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Pregnant women's experiences on the nurse consultation for the construction of a delivery plan

Experiência de gestantes na consulta de Enfermagem com a construção do plano de parto

Experiencia de gestantes en la consulta de Enfermería con la construcción del plan de parto

Tatiane Herreira Trigueiro[1]
Karine Amanda de Arruda[2]
Sinderlândia Domingas dos Santos[3]
Marilene Loewen Wall[1]
Silvana Regina Rossi Kissula Souza[1]
Letícia Siniski de Lima[4]

1. Universidade Federal do Paraná, Departamento de Enfermagem. Curitiba, PR, Brasil.

2. Universidade Federal do Paraná, Curso de Graduação em Enfermagem. Curitiba, PR, Brasil.

3. Universidade Federal do Paraná, Programa de Pós-graduação Prática do Cuidado em Saúde. Curitiba, PR, Brasil.

4. Universidade Federal do Paraná, Programa de Pós-graduação em Enfermagem. Curitiba, PR, Brasil.

Corresponding author:
Tatiane Herreira Trigueiro.
Email: tatiherreira@gmail.com

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ABSTRACT

Objective: To describe the experience of pregnant women at 37 weeks of gestation or more attended at the Nursing Consultation who had developed their delivery plan. **Method:** Qualitative exploratory research with 19 pregnant women at 37 weeks of gestation or more with a bond to a low-risk maternity hospital in Curitiba, Paraná state, Brazil, who attended nursing consultation between November 2019 and March 2020. The data was collected through interviews and submitted to thematic content analysis. **Results:** The pregnant women were unaware of issues related to childbirth, which contributes to the emergence of doubts, fears, and insecurities. They also had no knowledge, or had only superficial knowledge, of the delivery plan. The nursing consultation and the maternity's delivery plan contributed to the clarification of doubts, the reduction of anxiety, the possibility of strengthening and empowering the pregnant woman and her companion in the face of the provision of information for vaginal delivery, and the establishment of a bond with the maternity. **Conclusions and implications for the practice:** Adequate to reality and focused on the individuality of the pregnant woman, the nursing consultation and the birth plan were shown to be a space for health education and an educational tool, respectively, efficient for the nurse's performance and improvement of prenatal care.

Keywords: Obstetric Nursing. Office Nursing. Pregnant Women. Humanizing Delivery. Prenatal Education.

RESUMO

Objetivo: Descrever a experiência das gestantes atendidas na Consulta de Enfermagem a partir de 37 semanas e que elaboraram seu plano de parto. **Método:** Pesquisa exploratória qualitativa, com 19 gestantes a partir de 37 semanas vinculadas à maternidade de risco habitual em Curitiba, Paraná, e que passaram pela consulta de enfermagem entre novembro de 2019 e março de 2020. Os dados foram coletados mediante entrevista e submetidos a análise de conteúdo temática. **Resultados:** As gestantes apresentaram desconhecimento sobre assuntos relacionados ao parto, o que contribui para o surgimento de dúvidas, medos e inseguranças. Também não conheciam, ou conheciam de forma superficial, o plano de parto. A consulta de enfermagem e o plano de parto na maternidade contribuíram para o esclarecimento de dúvidas, redução da ansiedade, possibilidade de fortalecimento e empoderamento da gestante e do acompanhante diante da oferta de informações para o parto vaginal e o estabelecimento de vínculo com a maternidade. **Conclusões e implicações para a prática:** Adequados à realidade e focados na individualidade da gestante, a consulta de enfermagem e o plano de parto foram respectivamente evidenciados como espaço para educação em saúde e ferramenta educativa, mostrando-se eficientes para a atuação do enfermeiro e melhora da assistência pré-natal.

Palavras-chave: Enfermagem Obstétrica. Enfermagem no consultório. Gestantes. Parto Humanizado. Educação Pré-Natal.

RESUMEN

Objetivo: Describir la experiencia de gestantes atendidas en la Consulta de Enfermería a partir de las 37 semanas y que desarrollaron su plan de parto. **Método:** Investigación exploratoria cualitativa con 19 gestantes a partir de 37 semanas vinculadas al hospital de maternidad de riesgo habitual en Curitiba, Paraná, y que asistieron a la consulta de enfermería entre noviembre de 2019 y marzo de 2020. Los datos fueron recolectados a través de entrevistas y sometidos a análisis de contenido temático. **Resultados:** Las gestantes presentaron desconocimiento sobre temas relacionados con el parto, lo que contribuye al surgimiento de dudas, miedos e inseguridades. Tampoco conocían, o conocían superficialmente, el plan de parto. La consulta de enfermería y el plan de parto en la maternidad contribuyeron a la aclaración de dudas, la reducción de la ansiedad, la posibilidad de fortalecer y empoderar a la gestante y su acompañante ante la provisión de información para el parto vaginal y el establecimiento de un vínculo con la maternidad. **Conclusiones e implicaciones para la práctica:** Adecuada a la realidad y enfocada a la individualidad de la gestante, la consulta de enfermería y el plan de parto se evidenciaron como un espacio de educación en salud y una herramienta educativa, respectivamente, eficiente para el desempeño del enfermero y mejoramiento del cuidado prenatal.

Palabras clave: Enfermería Obstétrica. Enfermería de Consulta. Mujeres Embarazadas. Parto Humanizado. Educación Prenatal.

INTRODUCTION

Prenatal care consists of a set of clinical, psychosocial, and educational actions aimed at early prevention and detection of pathologies and maternal and fetal complications, in addition to following pregnancy development with the objective of obtaining positive outcomes for the baby and a reduction of maternal risks[1,2]. This care should be performed so as to meet specific demands and needs of pregnant women, with the inclusion of humanized and welcoming conducts and the absence of unnecessary intervention[1].

Through work based on technical and scientific knowledge, obstetric nursing plays an important role in prenatal care due to its capacity for humanized, comprehensive, remedial, and high-quality care to pregnant women during this period, in addition to playing an important role in the process of health education[3,4]. The presence of this expertise among the health team members in prenatal care to pregnant women has legal support; one of its attributions is nursing consultation as an exclusive activity[5,6]. During consultation, through a contextualized and participatory approach,[1] information and orientation are provided to pregnant women, in addition to an encouragement for them to express their needs and desires, aimed at empowerment and leadership during pregnancy and postpartum[7,8]. Tools which may be used to manage these issues during nursing care in the office for prenatal education include the delivery plan.

Since 1996 the delivery plan is recommended by the World Health Organization for assisting normal birth[9], reinforced in 2018 when last updated for delivery and birth care, which confirms that this should be individualized, considering the preferences and needs of pregnant women[10]. This document is written during the prenatal period, in which the pregnant woman, after receiving information about pregnancy and birth, considering her personal values and desires, establishes preferences and makes informed decisions on obstetric conducts which should or should not be accepted during birth in normal conditions[11]. This contributes thus to empowerment and encouragement of women's autonomy, turning them into protagonists of their process of parturition, making informed decisions[8].

The delivery plan is a tool for prenatal education and communication, since it promotes the pregnant woman's understanding of factors involved in the process of parturition and facilitates exchanging information with the multiprofessional team which provides care during this process[12], since through this the team may understand the wishes and preferences of the pregnant women, contributing for them to be met and respected.

The use of the delivery plan has shown a positive relation with evidence-based conducts in the process of parturition in a hospital in Spain, with the increase of skin-to-skin contact, delayed cord clamping, and vaginal delivery rates[11], a result which is similar to that of another Spanish study, which has shown a direct relation between a higher degree of fulfillment of the delivery plan and better results both for mother and child[13].

However, women and their companions are known to be more anxious at the end of pregnancy, when they become more receptive and interested in delivery and the issues involved[7,14] and that, despite the importance of health education on the process of parturition occurring in all opportune moments of prenatal, emphasizing, educating, and reminding of certain aspects of this moment is necessary, as is establishing a bond with the reference maternity unit after six months of pregnancy, preferably after 37 weeks.

In this sense, understanding all factors involved in prenatal care and the attributions of nurses in this process, the Nursing Consultation at 37 weeks of gestation or more, performed in a low-risk maternity unit in Curitiba, Paraná state, Brazil, in addition to the established aspects for prenatal consultations, aims at elaborating the delivery plan with the pregnant woman and her companion, favoring the creation of a bond with the maternity unit, and orienting and clarifying questions about labor, delivery, and puerperium, according to legal aspects and routines of the maternity unit.

A Systematic Review on the effects of the use of the delivery plan on the birth process, performed in 2018, has emphasized the need for conducting research on this theme, given that, although the analysis of three publications pointed to a better delivery experience in the groups using the delivery plan, there are no strong evidences to support this statement yet[15]. Thus, given the need for promoting and disseminating knowledge of this theme, the following question emerged: What is the experience of pregnant women who participated of the Nursing Consultation at 37 weeks or more and elaborated their delivery plan? The objective of this article was to describe the experience of pregnant women who attended the Nursing Consultation at 37 weeks or more and elaborated their delivery plan.

METHOD

This is an exploratory, qualitative study related to an extension project of the nursing undergraduate course of a public university in the city of Curitiba, Paraná state, Brazil, developed at a low-risk maternity unit in that city.

This low-risk maternity unit in Curitiba employs a model of humanized care, centered on pregnant, parous, and puerperal women. It is divided into Emergency Service (ES), with a mean of 615 patients per month, the Obstetric Center, which has six beds dedicated to pre- to post-partum (PPP) and three dedicated to clinical observation, with a mean of 200 deliveries per month, Rooming-in (RI), with 37 beds, and the maternity unit, which has also 10 beds of the Intermediate Newborn Care Unit. It has also an outpatient facility for gynecological and obstetric care, with four offices with a mean production capacity of 2,112 consultations per month for Medical, Nursing, and Psychology care, as well as Speech Therapy and Social Assistance. Thus, this maternity unit provides care to a population of 38 Basic Health Units in Curitiba.

The extension project is conducted since September 2018, offering nursing consultations at 37 weeks or more and elaboration of individual delivery plans to pregnant women with a bond with the maternity unit, who are presented to the project through

a visit to the maternity unit and posters in the ES. If required, consultations can be scheduled according to time availability.

The consultations are carried out in the maternity's outpatient facility once a week in Friday afternoons; they last around one hour. A mean of five pregnant women is received every week, and all are allowed to bring a companion of choice. The consultations aim at creating a bond between maternity unit and pregnant woman, offering orientation on delivery and postpartum, according to legal aspects and the maternity's routines, answering questions, and elaborating the delivery plan. In addition, a clinical exam is performed, with measurement of vital signs, as well as a directed physical examination. Finally, nursing progress is registered in the maternity unit's system.

These consultations are conducted by the university's undergraduate nursing students involved in the project, supervised by the obstetrics nursing professors who coordinate the project, supported by nurses in that sector. After each consultation, students and professors informed the pregnant women and their companions about the study. Whenever they were interested, the researchers, who were in the private room next door, were informed and pregnant women were thus led there individually. Research participation was confirmed through signing the Informed Consent Form in two copies and anonymity was guaranteed through substitution of the names of participants with the letter G (for *gestante*, Portuguese for "pregnant woman"), followed by numbers according to the order in which the interviews were conducted (G1, G2, and so on).

The eligibility criteria were: pregnant women over 18, with a bond with the maternity unit and who had participated of the Nursing Consultation at 37 weeks or more and of the delivery plan elaboration. For data collection, interviews were conducted by the professor in charge of the study and a student from November 2019 to March 2020 in five Friday afternoons; out of 20 pregnant women who were invited to participate, 19 accepted and one did not due to lack of time for her and her companion to stay after the consultation. The data collection was ended when the researchers identified repetitions in the statements and achievement of the proposed objective, which was noticed in the interview 17; two more interviews were conducted for confirmation[16].

A semi-structured interview script was developed containing the following guiding question: "How would you describe the experience of coming to this Nursing Consultation and elaborating the delivery plan?" In addition, data of the nursing progress registered during the consultation were considered to characterize the participants. The interviews were registered in an audio file totaling one hour, 50 minutes, and 21 seconds.

This study was assessed and approved by the ethics committee of the institution in opinion 3.527.412, approved on March 24, 2019. The ethical aspects were guaranteed according to Resolution n. 466, dated December 12, 2012, by the National Health Council[17].

After collection, the interviews were fully transcribed, resulting in a 34-page document. The data were analyzed through thematic content analysis, organized into three phases: pre-analysis, exploration of the material and result treatment, inference, and interpretation. The first phase consists of the first contact with the data, the formulation of hypotheses and objectives, and the establishment of indicators to interpret the data, following exhaustivity, representativity, homogeneity, pertinence, and exclusivity rules. In the second phase, context units are identified, considering the semantic level of content. In sequence, these units are named, forming registration units or themes. The third phase includes result treatment, inference, and interpretation, in which, based on the theoretical framework, the analyst attempts to give meaning to the interpretation, making it valid and meaningful[18].

After reading, rereading, and analyzing the transcriptions, 12 registration units, or themes, were identified; through affinity and exclusion, they led to three categories named "Perceived difficulties and deficiencies regarding prenatal", "The importance of dissemination and promotion of information for pregnant women empowerment", and "Nursing consultation as a means to health education and a stronger bond with pregnant women".

RESULTS

The participant's age group ranged from 21 to 36; 16 were white and three were brown; 11 were married, six were single, and two were in a domestic partnership; 13 had higher education, five had completed secondary education and one had incomplete higher education. In relation to pregnancy record, 17 were primigravidae, one was secundigravidae with previous cesarean section, and one multigravida with two previous abortions; 14 had their prenatal follow-up exclusively in the health units to which they had a bond, and five pregnant women received follow-up both in the health unit and in the private health insurance plan.

The number of prenatal consultations ranged from 5 to 14; 15 pregnant women had been to seven or more consultations, two had been to six consultations, one had been to five consultations, and for another one this information was not registered in the instrument that was filled during the consultation. The pregnant woman who had been to five consultations and the one whose number of consultations was not registered had their prenatal follow-ups both in the health unit and the health insurance plan. Thus, it was not possible to access the information on the pregnant woman's health insurance plan card, since it was not presented during the consultation. Out of 19 women who were interviewed, 17 had been to the maternity unit before the day of the interview. Out of the two who had not, one had a visit scheduled for a later date and the other one knew the maternity from previous hospitalizations.

Perceived difficulties and deficiencies regarding prenatal

The utterances of the interviewees enabled the identification of issues related to difficulties and deficiencies during prenatal involving the content of the consultations and the communication between the health units and the reference maternity unit. Thus, seven interviewees reported not receiving information about delivery during the consultations in the health units:

She (the health unit professional) used to follow the exams [...]. But, talking, approaching delivery, how it was to happen and so on, I only got that from today's consultation. (G1)

No. The consultation was quite basic. (G19)

Only two of the interviewees reported receiving information on delivery during the prenatal consultations and other four reported that the theme was commented sometimes, particularly if they asked about it:

Sometimes I would ask something, then he would clarify some of my questions. (G6)

Everything we asked, he (physician) always explained correctly and so on, but when we don't ask, it's like "Hello, how are you? Bye". (G9)

Regarding communication between health units and maternity units, three pregnant women emphasized the need for improvements in the communication between these services, since the units' lack of information on what the maternity unit can offer to the pregnant women needs to be reviewed. In this sense, the lack of knowledge of routines and of the reference maternity unit team was mentioned by three interviewees, indicating a sense of insecurity:

I think this is a flaw of the health unit, [...] imagine how many mothers do not know, do not have this information. They should do something and inform people: "just go, look for information, here is their phone number, they have a nice plan, you can visit the place [...]". Which the mother should know, particularly when it's her first time [...], when she's lost. (G3)

[...] who knows if the place you're giving birth at also thinks so. So, I know that Maternity X and Maternity Y are a model for humanized birth. But calling it a model is one thing and seeing that the procedures are really what they say is something else, right?! (G18)

And other two mentioned the importance of knowing the team beforehand and which professionals are necessary during delivery:

I think that what frightens me the most is not the delivery itself, but the professionals who may assist it, you see? Sometimes you may get very lucky but may also not [...]. (G7)

I think it would be nice if we could meet beforehand the nurses who are going to provide assistance. [...] if we could know who is going to be in there with us. Who is going to be the doctor or nurse. [...] at least see the person before [...]. I think we would be more relaxed if we did [...]. (G2)

This category has enabled the identification of positive points, frailties, and needs pointed out by the group of interviewees, as well as the need for integration between primary care and maternity unit.

The importance of dissemination and promotion of information for pregnant woman empowerment

In relation to the delivery plan, 13 interviewees reported to have no knowledge of this instrument or to have heard about it while not knowing exactly what it was:

So, I didn't know all the content, but I could imagine a bit what it was. (G4)

No, I had no idea. I couldn't even imagine that this existed, you know? I found it super important. (G6)

I had read about it somewhere, but I thought it was only available in the private network. I thought it wasn't available in the public network. (G16)

The utterances of 15 interviewees showed that different means provided access to information about the delivery plan and issues related to pregnancy and birth, such as: visit to the maternity unit, support networks, and resources available on the internet, such as search engines, social networks, and documentaries:

I found out about the delivery plan in the visit. I was interested right away. I said: "Hey, that's nice! I'm going to see how it's like. If I can do it". (G2)

Some of my friends who have children, who made their delivery plans and that we could follow [...]. And also, documentaries, things we watched. (G9)

Obviously, because we, as first-timers, look for information on the internet a lot, right?! We want to know about people who have been through this. (G11)

[...] I'm in a group of mothers (of a social network on the internet), and they always mention it, you know? We share experiences. (G12)

Three interviewees mentioned also that the possibility of knowing the maternity unit and attending the talk offered there provided a sense of relief when they identified that the adopted practices matched their principles and desires:

And then we came visit the maternity and when I left, I was so happy. I even cried, because I understood that everything that made me want home birth was the norm here. So, I was very grateful, I said: "My God! I was worried for no reason, sad for no reason, you know?!" And here I'll have everything I ever wanted for free. When I left I was very grateful and moved. (G9)

[...] when we came to visit, we found it very clarifying. [...] it gave me a really good impression of the procedures.

We hear about obstetric violence [...]. In here (maternity) it seems quite peaceful. (G13)

So, it has shown, like, it really is humanized, you know?! So, you get more relaxed also in relation to that, you know?! (G18)

This category shows the lack of knowledge of the delivery plan in this group of pregnant women, in which it was necessary to search for information on delivery in different media; the possibility of getting closer to the maternity unit brought positive feelings.

Nursing consultation as a means to health education and a stronger bond with pregnant women

In the utterances of 12 pregnant women, it was possible to observe that the expectations regarding delivery were related to diverse factors, such as worry with the baby's health, moment to go to the maternity unit, desire for vaginal delivery, fear of pain, and humanized care:

I hope all goes well. I hope I don't have to go right now to surgery, you know?! To undergo a cesarean section. (G15)

My expectation is that it really is humanized, that they won't do any procedure, like, without telling me, you know? Because I know that some procedures there are essential for well-being, both mine and hers at that moment, but I would really like to be informed. To be treated with respect, both her and me. (G17)

The utterances of 14 interviewees demonstrated that the questions were mostly related to labor, physiological processes of delivery, breastfeeding, the rights of pregnant women, and the maternity unit's procedures and routines:

So, to know [...] if you have the right to a companion, right?! It's really 24 hours. I had many questions about that. (G1)

[...] questions about the moment of delivery, how it happens. It's not that it wasn't explained, but it's really because it was the first time. Like: "Wow, how long does it take for the placenta to come out?" You know?! Hey, why has no one ever told me that it doesn't come out with the baby? (G9)

My biggest question was about breastfeeding, which was my main question. (G10)

In this sense, in the utterances of 16 interviewees, the nursing consultation was shown to be an important means for clarifying questions through promoting knowledge of the approached issues. Four of them pointed out this moment as important to clarify the companions' questions:

Oh, I liked it! I thought it was really cool. I think this is very important for mothers because it answers some of our questions. (G2)

What is good about it is that it clarifies how it's really going to be, you know? So, you're no longer in the dark, like, I don't know, I'll just come and we'll see what happens [...]. So, I already know how it goes, how things are going to happen. (G3)

That he (companion) can't come to the talk. So, I said: "I want you to come for the delivery plan, okay?! So that you can hear everything and have all the information." It's also important so that he won't get lost. (G1)

Out of the interviewees, 13 reported that the consultation led to a reduction of anxiety and fear and that they felt more relaxed, safe, and confident for the delivery at the maternity unit, both regarding physiological aspects and the routines and conducts:

It made me feel safe [...]. I was more relaxed knowing that, for instance, I can, during delivery, choose the position to have my baby and knowing that makes me relaxed [...]. (G2)

Because I was very anxious and concerned about how the pain is going be. So, they (nursing students) made me feel relaxed. I really liked it! I think I'm more relaxed now, and more confident too. (G6)

[...] understanding how it works in here, which are the principles, what is valued, it makes us very relaxed. I think she reinforces that I'll have what I've ever wanted. It makes me even more relaxed for the delivery. (G9)

In addition, the nursing consultation was shown to provide an individualized care, according to three interviewees, and a welcoming environment, according to two interviewees:

I think that you have more possibilities of having your questions answered here, you know?! [...] because contact is more individualized. (G7)

Coming to the consultation was exactly what I thought: welcoming. The girls are very friendly, you know?! They make you feel closer, call the baby by the name. These are small details, it sounds stupid, but this is my first pregnancy, you know?! Even though you may receive many pregnant women, each of them carries a baby in her belly. So, you see how kind they are. (G18)

Thus, the need for a closer relationship between the pregnant woman at the end of prenatal and the reference maternity unit is pointed out; this is helpful for answering questions and acquiring evidence-based information on the process of parturition and breastfeeding, which extended also to the companion. This bond with the maternity unit at the end of gestation was promoted with the nursing consultation and the elaboration of a delivery plan.

DISCUSSION

The characterization of this study's participants concerning age, marital status, and pregnancy record is similar to data presented by a Brazilian study showing more young and young adult pregnant women who had a partner and were primigravidae. In relation to education, the pregnant women had predominantly complete higher education, the opposite of what this study presents, showing a predominance of complete secondary education[19].

All of the interviewed pregnant women had a bond with the study maternity unit and recognized this site as a reference for delivery, given that bond was one of the requirements for participation in the nursing consultation; this fact is in line with that of other studies, which show a high number of pregnant women who have not received information on their bond to a reference maternity unit, contributing to the search for other health establishments[19,20,21].

Although most pregnant women had visited the maternity unit, utterances by some of them show that knowledge of this possibility was not obtained from the staff of the health unit where they receive prenatal care, but through different means. This shows that, in this context, there are flaws in the communication between the prenatal site and the maternity unit concerning what the latter offers. These findings are similar to results of a study in Florianópolis, Santa Catarina state, Brazil, with 12 pregnant women who received follow-up in the municipality's primary healthcare, which points out that flaws in the orientation received by them on the reference maternity unit are related to an unintegrated work network[22].

Thus, the importance of the articulation between primary healthcare and maternity unit for planning actions to orient pregnant women is verified, since a previous knowledge of the reference maternity unit enables familiarization with the facilities, understanding routines and how delivery is approached in this context[23]. This may contribute to a reduction of delivery-related anxiety[24], as reported by some pregnant women in this study.

Almost all the interviewed pregnant women attended the minimum number of prenatal consultations recommended by the Ministry of Health, which should be equal or higher than six consultations[1]. Although prenatal care has been quantitatively adequate, the results of this research point out deficiencies related to the content on delivery during the consultations and prenatal education. These findings corroborate different studies. A study conducted in Brasília, Brazil, with primigravidae women has pointed out that the theme delivery was not present in the prenatal consultations of most pregnant women, although some were close to their probable date of delivery[25]. Another study, carried out in a low-risk public maternity unit in Londrina, Paraná state, Brazil, pointed out that 52% of 358 study participants had not received any delivery orientation during the prenatal consultations; 38.2% of them were primigravidae. Summing up the number of consultations, 81.7% of the pregnant women who attended six consultations or more did not receive information on delivery[21], showing the need to incorporate delivery as a theme in the prenatal consultations. The literature emphasizes that the qualitative aspects of prenatal are insufficient, showing the need to approach, among other themes, those related to labor and delivery during prenatal care[22].

The delivery plan is possibly a helpful instrument for prenatal education on delivery. The lack of knowledge or superficial knowledge of the participants was demonstrated; this is not exclusive to this study. Other studies have shown that a large share of pregnant women is unaware of this instrument[14,26]. The professionals' lack of knowledge and barriers imposed by health services are also noteworthy. A study conducted with 15 primary health nurses in a municipality in Rio Grande do Sul state, Brazil, has shown a lack of knowledge and misconception of the delivery plan by all the interviewed professionals. However, these professionals have demonstrated interest in using this tool, but emphasized the need for training, partnership with maternity units, and change in the care model so that the issues planned in primary care can be executed in hospital care, given that in this context delivery care is based on the biomedical model[7].

The study's maternity unit is emphasized to have as its focus humanization and respect when providing care to pregnant women. The delivery plan was built in a partnership between academia and maternity unit professionals, suiting the context of care and making it thus accepted and followed by the team.

A study in a Scottish maternity unit with women (before and after delivery) and local employees on the use of the delivery plan has pointed out some benefits, such as the opportunity of women pointing out their preferences, the possibility of stimulating discussions with the team and as a means of coping with anxiety. However, not all women elaborated their delivery plan or understood its purpose, since they were unaware of this opportunity; others had no access, and others were reluctant to elaborate it. The team understood the need to support women with the delivery plan, but observed practical challenges to that, such as the need for training and time meeting with the women to elaborate this document[27].

The lack of knowledge of many pregnant women, professionals, and health services about the delivery plan and the lack of encouragement and professional support for its construction are contributing factors to this instrument being unused[26,28], leading to the misconception that it is restricted to some sites[26] or as exclusive to the private health system, as pointed out by one of the interviewees of this study. This reinforces the importance of the health professional in disseminating and encouraging the use of the delivery plan, according to a study conducted in the health units of Belo Horizonte, Minas Gerais state, which pointed out health professionals as the main disseminators of the delivery plan during prenatal consultations for the pregnant women participating of that study[14].

A study conducted in Spain on the influence of the delivery plan points out the need for creating public policies for dissemination and ways of promoting this document so as to encourage its use and knowledge among pregnant women. That study also shows that

the obstetric nurse in Primary Care is the adequate professional to follow up women in the elaboration of this document[11].

It should be emphasized that the visit to the maternity was the main mean of disseminating the Nursing Consultation at 37 weeks or more. The topics discussed by the nurse in charge included the possibility of participating of this consultation to elaborate a delivery plan. This was the first time that most of the pregnant women heard of this instrument. It should be emphasized that the elaboration of the delivery plan was not a routine in the maternity unit and was implemented after a partnership between the maternity unit and the undergraduate nursing course of the university through an extension project.

Support networks and the internet were also pointed out by the pregnant women as a means to knowledge of the delivery plan and other issues related to pregnancy and delivery. Evidence shows that the internet is the main source in searching for health information, that this information enables more autonomy and freedom of choice[29], and that experiences shared by other people contribute to the women's decision-making[30].

During care and prenatal education, the nurse plays an important role in stimulating and helping the pregnant woman to express her needs and desires, orienting her in the construction of the delivery plan[7]. When performing these actions, the nurses perform their roles as educators, promoting the pregnant woman's knowledge and stimulating her autonomy, making her a protagonist of her pregnancy, delivery, and post-partum[7,26]. To this end, nurses should know and understand the objective of this instrument, observing its use and construction as means for qualification of their professional practice and improvement of pregnant women's care[7,8].

The joint construction of the delivery plan contributes to the development of confidence and safety, in addition to promoting a bond of the pregnant woman with the professional and with the service[31]. The importance of the professional orientation in the construction of the delivery plan for all the pregnant women to understand that labor and delivery are not entirely predictable moments and that in unexpected situations flexibilization of their choices might be necessary is emphasized[28], which nonetheless does not invalidate the fact that the parous woman must be communicated of situations which require changes[8]. This orientation is also necessary for this tool to be applicable to the context of delivery. This precludes the creation of unrealistic expectations and the dissatisfaction with its use[28].

Professionals, particularly the nurse, must reinforce health education actions to improve care and favor the creation of a bond between pregnant women and health service[32]. Simultaneously, professionals and pregnant women should be involved in the educational process and its expansion is required to favor empowerment and informed choice of pregnant women in relation to delivery[33].

The process of parturition should be understood as unique for each woman and so is the view that she is an active participant of this process. She should be welcomed and provided with clarifications, orientation, and encouragement to understand the factors involved in the process of delivery and birth and possible choices, and then opt for those which best suit her needs and preferences, becoming co-responsible for this process[34].

FINAL CONSIDERATIONS

The final period of the pregnancy is marked by doubts, fears, and uncertainties related to the process of parturition, mainly when experienced for the first time. In addition to that, based on the presented findings, difficulties with orientation received during the prenatal can also be a contributing factor to these feelings. The need for improving health education actions, orientation, and dissemination of information in meetings between pregnant women and health professionals is pointed out.

Considering the nursing consultation as inherent to the practice of the nursing professional, the importance of using it to guarantee the totality of pregnant women care is emphasized. It is noteworthy that the prenatal nursing consultation at the maternity unit enables perspectives for strengthening the bond and improving the obstetric setting by reducing the pregnant women's and her companion's negative feelings and that may result in positive experiences of delivery. Nonetheless, it encourages the insertion of Nursing into the offices of maternity units and the need for updating and insertion of obstetric nursing among services.

The satisfaction with the nursing consultation at 37 weeks or more and with the elaboration of the delivery plan is related to the possibility of providing a welcoming and individualized environment, creating a bond, and getting closer to the maternity unit, as well as answering questions and reducing anxiety and fear. From the moment the pregnant woman feels welcome, she incorporates this knowledge and understands her rights, becoming capable of being active, questioning, and making informed decisions for that moment.

Concerning the delivery plan, a need for broader use and dissemination of this document was noticed. The strategies for incorporating the delivery plan into the health services must be discussed with the local management and the document must be developed through the involvement of health professionals who provide care in the maternity units, so that it can be adapted and suit the context, as well as be discussed with pregnant women and companions. Nonetheless, this should be constantly updated to become a care tool offering the best indicators and positive delivery experience for all involved.

The importance of approximating university and service for the development and strengthening of actions targeted at improving care provided to the population is emphasized, given that the incorporation of this modality of care was strengthened and instituted with this partnership. Thus, the contribution to Nursing through its insertion, knowledge, and leadership in prenatal consultations and direct delivery assistance is emphasized, from the recognition by the pregnant women and their companions, as well as the multiprofessional team.

Study limitations include the fact that this research was conducted in a single maternity unit, with a restricted group of pregnant women, precluding data generalization, given that the extension project was only conducted in the study maternity unit. The need for other similar studies in other places in Brazil which also perform this modality of nursing consultation and elaboration of the delivery plan is thus pointed out; this is aimed at understanding the experience of participation of pregnant women and their companions in different contexts.

AUTHOR'S CONTRIBUTIONS

Study design. Marilene Loewen Wall. Letícia Siniski de Lima Tatiane Herreira Trigueiro.

Data collection or production. Karine Amanda de Arruda.

Data analysis. Karine Amanda de Arruda. Tatiane Herreira Trigueiro.

Interpretation of results. Karine Amanda de Arruda. Sinderlândia Domingas dos Santos. Marilene Loewen Wall. Tatiane Herreira Trigueiro. Tatiane Herreira Trigueiro.

Writing and critical review of the manuscript. Tatiane Herreira Trigueiro. Karine Amanda de Arruda. Sinderlândia Domingas dos Santos. Marilene Loewen Wall. Silvana Regina Rossi Kissula Souza. Letícia Siniski de Lima.

Approval of the final version of the article. Tatiane Herreira Trigueiro. Karine Amanda de Arruda. Sinderlândia Domingas dos Santos. Marilene Loewen Wall. Silvana Regina Rossi Kissula Souza. Letícia Siniski de Lima.

Responsibility for all aspects of the content and integrity of the published article. Tatiane Herreira Trigueiro. Karine Amanda de Arruda. Sinderlândia Domingas dos Santos. Marilene Loewen Wall. Silvana Regina Rossi Kissula Souza. Letícia Siniski de Lima.

SCIENTIFIC EDITOR

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ASSOCIATED EDITOR

Stela Maris de Melo Padoin

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