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Building a model birth plan based on the perception of pregnant women

Construção de um modelo de plano de parto a partir da percepção das gestantes

Construcción de un modelo de plan de parto a partir de la percepción de embarazadas

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Objective: to understand the construction of a birth plan based on the perception of pregnant women. **Methods:** qualitative approach study carried out from July to September 2020, with pregnant women recruited by a specific WhatsApp group, composed of pregnant women, mothers and health professionals. An online script and interview were used. The speeches were analyzed using the Collective Subject Discourse. **Results:** 50 pregnant women participated, with a mean age of 29 years, 58% were married, and 76% had a higher education degree. The subjects mentioned were: *Birth Plan: items revealed by women - Episiotomy, Kristeller, Freedom of position and movement, Pain medication, Skin-to-skin contact and breastfeeding in the newborn's first hour of life and Delayed clamping of the umbilical cord, Right to a companion, Vaginal touch, Labor induction*. **Conclusion:** there was a perceived knowledge on the subject by the characteristics of the researched public, directing the construction of the birth plan, with the addition of the items: early bath, prevention of neonatal ophthalmia, desire to eat. The birth plan is defended as a possibility of individualized and humanized assistance, with information and guidance about the rights of pregnant women, and within their desires.
Descriptors: Pregnant Women; Parturition; Planning; Decision Making.

Objetivo: compreender a construção de um plano de parto a partir da percepção das gestantes. **Método**: estudo de abordagem qualitativa realizado de julho a setembro de 2020, com gestantes a partir de recrutamento por grupo especifico de Whatsapp, composto por gestantes, mães e profissionais de saúde. Utilizou-se um roteiro e entrevista no modo *online*. Os discursos foram analisados através do Discurso do Sujeito Coletivo. **Resultados**: participaram 50 gestantes, com média de idade de 29 anos, 58% casadas, e 76% com nível superior. Levantou-se o discurso: *Plano de Parto: itens revelados pelas mulheres - Episiotomia, Kristeller, Liberdade de posição e movimento, Analgesia, Contato pele a pele e aleitamento materno na primeira hora de vida do recém-nascido e Clampeamento oportuno do cordão umbilical, Direito ao acompanhante, Toque vaginal, Indução de parto*. **Conclusão**: percebeu-se conhecimento sobre a temática pelas características do público pesquisado, direcionando a construção do plano de parto, com os acréscimo dos itens: banho precoce, prevenção de oftalmia neonatal, desejo de comer. Defende-se o plano de parto como possibilidade de assistência individualizada e humanizada, com informações e orientações acerca dos direitos das gestantes, e dentro de seus anseios.
Descritores: Gestantes; Parto; Planejamento; Tomada de decisões.

Objetivo: comprender la construcción de un plan de parto a partir de la percepción de embarazadas. **Método:** estudio de abordaje cualitativo realizado de julio a septiembre de 2020, con gestantes a partir de reclutamiento por grupo específico de *WhatsApp*, compuesto por gestantes, madres y profesionales de la salud. Se utilizó un guion y una entrevista en línea. Los discursos se analizaron a través del Discurso del Sujeto Colectivo. **Resultados:** participaron 50 gestantes, con una media de edad de 29 años, 58% casadas, y 76% con nivel superior. Se planteó el discurso: *Plan de parto: puntos revelados por las mujeres - Episiotomía, Kristeller, Libertad de posición y movimiento, Analgesia, Contacto piel con piel y lactancia materna en la primera hora de vida del recién nacido y Pinzamiento oportuno del cordón umbilical, Derecho a estar acompañada, Tacto vaginal, Inducción del parto.* **Conclusión:** Se percibió conocimiento sobre la temática por las características del público encuestado, orientando la construcción del plan de parto, con la adición de los elementos: baño temprano, prevención de la oftalmia neonatal, deseo de comer. El plan de parto se defiende como una posibilidad de asistencia individualizada y humanizada, con informaciones y orientaciones sobre los derechos de la embarazada, y dentro de sus deseos.
Descriptores: Mujeres Embarazadas; Parto; Planificación; Toma de Decisiones.

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INTRODUCTION

The intensification of childbirth care led to an increase in unnecessary interventions and women's dissatisfaction with the care received, which contributed to the emergence of the movement of humanization of childbirth around the world, looking to improve quality of care regarding giving birth and being born, making the woman the protagonist of her labor and respecting her choices and decisions[1].

This movement proposes democratization for women's freedom of choice and respect for her decisions. The current care model is centered on what is convenient for the physician, and does not respect the particularities of the parturient, who, most often than not, does not have the right to choose where she wants to give birth, the position she wants to be in, if she wants the presence of a companion and the procedures that she wants or does not want to go through. These choices are not part of a negotiation; on the contrary, they are almost always imposed by physicians[1].

At the end of the 1970s, the birth plan (BP) emerged, propagated by prenatal care scholars. The World Health Organization (WHO) has been advocating for the BP since 1996, with several recommendations related to "*Good Practices in Labor and Birth Care*" with the purpose of restructuring and making childbirth care more respectful around the world. The BP is a legal document, in which women write down their concerns before receiving childbirth care, their expectations regarding the care they wish to receive during labor and delivery according to their needs and beliefs, in order to avoid and reduce unnecessary interventions[2-3].

The BP is an essential tool that empowers the autonomy of women and families, encourages co-participatory care and discusses the obstetric scenario[3].

It is a tool for women's empowerment to be used during prenatal care, childbirth and postpartum period, as it allows respect for the principle of Bioethics,as well as independence in this time, and can be prepared by the woman with guidance of health professionals, especially from nurses. The quality of care offered to mother-child is also ensured with the use of this document, as it favors the reduction and eradication of malpractice, negligence and recklessness, as well as promoting women's autonomy. Furthermore, it can strengthen family ties when the woman transfers or divides the choices regarding the birth process with family, friends and partner[4].

The BP should be prepared after the woman has been assisted on issues related to pregnancy, labor, the right to choose, the benefits of natural childbirth, the risks of unnecessary procedures (such as cesarean section) and other information. As soon as the pregnant woman

is admitted to the maternity ward, the BP must be handed over to the professionals so that decisions are shared between the team involved in childbirth care and the pregnant woman[2-3].

Women refer to the birth plan as "care/attention", which represents the alignment between scientific knowledge and respectful assistance; it is not just about accepting wishes and worries, it also involves an attentive and gentle look, providing security and acceptance, and allowing them to feel calm and satisfied[3].

Thus, it can be understood that the BP is a technological tool that promotes respect for the care of women and newborns (NB), and has facilitated the improvement of the quality of obstetric care. However, there are some obstacles to putting this into practice, such as: the need to increase disclosure among professionals and encourage its use among pregnant women; introduction to Primary Health Care services as a routine tool; help and guide the preparation of the document to increase compliance rates, especially by obstetric health professionals who have knowledge about the clinical particularities of pregnant women and the real scenario of obstetric services; and, also, to build adjustable BPs that take into account that a birth is unpredictable, to encourage its implementation and realization, as well as the woman's satisfaction[3-5].

Thus, given the lack of use and knowledge of professionals and parturients regarding the benefits and advantages of making the a habitual and routine tool BP health services, this study aimed to understand the construction of a model birth plan from the perception of pregnant women.

METHODS

This is a descriptive study with a qualitative approach. The interviews were conducted with pregnant women residing in the city of Uberaba, Minas Gerais, Brazil. The inclusion criteria were: pregnant women over 18 years of age at any gestational age, and the exclusion criterion was absolute indication for cesarean section.

For data collection, a semi-structured script was used for the interviews and a form with questions related to sociodemographic characterization. The interviews took place from July to September 2020 and, due to the COVID-19 pandemic, were carried out online.

Recruitment took place through a WhatsApp group. The group was an environment for exchanging information based on scientific evidence that helped in a conscious pregnancy, childbirth and motherhood, therefore, the main condition was to be open to deconstructing in order to construct. During the period of data collection, the participants of the group consisted of pregnant women, mothers and professionals from different areas (nurses, doulas,

nutritionists, physical therapists, occupational therapists and psychologists). To participate in the group, a member must give an invitation and pass on the group rules to the person being inserted.

The pregnant women were invited through a private online message, explaining the research and inviting them to participate voluntarily. The snowball sampling technique was also used for data collection[6].

For the interview script, the questions selected guided a description based on the women's narrative, with the aim of understanding the construction of a birth plan, such as: *You need to guide a friend on how to use the birth plan, how would you do it? Imagine that, for that same friend, you were talking about her birth plan, what would you tell her? What items do you think you must have in a BP model?* The audios of the interviews were recorded and digitized.

The information regarding the characterization of the interviewed women was submitted to descriptive analysis, with the calculation of absolute frequencies and percentages.

After exhaustive reading of the material gathered from the interviewees' testimonies, the set of relevant ideas and concepts from each statement was extracted, the central ideas and their respective key expressions[7].

The extracted content was submitted to analysis using the Discourse of the Collective Subject (DCS) method, developed by Lefevre and Lefevre in the 1990s, a qualitative data organization technique based on the Social Representations Theory. Central ideas are understood as a precise synthesis of the meaning of each discourse, and by key expressions the essence of the discourses[7].

The processing of these data resulted in the construction of collective subject discourses, which are based on a synthesis discourse, composed of the union of similar individual reports. These speeches written in first person singular seek to create an impression of "collectiveness speaking", and the opinions and ideas of the participants are solidified and enriched[7].

The project was evaluated and approved by the Research Ethics Committee of the Universidade Federal do Triângulo Mineiro (UFTM) under Opinion No. 3,957,474. The research followed the ethical aspects of research involving human beings, according to Resolution No. 466/12 of the National Health Council of the Brazilian Ministry of Health (CNS/MS). All participants signed a Term of Free and Informed Consent Form (FICF) after being given an explanation about the purposes of the study and detailing its process.

RESULTS

Participant characteristics

The participants were 50 pregnant women from a group of 144 people. The ages of these pregnant women presented a minimum of 20 years and a maximum of 39 years, with an average of 29 years. Regarding marital status, 58% were married, 34% cohabited with a partner, 6% were single and 2% were divorced. As for education, 76% reported having a higher education degree, 36% had a high school degree and 2% had an elementary school degree.

When questioning the obstetric history of these women, it was found that the age of the first pregnancy occurred between the ages of 17 to 39 years; regarding the number of pregnancies, 70% reported having had only one pregnancy, 24% two pregnancies and 6% three pregnancies. Regarding the route of birth, 22% had a cesarean section and 4% had a vaginal delivery, 14% women reported having had a miscarriage at least once in their lives, and the number of miscarriages was not asked.

The Discourses of the Collective Subjects were ordered based on common themes extracted from their key expressions that were similar and separated in *Birth Plan: items revealed by women - Episiotomy, Kristeller, Freedom of position and movement, Pain medication, Skin-to-skin contact and breastfeeding in the newborn's first hour of life and Delayed clamping of the umbilical cord, Right to a companion, Vaginal touch, Labor induction.*

Birth Plan: items revealed by women

The items pointed out in the BP concern women's rights, wishes and active participation in the delivery process.

Episiotomy

The participants' speeches showed denial or desire for its non-realization, but with justifications that, if something happens or if it is necessary, it will be/may be allowed. And some reported knowledge about its lack of necessity, and denial of its practice at the time of their deliveries:

What I think about the most is the issue of the episiotomy, that I don't want this procedure to be done, I'll say that I don't want it, but for example, there might be some kind of very serious intercurrence and then the procedure will be super necessary, then I might change my mind on the day, but this is an issue that I don't want to happen on the day of delivery. It is a very common practice, most women who have had vaginal delivery that I know here in Uberaba have had an episiotomy, and many times without indication. This is my biggest fear, it's something that worries me so much that I'm scared to death. I don't want it at all, only if it's really necessary. (04, 07,12,13,17)

The right to speak if I want the cut or I don't. I do not accept an episiotomy, the cut, the nick. From what I've read, it's not recommended or necessary, people only do it to speed up the delivery. Many doctors do not ask for your consent, even if you write about it on you birth plan. (19,32, 33, 34, 36, 38,44, 46)

Kristeller

The Kristeller's maneuver, characterized as fundal pressure, can cause several serious complications and there is no evidence that it benefits mother and baby. The speech below represents some of the women who recognize the discontinuation of this practice:

I would like all those procedures that the World Health Organization took away, because they are dangerous for mother and baby, like that Kristeller maneuver. I do not accept the disrespect to the woman's body such as climbing on top of her belly. (04,13,25)

Freedom of position and movement

The right to walk, move around during labor, the freedom to choose the position for childbirth, are considered good practices of humanized assistance of delivery and birth and are represented in the following speech:

Being able to give birth in the position you want, in the position that is most comfortable and having freedom of movement, being able to walk around. (04, 05,16,25,34)

Pain medication

The question of medication, right, make it very clear, right, for those who are going to follow up, if they want pain relief or not. I would say that I wanted to receive anesthesia [laughing]. *I don't know how long it takes, how long the anesthesia can be used, but I wanted to.* (02, 09)

They keep saying, you know, like "no, take painkillers". I think this is also important for those who are willing to do it very naturally, because sometimes they don't want to, but when you're in pain, if they keep talking, talking, talking, you end up giving in. (37)

Skin-to-skin contact and breastfeeding in the newborn's first hour of life and Delayed clamping of the umbilical cord

Although some women showed knowledge about delayed clamping of the umbilical cord, it was not mentioned who she would like to cut or section the cord. This is an item that is generally advised to include in the birth plan:

This golden hour issue is like that, there are people who think it's silly, I've heard it too, but I think it's an essential item, as long as the baby doesn't have to be rushed to an ICU. Let them have contact with the mother in the first hour, if they're fine and the mother is too. Not letting them be taken away from me and touch my baby unnecessarily. I want to spend the first hour with him, you know, I want to enjoy that moment, I want him to come straight to my lap, my arm, skin to skin and let him breastfeed. And even if it's a cesarean section, because I already tried to find out if there

is a way for the baby to come and have contact with me. So, from what I've read, I think it's something that every birth plan should have. (04, 06, 07, 08, 10.16, 19, 26, 49)

Everything is already very well defined in my head, from the issue of cutting the umbilical cord, delayed clamping, so, I already saw the importance of waiting for the pulsation to stop and I want as much as I can. I don't agree that the baby is born and the cord is immediately cut, because I know that the blood in the placenta will all go back to the baby. (04, 06, 12, 13, 16, 19, 34, 43)

Right to a companion

Pregnant women reveal the desire to have a companion during the birth process of their children, showing knowledge about the law that guarantees this right:

I think the partner should be there all the time, it should never be prohibited, not even during a pandemic. I think they are a person who gives you strength, they are a fundamental person to be with and they see everything that is happening. To have my active participation and that of my partner in whatever is possible. I informed myself, I know I have the right, and what I want most is this. (05,10,28,44)

Vaginal touch

Among the unnecessary interventions, the women highlighted excessive touching performed indiscriminately:

I have a lot of difficulty with unnecessary touching, repetitive touches. In fact, I don't want them to touch me, only if it's strictly necessary, I have this barrier, my birth plan says that, it's a more private thing for me, but for me it's very important. (26,28)

Labor induction

The essential thing is not to have that injection that will increase the pain, oxytocin induction, for personal reasons, because I think that if I want a vaginal delivery, from the moment I'm inducing it with a chemical product, I'm already ceasing to making the birth as natural as possible, for me that would no longer work, but there are women who agree with oxytocin. I would like you to ask me first to see if I want it and only if it is absolutely necessary. (08,09,18,19)

DISCUSSION

Scientific evidence has shown that there are no real indications for performing an episiotomy. Its execution does not facilitate the passage of the cephalic pole of the fetus and neither does it have protective factors in relation to lacerations, as the episiotomy itself is a second-degree laceration, nor does it improve maternal and fetal outcomes in labor and dystocia deliveries, such as shoulder dystocia or the need for instrumental delivery using forceps or a vacuum extractor[8-9].

There is no clear evidence to support real indications for episiotomy[1,4] and a systematic review published in the Cocharane Library pointed out that there is no definite evidence

regarding the indications for routinely performed episiotomies[8]. The Brazilian National Guidelines for Assistance to Normal Childbirth and the World Health Organization advise against performing a routine episiotomy in vaginal birth[10-11].

The practice of episiotomy performed on women during childbirth with the intention of helping the passage of the fetus results in complications, in particular pain at the cut site, pain during sexual intercourse, fear of resuming sexual activities, loss of vaginal sensitivity, issues of self-acceptance and self-esteem related to body image linked to changes in the anatomy of the sexual organ[3,8].

Studies show that women are not informed about the procedure, neither during pregnancy nor at any stage of labor and delivery. The awareness to which it was submitted, for some, only happens when the suture performed[8].

The realization of the episiotomy practiced by the health professional, without clarification about its execution, configures in a loss of the woman's protagonism regarding her body, besides expressing a display of power over the right of decision that they possess[7]. The recurrent use of this procedure can only be supported by scientific data that corroborate its real need and positive effects. Thus, episiotomy, when routinely practiced and without the parturient's consent, is considered obstetric violence[12].

Regarding the Kristeller maneuver, the Brazilian Federation of Gynecology and Obstetrics Associations (FEBRASGO) prohibits this practice, because it is associated with maternal and neonatal complications and the Brazilian National Guidelines for Normal Childbirth do not recommend the use of this maneuver[10,13].

However, a national survey carried out in Brazil with interviews with 23,894 women showed that 36% reported having undergone the maneuver. These reports show that this practice still remains, even though it usually its performance is not registered in medical records, proving it is a veiled practice[14].

As for freedom of position and movement, puerperal women in a survey entitled *Nascer em Belo Horizonte* (Being born in Belo Horizonte), characterized by an inquiry about childbirth and birth, showed that the interviewees recognize the benefits of vertical positions for childbirth, such as less discomfort; contribution to locomotion and the participation of women; reduced tiredness and the use of strength in the expulsive period[15].

Pharmacological anesthesia can bring about changes in the delivery outcome, by increasing the probability of an instrumental delivery and the duration of labor, especially in high-risk pregnancies, and this association does not depend on maternal age, the amount of

previous births, the presence of a companion or doula and how many centimeters of dilation there is at the time of anesthesia[16].

It is necessary to talk about the meaning of pain during labor and advise women about the risks and benefits of anesthesia, giving them the opportunity to choose. Also, the proper use of technological tools is essential to prevent iatrogenic labor and birth and the discredit of consistent care, but with low technological density[16].

Good care practices based on respect for decisions showed a reduction in the demand for pain relief[13](14%), in a study carried out in the city of Belo Horizonte with 238 women from two institutions, where delivery and birth assistance is performed by doctors and obstetric nurses. Anesthesia offered in a more restricted manner associated with guidance on risks and benefits should be incorporated as a conduct that favors the humanization of childbirth[15].

Putting the newborn in contact with the maternal skin during vaginal delivery or cesarean section is significant for both, simple and low economic cost. This practice contributes to a better adaptation to maternal and neonatal physiological levels[3,17].

An integrative review showed that the benefits of skin-to-skin contact are of paramount importance for the mother-baby binomial. However, for this to be a routine practice, successfully carried out, essentially in the first sixty minutes after delivery, health professionals need to promote this care, favor the environment and mother-infant interaction[17].

In the contact between mother-baby after childbirth, the clamping of the umbilical cord is discussed. Delayed clamping is a simple procedure and, at the same time, provides early contact between mother and child, considerably increases the bond between them and the success rates of breastfeeding[16].

Neonatal resuscitation guidelines recommend that the umbilical cord be cut one to three minutes after delivery for full-term newborns in good birth condition[18].

The benefits of delayed clamping are increased iron reserves in the NB, lower risk of intraventricular hemorrhage, lower risk of necrotizing enterocolitis, lower chance of childhood sepsis and less need for blood transfusion[18].

An investigation carried out with 84 pregnant women in the city of Belo Horizonte regarding the wishes and desires fulfilled in a birth plan showed that 51.19% chose that it be carried out by the husband/partner/father of the NB, while 46.43% by the professional and only 2 .38%, by themselves[2].

It is important to realize that a sensitive team provides this experience for the family, in addition to the need for adequate guidance and information during prenatal care regarding

rights, when and under what conditions this procedure can be performed by people other than the technical team[2].

In 2005, Law 11,108 was regulated by the Ministerial Order of the Brazilian Ministry of Health, which guarantees the presence of a companion of the woman's choice in all phases of the pregnancy-puerperal cycle, that is, any moment of the phases of labor, delivery and after the immediate delivery, defined as up to 10 days[19].

The presence of a companion during labor and delivery is considered positive, providing the pregnant woman with a sense of security during a moment of emotional fragility and pain. The presence of a companion aims to encourage and support, verbally or gesturally, women in order to ensure a good evolution of the delivery[11].

However, despite the advances after the incorporation of the Law, there are still issues in this aspect of obstetric care. A survey conducted in all of Brazil showed that 24.5% of the women had no companion at all, 56.7% had partial companionship, and only 18.8% had continuous companionship. When comparing with socioeconomic variables, it was found that the presence of a companion is still reserved to a privileged white minority, with greater financial status and higher educational level, who had hired a private team and who had a cesarean section[20].

The companion must be included in educational activities and prenatal consultations early in the pregnancy, so that they can provide uninterrupted and effective support. The professional or companion who provides care to the parturient needs to know how to guide, soothe anxieties, attend to the woman's demands and contribute to the relationship between her, the family and the professional team[11,21].

Regarding vaginal examination, a systematic review did not find convincing data supporting its routine performance during labor. Vaginal touch should be avoided outside active labor, that is, when the woman does not have rhythmic contractions[21-22]. Furthermore, the WHO recommends that vaginal examination to assess labor should be carried out at least every four hours[22].

The infusion of synthetic oxytocin and amniotomy are techniques widely used to accelerate labor, and, comparing this intervention with socioeconomic factors, it is more frequent in pregnant women using the SUS, with a lower level of education[14].

In a Brazilian survey, among the practices that are often used inappropriately during the first stage of labor, it was found that 41.7% of women who received oxytocin infusion during labor demonstrating that interventionist practices such as artificial disruption of the amniotic

sac, use of oxytocin and indiscriminate anesthesia are still common in the professionals' conduct[16].

One of the most surprising issues in obstetric care in Brazil is the lack of patience in waiting for the moment of birth, without respecting the role of women in this journey of labor and delivery. The high rates of unnecessary interventions, including cesarean sections, are justified by the dominance of the duration and determination of the parturition process, making obstetric care in Brazil concentrated in the hands of professionals and not in the physiology and body of the woman. This starts with prenatal care, when women are excluded from adequate guidance and information related to good practices and effective obstetric care, about the advantages of a natural delivery, and are not encouraged to command their own delivery[14].

CONCLUSION

Many women have knowledge about some items that can compose a BP, even with some issues with the answers, such as episiotomy. They know that it is not a necessary procedure, that it does not change the maternal-neonatal outcome, but they still feel insecure when expressing their knowledge, making them vulnerable and fragile for its execution.

Some expected items were not mentioned at all, such as unnecessary procedures with NBs: early bathing and prevention of ophthalmia neonatorum without scientific basis, among other procedures and/or conducts.

The participants' reports presented items considered important for women to have as a tool to discuss conduct with their prenatal professional. Elements appeared that make up not only themes related to practices considered unnecessary, but also those that are the right of the assisted woman.

The birth plan is a flexible document, through which each user can add what best suits her. With the BP, it will be possible to know and analyze whether women are receiving individualized and humanized assistance in prenatal care, with information and guidance about their rights, and according to their desires.

Among the limitations, there was the COVID-19 pandemic, as the initial idea was to conduct interviews with women assisted in prenatal care at a Basic Health Unit. When recruiting women from a WhatsApp group, it was noticed that the group was composed of women that had received guidance on the subject, including those who hired private teams of doulas and midwives. It was also not specified whether the interviewee was a SUS patient or had private health care/health insurance.

It is noteworthy the fact that, despite the group receiving guidance, it was perceived the need for dissemination and awareness of women's rights related to pregnancy, labor and delivery.

On the other hand, the question still remains: "*How, despite having knowledge about humanization in childbirth, do the women surveyed have a greater history of cesarean sections than vaginal delivery?*" It is important here to reflect on the paths taken by women to the world of obstetric care in a respectful manner based on scientific evidence, which calls for more study on the subject in different contexts, such as public or private health care.

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Nara dos Santos Costa participated in the design, collection and analysis of data and writing. **Efigênia Aparecida Maciel de Freitas** contributed to the conception and writing. **Ana Rita Marinho Machado** worked on the design, data collection and analysis, writing and revision. **Andressa Cintra Ferreira** contributed to data collection and analysis and revision. **Carolina Feliciana Bracarense** collaborated in the revision. **Ana Lúcia de Assis Simões** collaborated in the design of the study and revision.

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