# Consequences of cesarean delivery without clinical indication

## Consequências do parto cesárea sem indicação clínica

## Consecuencias de la cesárea sin indicación clínica

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**RESUMO**

**Objetivo:** analisar o conhecimento sobre as consequências do parto cesárea sem indicação clínica por mulheres da rede privada. **Método:** A metodologia utilizada foi de abordagem qualitativa e método descritivo seguindo os pressupostos de Minayo. **Resultados:** A coleta de dados ocorreu em uma página virtual da rede social Facebook designada Espaço Gestante. Teve como critérios de inclusão para participar mulheres que tiveram parto cesárea sem indicação clínica e que tiverem idade igual ou superior a 18 anos, que aceitaram o convite e concordaram com o Termo de Consentimento Livre e Esclarecido. A entrevista ocorreu por meio da ferramenta de formulário Google Forms, onde as participantes responderam a um questionário de 7 perguntas norteadoras. A análise de dados ocorreu concomitantemente a coleta de dados, seguidamente foram transcritos e agrupados conforme a semelhança. Nos resultados foram entrevistadas 5 mulheres com idade entre 23 e 42 anos, que tiveram ao menos uma cesárea. **Conclusão:** Na discussão foram apresentadas 6 categorias, dentre elas a de maior relevância a orientação sobre riscos e consequência da cesárea sem indicação clinica onde se revela divergência quanto as orientações recebidas de riscos do procedimento. É preciso ser analisado o nível de importância dado ao acesso as informações pelas mulheres sobre indicação, riscos maternos e fetais e o seu direito a participar efetivamente no processo de decisão da escolha da via de parto.
**Descritores:** Saúde da mulher; Enfermagem obstétrica; Cesárea.

**ABSTRACT**

**Objective:** to analyze the knowledge about the consequences of cesarean delivery without clinical indication by women in the private network. **Method:** The methodology used was a qualitative approach and descriptive method following the assumptions of Minayo. **Results:** Data collection took place on a virtual page of the social network Facebook called Espaço Gestante. The inclusion criteria for participating were women who had cesarean delivery without clinical indication and who were 18 years of age or older, who accepted the invitation and agreed to the Free and Informed Consent Form. The interview took place through the Google Forms form tool, where the participants answered a questionnaire with 7 guiding questions. Data analysis occurred concomitantly with data collection, then they were transcribed and grouped according to similarity. In the results, 5 women aged between 23 and 42 were interviewed, who had at least one cesarean section. **Conclusion:** In the discussion, 6 categories were presented, among them the most relevant guidance on risks and consequences of cesarean section without clinical indication, where divergence regarding the guidelines received on the risks of the procedure is revealed. It is necessary to analyze the level of importance given to access to information by women about indication, maternal and fetal risks and their right to effectively participate in the decision-making process of choosing the route of delivery.
**Descriptors:** Women's health; Obstetric nursing; Cesarean section.

**RESUMEN**

**Objetivo:** analizar el conocimiento sobre las consecuencias del parto por cesárea sin indicación clínica por parte de las mujeres en la red privada. **Método:** La metodología utilizada fue de enfoque cualitativo y método descriptivo siguiendo los supuestos de Minayo. **Resultados:** La recolección de datos ocurrió en una página virtual de la red social Facebook llamada Espaço Gestante. Los criterios de inclusión para participar fueron mujeres que tuvieron parto por cesárea sin indicación clínica y que tenían 18 años o más, que aceptaron la invitación y accedieron al Término de Consentimiento Libre e Informado. La entrevista se realizó a través de la herramienta de formularios Google Forms, donde los participantes respondieron un cuestionario con 7 preguntas orientadoras. El análisis de los datos ocurrió concomitantemente con la recolección de los datos, luego fueron transcritos y agrupados de acuerdo con la similitud. En los resultados se entrevistaron 5 mujeres con edades entre 23 y 42 años, que tuvieron al menos una cesárea. **Conclusión:** En la discusión se presentaron 6 categorías, entre ellas las orientaciones más relevantes sobre riesgos y consecuencias de la cesárea sin indicación clínica, donde se revela divergencia en cuanto a las orientaciones recibidas sobre los riesgos del procedimiento. Es necesario analizar el nivel de importancia otorgado al acceso a la información por parte de las mujeres sobre la indicación, los riesgos maternos y fetales y su derecho a participar efectivamente en el proceso de toma de decisiones de elección de la vía del parto.
**Descriptores:** Salud de la mujer; Enfermería obstétrica; Cesárea.

ORIGINAL

## Introduction

Cesarean section is one of the oldest in medicine, its origin remains unknown, since history presents some controversial versions about the procedure. At its origin, the cesarean section was performed to save the life of the conceptus, when the parturient was dying. Currently, cesarean section has evolved into a safe procedure, which can be planned and is often performed at the woman's choice and medical convenience in cases without a clinical indication, resulting in exponential increase in the operation.[1]

In cesarean section, an incision is made in the abdomen and wall of the uterus for removal of the conceptus. The woman is submitted to anesthesia, usually spinal anesthesia, but in cases where during labor cesarean section was indicated, epidural anesthesia is also adequate[2].

Cesarean surgery is an important method used in cases with complications, to ensure greater safety for women and fetuses. However, maternal morbidity and mortality rates are higher in cesarean sections, so their choice should be substantiated, where the benefits should outweigh the risks[3].

Cesarean rates have been growing worldwide, this increase is associated with cultural changes, improvements in the technique, the provision of information about it and the influence of obstetricians who spread their practice by choice of the parturient as a form of autonomy over the choice of the route of delivery, in addition to the economic factors involved[1].

By 2020, the cesarean rates presented by health operators in recent years are above 80%. In 2017 and 2018, 83% of deliveries were cesarean sections and in 2019 were 83.2%[4].

The cesarean rate in countries with good medical care does not exceed 28% in all customer profiles. In the public system of Brazil the value is between 40 and 50% of births, but in private hospitals the value is much higher reaching 90% in some cases. The Ministry of Health has been employing measures to reduce these rates, since there is no evidence that these rates are associated with improved care[3].

Determine an optimal rate of reckless cesarean section, since it is not possible to perform a broad and safe global analysis to apply in the individuality of each country. There are no studies that provide clear evidence on cesarean rates above 10% on mortality and morbidity[1].

The high rates of cesarean sections performed in Brazil show that at the time of choice of the mode of delivery women tend to opt for cesarean section even in situations where normal delivery is possible, so it is necessary to understand how women are instructed about the consequences of cesarean delivery. This study presents the following problem: What knowledge does the woman have about the consequences of cesarean section without clinical indication?

This study becomes important because it can equip obstetric nurses in order to improve the orientation of pregnant patients in the private network to obtain data regarding their knowledge and how women understand this process.

It may demonstrate that the guidance and assistance of the health team can influence the choice of women by cesarean section, and thus stimulate the improvement in the provision of information, as well as influence new research in the area.

This study aims to analyze the knowledge about the consequences of cesarean section without clinical indication by women from the private network users of the social network Facebook.

## Methodology

This study used with the qualitative approach and descriptive method, following the author Minayo (2014)[5]. This method describes an event by analyzing in detail.

Data collection took place from June to August 2021 on a virtual page of the Social Network Facebook called Pregnant Space, through an electronic form of Google Forms, where participants answered a questionnaire of 7 guide questions.

The participants were invited to participate through a written statement with a brief clarification regarding the objective of the research. After the participants agreed to participate in the research, they were contacted to schedule the interview. The inclusion criteria were to participate in women who were members of the virtual group, who were 18 years of age or older and enjoy full mental health, had cesarean section without clinical indication previously and who accepted the invitation and agreed to the Free and Informed Consent Form.

It also had as exclusion criteria women who were not members of the virtual group, did not enjoy full mental health, under the age of 18 years, did not have passed cesarean section without clinical indication or did not agree with the Informed Consent.

Considering resolution 510/16 that provides for the guarantee of rights and duties to research participants, as well as those covered by bioethical factors such as autonomy, justice, among others. The data and information collected were used in a reliable way maintaining the confidentiality and confidentiality of the participants as determined by the resolution they had their names replaced by flower names.

Given the resolution, this study did not benefit any of the participants, as well as had their right guaranteed to, in their freedom to give up the research without causing the same losses.

The data analysis of this study occurred following the steps of ordering the data, this step includes the rereading of the material, the organization of the reports in a given order with a beginning of classification giving the researcher an overview of the material, ordering in sets and subsets in order to obtain a reading that seeks similarities and differences through comparations and contrasts between each other. In the classification occurred the horizontal and exhaustive reading of the texts, the researcher at that moment had all his attention focused on the material. During the reading, the researcher made notes about his impressions, starting the search for the coherence of the information obtained, performing a careful analysis.

Subsequently, a cross-verse reading occurred, of each subset obtained and of the whole set in order to perceive the connections between them and establish relationships of similarity and logic. In the final analysis of this study, the researcher analyzing the material studied sought to present the answers obtained in order to clarify the logic presented to the group's behavior on the subject studied and finally the report with the synthesis of the objective of this study and the interpretation of the researcher of the results obtained.

The study was approved by the Ethics and Research Committee (CEP) on June 1, 2021 under opinion number 4,748,047.

## Results and Discussion

The participants of this study were 05 women who had their identifications preserved and fictitious names were assigned the same according to the following table.

**Table 1 -** Profile of participants, 2021.

| Fictitious Name | Age | Marital Status | Education | N. of Deliveries |
|---|---|---|---|---|
| Sunflower | 42 | Married | Incomplete Higher Education | 2 |
| Lily | 23 | Single | Incomplete Higher Education | 1 |
| Rose | 32 | Married | Incomplete Higher Education | 1 |
| Daisy | 35 | Married | Complete High School | 2 |
| Tulip | 26 | Married | Complete Higher Education | 1 |

### Choice of the route of delivery

The informants in this study reported how they were choosing the route of delivery, as follows:

> From the moment I had an abortion, it was very painful did not want to wait whenever 38 weeks the doctor removed the baby (GIRASSOL)
>
> Since the beginning of pregnancy. I was able to choose to have a covenant (LILY)
>
> At the beginning of pregnancy (ROSE)
>
> Since the beginning of pregnancy, I have always said that I would only have caesarean section (DAYSY)
>
> End of pregnancy. I had everything to be normal. Then she (the doctor) asked if I wanted to score because then she would do but normal would not give with her, then in the end was a choice of mine (TULIP)

Women assisted by the supplementary health network enjoy the right to choose the route of delivery and opt for cesarean delivery mostly, being evidenced by the high rates of cesarean sections performed in private hospitals[6].

The care provided in the private network provides a greater autonomy to the woman over the decision on the choice of the route of delivery. However, there is a priority for cesarean delivery in the supplementary health network, during the time women who previously desired a normal delivery decide to give up a cesarean section[7].

It is the right of women to participate in the choice of the route of delivery, she has the right to choose cesarean delivery and her desire must be respected by the professional. However, it is verified that there is an excess in the performance of the procedure[8].

**Guidance on indications and risks of cesarean section at the time of choice of delivery route**

About the orientation received when the woman chose the route of delivery, the participants' responses were very heterogeneous, where some were informed and others were not.

> He (the doctor) did not guide me, but my decision would be cesarean section (SUNFLOWER)
>
> Yes. My mother's a nurse and she explained everything to me. Together with the doctor I opted for cesarean section (LILY)
>
> I chose cesarean section, was not aware of possible risks (ROSE)
>
> I was not informed about the risks (DAYSY)
>
> Yes. At the last pre-delivery consultation (TULIP)

The woman and her legal guardian must be aware of the risks and adverse events that can potentially be caused by cesarean delivery, as well as the administration of medications for the surgical procedure[9].

Information on the risks and benefits of a cesarean delivery compared to normal delivery is often overlooked, and these when passed on are passed on by the medical professional predominantly. Past guidelines do not cover all the doubts of women[10].

Health professionals have the role of educator and advisor in the selection process. The dialogue should be clear and cover all the points necessary for women's understanding of the risks and benefits of the procedures to which they will be subjected[11].

**Doubts clarified during the orientation about the choice of the route of delivery**

The participants of this study describe their understanding of the clarification of doubts, where the results were divergent as follows.

> Yes, I had no doubt that my choice would be the c-section I came to see a normal delivery in the hospital xxx saw how much was suffered for woman I did not have the courage to face (SUNFLOWER)

> Yes (LILY)
>
> No, because from the beginning I told the doctor I wanted a C-section and he didn't question me (ROSE)
>
> No, it was hit at the beginning of pregnancy and I didn't ask any more even with doubts (DAYSY)
>
> No. Had the birth and there were still doubts (TULIP)

By law, the woman must understand the information and guidance received about her condition, as well as about the procedures to which she may be submitted and duly informed to refuse in a free and enlightened manner. In case of remaining doubts, they should be instructed[12].

The orientations carried out during prenatal care are centered on the alterations of pregnancy. Information about childbirth, postpartum and its specifications are not the priorities in care[13].

The health care provider must inform her and guarantee her rights. The same when choosing to perform a cesarean delivery should sign the Free and Informed Consent Form, after detailed dialogue on risks of the procedure in cases without indication in order to ensure a conscious and oriented choice[14].

**Support and support by the team in choosing the route of delivery**

Regarding the involvement with the care team, the women declare a good interaction:

> Very good, support from the obstetric doctor, nurses before and after cesarean section (SUNFLOWER)
>
> Wonderful. It was at the hospital that my mother worked as a nurse, she attended the birth and the whole team worked with her (LILY)
>
> Very good, respected my choice (DAYSY)
>
> Comprehensively (TULIP)

The women assisted in the private network show greater satisfaction with the assistance offered. The interaction with the care team is respectful and satisfactory in general resulting in a pleasant experience for women[13].

The relationship of trust developed during prenatal care between doctor and patient contributes to a favorable evaluation of the care and care received. The quality of care is evaluated contaminant to the respect and reception received by the woman[10].

The autonomy of women over decision-making about the type of delivery is ethically accepted at the medical level, provided that the woman is aware and oriented about the procedure to be performed. The medical professional is still guaranteed the autonomy of referring the patient to another professional in case of disagreement between the woman's desire and the medical decision[15].

**Factors that influenced the choice of a cesarean section**

Women describe which factors led them to opt for a cesarean delivery:

> Due to an abortion and an unsuccessful curettage, I suffered a lot due to this never wanted to wait for a normal delivery (SUNFLOWER)
>
> Fear of having complication and my daughter being born without oxygen bringing sequelae (LILY)
>
> Pain, thought I would feel a lot of pain in normal childbirth (ROSE)
>
> Fear of feeling pain, and having a bad experience (DAYSY)
>
> Normal delivery in the public hospital without knowing what the doctor would be scared, because of the reality in which the hospital was. With several cases of neglect (TULIP)

In Brazil, deliveries performed by the supplementary network enable women to participate more in the choice of delivery route. However, it suffers medical, social and family influences to choose the abdominal route, on the grounds that cesarean delivery is safer and it is possible to prepare for the event. Another important point is the perception that cesarean delivery causes less pain to women, which to many women is a strong fear in relation to childbirth[16].

The autonomy of the woman is guaranteed when she is able to make her decision by holding all the information about consequences and benefits of each route of delivery and without harmful influences on the part of the assistant professional. The doctor-patient relationship when well developed results in a patient's confidence in relation to the physician. In this way, the medical professional for his position holds a great role of influence on the woman[17].

The lack of knowledge about the physiology of childbirth, about forms of pain relief and social influence reinforce the idea that normal childbirth is synonymous with pain and suffering. Causing women to desire for a cesarean section in order to avoid the suffering attributed to normal childbirth.

**Intercorrence during childbirth**

When asked about occurrences of complications during childbirth, they report as follows:

> No (SUNFLOWER)
>
> No (LILY)
>
> No (ROSE)
>
> No (DAISY)
>
> Yes. Pressure has dropped a lot (TULIP)

The culture of cesarean section normalization provides an evolution of the surgical technique, resulting in better results and attenuation of potential

complications associated with the procedure. Cesarean section for obstetricians is seen as a technological achievement that is often routinely used, even in situations where normal delivery is feasible on the grounds that caesarean section is a safe delivery[18].

With the constant performance of the procedure, physicians feel safe and confident to perform cesarean deliveries even in situations without clinical indication, disregarding the potential risks of both maternal and fetal[18].

Prenatal and delivery follow-up performed in the private network increase the occurrence of cesarean section, however there is a reduction in the possibility of complications when performed by the same professional. In the private network, there is a lower occurrence of complications in cesarean deliveries, although cesarean delivery increases the risk of postpartum complications[19].

## Final Considerations

This study aimed to analyze the knowledge about the consequences of cesarean section without clinical indication by women from the private network, and reveals that the orientations are passed differently. Some women had access to the information needed to make their choice, while others, despite respecting the right to choose the route of delivery, were not informed in the full scope of risks and consequences. In view of the particularities of the care provided in the private network, where the medical professional is the main advisor, it is necessary to analyze the level of importance given to access to information by women about indication, maternal and fetal risks and their right to participate effectively in the decision-making process of the choice of the route of delivery.

The study brings a reflection on the relevance of multidisciplinary care where women obtain care centered on women, providing early identification of risks and conditions, and thus collaborating in a safe experience for mother and child.

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## References

1. Zugaib MF [Livro]. Zugaib Obstetrícia. 3.ed. Barueri, SP: Manole, 2016. p 425-428.
2. Montenegro CAB, Rezende Filho J [Livro]. Rezende obstetrícia fundamental. 13. ed. Rio de Janeiro: Guanabara Koogan; 2014. p 973-995.
3. Sá RA, Oliveira CA [Livro]. Hermógenes: Obstetrícia Básica. 3.ed. São Paulo: Editora Atheneu, 2015. p 1283-1291.
4. Ministério da Saúde (BR). Agência nacional de Saúde Suplementar. Taxas de partos cesáreas por operadora de plano de saúde [Internet]. Brasil: SIP/ANS; 20 1.tri. 2019. Taxas de partos cesáreas por operadora de plano de saúde. [Revisado 6 mai 2020 e citado 20 julho 2021]. Disponível em:

https://agenciabrasil.ebc.com.br/saude/noticia/2021-08/cesareas-respondem-por-84-dos-partos-realizados-por-planos-em-2019
5. Minayo, MCS [Livro]. O desafio do conhecimento: Pesquisa qualitativa em saúde. 14.ed. São Paulo: Hucitec editora, 2014.
6. Câmara R, Burlá M, Ferrari Junior, LL, Lima Junior JA, Braga A, et al. Cesarean section by maternal request. Revista do Colégio Brasileiro de Cirurgiões [online]. 2016, v. 43, n. 04, pp. 301-310. [Acessado 01 Jan 2022]. Disponível em: https://www.scielo.br/j/rcbc/a/44yLTZ766jrmDJLCD3XxqrM/?lang=en
7. Vicente AC, Lima AKBS, Lima CB. Parto cesárea e parto normal: uma abordagem acerca de riscos e benefícios [online]. Temas em saúde Volume 17, Número 4 ISSN 2447-2131 João Pessoa, 2017 Páginas 24 a 35 24. Disponível em: https://temasemsaude.com/wp-content/uploads/2018/01/17402.pdf
8. Rodrigues JCT, Almeida IESR, Oliveira Neto AG, Moreira TA. Cesariana no Brasil: uma análise epidemiológica. Revista Multitexto [internet]. 2016, v. 4, n. 01, 2016. [ Acessado 01 Out 2021]. Disponivel em: http://www.ead.unimontes.br/multitexto/index.php/rmcead/article/view/166/93
9. Ministério da Saúde, Secretaria de Atenção à Saúde. Portaria nº306/2016. Aprova as Diretrizes de Atenção à Gestante: a operação cesariana [online]. Brasil: 2016. [Citado 01 Nov 2021]. Disponível em: http://bvsms.saude.gov.br/bvs/saudelegis/sas/2016/prt0306_28_03_2016.html
10.Gama AS, Giffin KM, Tuesta AA, Barbosa GP, d'Orsi E. Representações e experiências das mulheres sobre a assistência ao parto vaginal e cesárea em maternidades pública e privada. Cadernos de Saúde Pública [online]. 2009, v. 25, n. 11 [Acessado 3 Dez 2021] , pp. 2480-2488. Disponível em: https://www.scielo.br/j/csp/a/zXsFHVmqgKRDcdq7wnwzPdh/?lang=pt
11. Freire NC, Nunes IM, Almeida MS, Gramacho RCCV. Parto normal ou cesárea? a decisão na voz das mulheres [online]. Revista Baiana de Enfermagem, Salvador, v. 25, n. 3 [ Acessado 10 Out 2021] , p. 237-247, set./dez. 2011 . Dísponivel em : https://periodicos.ufba.br/index.php/enfermagem/article/view/6027/4901
12. Ministério da Saúde (BR). Carta dos direitos dos usuários da saúde [online]. 3. ed. Brasília: Ministério da Saúde, 2011. [Citado 16 Jan 2022]. Disponível em: http://www.conselho.saude.gov.br/biblioteca/livros/AF_Carta_Usuarios_Saude_site.pdf
13. Rett MT, Oliveira DM, Soares ECG, Santana JM, Araújo KCGM. Satisfação e percepção de dor em puérperas: um estudo comparativo após parto vaginal e cesariana em maternidades públicas de Aracaju [online]. ABCS Health Sci. 2017; 42(2):66-72. [Citado 16 Jan 2022]. Disponível em : https://docs.bvsalud.org/biblioref/2017/09/849011/42abcs66.pdf
14. Brasil. RN Nº 368/2015. Dispõe sobre o direito de acesso à informação das beneficiárias aos percentuais de cirurgias cesáreas e de partos normais, por operadora, por estabelecimento de saúde e por médico e sobre a utilização do partograma, do cartão da gestante e da carta de informação à gestante no âmbito da saúde suplementar [online]. Diário Oficial da União. 2015 Jan 06. [Citado 18 Jan 2022]. Disponível em: https://www.ans.gov.br/component/legislacao/?view=legislacao&task=Text

oLei&format=raw&id=Mjg5Mg
15. Conselho Federal de Medicina. Resolução CFM Nº 2.144/2016. É ético o médico atender à vontade da gestante de realizar parto cesariano, garantida a autonomia do médico, da paciente e a segurança do binômio materno fetal [online]. [Citado 24 Dez 2021]. Disponível em: https://portal.cfm.org.br/images/stories/pdf/res21442016.pdf
16. Nakano AR, Bonan C, Teixeira LA. O trabalho de parto do obstetra: estilo de pensamento e normalização do "parto cesárea" entre obstetras. Physis: Revista de Saúde Coletiva [online]. 2017, v. 27, n. 03 [Acessado 2 Jan 2022], pp. 415-432. Disponível em: https://www.scielo.br/j/physis/a/b9tSSPmDGmf7hwCNw7MV4rg/?lang=pt
17. Rossetto M, Schmalfuss J, Bedin K, Pinheiro A, Batista J (2020). Fatores associados à cesariana eletiva em mulheres atendidas em um hospital referência do oeste catarinense. Revista de Enfermagem da UFSM, 10, e54. [Acessado 26 Jan 2022]. Disponivel em: https://periodicos.ufsm.br/reufsm/article/view/39398
18. Gullo CE, Soler ZASG, Cabrera EMS, Irigoyen BBTJ, Rodrigues DA. Cesárea eletiva no Brasil: imposição da autonomia da mulher ou do poder médico? Enfermagem Brasil, 2011 [online]. [Citado 26 Jan 2022] Disponível em: https://www.portalatlanticaeditora.com.br/index.php/enfermagembrasil/article/view/3887/5886.
19. Freitas PF, Savi EP. Desigualdades sociais nas complicações da cesariana: uma análise hierarquizada. Cadernos de Saúde Pública [Internet]. 2011, v. 27, n. 10 [Acessado 29 Jan 2022], pp. 2009-2020. Disponível em: https://www.scielo.br/j/csp/a/mkHd76c4YjmVJ4kPDK3Mvgg/?lang=pt

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