REVISTA DE ENFERMAGEM REFERÊNCIA
homepage: https://rr.esenfc.pt/rr/
ISSNe: 2182.2883

RESEARCH ARTICLE (ORIGINAL)

The couple's expectations for the birth plan

A expectativa do casal sobre o plano de parto

La expectativa de la pareja sobre el plan de parto

Teresa Maria de Campos Silva[1]
https://orcid.org/0000-0002-0712-2567

Marlene Isabel Lopes[2]
https://orcid.org/0000-0002-8120-9644

[1] Health Sciences Research Unit: Nursing, Nursing School of Coimbra, Coimbra, Portugal

[2] Obstetrics A – Maternal-Fetal Health Middle Management Unit – Coimbra Hospital and University Center, Coimbra, Portugal

Corresponding author:
Teresa Maria de Campos Silva
Email: tmcs@esenfc.pt

Received: 28.11.19
Accepted: 26.02.20

Abstract
Background: The birth plan (BP) is a reflexive and decision-making process of the expectant couple, exposed in a written document, allowing a better communication with health professionals and the women's autonomy.
Objective: The present study, inserted in a larger investigation, aimed to describe the couple's expectation about BP.
Methodology: A qualitative, exploratory-descriptive study. Participants were 10 couples who attended the Parenthood and Birth Preparation Program at a maternity in central Portugal. The data collection instrument was the semi-structured interview and data analysis performed using the Bardin content analysis method and the NVivo10 software.
Results: Half of the participants did not know the concept of the Birth Plan, but recognize the importance of discussing their preferences with a midwife for a positive childbirth experience.
Conclusion: This study allows innovation and improvement in safe care for women/ couples, in order to respond to their expectations and needs.

Keywords: birth plan; midwife; empowerment for health; expectation; decision making

Resumo
Enquadramento: O plano de parto (PP) é um processo reflexivo e de tomada de decisão do casal grávido, exposto num documento escrito, promovendo uma melhor comunicação com os profissionais de saúde e a autonomia das mulheres.
Objetivo: O presente estudo, inserido numa investigação mais vasta, teve como objetivo descrever a expectativa do casal sobre o PP.
Metodologia: Estudo qualitativo, tipo exploratório-descritivo. Os participantes foram 10 casais que frequentaram o programa de preparação para o parto de uma maternidade do centro de Portugal. O instrumento de recolha de dados foi a entrevista semiestruturada e a análise dos dados, realizada com o método de análise de conteúdo de Bardin e com o *software* NVivo10.
Resultados: Metade dos participantes não conheciam o conceito de PP, mas reconhecem a importância da discussão das suas preferências com um Enfermeiro Especialista em Saúde Materna e Obstétrica para uma experiência de parto positiva.
Conclusão: Este estudo pode permitir a inovação e melhoria na assistência segura à mulher/casal, respondendo eficazmente às suas expectativas e necessidades.

Palavras-chave: plano de parto; enfermeiro especialista em saúde materna e obstétrica; empoderamento para a saúde; expectativa; tomada de decisão

Resumen
Marco contextual: El plan de parto (PP) es un proceso reflexivo y de toma de decisiones para la pareja embarazada, establecido en un documento escrito, que promueve una mejor comunicación con los profesionales de la salud y la autonomía de la mujer.
Objetivo: Este estudio, incluido en una investigación más amplia, tuvo como objetivo describir las expectativas de la pareja sobre el PP.
Metodología: Estudio cualitativo, de tipo exploratorio-descriptivo. Los participantes fueron 10 parejas que asistieron al programa de preparación al parto de un servicio de maternidad en el centro de Portugal. El instrumento de recogida de datos fue la entrevista semiestructurada y el análisis de datos se realizó con el método de análisis de contenido de Bardin y con el *software* NVivo10.
Resultados: La mitad de los participantes no estaban familiarizados con el concepto de PP, pero reconocieron la importancia de discutir sus preferencias con una matrona una matrona para tener una experiencia positiva en el parto.
Conclusión: Este estudio puede permitir innovar y mejorar la atención segura a las mujeres/parejas, al responder eficazmente a sus expectativas y necesidades.

Palabras clave: plan de parto; matrona; empoderamiento para la salud; expectativa; toma de decisiones

How to cite this article: Silva, T. M., & Lopes, M. I. (2020). The couple's expectations for the birth plan. *Revista de Enfermagem Referência*, *5*(2), e19095. doi: 10.12707/RIV19095.

Introduction

The birth plan (BP) is a strategy to promote the involvement of women in preparation for and during labor and an opportunity for them to express their labor-related expectations and desires. The couple's and woman's reflection is important to raise awareness of the relationship between decisions and choices and the course of labor itself, to make responsible and informed decisions. In this sense, it is essential to reinforce the couple's health literacy concerning the delivery process, including the crucial support of the midwife (Ordem dos Enfermeiros, Mesa do Colégio da Especialidade de Saúde Materna e Obstétrica, 2012).

The concern about this topic arises from a professional context, the maternity hospital in central Portugal, where the researcher develops her professional activity, also participating in the parenthood and birth preparation program (PPP). According to scientific evidence, obstetric care will focus increasingly on the safe choices of duly informed couples, contributing to better obstetric and neonatal outcomes. In this way, the BP is a tool for a positive experience of birth (World Health Organization, 2018), contributing to the empowerment and satisfaction of these couples in the process of their children's birth. In this sense, it is important to describe the expectations of the couple for the BP and, specifically, the expectations of the mother and the father, as this information could be used to innovate and improve the PPP, responding to the expectations and needs of each one of the elements of the couple, taking into account gender differences, and helping them, if they so wish, in the development of their BP.

Background

Women, in their family and community environment, always planned the birth of their children, before this process was transferred to the hospital environment, where the experience of birth changed. In this context, the BP was developed in the 1980s by normal childbirth advocates, to counteract the feeling of loss of prominence of pregnant women in their childbirth (Lothian, 2006). Creating a BP is a particular way of encouraging women to think on what is important for them, to explain their desires and expectations, and to communicate with their caregivers, in order to build a realistic plan, based on informed decisions, allowing the rediscovery and restoration of traditional women's control over the environment of labor (Kitzinger, 1992). The development of a BP is a fundamental component of the majority of childbirth preparation programs. It evolves from the efforts of the woman/couple to realize and understand their values, needs, and concerns related to the process of birth, as the 21st century BP may reflect different philosophies, ranging from the natural childbirth without intervention to the high-tech delivery (Bailey, Crane, & Nugent, 2008). Also, according to Lothian (2006), developing a BP is the opportunity for the woman/couple to define their expectations, develop the therapeutic relationship with health professionals, and share the decision-making process, which are crucial components for a satisfactory experience of birth. Due to its sometimes-unpredictable nature, childbirth cannot be planned, but the preferences associated with it can be thought of and shared with the health professionals (Afshar, Mei, & Gregory, 2016).

The BP is also the target of some controversy since it can raise concerns about the paternalism of health professionals, the autonomy of women, their ability to choose, control, therapeutic relationships based on trust, and the divergence between the evidence-based care and the preferred and routine obstetric practice. As a result, the woman/couple who wants a birth that is not fully in accordance with the hospital routines or with the current and customary obstetric practice can cause discomfort among health professionals (Bailey et al., 2008). However, according to Afshar et al. (2016), the main purpose of a BP is to promote communication, not to cause friction between professionals and women/couples, being that the best results arising from a BP depend on the flexibility and support given in the discussion during pregnancy and labor. Even when the preferences of women are not fully satisfied, they tend to keep the positive opinion about the use of a BP, since the possibility to talk openly about the various options of labor is important, and not necessarily the BP itself, either in writing or merely verbalized (Yam, Grossman, Goldman, & García, 2007; Whitford et al., 2014). Hidalgo-Lopezosa, Hidalgo-Maestre, and Rodríguez-Borrego (2017) noted that the BP has a low rate of compliance, although it is observed that the higher the compliance, the better the maternal and neonatal outcomes. According to Bailey et al. (2018), within the context of health care nowadays, the paradigm is moving from paternalism to the person's autonomy, considering that patients are, in general, more assertive, question the recommendations given by professionals, and require that their desires are met. The same authors consider that health professionals are increasingly encouraged to involve patients in care-related decisions, recognizing that people have a better knowledge of their health. Midwives who monitor women/couples in the pregnancy surveillance consultations or help them in creating the BP should inform them that the childbirth planning does not begin with a list of interventions or options, but with learning about the normal physiological process of labor and evidence-based practices that promote, protect, and support the normal delivery. Health literacy in the delivery process is essential to ensure that women/couples can make truly informed decisions. The communication should also focus on the decision-making process of the woman/couple, including the informed consent, as well as the right to informed refusal. When developing their BP, each woman/couple should not focus on interventions they want or do not want, but on what they need to experience their labor in the most normal, safest way possible, even in the face of unexpected situations. According to Afshar et al. (2016), the BP tends to become increasingly prevalent and supported by national and international organizations and, although they do not cause an immediate change in

care practices, they can, over time, contribute to increasing the real choice of women and, thus, continue to be an important tool in childbirth preparation.

Research Question

What are the couple's expectations for the BP?

Methodology

A qualitative, exploratory-descriptive study was conducted, using the content analysis according to Bardin (2013). The selected participants were 10 couples who attended the parenthood and birth preparation program (PPP) in a maternity hospital in central Portugal. According to an intentional process, the sample was non-probabilistic by convenience, fulfilling the following inclusion criteria: to be registered for the PPP; to have attended at least one session; to be in the 3rd trimester of pregnancy; a single pregnancy; a pregnancy without associated risks; understanding and speaking Portuguese correctly; and the couple being present for the interview. All selected couples agreed to participate in the study and remained until its end. The semistructured interview was the data collection technique selected: a script was prepared, with 20 questions for the mother, father, and couple, divided by five domains values/meanings assigned to childbirth; environment; comfort measures; openness to interventions during labor; early contact with the baby; knowledge and importance assigned to BP (Lopes, 2019). For the training of technical skills relating to the interview, the researcher carried out an exploratory interview with a couple who met the necessary conditions to participate in the study. In general, the interview script responded to the proposed objectives. The point of saturation of data was reached with the completion of 10 interviews, conducted by the researcher between January and March 2018 in a maternity outpatient consultation room, lasting on average 52 minutes, ensuring the comfort and acoustics conditions and no possible interruptions. The six ethical principles of research were respected (Nunes, 2013), and the UICISA: E issued a favorable opinion (no. P425-05/2017), as well as the Ethics Committee and Board of Directors of the hospital where the study took place (Lopes, 2019). The content analysis according to Bardin (2013) was carried out, and the data analysis use the qualitative data treatment program QRS NVivo10. The scientific rigor was ensured throughout the research process, preserving the value and reliability of results, through the prolonged contact of the researcher with the topic under study, whether by the previously carried out or the clinical experience as a midwife who integrates the PPP, whose topics are usually discussed with the couples. Scientific rigor was also preserved throughout the process of interviewing, notably in observing the participants during the interviews and taking field notes and in committing to their implementation, to ensure that the participants understood the questions and responded to what was expected, in hearing them and immediately transcribing, including their countless readings. After a verbatim transcription of the interviews coded with ME (mother interview) and PE (father interview), the participants were also asked to verify if the reports were in line with their values, opinions, and experiences to make the necessary changes, which was not necessary for any of the participants. Data triangulation was also conducted since the study's supervisor followed the whole analysis process. During the period of the interviews, the researcher, being a midwife, did not practice clinical midwifery in the PPP, so as not to influence participants' responses (Lopes, 2019).

Results and Discussion

The pregnancies of the 10 participating couples were between the 34 and 39 weeks, and the mothers were between 31 and 41 years old, and the fathers between 31 and 44 years old. Eight mothers were primiparous and lived only with their partner, and two mothers were multiparous, with a previous delivery, and lived with their partner and their first child. Concerning academic qualifications, three mothers had secondary education (12 years of schooling), four had a bachelor's (15 years of schooling), one was a master (17 years of schooling), and two were Ph.D. (21 years of schooling). Four fathers had secondary education, five a bachelor's degree, and one a Ph.D. In relation to the employment status, eight mothers were employed, one was unemployed, and one was a student, and all the fathers were employed. From the analysis of the reports of the participants, either the mother or the father, two domains emerged: knowledge of the concept of birth plan and the importance given to birth plan.

Knowledge of the concept of birth plan

In relation to the knowledge of the concept of BP, there were two categories, knows and does not know, common to the couple. It was found that five mothers and one father already knew about the concept of BP at the moment of the interview. One mother knew about it in a tv report, "heard about it in a tv show some time ago . . . then also read about it in a magazine . . . about the plan and the fact that people want . . . I was interested because I had no idea" (ME1; January 2018). Another mother knew about it in the PPP, another one in the health center, and two from a friend. The father knew about it through their partner. Five mothers and nine fathers were completely unaware of the concept of BP, "no, I do not know, I have no idea what it is" (PE4; February 2018). In contrast, in the study of Sardo and Pinheiro (2018) about the perspective of the Portuguese people of the BP, it was found that more than 80% of the 150 participants had already heard about the BP and knew its purpose, arguing that the BP should be mandatory in Portuguese maternities. In this study, the importance attributed to the BP became evident, and it was acknowledged as a facilitating strategy to guide the woman/couple in the process of childbirth, promoting a closer relationship with

health professionals and increasing the empowerment and satisfaction of women in this experience, making it more positive. Within this context, the participants stressed the importance of the vital role of midwives in the promotion and implementation of the BP, recognizing it as a key element in the delivery of prenatal care.

Value assigned to birth plan

In relation to the value attributed to BP, three categories emerged, common to the couple: Decision-making resources, Advantages and Disadvantages of BP, whether in the form of discussion with a healthcare professional in a BP consultation or in the implementation of the BP itself. The couples participating in this study, when asked about their motivation and interest to develop their BP, reported the internal, cognitive, and affective resources that guide them in their decision-making. Thus, faced with the possibility of explaining to health professionals their expectations and desires, that they were becoming aware of and mentioning during the interview, approximately half of the participants, mothers and fathers, said they trusted in the decision-making of health professionals regarding their childbirth, "I trust myself in the hands of professionals because they, better than anyone, know . . . they have a lot of experience and know what is best in that situation" (ME5; February 2018). These reports show that the participants accept the paternalistic attitude of health professionals to let them decide for themselves because they believe that they have greater knowledge and experience. Besides, the reports of some study participants show that they assign a negative meaning to couples who present desires to health professionals as if it was wrong and nonsense: "provided that the person does not exaggerate, it is not . . . I do not get what kind of things people may want for childbirth" (PE8; March 2018), although other admit that, although they do not want to create a BP, they respect those who wish to do so. Also, for Divall, Spiby, Nolan, and Slade (2017), there is little consensus among women in relation to the benefits of using a BP, as the term *birth plan* may not be the most suitable for expressing their preferences. However, it is undisputed that the BP still is a key element for the promotion of individualized care either in prenatal care or in intrapartum care. According to Lothian (2006), the imbalance of power between patients and health professionals is very evident in obstetrics because the biomedical model encourages women and health professionals to consider the birth as a riskful event, and a more interventionist practice is accepted to reduce that risk and uncertainty. However, evidence has demonstrated that this approach does not provide the best care and increases the risks, which is not ethically acceptable. In this respect, the WHO promotes "the centralization of the pregnant woman/couple in the clinical team that will provide personalized assistance through the implementation of the autonomy paradigm at the expense of the paternalistic paradigm" (OE, 2015, p. 19). Approximately one-third of the mothers participating in this study were also experiencing difficulty and embarrassment in exposing their preferences to health professionals.

> We wish we could keep the umbilical for one minute . . . I asked in the appointment with the obstetrician. . . I did not feel comfortable saying that I would like a minute, but then I do not know whether, at the moment of birth, I will have the courage to say (looking at the father). (ME6; February 2018)

A couple with a 39-week pregnancy, knowing clearly what they want for their childbirth, still feels unsure in preparing and submitting their plan, "why is that until now, at 39 weeks pregnant, we still have not decided whether we will submit it or not" (ME6; February 2018) because they anticipate the possible disregard which they may be subject to by health professionals, even if their requests are supported by scientific evidence. Another mother reports that she believes that she will have no problems if she asks for more privacy during the birth, and another underestimates her expectations, like the early skin-to-skin contact, in case it is not done. In this way, the participants assume the imbalance of power between themselves and the health professionals, with a focus on the paternalistic attitude of the latter. However, although the majority of the participants report that they do not want to draw up a written BP document, they show interest and appreciation in a BP consultation, like the interview, as it allowed them to know some aspects, clarify doubts, and talk with their partner about labor, because they alone would not have the opportunity to do so, being evident that the conjugality was promoted. According to Kaufman (2007), even couples who prefer to follow the advice of the health team without question, benefit from a moment to discuss their expectations and wishes for childbirth because it allows them to learn more about the process and identify and discuss their concerns and wishes with the health team because being well-informed increases their confidence and ability to achieve their wishes. Besides, in order to overcome the difficulty of couples in presenting their preferences, they should learn to approach the health team with respect and confidence, which is challenging. Thus, both mothers and fathers participating in this study considered that it is advantageous to discuss the BP with a health professional because people feel like it can increase their safety and confidence, in particular the mother's, "I think it facilitates because it is all so uncontrollable, at least we have a way to control it a bit, or we think that we control a bit what will happen" (ME7; March 2018). It is an important source of information and preparation for the couple, "when a birth plan is made, parents become more aware of what it is that they will find and how they should prepare for a future childbirth . . . , They can research, search this kind of thing" (PE6; February 2018). It promotes the communication between the couple and the health professionals and the autonomy and decision-making: "we explain what we want or ask questions and the doctors and nurses ask us our opinions, I think that this is very important" (ME1; January 2018). In addition, health professionals have the opportunity to provide more individualized health care and appropriate to the preferences of each couple: "makes the professionals having to stop

a little . . . to think of this couple, it is not one more, and I think that is the main advantage not only for us but also for the professionals" (ME6; February 2018). A third of the mothers considered that thinking previously about labor gives them a more positive perspective of it: "it is a moment so unique, why not prepare it, they say it is a day that marks people so much" (ME6; February 2018). These results are in line with those of Aragon et al. (2013), whose study showed that women find advantages in using a BP because it can work as a communication tool, allowing the woman's partner, her families, and the health professionals to understand her expectations and preferences for the birth. It also has an educational nature because knowledge is acquired through the development of a BP, they become aware of their concerns, wishes, and hospital practices. This study also showed that women consider that the use of a BP gives them an increased autonomy for informed decision-making and helps to promote a more positive perspective on their childbirth, increasing their sense of control and empowerment. Also, Whitford et al. (2014) concluded that women consider the inclusion of BP as a care standard positively because it highlights their preferences and stimulates their discussion with the health team, contributing to the reduction of the woman/couple's anxiety. Pennell, Salo-Coombs, Herring, Spielman, and Fecho (2011) also found that the majority of women considered the use of BP favorable, regardless of their preferences are all fulfilled or not, because it improved their experience of labor, providing a new sense of control and improving communication with health professionals. This is because, when changes occur to the wished-for BP, the mother's feeling of control about these changes is as important as the change itself, so the continuous communication and negotiation, since the couple creates the BP until the moment of labor, are fundamental (Cook & Loomis, 2012).

However, both mothers and fathers participating in this study also acknowledged some disadvantages in the use of BP, although less significantly, in particular the feeling of dissatisfaction, if the plan cannot be fulfilled, "I think creating many expectations may not be possible . . . then if something does not come out exactly as we expected, it can be complicated" (PE5; February 2018), the inflexibility and severity of couples or health professionals, "the only downside is if the plan is fulfilled to the letter, if there is no flexibility from the mother or even the father and the professionals . . . Being on the outside and being in labor are two completely different things, everything changes" (ME9; March 2018), and the possibility that the BP can cause negative reactions in health professionals, "for me, the disadvantage is that some professionals underestimate the birth plans because they think that having a birth plan is ridiculous . . . sometimes the couple ends up being ridiculed" (ME6; February 2018). The participant mothers also consider as disadvantages that the BP can be very detailed or limiting and still offer a false sense of control and confidence. These results were also found in the study of Aragon et al. (2013), where the negative emotions of disappointment and dissatisfaction, arising from a plan that cannot or has not been fulfilled, and the inflexibility and severity, potentially caused by the BP, which may compromise the results, constitute the major disadvantages identified by women. In addition, the false sense of control, not allowing the woman to prepare for the unexpected, and the possibility of the use of BP causing negative reactions in health professionals were also pointed out as disadvantages. Also, the study of Sardo and Pinheiro (2018) revealed some weaknesses in personalized care in maternity hospitals in Portugal, where some participants referred to having difficulty in discussing and defending their choices regarding labor, feeling helpless in front of health professionals. Furthermore, of 64% of participants who had already used the BP, about 10% said that it was not accepted by health professionals who assisted in their labor. However, in the study of Yam et al. (2007), all the women who created a BP with the help of a health team professional reported their experience of birth as very satisfactory, although, in some cases, their childbirth had not occurred as they had wished. It seems evident that the most beneficial and important is the discussion and negotiation between the couple and the health team, involving the couple in decision-making, and not necessarily the plan itself, as a written or verbalized document, which calls upon the clinical implementation of the BP as an integral (and inclusive) care component, to promote highly satisfactory birth experiences for couples and, consequently, to all those involved in this experience. The reports of the participants, shown in Figure 1, present the mother's, father's, and couple's different expectations for the BP.

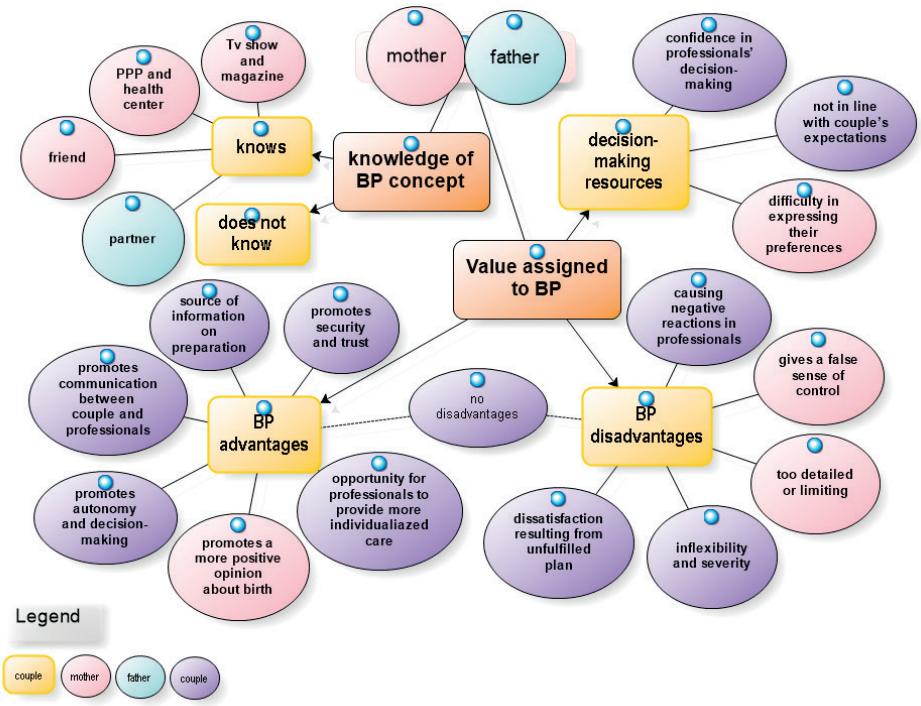

Figure 1. Schematic view of the results of the analysis of mother's and father's reports relating to the expectations for the birth plan. Abbreviations: birth plan (BP); Parenthood and Birth Preparation Program (PPP).

The results presented above allow noting that the couples participating in this study have shown to be involved in their labor, the participating mothers had the opportunity to think effectively in what they wish from their partner during labor and to express it, admitting that they had not yet had the opportunity to talk between the two of them about the birth of their baby. It is observed that this was a very interesting aspect of the interview because the couples faced imagined scenarios that made them raise questions they wanted to be answered. The prominence of the paternalistic paradigm in obstetric care was noted, although the attempt to affirm the autonomy of the woman/couple is also evident. Despite all the interest in the topic shown by couples during the interview, only half of the mothers knew the concept of BP, which allows inferring that the information and promotion of the BP still do not seem to be carried out continuously in the pregnancy surveillance consultations nor the PPP. The conduction of these individual interviews with each couple made them aware of aspects of their individuality and conjugality, impossible to realize when only group interventions are developed, as is the case of the PPP. Although group interventions have the possibility of sharing experiences among participating couples as its greatest advantage, mass training is not possible without meeting the individual needs of each couple, which is only possible by associating a more individual strategy, such as the BP consultation, so as to know the preferences of the woman/couple and clarify the consequences and/or benefits of every decision concerning the course of labor.

The limitations of this study, inherent to the other qualitative, descriptive studies, result from using the intentional selection of participants, couples only from the central region of Portugal, which hinders the generalization of results. However, this process of selection was due to easy access to the participants and interest in the improvement of clinical practice in the researcher's professional context, as the participants came from the available couples in the PPP at the time of the investigation.

Conclusion

The study identified that not all participating couples knew the concept of BP. However, when expressing their expectations for the BP, although most manifest that they do not wish to create a written document, they showed interest and appreciation in a BP consultation. The implications of this study to the practice of maternal health and obstetric nursing highlight the importance of implementing a BP consultation, being that the results refer to the importance of the discussion among the midwives in various professional contexts, on the training of interviewing skills to obtain necessary information and promote literacy about the childbirth process, enabling the couple to negotiation and empowerment. In the field of research, the authors consider important to study the perspective of midwives on the BP to understand their difficulties in the promotion and validation of this strategy and conduct this study with couples from other regions

and different types of families in today's society. The new health policies in Portugal have shown willingness to support a less medicalized and interventionist environment for childbirth and to universalize the BP. For this purpose, the nurse specialists in maternal health and obstetric nursing must recognize the advantages of this strategy and encourage and support the couples to develop a BP so as to promote a more positive birth experience.

Author contributions:
Conceptualization: Lopes, M. I., Silva, M. T
Data curation: Lopes, M. I., Silva, M. T.
Methodology: Lopes, M. I., Silva, M. T
Writing – original draft: Lopes, M. I.
Writing – review & editing: Lopes, M. I., Silva, M. T.

References

Afshar, Y., Mei, J., & Gregory, K. (2016). Birth plans: Birth preferences or labor manifesto. *Gynecology & Obstetrics Case Reports*, *2*(1),12. Retrieved from https://gynecology-obstetrics.imedpub.com/birth-plans-birth-preferences-or-labor-manifesto.php?aid=8656

Aragon, M., Chhoa, E., Dayan, R., Kluftinger, A., Lohn, Z., & Buhler, K. (2013). Perspectives of expectant women and health care providers on birth plans. *Journal of Obstetrics and Gynaecology Canada*, *35*(11), 979-985. doi:10.1016/S1701-2163(15)30785-4

Bailey, J. M., Crane, P., & Nugent, C. E. (2008). Childbirth education and birth plans. *Obstetrics and Gynecology Clinics of North America*, *35*(3), 497-509. doi:10.1016/j.ogc.2008.04.005

Bardin, L. (2013). *Análise de conteúdo*. Lisboa, Portugal: Edições 70.

Cook, K., & Loomis, C. (2012). The impact of choice and control on women´s childbirth experiences. *The Journal of Perinatal Education*, *21*(3), 158-168. doi:10.1891/1058-1243.21.3.158

Divall, B., Spiby, H., Nolan, M., & Slade, P. (2017). Plans, preferences or going with the flow: An online exploration of women's views and experiences of birth plans. *Midwifery, 54,* 29-34. doi:10.1016/j.midw.2017.07.020

Hidalgo-Lopezosa, P., Hidalgo-Maestre, M., & Rodríguez-Borrego, M. A. (2017). Birth plan compliance and its relation to maternal and neonatal outcomes. *Revista Latino-Americana Enfermagem*, *25*, e2953. doi:10.1590/1518-8345.2007.2953

Kaufman, T. (2007). Evolution of the birth plan. *The Journal of Perinatal Education*, *16*(3), 47-52. doi:10.1624/105812407X217985

Kitzinger, S. (1992). Sheila Kitzinger´s letter from England: Birth plans. *Birth, 19*(1), 36-37. doi:10.1111/j.1523-536x.1992.tb00373.x

Lopes, M. I. (2019). *A expetativa do casal sobre o plano de parto* (Master's dissertation). Escola Superior de Enfermagem de Coimbra, Portugal. Retrieved from http://web.esenfc.pt/?url=J09yShAZ

Lothian, J. (2006). Birth plans: The good, the bad, and the future. *Journal of Obstetric, Gynecologic, and Neonatal Nursing: JOGNN*, *35*(2), 295-303. doi:10.1111/j.1552-6909.2006.00042.x

Nunes, L. (2013). Considerações éticas a atender nos trabalhos de investigação académica de enfermagem. Departamento de Enfermagem. Instituto Politécnico de Setúbal, Escola Superior de Saúde. Retrieved from https://comum.rcaap.pt/bitstream/10400.26/4547/1/consid%20eticas%20na%20investig%20academica%20em%20enfermagem.pdf

Ordem dos Enfermeiros, Mesa do Colégio da Especialidade de Saúde Materna e Obstétrica. (2012). *Parecer n.º 7/2012: Plano de parto*. Lisboa, Portugal: Autor. Retrieved from https://www.ordemenfermeiros.pt/arquivo/documentos/Documents/MCEESMO_Parecer_7_2012_Plano_de_parto.pdf

Ordem dos Enfermeiros. (2015). *Livro de bolso: Enfermeiros especialistas em saúde materna e obstétrica/parteiras*. Lisboa, Portugal: Autor. Retrieved from https://www.ordemenfermeiros.pt/media/8891/livrobolso_eesmo.pdf

Pennell, A., Salo-Coombs, V., Herring, A., Spielman, F., & Fecho, K. (2011). Anaesthesia and analgesia-related preferences and outcomes of women who have birth plans. *Journal of Midwifery & Women's Health, 56*(4), 376-381. doi:10.1111/j.1542-2011.2011.00032.x

Sardo, D., & Pinheiro, A. (2018). Birth plan: Portuguese women's perceptions. *The European Proceedings of Social & Behavioural Sciences*, 102-112. doi:10.15405/epsbs.2018.11.11

Whitford, H., Entwistle, V., Teijlingen, E., Aitchison, P., Davidson, T., Humphrey, T., & Tucker, J. (2014). Use of a birth plan within woman-held maternity records: A qualitative study with women and staff in Northeast Scotland. *Birth*, *41*(3), 283-289. doi:10.1111/birt.12109

World Health Organization. (2018). *WHO recommendations: Intrapartum care for a positive childbirth experience*. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/260178/9789241550215-eng.pdf;jsessionid=3403B5A4778758180F5ACE8A1393ABA1?sequence=1

Yam, E., Grossman, A., Goldman, L., & García, S. (2007). Introducing birth plans in Mexico: An exploratory study in a hospital serving low-income Mexicans. *Birth, 34*(1), 42-48. doi:10.1111/j.1523-536X.2006.00124.x.