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BIRTH PLAN: PORTUGUESE WOMEN'S PERCEPTIONS

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Abstract

The Birth Plan (BP) is a document drawn up by the couple to express their wishes regarding their labour. It promotes the couple's expectations regarding their delivery and allows better communication with health professionals. The use of the BP increases the autonomy and satisfaction of women. As midwives we wanted to know the perception of Portuguese citizens about the use of the birth plan. The study undertaken during the month of April 2018 was exploratory and descriptive. The data was obtained from a self-completed online survey containing 21 questions. The sample which was non-probabilistic and intentional targeted 150 Portuguese citizens aged ≥18 years. The findings revealed that 83.6% are aware of the BP, 64% have used it while 75% used it once. The BP was drawn up between 32-38 weeks of pregnancy. Most did not mention difficulties but some reported difficulties in discussing their preferences and a lack of information. When they presented the BP at the maternity ward, 10.1% said it was not accepted by health team. 79.3% considered BP as mandatory, while 54.8% wanted a single model BP. The BP appears to be a key element in the provision of antenatal care. The results show that citizens living in Portugal are aware of the importance of using the BP, recognizing it as a facilitating strategy to reorient the woman/couple in the birth process, promoting a closer relationship between formal caregivers and citizens.

Keywords: Birth plan, women's rights, decision-making.

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1. Introduction

Pregnancy and childbirth are considered natural physiological processes, although they are wrapped in expectations and fears that generated rituals and myths according to regions and cultures, regardless of the time or technology available. In the mid-twentieth century, to control the high rates of peri-neonatal, fetal and maternal mortality, there was a change in the place of birth from the house to the hospital. This caused a change in the health paradigm, passing the professionals to look at the childbirth as a health problem that requires medical attention. (Suárez-Cortés, Armero-Barranco, Canteras-Jordana & Martínez-Roche, 2015; Sánchez et al., 2012). Since that time, several practices have been introduced, sometimes generating protocols, such as episiotomy, trichotomy, enemas, induction of labour, continuous monitoring, lithotomy position, no feeding or walking during the period of dilation; routinized practices that lacked scientific basis (Suárez-Cortés et al., 2015). These practices were reinforced because it was believed that they depended on the good results achieved in relation to the indicators of perinatal morbidity and mortality.

With the institutionalization of childbirth for the hospital environment and with the increase of instrumental practices in childbirth, intrapartum care has become more focused on professionals and health technologies than on women, not respecting their options and their decisions; consequently, leaving them the possibility of living their experience of childbirth in a unique and irreparable way. The situation has become so extreme that the Director-General for Family, Women, Children and Adolescents said in 2018 that "The increased medicalization of normal childbirth processes is undermining a woman's ability to deliver and negatively impact her delivery experience" (Simelela, 2018 in http://www.who.int/reproductivehealth/intrapartum-care/en).

Over the last two decades, a social movement has emerged to neutralize established birth practices and to reinstate the role of the woman as the protagonist and to the couple which had been usurped by the increasing institutionalization of childbirth for the hospital environment.

In 1985, with WHO's birth recommendations, governments were encouraged to reconsider the technology applied to childbirth. In 1996, WHO published "Normal Delivery Assistance: A Practical Guide," advocating practices that promote normal childbirth and reducing unnecessary medical interventions.

More recently, according to WHO (2018), the Global Strategy for Women, Children and Adolescents' Health (2016-2030) emphasizes "the importance of ensuring safe births from a clinical perspective, including the psychological and emotional needs of women, ensuring their involvement in decision and a sense of personal fulfilment, making this experience more satisfying. This philosophy focuses women in the care process and is based on human rights, recognizing the importance of women's options for the care process. These recommendations are all evidence-based, optimize health and well-being and have been shown to have a positive impact on women's delivery experience" (WHO, 2018, s/pp).

The need to reinstate women into the birth process began in the United States, in 1980, with the introduction of the birth plan promoted by Sheila Kitzinger, who considered it a formal, emergent and obligatory document to experience a positive birth experience (Lundgren, Berg & Lindmark, 2003).

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A birth plan (BP) is a written document, prepared during pregnancy, after having received adequate information, and taking into account the best praxis. In this document, the pregnant woman expresses her expectations about her delivery and birth, according to personal values, desires and preferences about the practices that want to implement.

A birth plan is built on the relationship between the midwife and the pregnant woman, helping her to gain more control over the events and the processes during the birth, allowing her choices and options to be considered about the practices that may occur during childbirth.

The importance of BP is based on respect for the bioethical principle of autonomy because it promotes women's control over the labour process, contributing to a more positive and satisfactory delivery experience (Whitford & Hillan, 1998). The achievement of this document is an important strategy for preparation the childbirth (DeBaets, 2017; Kaufman, 2007; Peart, 2004), reducing their fears according to the information and communication they received (Kaufman, 2007; Simkin, 2007; Lothian, 2006; Perez & Capitulo, 2005; Peart, 2004; Lundgren, Berg & Lindmark, 2003), allowing a process of reflection for decision making (De Fernández & Sellé, 2010), thus increasing the empowerment of women and couples in the birth process.

2. Problem Statement

The birth plan is a document drawn up by the couple or a single mother to express their/her wishes regarding the labour. It promotes the couple /single mother's expectations regarding the delivery and allows better communication with health professionals.

Although the use of BP was widely adopted in some European countries, as in the UK, where 78% of delivery rooms have already used it since 1993. In 2012, in Spain, the Ministry of Health, Social Policy and Equality published a model of BP (Suárez-Cortés, et al., 2015), but in Portugal there is no specific legislation that legally protects the use of BP.

However, in Portugal, civil society and some professional organizations such as the Associação Portuguesa dos Enfermeiros Obstetras (2009, 2017), the Project "Pelo Direito ao Parto Normal: Uma Visão Partilhada" (2010) and the Associação Portuguesa dos Direitos da Mulheres na Gravidez e Parto (2017) initiated actions promoting the disclosure and construction of the birth plan as a strategy for empowering Portuguese women taking into account that birth is a physiological process in which intervention should only be done to correct problems that may exceed normal circumstances. Health professionals working in this area should be the guarantor of an environment built on trust, security and privacy. They should respect and promote the right of informed decision, individuality, dignity and confidentiality of women (Pinheiro, Catarino, Leite, Freitas, & Marques, 2012).

3. Research Questions

The use of the birth plan increases the autonomy, the empowerment and satisfaction of women. As nurse midwives, we wanted to know the perception of Portuguese citizens about the implementation of the birth plan.

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4. Purpose of the Study

With the accomplishment of this study, we would be able to identify the perceptions of Portuguese citizens on the use of the birth plan and to reflect on how the results can be used to help change the practices of care in childbirth

5. Research Methods

5.1. Research method

A qualitative, exploratory and descriptive study was carried out during the month of April 2018.

A survey with 21 questions was implemented to obtain the data sought to answer the research question. Of the 21 questions, 12 were closed out of which 8 were related to the sociodemographic characterization of the sample and 4 were related to the BP. The remaining 4 questions were mixed with 5 open questions related to the BP. The study was released via email and on the social network; data collection was done on the online platform (Google). The anonymity and confidentiality of the data was guaranteed. Participants were informed that they could only complete the inquiry once.

5.2. Sample

A non-probabilistic, intentional sample comprising 150 citizens aged 18 years and above residing in Portugal was obtained. The participation was voluntary which corresponds to the informed consent of the participant. One criteria was that they must be able to read and write Portuguese.

5.3. Data Analysis

Statistical treatment was performed using SPSS version 25.

Content analysis technique proposed by Bardin (2010) and the contributions of Braun & Clark (2006) regarding the thematic analysis was used to analyse the open ended questions. We applied the Bardin (2010) method according to 3 phases: pre-analysis, material exploration and treatment of results, and inference and interpretation. In the exploratory phase, we used Braun & Clarke (2006) on the thematic analysis, posting the categories a priori supported in the researched literature and according to the objective of this study. However, in the exploration phase of the analysis corpus, we tried to maintain openness and flexibility to recognize emerging categories.

For data analysis and treatment, the INVO computer tool version 11 was used to reinforce the trend of the responses.

As observed in table 1, the sample was mostly composed of women, married, with an average age of 32.5 (19-67), with higher education and primiparous.

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Table 01. Sample demographics

n =150		**%**			**%**
Age	<29	30.1	**Marital status**	Single	13.8
	30-39	**58.1**		**Married/with companion**	**83.6**
	40-49	10.8		Other	2.6
	50-59	0.53	**Employment**	**Yes**	**70.4**
	>60	0.53		No	29.6
Sex	**Female**	**97.8**	**N.º of children**	0	16.6
	Male	2.2		**1**	**52.6**
Educational qualifications	9th year	1.6		2	25.3
	12th year	28.4		3	3.5
	Graduation	**52.7**		4	2
	Master's/PhD	17.3	**Age of the last child**	**Up to 1 year**	**18.4**
Place of residence	North Zone	**36.4**		1-up to 2 years	27.6
	Central Zone	13		2-up to 3 years	14.1
	Lisbon and Vale do Tejo Zone	**36.4**		3-up to 4 years	11.7
	South Zone	12		4-up to 5 years	9.1
				5 or more years	19.1

6. Findings

In this study, we identified a priori six categories that referred to the knowledge and construction of BP in pregnancy, difficulties experienced and the application BP in childbirth, expectations about BP and suggestions for the application of BP.

According to the objective of the study, the concerns of the literature consulted and the reality about the use of the birth plan in Portugal, we can observe that the majority of the sample had already heard of and used the BP according to the results in table 2:

Table 02. Birth Plan

	Yes	**No**	**Not applicable**
Have you heard of the birth plan?	**87.3%**	12.7%	
Do you know what the birth plan is for?	**83.6%**	16.4%	
Do you know the benefits of using the birth plan?	**77,3%**	22,7%	
Have you used the birth plan?	**64%**	27.6%	8.5%
If you used the birth plan did you have someone's help?	**35.2%**	17.9%	46.9%

We can also observe from the participants' responses that 75% used the BP once, 23% used it twice and 2% used three or more times.

Regarding the time that they used it, it was observed that BP was performed during pregnancy, more specifically between 32-38 weeks of gestation.

Regarding the construction of the BP, 35.2% had been helped by a health professional while 17.9% did not have any help. The women's support in the construction of the BP, there were 14

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references concerning the midwife, 6 references concerning the doula and 5 references concerning the obstetrician.

Regarding the difficulties in constructing of the BP, some of the participants reported feelings of distrust regarding the information obtained from professionals. They also refer to distrust regarding the resources made available by the institutions. They mentioned the inability to discuss and defend their options, as well as, feeling powerless in the face of health professionals to keep their options. They also reported that they had doubts about the appropriateness of their choices. However, most BP users said they did not find it difficult to do so because they had the support of health professionals as well as the support of the models on the internet.

Relative to the time of presentation, they said that they presented the birth plan to the health team at the place of birth during or at the end of pregnancy.

Regarding the perception of the acceptance of BP by the team of health professionals, 10.1% answered that it wasn't accepted while 33.9% said it was. The reasons given for the rejection of their BP were: "*…mothers do not have the literacy to build the birth plan*"; "*…midwives who provide care during pregnancy are not the same as attending childbirth*"; *"...it was simply ignored*"; *"The doctor said that she did not give birth in these conditions and sent me to look for another hospital*"; "*…the doctor said to be insulting to receive a birth plan*"; *"…the birth plan was just my expectation, we do not know if it is correct or not*"; *"I was forced to throw the BP in the trash, although it was well prepared*"; "*Some of the health professionals seemed to accept BP, while others said that BP was to be used in home birth with the doulas*".

Regarding the expectations on the use of the BP, 79.3% believe that BP should be compulsory in all maternity wards of the country because it is *"...a right of the women*"; *"...a way to respect their wishes, desires and expectations*"; *"...a way to make childbirth more humane*"; *"...a way to increase knowledge about the physiology of childbirth*"; *"…to increase the empowerment of the couple*".

When asked about the use of one model in maternity wards across the country, 54.8% agree because "*It would facilitate the understanding of professionals and women*"; "…promote standardization"; "*…it would promote its use and interpretation*"; *"...it would facilitate its elaboration*". However, 45.2% disagreed because "*...every woman makes her decisions, has her needs, beliefs and lifestyles*"; *"...BP is unique for every woman*"; "*...an equal BP model is very limiting, because one loses one's individuality*"; "*...every woman is different in thought and her volition"*; *"...model becomes limited*"; "*…we lose our individuality*"; *"...we have no choice*".

When asked to give suggestions on how the BP could be implemented, the responses included *"Be obliged to explain why the birth plan was not followed*"; "*…elaboration of a hospital project that is friendly to mothers*"; "*…increase information*"; "*…created a document required at admission*"; "*…required integration in preparation classes*"; "*…to create a consultation for the construction of BP*"; *"...improve the training of health professionals"; "...involve all the professionals in the elaboration of a unique model*"; "*…a normative orientation should be developed by the government health organizations (ARS, DGS, MS)*"; "*…create an appointment for building the BP*"; "*…create a national BP*"; "*…train the health team about BP*".

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7. Discussion

According to the results of this study, as in other European countries, a great deal can be discussed about the implementation of the birth plan in Portugal, namely its concept, importance, content, applicability, advantages and constraints (DeBaets, 2017; Lothian, 2006; Beech, 2011; Suárez-Cortés, et al., 2015; Divall, Spiby, Nolan & Slade, 2017).

This discussion has been driven by concerns of non-governmental and professional organizations which call for the application of human rights, particularly in the area of sexual health and reproductive health (eg. APEO, APDMGP, etc.)

There is still no legal framework in Portugal, for the implementation of the BP and the health units that attend childbirth do not recognize it as an important and integrative element to be included in the provision of care at birth. However, we can say that is a reality in the primary health care; its construction is already included in the sessions of preparation for labour, performed mostly by nurse midwives who can be considered the force behind this practice.

In this research, from the perspective of the sample, we can observe that the construction of a BP allowed them to have greater control over their birth, giving an opportunity to have more information about the options available on childbirth practices; at the same time, enabling them to develop a closer and more trusting relationship with their formal caregivers and to become aware of their rights, duties and limits in this event.

There are contradictory positions within the health teams regarding the literacy, the capacity and the autonomy of women to elaborate and implement their BP, and this result is also supported by other studies (DeBaets, 2017; Divall et al., 2017). On the other hand, we can report on the benefits of the full implementation of the birth plan, referring to the participants' responses as giving them greater freedom, greater autonomy and greater satisfaction in the decision making regarding the birth of their children, based on the greater knowledge and information acquired throughout of the BP elaboration process; thus allowing women to recognize that the preparation of a BP increases their autonomy, their security and allows respect for their choices subsequently empowering them.

Reflecting on these results, we can infer that in Portugal, there are some professionals whose care model is focused on the health professional and his/her decision, not admitting in this process a space for information, clarification and discussion about the different options of the women, even if these are supported by scientific evidence. Regardless of the resources available, the situation of each woman and her knowledge, there are professionals who devalue women's options expressed in their BP causing them embarrassment and "fears".

Some studies refer that the non-inclusion of women's preferences in the intrapartum generates a more negative experience and these women easily lose their self-control when they feel that the caregivers do not pay attention or disrespect their plans of delivery (DeBaets, 2017; Divall et al., 2017; Whitford et al., 2014; Brown & Lumley, 1998; Whitford & Hillan, 1998; Too, 1996). The uncompromising position of some health professionals regarding the presentation of a BP can be linked to the denial of ethical-professional principles, as evidenced by the participants' responses that they even refuse assistance to these women who wish to use a BP.

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As mentioned by the participants, it is important to question and review the training models of health professionals, as well as organizational models of childbirth care. Allied to this last aspect, another important element for the discussion was the sample's reference about the existence of several and different professionals involved in the assistance from the pregnancy to the postpartum. This causes disruptions in the philosophy of care, generating dissatisfaction with regard to their expectations created during pregnancy with possible repercussions on the adequate use of resources and losses of health gains.

We could also observe that the participants of this study reported that midwives were the professionals who contributed a great deal to the creation and use of the BP. These results reinforce the findings of other studies regarding the importance of the role of these professionals in the use of care models that promote continuity of care, increase maternal health literacy and applied less birth interventions and more satisfactory births for women and couples (Sandall, Soltani, Gates, Shennan & Devane, 2016; UNFPA ICM, WHO, 2014).

It was also mentioned by the participants that the implementation of the BP could be promoted if it was a legal obligation to present the BP in the admission of places of birth, a rule that should be elaborated with the involvement of all stakeholders including state bodies, professional societies, non-governmental organizations, as well as civil society.

As for the possibility of a single BP model, the respondents presented several different reasons for their choice. Some of them appealed to individual choices and decisions based on personal needs, beliefs and lifestyles, and the limitation that a single plan might have. Others believed that the existence of a single instrument would facilitate the guidance, use and understanding of the health professionals and the women concerned.

Some limitations of this study include the fact that because this study was only carried out via online did not make it possible to clarify some of the answers given by the respondents, although in the survey a guiding note was presented to complete the survey. Another limitation is the small number of sample used in this study which does not allow for generalizability of the results to the entire population. However, it must be reiterated that this was an exploratory study and future studies can explore this area with a larger more representative sample.

This study presents only an overview of the experiences and opinions of the sample without more in depth discussion. However, as an exploratory study, it offers an instantaneous contemporary overview of BP in the Portuguese context.

This article only refers to a part of a larger study on "Birth Plan: a right and a duty", in which only the perception of the citizens residing in Portugal is presented, in tandem with the perception of health professionals which has also been studied and will be displayed.

8. Conclusion

According to the results of this study, there seems to be a general awareness of Portuguese about the importance of using the BP, recognizing it as a facilitating strategy to refocus the woman and the couple on the process of delivery, promoting a closer relationship between formal caregivers and citizens, increasing greater empowerment and women's satisfaction in this experience, making it more positive, unique and nonreplicable.

The BP appears to be a key element in the provision of antenatal care as the study participants recognized the importance of nurse midwives' vital role in the promotion and implementation of the BP, as well as the reference and a close professional in sexual health and reproductive health.

On the other hand, this study revealed weaknesses regarding personalized care in birth places, as well as the different types of care models existing in the country. We consider these fragilities to be significant challenges that need to be addressed when promoting the BP as a strategy supported by the ONU in the Recommendations for the Health of Women, Children and Adolescents (2016-2030).

The existence of a single birth plan is also another challenge, both in terms of its content as in the different positions taken by citizens.

Nevertheless, it is very clear from the findings of this study that the BP is a necessity not a luxury or a hindrance (as seen by the negative attitude of some health professionals revealed in this study) to a more positive and fulfilling birth experience for all the parties concerned. With the implementation of the BP, the experience of giving birth will finally and rightfully, be handed back to the rightful owners; the women and their partners.

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