Group		
Yes	11	18,6
No	47	79,7
Undeclared	1	1,7
TOTAL	**59**	**100**
Desire Postpartum Home Visiting		
Yes	46	78
No	13	22
Undeclared	0	0
TOTAL	**59**	**100**

Source: the authors

There was a higher proportion of single mothers. Studies show that marital status influences women's health, and single women are more vulnerable to illness, unplanned pregnancies, and STIs. Women who become pregnant at an early age have different consequences in their lives than men; due to the structured machismo, hopelessness in the future occurs, in which issues such as education and career are abandoned. Another factor that needs to be mentioned is adolescents who have lived in unsafe environments have a higher risk of becoming pregnant in adolescence, a woman with low educational and economic level may have a higher risk of becoming pregnant in adolescence, as well as poverty, lack of schooling, and unemployment. Teenage pregnancy can stem from underlying social problems that have not been addressed and treated in the right way such as in early childhood and youth programs and existing structural and economic problems, thus only providing condoms is not enough. Since social, structural, economic, and environmental factors are involved in teen pregnancy. Sexual education and promotion of sexual health services and investments in public policies are factors of paramount importance to decrease the rates of teenage pregnancy.[8]

Regarding gestational age, we observed a predominance of pregnant women in the first trimester of pregnancy. In the third trimester of pregnancy, significant physiological and psychological changes occur[9]. Regarding parity, in this study multiparous women prevailed. Biologically, pregnancy begins at conception, but psychologically, there is a history of parents in which relationship patterns are already reserved to be established with the arrival of the child. Studies show that in multiparous women there is an impact of pregnancy on the family system relative to the feelings aroused in the older children.[10]

In the last two decades, the total fertility rate in Brazil has dropped from 2.4 children to just under 1.8 children per woman. This drop has three key positions: the impact of socioeconomic and cultural transformations on the desire for children; the ability to reconcile them with the dynamics of modern life; and issues related to the contraceptive ability of women to carry out their reproductive planning and factors such as greater female participation in the labor market and the growing search for a higher level of education.[11]

In the present study, most of the pregnant women declared their desire to give birth naturally. Studies describe the desire for vaginal delivery in all the women considered. They believed they were capable of giving birth, hoped to experience the evolution of birth, and believed it would bring well-being to them and their children. Security, family and partner support are essential in making the decision of how to give birth. However, what constantly happens are interferences linked to medical institutional interests that cause these pregnant women to change their decision about a normal birth.[12]

Studies show a high proportion of cesarean sections among teenage primiparous women. Vaginal delivery is safer for the baby and the mother and brings numerous benefits. Labor is divided into 3 stages, and each one of them requires a qualified, humanized, and specific assistance. The World Health Organization describes that the purpose of birth assistance is to provide the least possible intervention, safely, in order to have a healthy mother and child. There is a recovery of the appreciation of the physiology of childbirth; the encouragement of a harmonious relationship between technological advances and the quality of human relationships, and highlighting the respect for citizenship rights. The humanization of childbirth refers to the need for qualified assistance and holistic care. Welcoming, listening, guiding, respecting, and creating a bond are aspects of paramount importance.[13]

Since the 1970s the cesarean rate has increased dramatically. Regarding the previous route of delivery in this study, a higher prevalence of cesarean sections was observed. The number of cesarean sections in Brazil is the second highest in the world. The World Health Organization recommends that only 15% of births should be performed by cesarean section and describes that humanizing childbirth is to adhere to a group of actions and techniques that encourage healthy labor and birth, respecting the natural way and avoiding unnecessary procedures that pose risks to the mother and fetus. Thus, it is extremely important to empower pregnant women, providing information and qualifying professionals to provide care based on scientific evidence. Re-

search proves that the term "once a cesarean, always a cesarean" is totally wrong.[14]

The cesarean rates in Latin America and the Caribbean reach four out of ten (43%) births. In Brazil it reached 56.7% of all births in 2012. In the Dominican Republic, Brazil, Chile, Egypt, and Turkey, cesarean sections outnumber normal deliveries. Providing information about risks and immediate and future deleterious effects on the child's health, such as epigenetics, in which there is a higher risk of obesity and chronic diseases in childhood and adulthood for babies born by cesarean section, is of paramount importance to reduce the rates of cesarean sections and decrease infant mortality rates.[15]

Brazilian surveys point to a prevalence of prematurity of 11.5%, about 50% higher than in countries such as England. Such research points to the contribution of scheduled cesarean sections to the increase in premature births, with a higher risk of ICU admission due to respiratory or other problems. Worldwide rates of C-sections have risen and are estimated to continue to rise this decade. If this trend continues, by 2030 the highest rates are likely to be in East Asia (63%), Latin America and the Caribbean (54%), West Asia (50%), North Africa (48%), according to research. The WHO stresses the importance of focusing on the unique needs of each woman during pregnancy and childbirth.[15]

In the present study there was a predominance of women who had public prenatal care. Studies state that prenatal care provides better pregnancy outcomes in all pregnant women and especially in adolescence. Adolescents usually have inadequate prenatal care, due to the late time of seeking assistance and attendance in fewer consultations. Consultations need a holistic and individual look in order to recognize and respond to the disparate needs of pregnant adolescents. Data from the Information System on Live Births (Sinasc) reveal the evolution of prenatal care coverage in Brazil, reflecting the importance of the Unified Health System (SUS).[16]

Prenatal care is an indispensable factor related to women's health care in the gravidic-puerperal period and methods carried out in this period are associated with better perinatal outcomes, lower morbidity and mortality, no unnecessary medical interventions, and positive results in labor. It promotes and prepares the mother or couple for baby care and familiarizes them with the episodes that will occur during the gravidic-puerperal period. It is an important method of health promotion, prenatal education is the most important part regarding prenatal public policies, reduces anxiety related to labor and delivery, and stimulates and increases the involvement of partners in the neonatal period, clarifies doubts and what to expect during prenatal care and how to manage labor, delivery, and the newborn.

The Ministry of Health recommends welcoming manners, health education, early detection of pathologies, and gestational risk situations. The World Health Organization (WHO) launched in Geneva its first global guidelines for supporting women and newborns in the postnatal period. Worldwide, more than three in 10 women and babies currently do not receive postnatal care in the first days after birth, and this period is when most maternal and infant deaths occur.[17]

With regard to the presence of the companion in the group meetings, most reported that they were not present. It is known that there is a struggle for deconstruction in society to dictate the role of the woman/mother and the man/father, where the woman is the one who takes care of the home and children, and the man is the one who provides for the household needs. The presence of a companion during prenatal care is one of the factors that help to improve health care during pregnancy and childbirth, favoring women's safety and better maternal and neonatal outcomes. The WHO recommends it as one of the practices that favor reduction of unnecessary interventions and reduction of obstetric violence. The presence of a companion of the woman's choice during labor, delivery, and the immediate postpartum period is regulated by Law No. 11,108 of April 7, 2005.[18]

Regarding the desired contraceptive method after childbirth, sterilization prevailed. It is important to have a puerperal follow-up in order to provide guidance and health education about contraceptive methods, as well as their risks and benefits. Most pregnant women reported the desire for a postpartum home visit. During the puerperal period, it is of great importance the primary care assistance that has as one of its characteristics the Home Visit (HV), considered a care strategy tool. During prenatal care, the team needs to strengthen the bond with the pregnant woman. Studies show that the HV increases access to information, self-confidence to perform the necessary care, and opens a space to share her experiences and impressions of the birth.[19]

CONCLUSION

This study made it possible to know the reproductive profile of women participating in a group for pregnant women and enabled the identification of needs, related factors, and vulnerabilities in reproductive health with a view to implementing primary care aimed at health promotion, disease prevention, and early detection, such as the predominance of adolescent women, who have had a previous cesarean section, who desire vaginal delivery, and who participated in the group for unaccompanied pregnant women.

The results point to the importance of the role of nurses in educational practices in women's health and the performance of Nursing Offices in the context of primary health care and the need and importance of sexual education, promotion of sexual and reproductive health services, reproductive planning consultations and investments in public policies.

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