

CUIDADO É FUNDAMENTAL

Escola de Enfermagem Alfredo Pinto – UNIRIO

ORIGINAL ARTICLE

DOI: 10.9789/2175-5361.rpcfo.v17.13830

KNOWLEDGE AND PROFESSIONAL PRACTICE OF NURSES IN THE USE OF THE BIRTH PLAN

Conhecimento e prática profissional de enfermeiros no uso do plano de parto
Conocimiento y práctica profesional de enfermeros en el uso del plan de parto

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RESUMO

Objetivo: analisar o manejo e o conhecimento dos enfermeiros sobre a inserção do plano de parto em hospital de referência. **Metodologia:** estudo qualitativo, de abordagem descritiva, realizado em novembro de 2023 com enfermeiros do Hospital Universitário Ana Bezerra, em Santa Cruz/RN. Os dados foram coletados por entrevistas, transcritos e submetidos à análise de conteúdo segundo Bardin. **Resultados:** identificaram-se três categorias: a compreensão do significado do plano de parto para os enfermeiros; a execução prática desse instrumento; e a necessidade de aprofundar conhecimentos para sua efetiva implementação. Constatou-se que os profissionais apresentam domínio teórico e prático, reconhecem a importância do plano de parto e relatam limitações pontuais na sua aplicação. **Conclusão:** os enfermeiros possuem condições favoráveis à execução do plano de parto, sendo indispensável a contínua qualificação profissional para assegurar maior segurança e eficácia no cuidado prestado.

DESCRITORES: Plano de Parto; Parto Humanizado; Assistência Hospitalar; Enfermagem Obstétrica.

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Received: 2025/04/28. **Accepted:** 2025/08/20

How to cite this article: Borges RS, Santiago JCD, Oliveira RC, Bezerra HS, Oliveira KKD. Knowledge and professional practice of nurses in the use of the birth plan. R Pesq Cuid Fundam (Online). [Internet]. 2025 [cited year month day];17:e13830. Available from: <https://doi.org/10.9789/2175-5361.rpcfo.v17.13830>.



ABSTRACT

Objective: to analyze nurses' management of and knowledge about implementing birth plans in a referral hospital. **Method:** a qualitative, descriptive study was conducted in November 2023 with nurses from the Ana Bezerra University Hospital in Santa Cruz, Rio Grande do Norte, Brazil. Data was collected through interviews, transcribed, and analyzed using Bardin's content analysis method. **Results:** three categories were identified: nurses' understanding of the meaning of the birth plan, the practical implementation of this instrument, and the need to expand knowledge for its effective application. The study found that the nurses demonstrated theoretical and practical knowledge, recognized the importance of the birth plan, and reported specific limitations in its use. **Conclusion:** nurses have favorable conditions for implementing the birth plan. Continuous professional development is essential to ensure greater safety and effectiveness in care.

DESCRIPTORS: Birth plan; Humanized birth; Hospital assistance; Obstetric nursing.

RESUMEN

Objetivo: analizar el manejo y el conocimiento de los enfermeros sobre la implementación del plan de parto en un hospital de referencia. **Metodología:** estudio cualitativo, de enfoque descriptivo, realizado en noviembre de 2023 con enfermeros del Hospital Universitario Ana Bezerra, en Santa Cruz/RN, Brasil. Los datos fueron recolectados mediante entrevistas, transcritos y analizados según el método de análisis de contenido de Bardin. **Resultados:** se identificaron tres categorías: la comprensión del significado del plan de parto para los enfermeros; la ejecución práctica de este instrumento; y la necesidad de profundizar los conocimientos para su aplicación efectiva. Se constató que los profesionales poseen dominio teórico y práctico, reconocen la importancia del plan de parto y señalaron limitaciones puntuales en su implementación. **Conclusión:** los enfermeros presentan condiciones favorables para la ejecución del plan de parto, siendo indispensable la capacitación continua para garantizar mayor seguridad y eficacia en la atención brindada.

DESCRIPTORES: Plan de parto; Nacimiento humanizado; Asistencia hospitalaria; Enfermería obstétrica.

INTRODUCTION

Over the years, childbirth has undergone many changes in relation to the care model. Until the sixteenth century, midwives were responsible for assisting with childbirth, and many popular beliefs existed about ways to reduce the pain of childbirth. Between the 16th and 17th centuries, surgeons began to play a role in childbirth, reducing the importance of midwives. With the rise of this practice, the dorsal position and the use of equipment became more common due to the greater ease for the doctors.¹

Currently, women's healthcare has involved unnecessary interventions, reflecting the medicalization of women's bodies and the use of maneuvers that are not supported by scientific evidence, such as the Kristeller maneuver.¹

However, the World Health Organization (WHO), the Pan American Health Organization (PAHO), and the Ministry of Health (MS) have implemented strategies to reduce the number of cesarean sections and increase the percentage of vaginal deliveries. One such strategy is the Birth Plan (BP), a strategic instrument developed with the health professional to respect women's choices during childbirth and ensure practices based on current scientific evidence.²

It is therefore recommended that the primary care nurse carry out the elaboration of the birth plan during prenatal consultations.

The nurse should clarify the physiological process of childbirth for the pregnant woman, offer her the opportunity to make her own decisions, and explain the subsequent complications of unnecessary interventions, among other information. Thus, the nurse is the fundamental link in the development of the BP.¹

In addition, despite the existence of the BP, there is still a lack of content on the subject, as well as a lack of demand for knowledge from professionals. Due to these circumstances, nurses and other professionals often disregard the procedure.³

The present research is therefore justified by the continuity of the study initially carried out with primary care nurses in Santa Cruz, RN, where it was concluded that nurses do not use the BP because it is not useful in the city's hospital network.

Additionally, nurses who admit pregnant women to the maternity hospital need knowledge about prenatal care to effectively guide pregnant women. According to Barros *et al.* (2017), health professionals lack knowledge about prenatal care, which is the main reason they have not incorporated guidance on the subject into their routine care.⁴

The BP is important for nursing professionals and hospital services because it guides the individualized care of each woman. For parturients, it guarantees human rights and empowers them during childbirth.⁵

Thus, the general objective of the research is to analyze the management and knowledge of the introduction of the birth plan by nurses at the Ana Bezerra University Hospital, a reference university hospital. Based on this explanation and considering the importance of providing women with safe, respectful, and autonomous care, the study asks: How do nurses at the Ana Bezerra University Hospital manage knowledge about the birth plan?.

METHOD

This qualitative research study takes a descriptive approach. Qualitative research analyzes specific situations within contexts of time, place, and people. It allows actions and ways of expression to be described according to their subjectivity, while preserving the identity and importance of each event.⁶

This study was conducted at the Ana Bezerra University Hospital (HUAB) in Santa Cruz, Rio Grande do Norte. HUAB is affiliated with the Federal University of Rio Grande do Norte (UFRN) and is managed by the Brazilian Hospital Services Company (EBSERH). HUAB plays a key role in healthcare in Santa Cruz and neighboring cities. It is a leading provider of maternal and child healthcare in the Trairi, Potengi and other regions and has become a state leader in humanized childbirth care and interprofessional teamwork.

A total of 19 HUAB professionals participated in the study. These nurses were assigned to the Welcoming sector (2 nurses), the Prepartum, Delivery, and Puerperium (PPP) sector (15 nurses), and the Outpatient Clinic sector (2 nurses). These sectors are most involved with prenatal care and the reception of parturients. According to Minayo (2008, p. 192), qualitative research is not based on the number of participants, but rather on the depth and quality of the data collected. Comprehensive praxis may use numerical criteria, such as the number of interviews, but this will not necessarily be the defining factor of relevance, which is often clarified by the speech of one or a few interlocutors.⁷

The inclusion criterion for the study was nurses who had worked in care for more than six months. The exclusion criteria were nurses performing administrative functions and nurses on vacation or leave during the data collection period. Thus, eight nurses did not participate in the study: four due to refusal and two due to leave. Therefore, the sample consisted of eleven nurses from HUAB.

First, the research team visited the nursing professionals at HUAB to formally invite them to participate in the study. The objectives of the research and the steps to be taken were explained, after which they were asked to sign the Informed

Consent Form (ICF) and set a date and time for the structured interview. Data collection began only after the document was signed and took place in November 2023.

During the initial data collection period, interviews were conducted at the HUAB in a designated room to ensure confidentiality. The interviews, which lasted approximately 10 minutes, were recorded in audio using a smartphone in MP4 format and were used exclusively for transcribing the collected data.

Next, the interviews were transcribed by listening to the recorded audio using headphones to ensure accuracy. The statements were typed in a Word document and separated by each question of the research instrument. The document was stored on a flash drive and archived for five years in the cabinet of the FACISA/UFRN office under the researcher's responsibility.

The researcher transcribed and evaluated the collected data according to the content analysis method described by Laurence Bardin. This method treats content analysis as a qualitative analysis technique that examines communication and aims to obtain knowledge related to the conditions of these messages through systematic and objective procedures for describing this content.⁸

The process consists of three structured stages: The first stage, called pre-analysis, comprises organizing the material to be analyzed, systematizing the initial ideas, and making it operational. The second stage involves exploring the material, which includes codifying it and defining categories of analysis. The third and final stage consists of condensing and highlighting the information for analysis, resulting in inferential interpretations. This stage involves intuition and critical reflective analysis.⁸

The study was submitted to the Research Ethics Committee (CEP) of the Trairi School of Health Sciences – FACISA/UFRN, with opinion number 6,055,818, in accordance with the recommendations of CNS Resolution No. 466/2012 for research involving human subjects, after obtaining a letter of consent from HUAB.

RESULTS

Of the professionals who participated in the research, nine (81.8%) were female and two (18.2%) were male. Six (54.5%) had more than five years of training in their field, and five (45.5%) had between one and five years. Regarding specialization, four (36.3%) were specialized in obstetric nursing, two (18.2%) in urgent care, and five (45.4%) did not have a postgraduate degree.

Three categories were identified: the first related to what the birth plan means for nurses, the second to the execution of the birth plan (with the following subcategories: professionals consider themselves safe to execute the birth plan; possibilities for executing the birth plan; and factors hindering the execution of the birth plan). The third category refers to the need to expand knowledge of the birth plan.

CATEGORY 1: WHAT THE BIRTH PLAN MEANS FOR NURSES

According to the professionals, a birth plan is an individual document that guides the planning, script, and model of childbirth for each woman. It guides labor care and the conduct of each woman during childbirth. It also serves as the woman's own guide and source of knowledge. The birth plan (BP) expresses the woman's wishes, directs her preferences, has legal value, and empowers women by allowing them to exercise their human rights.

It is a woman's plan for how she wants to be treated during childbirth (N1).

It is a tool that can provide patients with knowledge that will be useful during labor and delivery and procedures, in addition to caring for the baby (N2).

[...] It guides parturients about the childbirth process [...] It is a document that informs them about their choices and what they find coherent at the time of delivery (N3).

[...] It guides the wishes and plans of the pregnant woman and her support network throughout labor and delivery (N5).

[...] Its objective is to redirect wants and desires during childbirth (N6).

[...] It outlines, step by step, how the pregnant woman would like her labor and delivery to occur (N7).

[...] A birth plan is a way for women to express their wishes during labor (N8).

[...] It is a script, a template that pregnant women bring. We will act based more or less on the script she brings. It will show what they want, what they desire, and what they don't want done during labor (N11).

CATEGORY 2: EXECUTION OF THE BIRTH PLAN

SUBCATEGORY 2.1: PROFESSIONALS CONSIDER THEMSELVES SAFE TO CARRY OUT THE BIRTH PLAN

Professionals consider themselves capable of guiding the execution of the birth plan.

As far as possible, we do what the woman wants. If we have to change anything, we will explain the reason. I consider myself able to execute the birth plan with the pregnant woman at level 10 (N3).

In practice, sometimes we are faced with a more delicate birth than others, but I know how to help with the execution, and give myself a 10 (N7).

If a pregnant woman comes with a birth plan, I am familiar with it and consider it level 10. I believe the whole team should respect it. As soon as we admit the patient, we should talk to her about the birth plan and the possibilities, including the possibility that she may choose something that interferes with the hospital's routine. For example: "I don't want oxytocin in the postpartum period." We'll explain that she has the right to refuse, but there are risks of bleeding. We give these guidelines at the beginning of labor (N11).

SUBCATEGORY 2.2: POSSIBILITIES FOR THE IMPLEMENTATION OF THE BIRTH PLAN

Regarding the execution of the birth plan, it can be inferred that professionals carry out these tasks voluntarily as part of their care practices. These tasks include providing guidance on birth positions, breastfeeding, pain relief methods, the golden hour and the rights of the parturient within the maternity hospital. These tasks are present at all stages of labour.

During labour and delivery, I provide guidelines that align with the birth plan, but they are less effective when administered during pain. I provide guidance on pain, breastfeeding, positions, women's rights, skin-to-skin contact, the golden hour, and other topics (N2).

Yes, I provide practical and summarized information about the destination sector, the team that will assist, possible conduct during the process and ways to give birth (N5).

I do not specifically advise on the birth plan, but on signs during labor and pain relief maneuvers, among other things (N6).

Regarding the feasibility of executing the birth plan, the nurses listed the HUAB environment as having a viable physical structure to carry it out.

I believe we have great opportunities, and there are no difficulties in the sector (N1).

[...] there are no difficulties. The whole team collaborates, welcomes and executes the birth plan presented (N7).

No, we hope that there will be a birth plan for all pregnant women, including those at high risk. HUAB is also preparing the birth plan, Some high-risk pregnant women

already have it, and we really want to expand this to low-risk pregnant women. I don't see any issues that would make this difficult, people here respect it a lot (N11).

SUBCATEGORY 2.3 FACTORS THAT HINDER THE EXECUTION OF THE BIRTH PLAN

However, some factors that hinder the execution of the birth plan in a hospital setting have been highlighted by certain professionals. These include the demands of obstetric emergencies, the sector's dynamics, and the continued presence of a medicalized and interventionist approach to care.

One complicating factor is the continued presence of the medicalized and interventionist model in general care (N4).

As it is an obstetric emergency sector, the urgent demands and dynamics of the environment make it difficult to implement the birth plan, as it is a constantly changing patient population and it is not possible to provide the care that the pregnant woman wants (N5).

CATEGORY 3: THE NEED TO CONNECT THE LINE OF CARE FOR PREGNANT AND PARTURIENT WOMEN TO KNOWLEDGE ON THE BIRTH PLAN

Regarding the training and improvement of professionals, they reported the need to acquire more knowledge.

I identified the need to train health teams, especially those working in prenatal care, so they can support pregnant women in creating their birth plans and contribute positively (N4).

Training is welcome at all levels, not only to guide pregnant women in creating the instrument, but also to educate professionals on how to interpret the birth plan as something that can be executed (N10).

Through prenatal training, we observed the difficulty of providing quality prenatal care. Humanized delivery begins with humanized prenatal care, so it is necessary to train PHC physicians and nurses to value the birth plan and patient orientation (N11).

It can therefore be inferred that they want to allocate time to adding theoretical content to care, which is a demand for all professionals who make up the team.

Undoubtedly, health education activities for pregnant women will have a positive impact on the implementation of the birth plan (N2).

Yes, I feel the need to share this knowledge with other professionals (N6).

I believe that events and courses are necessary because the service only makes contact with the woman in labor, so guidance on creating the birth plan does not happen, we have no time with primary care functions (N7).

I think that with complementary and mandatory training, we would have more mastery over the birth plan (N8).

[...] I'm also improving myself in this area because when I joined this sector, I felt the need to develop ideas that hadn't been considered before, such as different positions. Sometimes, the birth plan only includes very brief information, and during labor, I may not be able to do things the way the woman planned. Therefore, we need to consider alternative ways of conducting childbirth (N9).

DISCUSSION

For the nurses participating in the research, the meaning of the BP is in accordance with the literature. The BP is a legal document written by pregnant women after receiving information about pregnancy and childbirth. This document forms the basis of the clinical relationship established between pregnant women and professionals and can guide healthcare provision throughout the process.⁹

The BP facilitates communication between pregnant women and health professionals, promoting autonomy during the childbirth process. It is also one of the first measures in a series of recommendations established by the World Health Organization (WHO) called 'Good Practices in Labor and Birth Care'.⁹

The BP, also known as a birth plan, conveys the woman's desires and expectations for labor and delivery and can be used during the immediate postpartum period to improve maternal and neonatal outcomes.¹⁰

According to the health literature on childbirth, it is essential for women to be able to make truly informed decisions; thus, there is a need to approach and build the birth plan during antenatal consultations and childbirth preparation and parenting courses.¹¹

Regarding the purpose of the BP, it is an instrument that increases women's awareness and preparedness for childbirth, acting as an educational tool.¹¹

The greater the number of preferences met, the better the maternal and neonatal outcomes and the more positive the birth experience, as female dissatisfaction has been associated with disrespect for the birth plan during obstetric care.¹²

Therefore, with regard to aspects related to the execution of the birth plan, the professionals consider themselves competent to guide its implementation based on their experience of

providing care. This inference is in line with Costa's 2021 study, which shows that nurses working in Normal Birth Centers promote good labor and birth practices, as well as increasing the importance and visibility of their role in maternal and child care.¹⁰

In addition, it is important for nurses to alleviate anguish and suffering by providing comfort and active listening, while considering the particular needs of each woman and requesting support from other professionals, such as psychologists, if necessary. To achieve this, it is necessary to establish a trusting and collaborative relationship with each postpartum woman, providing care that considers their individual needs and seeks to empower them to develop parental skills.⁵

Thus, nursing contributes most to the application of good practices in normal childbirth care, helping to promote natural childbirth and reduce the risks to women's and newborns' health, while making women feel empowered and minimizing unnecessary interventions.¹⁰

Regarding the execution of the birth plan, professionals carry out BP alongside care practices, as nursing care involves emotional and pain management for women throughout pregnancy, labor and the postpartum period. Therefore, when nursing professionals are skilled in non-pharmacological methods such as massage, aromatherapy, yoga, movement exercises and encouraging partners to participate in the process during labor, the care provided is more effective and increases women's satisfaction, fulfilling the stages that constitute prenatal care.¹³

In addition, the HUAB has the structure and human resources to make the birth plan viable. The structure comprises PPP suites with three nurses per day shift and two per night shift.

This is consistent with Braga's ideas that effective and safe communication strengthens good nursing care. For this, it is necessary to have a well-sized nursing team with an appropriate workload and good communication between sectors to reduce risks and harm to patients.¹⁴

Thus, women's non-use of this instrument is mainly related to a lack of knowledge about the birth plan and its purpose, as well as a lack of professional support to help them understand the available options and express their preferences.⁹

An example of a service that prepares and implements BPs at a national level is Hospital and Maternity Brazil - Rede D'Or São Luiz, located in Santo André, São Paulo. Birth plans can take various forms, differing mainly in terms of their shape, size, and complexity, with no single "standard" model that fits all women.⁹

Even with good physical facilities and a trained team of professionals, obstacles to executing the birth plan still exist, such as obstetric emergencies. Since the course of the delivery

process is uncertain, in the event of unforeseen circumstances and unexpected complications, it may be necessary to disregard requests.⁹

Another challenge is non-compliance with Birth Plans, which leads to dissatisfaction among women. In highly medicalized and interventionist obstetric settings, it is common to use the birth plan to protect against unnecessary interventions, improve communication and exercise more control over the process.¹⁵

As a result, unrealistic expectations and unnecessary requests can lead to frustration among women, as well as generating conflict with the professionals on the team. It has been observed that the greater the number of requests recorded in the document, the more dissatisfied women tend to be with their birth experience in general.¹⁵

In terms of the need for more knowledge about prenatal care, there is clearly a demand for professionals to receive training and improve their skills, as a study addressing the degree of satisfaction of women after childbirth revealed some flaws in the care provided by nurses. These failures highlight the importance of training professionals and providing guidance to pregnant women during prenatal care to promote good care for expectant mothers.¹⁴

Furthermore, the nurses emphasized the need for collective collaboration within the care network regarding birth plans. A study carried out in a public maternity hospital in Brazil showed the importance of training actions that bring professionals closer to the multidisciplinary team, focusing on evidence-based practices, physical and emotional issues, and comprehensive care based on the needs of the woman giving birth.¹⁶

Based on this information, the obstetric care offered differs from global and national proposals for humanized delivery, reinforcing the need to improve care quality through investing in the training of multidisciplinary team professionals and incorporating evidence-based practices.¹⁷

In addition to training initiatives, it is essential to encourage nursing professionals to adopt attitudes that contribute to breaking the hegemonic model in childbirth. Such actions include active listening to parturients and companions, using non-invasive technologies, applying theoretical and technical knowledge, communicating information about the phases of labor and fostering positive relationships within the team and with the institution. These measures are crucial for the adoption of good practices in childbirth care.¹⁸

This highlights the need for management practices to be transformed in a shared way, with investment in the training of maternity professionals, the elaboration and implementation

of good practice protocols, and the institution of evaluation processes in daily work.¹⁹

Thus, improving the sector is fundamental to ensuring the satisfaction of pregnant women and the quality of nursing care. However, despite advances in the implementation of good childbirth care practices, many reports of obstetric violence are still being made by women in the postpartum period, such as procedures being performed without explanation or consent, mistreatment by members of the care team, unnecessary vaginal touching for teaching purposes, and a lack of human resources and overcrowding.¹⁹

Finally, it is emphasized that the participation of the multidisciplinary team facilitates humanized practice, in a way that professionals who are up to date and open to innovation are essential.²⁰

In view of this, the research improved professionals' knowledge of birth plans, making them feel more confident in encouraging and helping pregnant women to develop theirs, thus improving nursing care.

CONCLUSION

The research concludes that the nurses participating in the study have theoretical and practical knowledge of birth plans. They also demonstrate satisfactory management of nursing care for pregnant women, and the BP is a tool that specifically guides labor for each woman.

Furthermore, investigating the knowledge and practice of nurses receiving parturients regarding birth plans revealed that they are well-positioned to provide preterm care in their work environment, which boasts good physical infrastructure, essential materials for non-pharmacological pain relief methods, and strong commitment among nursing professionals.

Conversely, it was evident that the few existing difficulties were restricted to obstetric emergencies in the care process and the prevalent medicalized and interventionist model.

It is essential to continuously qualify and improve all professionals involved in the care of pregnant women, from the maternity hospital door to the immediate postpartum period. They should educate and encourage women and their support networks, thus empowering them and guaranteeing their health rights.

Finally, the research is limited by the low frequency of birth plans in public maternity hospitals, resulting in occasional rather than constant analysis of nursing management. One of the outcomes for further research is the need to monitor the pregnant woman's perspective on the birth

plan from its creation to its implementation, alongside the nursing professional.

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