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Review Article

Birth plans: A systematic, integrative review into their purpose, process, and impact☆

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ABSTRACT

Background: The birth plan was introduced in the 1980s to facilitate communication between maternity care providers and women and increase agency for childbearing women in the face of medicalised birth. Forty years on, the birth plan is a heterogeneous document with uncertainty surrounding its purpose, process, and impact. The aim of this review was to synthesise the evidence and improve understanding of the purpose, process and impact of the birth plan on childbearing women's experiences and outcomes.
Methods: This systematic review followed the PRISMA guidelines. A comprehensive search strategy was designed and applied to electronic databases CINAHL, MEDLINE, PsychINFO, Cochrane Library, Scopus, and ClinicalTrials.gov. Articles were appraised using the Crowe Critical Appraisal Tool and a five-step integrative approach to analysis followed.
Findings: Eleven articles were identified, all quantitative in nature. It is clear that the general purpose of birth plans is communication, with decision making a key factor. Even though the processes of birth planning were varied, having a birth plan was associated with generally positive birth outcomes.
Conclusions: Despite the heterogeneity of birth plans, birth plans were associated with positive outcomes for childbearing women when developed in collaboration with care providers. The act of collaboratively creating a birth plan may improve obstetric outcomes, aid realistic expectations, and improve satisfaction and the sense of control.

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Background

A birth plan is a common term used to describe a document, often prepared by pregnant women, that details their decisions and desires for their childbirth experience. Birth plans were introduced in the 1980s in response to the increasing medicalisation of childbirth. In a medicalised childbirth experience, power rests with medical practitioners who are seen as the expert and childbearing women are relegated to a passive role; expected to comply with expert medical decision making (Davis-Floyd, 2001). In this scenario many women lost any sense of agency or autonomy over their bodies and decision making. The birth plan was intended to address this problem by returning agency to childbearing women (DeBaets, 2017); supporting informed decision-making and facilitating communication between them and their caregivers (Simkin, 2007) (Divall, et al., 2017).

Birth plans have been challenged by some providers due to a perceived loss of professional autonomy (Hidalgo-Lopezosa, et al., 2013). Soon after their introduction birth plans were institutionalised, evolving into hospital provided templates and checklists. These have been criticised for the way they potentially wrest control from the childbearing women; returning it to the health professionals or institutions concerned (Lothian, 2006). Some studies suggest a clinically led approach to birth plans, using standardised templates (Welsh and Symon, 2014, Whitford, et al., 2014), however, institutionally designed birth plans do not necessarily expose women to all options, but only the institution's preferred choices, thus limiting women's ability to make fully informed decisions (Medeiros, et al., 2019).

A recent systematic review compared satisfaction of women with a birth plan to those experiencing standard care (supine position, continuous foetal monitoring, enema and episiotomy)

Abbreviations: CCAT, Crowe Critical Appraisal Tool; PRISMA, Preferred Reporting Items for Systematic Reviews and Meta-Analyses; PROSPERO, International prospective register of systematic reviews.

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(Mirghafourvand, et al., 2019). The review included three studies, of which two found significantly higher satisfaction with birth plans, and one showed no significant differences. Another systematic, integrative review (Medeiros, et al., 2019) exploring the "repercussions" of birth plans found that for the most part, they are associated with positive clinical outcomes (more physiological birth and improved neonatal outcomes), and greater satisfaction of childbearing women. Unrealistic expectations and inflexible birth plans resulted in dissatisfaction. The authors also highlight that care givers play a key role in the success (or otherwise) of birth plans (Medeiros, et al., 2019). This review, however, did not describe the type of birth plans used in the included studies, nor did they assess the quality of the studies included. A recent meta-analysis described difficultly in assessing the impact of birth plans due to high heterogeneity (Ghanbari-Homayi, et al., 2021).

Birth plans have not always been well received by health professionals with some accused of responding defensively (Whitford, et al., 2014), perhaps in response to the changing power dynamic (Owens, 2009). Concerns have been raised by maternity care providers regarding the independent creation of birth plans by childbearing women (without the input of clinicians), the quality of the resources that may be informing them, and the inflexibility of some birth plans (Welsh and Symon, 2014). The term "birth plan" for example suggests, for some, a fixed agenda (Divall, et al., 2016) whereas labour and birth may unfold in unexpected ways. These concerns speak to the purpose and process of birth plans, topics that have not previously been explored in reviews of birth plans. It is important to understand the purpose and process of birth plans in order to properly assess their impacts. The heterogeneity of birth plans is a reflection on the heterogeneity of the women creating them, and as such current research into birth plans does not explore deeply enough or from the perspective of the women creating them.

This systematic, integrative review draws on a diverse body of research (qualitative and quantitative) to address the research question: what is the impact of birth plans on childbearing women's outcomes and experiences? In drawing out the impacts of the birth plan, this review is also able to respond to the question; does the purpose and process of the birth plan influence the outcomes?

This paper aims to understand the impact of birth plans on childbearing women's outcomes and experiences by exploring the purposes and processes used to create them (Fig. 1).

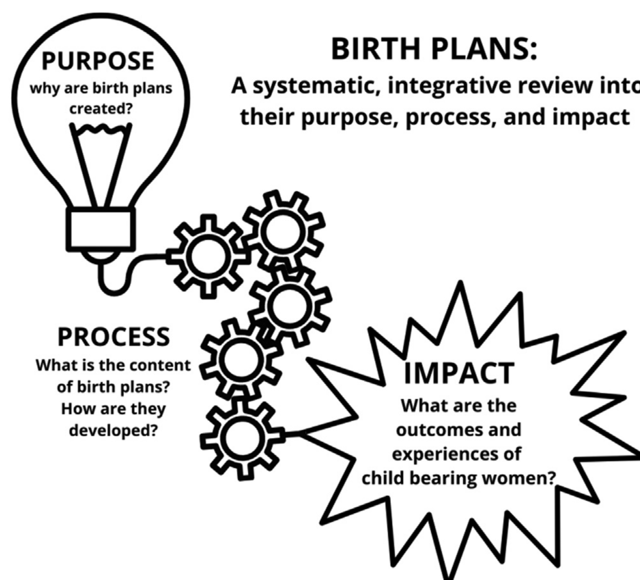

Fig. 1. Conceptualising birth plans.

Methods

This review takes an integrative approach, incorporating qualitative, quantitative, and mixed methods research designs. This approach was informed by the five methodological stages described by Whittemore and Knafl (2005) and follows the PRISMA guidelines (Moher D, et al., 2009). The research protocol was registered in the International Prospective Register for Systematic Reviews (PROSPERO Ref: CRD42020169338).

Literature search

A detailed search strategy was developed in collaboration with a specialist librarian in the following databases - CINAHL, MEDLINE, PsychINFO, Cochrane Library, Scopus, ClinicalTrials.gov. using the search terms: ("*birth plan**" OR "*labor plan**" OR "*labour plan**") AND (*childbearing OR pregnan** OR *matern** OR *birth**) AND (*experienc** OR *satisfaction* OR *outcome**). Full search documentation was recorded in Covidence (Veritas Health Innovation).

Data evaluation

Using Covidence, one reviewer (CB) judged titles and abstracts against the inclusion criteria. Three authors (CB, DD, SM) reviewed full text articles independently for relevance to the search aim and included articles were appraised and rated for risk of bias using the Crowe Critical Appraisal Tool (CCAT) (Crowe 2015). CCAT addresses each component of a paper, seeking to ensure valid inclusion and assessment, with an overall score out of 40 points accounted. This tool was chosen for its ease of use and depth of appraisal across different study designs. Two reviewers independently appraised each article. Any disagreements were resolved via discussion, with a third reviewer. Hand searching of reference lists ensured all relevant articles were included. Studies were included if published in English (due to author limitations), after 2000 and in a peer reviewed journal. The year 2000 was chosen as a turning point for wider access to the internet, and a shift towards using the internet for information (Lagan, et al., 2006). Opinion pieces and non-peer reviewed articles were excluded.

Observation and intervention studies were included if they included a comparison of birth plans or similar documents to no birth plan or similar, and reported on clinical maternity outcomes, psychometric scales (such as self-efficacy), measures of maternal satisfaction or women's experiences.

Data extraction and analysis

Based on protocols outlined by Chun Tie, et al. (2019) and Whittemore and Knafl (2005) all the relevant information required for this review was extracted into a Microsoft Excel database by the first author (CB). The categories of *purpose, process,* and *impact* were recorded in a second database.

The key terms for *purpose* were extracted by identifying the descriptions of the purpose and content of birth plans within each paper. The *processes* were recorded as being self-prepared or clinically led, and whether or not communication or discussion with healthcare professionals was involved. The *impacts* extracted varied with study design and were populated based on clinical outcomes and aspects of women's experiences including sense of control, communication, satisfaction, and expectations.

Similarities and differences within each category were compared and synthesised within themes until a framework emerged.

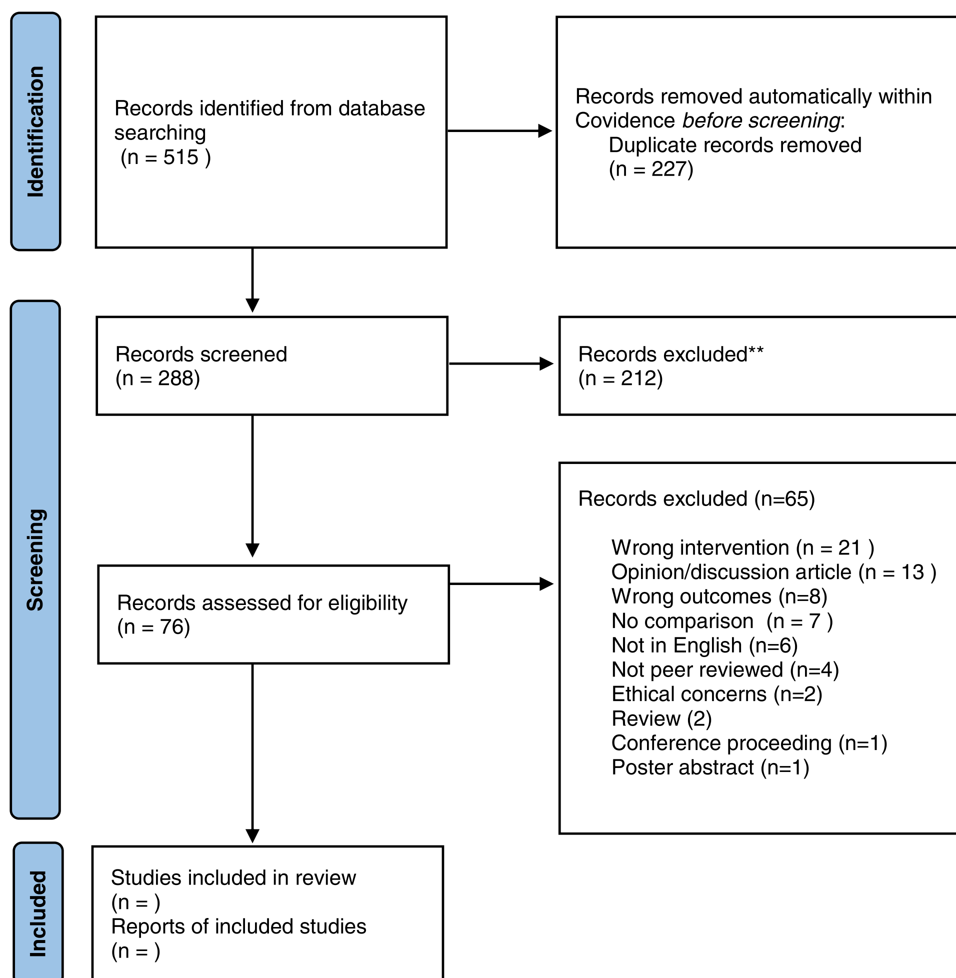

Fig. 2. PRISMA chart

This approach allowed for a systematic organisation of the literature in order to witness the specific details related to purpose and process, which was then placed into context with impacts. This process was immersive and required revisiting primary sources to ensure accuracy and confirmability until clear concepts emerged.

Findings

The search identified 11 papers (Table 1) that were included in the final analysis (Fig. 2). The 11 papers represent six countries: Spain (3), USA (3), Egypt (1), Israel (1), The Netherlands (1) and Taiwan (1) (Table 1). No qualitative or mixed methods papers were found, with all 11 papers quantitative in design. One was a Randomised Controlled Trial (RCT) (Kuo, et al., 2010), two were prospective cohort studies, six were retrospective, and two were cross-sectional. The primary carer in each cohort varied with country, with more obstetrician led care in the USA (Afshar, et al., 2018, Afshar, et al., 2017, Deering, et al., 2007) and Taiwan, midwifery care in Israel, Spain, The Netherlands and Sweden, and an Egyptian study reported a combination of physician and nurse care.

The quality findings were determined using CCAT (Crowe 2015), and recorded in Covidence (Veritas Health Innovation) with two assessors per paper (Table 2). Key issues found across the papers were the difficulties in accounting for confounders and possible bias.

The papers were reviewed for the key terms used to describe the purpose of birth plans and categorisation which was communication/discussion in all reviewed (Table 3).

Purpose

As shown in Table 3, seven of the papers referred to *decision making* in relation to the purpose of birth plans. Additionally, the content of birth plans is described in varying combinations of the terms: *preferences, expectations, wishes, requests, desires, views, demands* and *values*. The term *preferences* is used most commonly.

Process

Three categories for processes to birth planning were identified: *self-prepared, self-prepared with discussion* and *clinically-led with discussion* (Table 3 and Fig. 3).

Self-prepared birth plans

Six of the included studies were identified as being based on self-prepared birth plans. This category described a process that did not involve active or dedicated clinical involvement in the preparation of the plan, despite the purpose being described as for communication. The plan was presented at the time of admission in labour. Three of the six studies had a reference to decision making; one with decision making being described as women-led

Table 1
Characteristics of included studies.

STUDY REF	quality score	Primary carer	study type		study period	setting/place/details	country	no. participants	intervention	comparison
Afshar 2018	31/40	O	Quantitative Prospective cohort study	Recruited on arrival in labour. Medical records accessed. Postpartum satisfaction/experience/control questionnaire (day zero) likert scale	Between Sept 2013 and July 2014.	tertiary hospital LA (Cedar-sinai) Singleton pregnancies greater than 34 weeks gestation	USA	143 with birth plan 157 without birth plan	birth plan	no birth plan
Afshar 2017	34/40	-	Quantitative: retrospective cross sectional study	Medical records accessed to obtain data	August 2011 - June 2014 (35 months)	tertiary hospital LA (Cedar-sinai) Singleton pregnancies greater than 24 weeks gestation	USA	14630 total Of which: 1749 (12%) had a birth plan, 1291 (8.8%) had a birth plan and attended CBE, 4668 (32%) attended CBE	CBE and Birth plans	no CBE, No birth plan
Deering 2007	27/40	O	Quant. retrospective case control study	Medical records accessed to obtain data	"3.5- year period"	unspecified setting and location Case control 1:2, matched age and parity Participants experienced labour	USA	64 with birth plan 128 matched controls	birth plan (self prepared)	2 no birth plan controls matched for parity & age
Farahat 2015	20/40	P/N	Quantitative prospective cohort, quasi-experiment	Before: Socio demo data/expectations (birth plan) After: Birth plan fulfillment checklist /Satisfaction questionnaire (scale and open)/ Observed Outcomes	end of Feb 2013 to end of Oct 2013	antenatal clinic and labor unit in Obstetric and Gynecology Department at Mansoura University Hospital primiparious, gestation 36 – 42 weeks, woman 18 years or older	Egypt	260 divided into 130 intervention 130 standard care Intervention given birth plan and received focused care. Control, no plan, routine care	Study designed birth plan and preparation	routine care
Hadar 2012	33/40	M	Quantitative: retrospective case control study	Medical recorded accessed to obtain data	2007 - 2010	single major tertiary hospital Case control 3:1 matched for age, parity, gestational week. Singleton pregnancies who experienced labour	Israel	154 in study group, control matched 3:1 (462)	clinically guided birth plan	no birth plan
Hidalgo-Lopezosa 2013	32/40	M	Quantitative: retrospective case control study	Medical records accessed to obtain data	between August 2008 and September 2011	Reina Sofia Hospital in Córdoba case control 1:2.5 not matched singleton, term pregnancies experiencing labour	Spain	52 women in the treatment group and 130 women in the control group, (1:2.5)	birth plan (self prepared)	no birth plan
Hidalgo-Lopezosa 2021	26/40	M	Quantitative: retrospective case control study	Medical records accessed to obtain data	Between 2009 and 2013	Four tertiary public hospitals in the Andalusia Health Public System 1:1.5	Spain	178 with birth plan 279 without	birth plan (self prepared)	no birth plan
Jolles 2019	38/40	M	Quantitative: retrospective	Medical records accessed to obtain data	during 2017	Amalia Children's Hospital, Radboudumc, Nijmegen All women giving birth after 34 weeks gestation	The Nether-lands	1159 of which 402 with birth plan, 757 without	birth plan encouraged clinically at 30w	no birth plan
Kuo 2010	33/40	O	Quantitative: randomised control trial single blind	Before: demo data/expectations questionnaire. After: fulfilment questionnaire/control scale/experience questionaire	March to October 2007	seven hospitals, under 10 OBs in northern and central Taiwan. Primiparious, at least 32 weeks gestation, over 18 years, no complications, experienced labour	Taiwan	330 total: 165 treatment, 165 control, randomly allocated.	Clinically provided birth plan template	no birth plan
Suarez-Cortes 2015	22/40	M	Quantitative: cross sectional, observational, descriptive &, comparative cohort	'delivery room' records accessed to obtain data.	between January 2011 and Dec 2012	Clinical Teaching Hospital Virgen de la Arrixaca in Murcia, Spain. Singleton pregnancies greater than 37 weeks gestation, experienced labour.	Spain	Of 12,579 births in study period, 73.96% (9,303 births) were included 2.6% (240) presented a Birth Plan.	Delivery and Birth Plan	all births
Westergren 2020	36/40	M	Quantitative: cross-sectional study	Data from birth plans and medical records.	between March and June 2016	a tertiary hospital Singleton pregnancies of at least 28 weeks gestation, who experienced labour.	Sweden	239 women. Of these, 129 women (54.0%) had written a birth plan.	Optional birth plan clinically provided	no birth plan

PRIMARY CARER: P = physician M = midwives O= obstetrician P/N = physician and nurse

Table 2
Quality scores CCAT, showing score for each of the eight categories. Score in each category is 0 – 5, with a total out of 40.

CCAT CATEGORY STUDY REF	PRELIMINARIES	INTRODUCTION	DESIGN	SAMPLING	DATA COLLECTION	ETHICAL MATTERS	RESULTS	DISCUSSION	TOTAL SCORE
Afshar 2018	4	5	3	3	4	4	4	4	31
Afshar 2017	4	3	5	5	5	5	3	4	34
Deering 2007	3	1	5	3	4	4	4	3	27
Farahat 2015	2	3	3	3	2	3	2	2	20
Hadar 2012	4	4	4	4	4	5	4	4	33
Hidalgo-Lopezosa 2013	4	5	4	3	4	5	4	3	32
Hidalgo-Lopezosa 2021	3	4	3	3	3	4	3	3	26
Jolles 2019	4	5	4	5	5	5	5	5	38
Kuo 2010	4	4	5	5	3	4	4	4	33
Suarez-Cortes 2015	3	2	3	3	2	2	3	4	22
Westergren 2020	3	5	5	4	4	5	5	5	36

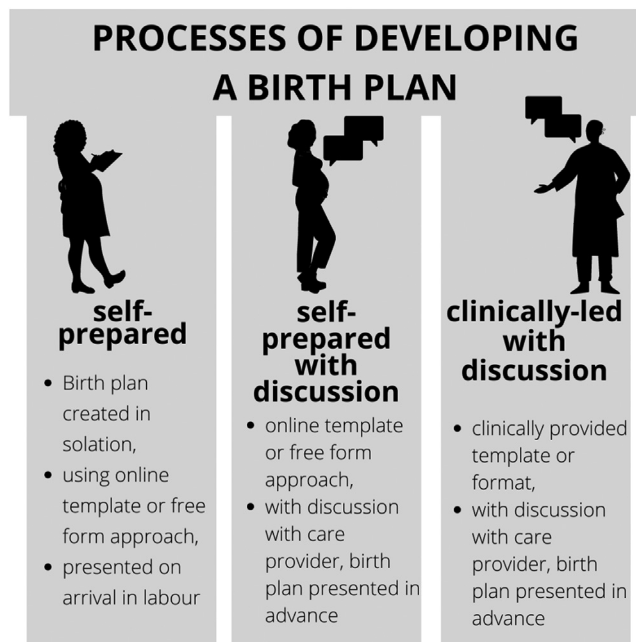

Fig. 3. process of developing birth plans. Three different processes were identified.

(Suarez-Cortes, et al., 2015) and one as clinically-led (Afshar, et al., 2018), and with the third referring to women as participants in decision making (Hidalgo-Lopezosa, et al., 2021).

Self-prepared birth plans with discussion

One study (Jolles, et al., 2019) involved a self-prepared plan with some level of engagement or encouragement during pregnancy in 92.5% of participants with a birth plan; described as shared decision making. The study, based in The Netherlands with a midwife-led model of care, was a prospective design in a system where women are advised to self-prepare a birth plan at their 30 week appointment, for discussion at the next appointment. This study focussed on satisfaction, and found that just over a third of women created a birth plan and discussed it, and just over half of these had the plan attached to medical records. Of those opting to prepare a birth plan, they were on average older, with one previous birth, a higher incidence of previous complexity, had used fertility treatment, or had a psychological condition. This study found overall high levels of satisfaction among all participants, and suggested that a response bias may occur as the questionnaire took place within a few weeks of birth, along with the possibility that asking about satisfaction is not the same as asking about trauma. This study had several limitations, including that the level of discussion was inconsistent and not always with the care provider who would be attending the birth. This study did not evaluate the content of the birth plans in relation to obstetric outcomes.

Clinically-led birth plans with shared discussion

Four studies were classified as clinically-led with some level of discussion during pregnancy. In these studies, a template was provided, with formal guidance in the process. Two of these studies described communication as woman-centred (Farahat, et al., 2015, Hadar, et al., 2012), with one study referring to clinically-led (Kuo, et al., 2010) and one study (Westergren, et al., 2020) referred to decision making as woman-led. Each of these four studies used a different template, with all aiming to provide women with an opportunity to become educated and communicate their 'desires/wishes/preferences'.

Table 3
Purpose and Processes of Birth Plans

STUDY REF	Purpose			Processes			Primary carer
	decision making	communication/ discussion	terms	self-prepared	Self-prepared with discussion	clinically led with discussion	
Afshar 2018	x	x	preferences	x			Obstetrician
Afshar 2017		x	preferences	x			-
Deering 2007		x	requests	x			Obstetrician
Farahat 2015	x	x	preferences			x	Physician and Nurse
Hadar 2012		x	expectations			x	Midwives
Hidalgo-Lopezosa 2013		x	views, wishes, expectations, preferences	x			Midwives
Hidalgo-Lopezosa 2021	x	x	Wishes, expectations, requests, demands	x			Midwives
Jolles 2019	x	x	preferences, wishes		x		Midwives
Kuo 2010	x	x	preferences			x	Obstetrician
Suarez-Cortes 2015	x	x	values, desires, preferences, expectations	x			Midwives
Westergren 2020	x	x	preferences			x	Midwives

The template provided in the Egyptian study (Farahat, et al., 2015), with the Physician and Nurse led care model, was quite detailed, including general 'preferences' and 'preferences' specific to 1st and 2nd stage of labour and after 'delivery'.

The midwife-led process from Israel referred to the plan as being self-prepared (Hadar, et al., 2012), but described a clinically-led process of 'personal birth plan service' involving the mother and her spouse to prepare a formal birth plan. A meeting during the third trimester between the midwife and the couple discussed the medical aspects alongside personal expectations and concerns. This process documented labour preferences such as monitoring, analgesics and intravenous lines, along with a discussion about episiotomy and a documentation of the 'wishes' of the couple. The couple could detail other 'requests or expectations' in a free text.

The RCT from Taiwan provided primiparous women with a list of options to choose from; including enemas, intravenous fluids, showers, monitoring, freedom to eat/drink and move, and the position for birth and choice regarding episiotomy (Kuo, et al., 2010). An option to add details about expectations was included by way of an open-ended question. These plans were discussed firstly with a nurse (after 32 weeks), then with an obstetrician in order to reach 'consensus'. Both the obstetrician and the woman then signed the agreed plan.

The study referring to woman-led decision making was a cross sectional study from Sweden (Westergren, et al., 2020), based on a clinically provided birth plan template offered to all women routinely. The template is a single sheet of paper with four open-ended questions; it is filled in at home and then used in the next antenatal visit to guide the discussion with an antenatal care midwife. The question that was the focus of this particular study was: "What methods for relaxation and pain relief would you prefer when you give birth?"

Impacts

The findings regarding impacts are shown in Table 4. Within the nine studies that measured obstetric outcomes, seven found positive, three neutral, and two slightly negative impacts of a birth plan compared to no birth plan. A neutral impact was one where no difference was found between those with and those without birth plans. Positive relates to less intervention, and negative with more.

Two studies looked at the sense of control, with one concluding that a birth plan did help achieve this (Kuo, et al., 2010), and one concluded it did not (Afshar, et al., 2018). The study (Kuo, et al., 2010) concluding that a sense of control did help, was an RCT in Taiwan, with a clinically-led discussion process. The study (Afshar, et al., 2018) concluding a sense of control did not help was a self-prepared process without discussion, and also found low satisfaction levels and that expectations were not met, whilst the other study (Kuo, et al., 2010) found higher satisfaction levels and expectations being met.

The two studies (Farahat, et al., 2015, Kuo, et al., 2010) reporting birth plans improving communication were clinically-led with discussion. Associated with effective communication, were high satisfaction (Farahat, et al., 2015, Kuo, et al., 2010) and the meeting of expectations (Kuo, et al., 2010). One study (Farahat, et al., 2015) reporting 'good' communication with birth plans, found that having a birth plan was associated with a shorter second stage, more vaginal birth and less pain. The other of these studies (Kuo, et al., 2010), reported the level of communication as effective and was related to a feeling of 'mastery and participation'.

Satisfaction/experience (measured from postpartum satisfaction scales) was mostly reported as high (Farahat, et al., 2015, Jolles, et al., 2019, Kuo, et al., 2010, Westergren, et al., 2020) when a birth plan was created, with one study (Afshar, et al., 2018) finding the opposite. Of the four studies reporting high satisfaction, all were discussion based processes, whilst the study reporting low satisfaction was a process without discussion. One of the four studies reporting a high satisfaction (Westergren, et al., 2020) did suggest that measuring satisfaction so soon after birth (within days) and in the presence of carers means there is a 'gratitude bias'. Another (Kuo, et al., 2010) seemed to link control, satisfaction and expectation, and also found that communication was improved, and even an essential component to the success of the birth plan.

For the three studies addressing expectation, two found participants with birth plans reported higher levels of expectations being

Table 4
Impacts of birth plans on childbearing women

STUDY REF	Primary carer	process	Obstetric Outcomes positive	neutral	negative	control higher	lower	Communication effective	ineffective	Satisfaction/ experience high	low	no difference	expectation met	not met
Afshar 2018	O	SP	less synthetic oxytocin, less AROM, less epidural	c/s, length of labour			c.f to no BP				c.f to no BP			c.f to no BP
Afshar 2017	-	SP	more likely to birth vaginally (including VBAC)		slightly more operative vaginal delivery except in nullip									
Deering 2007	O	SP	epidural used less (except nulli)	c/s episiotomy										
Farahat 2015	P/N	CL-D	shorter 2nd stage, more vaginal delivery/less c/s, less pain					reported as 'good' more		more positive experience Higher satisfaction				
Hadar 2012	M	CL-D	less cs, less iv analgesics		more 1st & 2nd degree tears more epidurals								mostly met, called 'compliance'	
Hidalgo-Lopezosa 2013	M	SP		overall										
Hidalgo-Lopezosa 2021	M	SP	Less epidural, less AROM, less oxy, longer 1st phase, less c/s in prmip	Second phase length, C/s in multip, Instrumental delivery, 3rd-4th degree tears, episiotomy										
Jolles 2019	M	SP-D								if spontaneous birth		postpartum		
Kuo 2010	O	CL-D				with BP		referred to as: mastery and participation		significantly more positive experience with BP			Significantly more with BP	
Suarez-Cortes 2015	M	SP	for skin to skin, delayed cord clamping, and eutocic birth*											
Westergren 2020	M	CL-D		due to medicalisation						suspected gratitude bias				

PRIMARY CARER: P = physician M = midwives O= obstetrician P/N = physician and nurse
PROCESS: SP = Self-prepared SP-D =self-prepared with discussion CL-D = clinically led with discussion
AROM = Artificial Rupture of Membranes BP = birth plan c/s = caesarean section mulip = has given birth before primip = this was first birth
* eutocic birth = vaginal birth without instruments

met (Hadar, et al., 2012, Kuo, et al., 2010), and one reported lower levels (Afshar, et al., 2018). The conditions for meeting expectations were related to compliance with the birth plan (Hadar, et al., 2012) and a process that was clinically-led with discussion (Hadar, et al., 2012, Kuo, et al., 2010). The study reporting that expectations were not met, involved a self-prepared plan without discussion.

In Table 4 the processes and impacts are shown in relation to each other. For added depth, the primary carer is included. Of the three studies (Afshar, et al., 2018, Afshar, et al., 2017, Hadar, et al., 2012) with impacts that could be regarded as negative, two were associated with self-prepared plans without discussion from the same obstetrician-led institution (Afshar, et al., 2018, Afshar, et al., 2017). Of these two, one (Afshar, et al., 2018) found a lower sense of control, lower satisfaction and less expectations met in the birth plan group compared to those without. The other (Afshar, et al., 2017) reported slightly more operative vaginal births (except in nulliparious women). The third study (Hadar, et al., 2012) was a clinically-led discussion process in a midwife-led institute. The negative obstetric outcome related to more 1st and 2nd degree tears and more epidural use, which was consistent with the positive finding of reduced caesarean.

Discussion

This integrative review highlights the heterogeneity in purpose and process for birth plans. Despite this heterogeneity, the impact of birth plans on women demonstrated generally positive outcomes, particularly where collaboration, through good communication, is involved.

What are the terms used to describe the purpose and content of birth plans?

All the reviewed studies referred to communication, in varying forms, as a key purpose of birth plans, with most also referring to decision making. However, even though communication was considered a key purpose, just under half of the studies included involved some level of discussion between women and their care providers. The role of the care provider is to help build understanding and create realistic expectations, whilst also respecting the needs of the woman (Villarmea and Kelly, 2020). This communication is important during preparation (WHO Reproductive Health Library, 2018), but effective communication is also needed during labour, especially if the birth becomes complicated (White-Corey, 2013).

The terms used to describe the content, are framed more as suggestions rather than decisions.

The term ‘preferences’ commonly used in the reviewed studies to describe the content of birth plans is generally considered to be ‘flexible’ (Afshar, et al., 2016). In birth preparation, flexibility is considered a strength when it allows room for ongoing communication and negotiation allowing women to retain a sense of control (Cook and Loomis, 2012) with the emphasis for flexibility on women rather than institutions (Peart, 2004). One issue raised by included studies in relation to birth plans is that due to the unpredictable nature of birth, women are ‘changing their minds’, and not following their own birth plan (Deering, et al., 2007, Westergren, et al., 2020). Women, of course, have the right to ‘change their minds’ on any preconceived ideas they had (Love and Pace, 2018). However, if birth plans are limited to one ideal scenario, women are vulnerable in the event of a deviation (Patterson, et al., 2019, Reed, et al., 2017). Being prepared for complications could help protect against negative birth experiences (Henriksen, et al., 2017).

What are the different processes for creating a birth plan, and how do these different processes impact the outcomes and experiences of childbearing women?

This review identified three different processes for creating a birth plan: Self-prepared, self-prepared with discussion and clinically-led with discussion. Of the reviewed studies, obstetric outcomes, control, communication, satisfaction/experience and expectation were evaluated.

Obstetric outcomes

The nine studies measuring obstetric outcomes were generally found to be positive or neutral for women with a birth plan compared to those without. Without clarity of women’s actual experience it is difficult to draw inference on the ultimate impact these births had for women. This is consistent with other findings showing that birth plans do not have an adverse impact on women’s obstetric outcomes (Divall, et al., 2016, Medeiros, et al., 2019).

Good obstetric outcomes are important (Carquillat, et al., 2016), as we know that long term physical impacts influence the long term social and emotional impacts (Hernandez-Martinez, et al., 2019). It is also understood that the emotional impact of a birth may also have a long term impact on the social and emotional state of women, babies and their families (McKenzie-McHarg, et al., 2015).

Negativity experienced by women is often due to feelings of coercion that arise from the power imbalance that is often experienced by women in maternity care (Consumers Health Forum, 2013, Owens, 2009) and due to an assumed decision hierarchy within the maternity system (Kruske, et al., 2013).

Control

Of the two studies evaluating control; the one finding a lower sense of control was in an obstetric-led model with a self-prepared birth plan (Afshar, et al., 2018), whilst the one reporting higher sense of control with a birth plan, was in an obstetric-led model with a clinically-led with discussion process (Kuo, et al., 2010). Birth trauma and disappointment are related to a loss of control (Cook and Loomis, 2012, Crossland, et al., 2020, Morton and Simkin, 2019), but this differs from one woman to the next and is generally based on her perception of risk (Regan, et al., 2013). Key to this sense of control, is an expectation of support from both partner and midwife (Westergren, et al., 2019). In regards to the need for flexibility, (Kuo, et al., 2010) states it is the care providers who should be flexible and “provide opportunities to increase a sense of control” (p. 812) through discussion to help identify uncontrollable situations.

Women’s autonomy can only be achieved when the power is balanced (Kotaska, 2017, Kruske, et al., 2013). One way to balance power, is through advanced discussion of various scenarios, particularly when it comes to pain management (Brooks and Sullivan, 2002). This can be achieved through continuity of midwifery care (Hawke, 2020), effective communication, which includes, but is not limited to, ensuring women know they have choices and that those choices are understood (WHO Reproductive Health Library, 2018) and that they have Respectful Maternity Care (White Ribbon Alliance, 2011, WHO Reproductive Health Library, 2018).

Communication

It was clear that where communication was measured (Farahat, et al., 2015, Kuo, et al., 2010), and clinical involvement followed more of a shared decision making model, the outcomes

for women were generally 'good'. The absence of effective communication could create an illusion of choice, limiting the role women realistically play in decision making (Yuill, et al., 2020).

Three of the six studies with self-prepared plans were Spanish. A recent qualitative study from Spain (Lopez-Toribio, et al., 2021) used focus groups with 23 first time mothers (low risk, over 18) who had birthed in the Hospital Clinic of Barcelona in the previous year. Sixteen of these women spoke of the self-prepared birth plan lacking engagement (mostly ignored), and suggested that birth plans should be embedded into the training for health professionals and women to improve the shared decision-making process. However, in the clinically-led studies reviewed, the study or institute provided template limited a woman's options and her ability to fully understand her options. Time constraints, such as discussion limited to one appointment (Farahat, et al., 2015, Hadar, et al., 2012), and late introduction (after 30 weeks) of templates (Kuo, et al., 2010, Westergren, et al., 2020) is not conducive to informed decision making, and occur within a power imbalance. Within the maternity context, 'shared decision making' can further skew the balance, when interpreted literally, with a focus on consenting rather than the process of decision making (Villarmea and Kelly, 2020).

Satisfaction

All the studies reporting on satisfaction of the childbirth experience involved discussion, and found higher levels of satisfaction for those with a birth plan. It is apparent that satisfaction in birth is higher if expectations (as listed in the plan) are met (Preis, et al., 2018). When the assumption is that birth plans are equated to natural birth or a tendency to seek to avoid medicalised birth (Deering, et al., 2007), the interpretation is that medicalised interventions have a negative impact. However, it has been established that women will report a positive or negative experience based on how respected or heard (Cook and Loomis, 2012, Henriksen, et al., 2017, Hernandez-Martinez, et al., 2019, Hollander, et al., 2017, Nilsson, et al., 2013) they felt, rather than solely on the obstetric outcomes. The feelings of respect and being heard are related to the process of informed consent (Bringedal and Aune, 2019).

Many studies suggest that care providers find birth plans useful to identify misconceptions and anxieties, which can then be addressed in advance (Afshar, et al., 2018, Deering, et al., 2007, Hidalgo-Lopezosa, et al., 2013, Mei, et al., 2016). As an education tool, a birth plan was considered over two decades ago as an advantage, with women reporting this as meaning that labour was less stressful, as *"we had evaluated all the options prior to labour"* (Brown and Lumley, 1998 p. 110). There is, however, some concern that women rely on care givers to guide and make decisions (Armstrong and Kenyon, 2017, Divall, et al., 2017), which is seen with the obedience phenomenon (Dempsey, 2013). This eagerness to hand over the power seemed to rest in a feeling that not being medically trained equates to not being qualified to make decisions (Divall, et al., 2017). This suggests a knowledge gap.

Within the birth plan related literature there is an absence of suggestions for how to address the knowledge gap, with most suggestions based around clinical management (such as the suggestions for universal and standardised plans). Concerns about the time required to involve 'patients' was raised in several papers (Cortezzo, et al., 2019, Kuo, et al., 2010, Westergren, et al., 2020), along with a loss of professional autonomy (Hidalgo-Lopezosa, et al., 2017, Hidalgo-Lopezosa, et al., 2013, Welsh and Symon, 2014). This professional autonomy is related to women's preferences which are in contrast to the care provider preference, particularly if the care provider feels this is beyond their scope of practice (Jenkinson, et al., 2016). Addressing this issue of tension requires communication in a way that benefits both the care provider and the woman, giving both a retained sense of autonomy (Jenkinson, et al., 2018). This includes the recommendation of multidisciplinary engagement, which was shown to have positive outcomes for scheduled caesarean planning (Lewis, et al., 2014) and preparations for life-limiting diagnosis (Cortezzo, et al., 2019).

A UK study (Welsh and Symon, 2014) found that women are seeking guidance in how to create and present a plan. Antenatal education is known to influence birth plans (Soriano-Vidal, et al., 2018) and birth outcomes, for better or for worse (Levett and Dahlen, 2019). A study in Iceland (Gottfredsdottir, et al., 2016) looked at the content of institutionally provided antenatal education, finding that if women experienced the birth as difficult, they would rate the classes as insufficient. This was particularly prevalent in first time mothers, who had no point of reference for the preparation, and did not know what they did not know. This hindsight perspective tells us, that it would be useful for women to be prepared for various possibilities (Henriksen, et al., 2017). When education is internally provided it can influence women's choices (Hands, et al., 2020). Accessing antenatal care outside of the hospital can be expensive, making it inaccessible; so many women will seek to fill their knowledge gap with informal resources (Sanders and Crozier, 2018).

Expectations

Of the three studies reviewed addressing expectations, two reported they were met (Hadar, et al., 2012, Kuo, et al., 2010), with both involving a clinically-led with discussion process. The study reporting expectations not being met (Afshar, et al., 2018), involved a self-prepared plan without discussion, first seen by care providers during labour. Expectations not being met, was accompanied by women being less satisfied and feeling less in control (Afshar, et al., 2018). Whereas when expectations were met, it was associated with higher satisfaction, sense of control and feeling in control (Kuo, et al., 2010).

As with increased sense of control to protect against dissatisfaction, good communication can build realistic expectations. All these elements are clearly interconnected, with communication the common thread. Birth plans created with discussion with care providers, show that these elements of control, satisfaction and expectation are better managed and likely to reduce trauma and disappointment. What would be most ideal was for this to occur in a continuity of care relationship so the person at the birth is fully cognisant of the discussion and woman's needs.

Recommendations for a universal approach to birth preparation

With the variability of birth plans combined with the variability of models of maternity care, it is unsurprising that the literature has suggested the need to have a universal approach (Afshar, et al., 2019, Afshar, et al., 2016, Mei, et al., 2016) using an embedded or standardised birth plan (Mei, et al., 2016, Welsh and Symon, 2014, Whitford, et al., 2014). A universal approach could provide structure to birth preparation, but would need to ensure that the woman is centred and the focus is on communication rather than being limited to an overly simplified, narrow or limited template.

This review recommends a universal, consistent and woman-led process to enhance communication and decision making where women's informed decisions allow for the creation of a living document. The new process requires a new term to address the identified barriers with the term *plan* (Divall, et al., 2016), and to reflect a flexible approach that does not compromise the autonomy of the woman.

Limitations

Limitations of this integrative review include the variable level of acceptance and attitudes towards birth plans by those conducting each study, which could influence how they perceive birth plans. Limiting the review to papers in English means that there are papers excluded that may have offered additional information. The Hawthorne Effect (behaviour change when observed) was raised as a potential limitation (Kuo, et al., 2010). In prospective studies, "*It is unclear the extent to which verbal communication between the patient and provider, among women without a birth plan, was similar or different to that which is written in a birth plan.*"(Afshar, et al., 2018 p.47). With retrospective study design asking women about their experience soon after birth, gratitude or recall bias can be an artefact of these studies. There is an absence of comparative research looking at birth plans in continuity of care models or of a qualitative nature from the woman's perspective.

It is also worth considering the variability of birth planning in low, middle and higher income countries, along with cultural differences expected to influence the values and decision making involvement of childbearing women.

Conclusion

Despite the heterogeneity of birth plans, birth plans demonstrated positive outcomes for childbearing women when in collaboration with care providers. The act of collaboratively creating a birth plan can improve obstetric outcomes, aid realistic expectations, improve satisfaction and increase a sense of control.

Declaration of Competing Interest

None declared

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References

Afshar, Y., Mei, J., Fahey, J., Gregory, K.D., 2019. Birth Plans and Childbirth Education: What Are Provider Attitudes, Beliefs, and Practices? J Perinat Educ 28 (1), 10–18.
Afshar, Y., Mei, J., Gregory, K., 2016. Birth Plans: Birth Preferences or Labor Manifesto. Gynecology & Obstretrics Case report 2 (1), 1–4 12.
Afshar, Y., Mei, J.Y., Gregory, K.D., Kilpatrick, S.J., Esakoff, T.F., 2018. Birth Plans-Impact on Mode of Delivery, Obstetrical Interventions, and Birth Experience Satisfaction: A Prospective Cohort Study. Birth 45 (1), 43–49.
Afshar, Y., Wang, E.T., Mei, J., Esakoff, T.F., Pisarska, M.D., Gregory, K.D., 2017. Childbirth Education Class and Birth Plans Are Associated with a Vaginal Delivery. Birth 44 (1), 29–34.
Armstrong, N., Kenyon, S., 2017. When Choice Becomes Limited: Women's Experiences of Delay in Labour. Health (London) 21 (2), 223–238.
Bringedal, H., Aune, I., 2019. Able to Choose? Women's Thoughts and Experiences Regarding Informed Choices During Birth. Midwifery 77, 123–129.
Brooks, H., Sullivan, W.J., 2002. The Importance of Patient Autonomy at Birth. Int J Obstet Anesth 11 (3), 196–203.
Brown, S.J., Lumley, J., 1998. Communication and Decision-Making in Labour: Do Birth Plans Make a Difference? Health Expect. 1, 106–116.
Carquillat, P., Boulvain, M., Guittier, M.J., 2016. How Does Delivery Method Influence Factors That Contribute to Women's Childbirth Experiences? Midwifery 43, 21–28.
Chun Tie, Y., Birks, M., Francis, K., 2019. Grounded Theory Research: A Design Framework for Novice Researchers. SAGE Open Med 7, 2050312118822927.
Consumers Health Forum. (2013), 'Informed Consent in Healthcare: An Issues Paper', (Eds.).
Crowe, 2015. 1. https://conchra.com.au/2015/12/08/crowe-critical-appraisal-tool-v1-4/. (Accessed 01 October 2019).
Cook, K., Loomis, C., 2012. The Impact of Choice and Control on Women's Childbirth Experiences. J Perinat Educ 21 (3), 158–168.
Cortezzo, D.E., Bowers, K., Cameron Meyer, M., 2019. Birth Planning in Uncertain or Life-Limiting Fetal Diagnoses: Perspectives of Physicians and Parents. J Palliat Med 22 (11), 1337–1345.
Crossland, N., Kingdon, C., Balaam, M.C., Betran, A.P., Downe, S., 2020. Women's, Partners' and Healthcare Providers' Views and Experiences of Assisted Vaginal Birth: A Systematic Mixed Methods Review. Reprod Health 17 (1), 83.
Davis-Floyd, R., 2001. The Technocratic, Humanistic, and Holistic Paradigms of Childbirth. International Journal of Gynaecology & Obstetrics 75, S5–S23.
DeBaets, A.M., 2017. From Birth Plan to Birth Partnership: Enhancing Communication in Childbirth. Am J Obstet Gynecol 216 (1), 31e1–31e4.
Deering, S.H., Zaret, J., McGaha, K., Satin, A.J., 2007. Patients Presenting with Birth Plans: A Case-Control Study of Delivery Outcomes. J. Reprod. Med. 10, 884–887.
Dempsey, R., 2013. Birth with Confidence: Savvy Choices for Normal Birth. Boathouse Press.
Divall, B., Spiby, H., Nolan, M., Slade, P., 2017. Plans, Preferences or Going with the Flow: An Online Exploration of Women's Views and Experiences of Birth Plans. Midwifery 54, 29–34.
Divall, B., Spiby, H., Roberts, J., Walsh, D., 2016. Birth Plans: A Narrative Review of the Literature. International Journal of Childbirth 6 (3), 157–172.
Farahat, A.H., Mohamed, H.E.S., Elkader, S.A., El-Nemer, A., 2015. Effect of Implementing a Birth Plan on Womens' Childbirth Experiences and Maternal & Neonatal Outcomes. Journal of Education and Practice 6 (6).
Ghanbari-Homayi, S., Hasani, S., Meedya, S., Asghari Jafarabadi, M., Mirghafourvand, M., 2021. Nonpharmacological Approaches to Improve Women's Childbirth Experiences: A Systematic Review and Meta-Analysis. J Matern Fetal Neonatal Med 34 (3), 479–491.
Gottfredsdottir, H., Steingrimsdottir, T., Bjornsdottir, A., Guethmundsdottir, E.Y., Kristjansdottir, H., 2016. Content of Antenatal Care: Does It Prepare Women for Birth? Midwifery 39, 71–77.
Hadar, E., Raban, O., Gal, B., Yogev, Y., Melamed, N., 2012. Obstetrical Outcome in Women with Self-Prepared Birth Plan. J Matern Fetal Neonatal Med 25 (10), 2055–2057.
Hands, K.K., Clements-Hickman, A., Davies, C.C., Brockopp, D., 2020. The Effect of Hospital-Based Childbirth Classes on Women's Birth Preferences and Fear of Childbirth: A Pre- and Post-Class Survey. J Perinat Educ 29 (3), 134–142.
Hawke, M, 2020. Subversive Acts and Everyday Midwifery: Feminism in Content and Context. Women and Birth.
Henriksen, L., Grimsrud, E., Schei, B., Lukasse, M., Bidens Study, G., 2017. Factors Related to a Negative Birth Experience - a Mixed Methods Study. Midwifery 51, 33–39.
Hernandez-Martinez, A., Rodriguez-Almagro, J., Molina-Alarcon, M., Infante-Torres, N., Rubio-Alvarez, A., Martinez-Galiano, J.M., 2019. Perinatal Factors Related to Post-Traumatic Stress Disorder Symptoms 1-5 Years Following Birth. Women Birth.
Hidalgo-Lopezosa, P., Cubero-Luna, A.M., Jimenez-Ruz, A., Hidalgo-Maestre, M., Rodriguez-Borrego, M.A., Lopez-Soto, P.J., 2021. Association between Birth Plan Use and Maternal and Neonatal Outcomes in Southern Spain: A Case-Control Study. Int J Environ Res Public Health 18 (2).
Hidalgo-Lopezosa, P., Hidalgo-Maestre, M., Rodriguez-Borrego, M.A., 2017. Birth Plan Compliance and Its Relation to Maternal and Neonatal Outcomes. Rev Lat Am Enfermagem 25, e2953.
Hidalgo-Lopezosa, P., Rodri-guez-Borrego, M.A., Munoz-Villanueva, M.C., 2013. Are Birth Plans Associated with Improved Maternal or Neonatal Outcomes? MCN: The American Journal of Maternal Child Nursing 38 (3), 150–156.
Hollander, M.H., van Hastenberg, E., van Dillen, J., van Pampus, M.G., de Miranda, E., Stramrood, C.A.I., 2017. Preventing Traumatic Childbirth Experiences: 2192 Women's Perceptions and Views. Arch Womens Ment Health 20 (4), 515–523.
Jenkinson, B., Kruske, S., Kildea, S., 2018. Refusal of Recommended Maternity Care: Time to Make a Pact with Women? Women Birth 31 (6), 433–441.
Jenkinson, B., Kruske, S., Stapleton, H., Beckmann, M., Reynolds, M., Kildea, S., 2016. Women's, Midwives' and Obstetricians' Experiences of a Structured Process to Document Refusal of Recommended Maternity Care. Women Birth 29 (6), 531–541.
Jolles, M.W., Vries, M., Hollander, M.H., Dillen, J., 2019. Prevalence, Characteristics, and Satisfaction of Women with a Birth Plan in the Netherlands. Birth: Issues in Perinatal Care 46 (4), 686–692.
Kotaska, A., 2017. Informed Consent and Refusal in Obstetrics: A Practical Ethical Guide. Birth 44 (3), 195–199.
Kruske, S., Young, K., Jenkinson, B., Catchlove, A., 2013. Maternity Care Providers' Perceptions of Women's Autonomy and the Law. BMC Pregnancy Childbirth 13 (84).
Kuo, S.C., Lin, K.C., Hsu, C.H., Yang, C.C., Chang, M.Y., Tsao, C.M., Lin, L.C., 2010. Evaluation of the Effects of a Birth Plan on Taiwanese Women's Childbirth Experiences, Control and Expectations Fulfilment: A Randomised Controlled Trial. Int J Nurs Stud 47 (7), 806–814.
Lagan, B., Sinclair, M., WG, K., 2006. Pregnant Women's Use of the Internet: A Review of Published and Unpublished Evidence. Evidence Based Midwifery 4 (1), 17–23.
Levett, K., Dahlen, H.G., 2019. Perspective: Childbirth Education in Australia: Have We Lost Our Way? Women Birth 32 (4), 291–293.
Lewis, L., Hauck, Y.L., Ritchie, S., Barnett, L., Nunan, H., Rivers, C., 2014. Australian Women's Perception of Their Preparation for and Actual Experience of a Recent Scheduled Caesarean Birth. Midwifery 30 (3), e131–e136.
Lopez-Toribio, M., Bravo, P., Llupia, A., 2021. Exploring Women's Experiences of Participation in Shared Decision-Making During Childbirth: A Qualitative Study at a Reference Hospital in Spain. BMC Pregnancy Childbirth 21 (1), 631.
Lothian, J., 2006. Birth Plans: The Good, the Bad, and the Future. JOGNN: Journal of Obstetric, Gynecologic & Neonatal Nursing 35 (2), 295–303.

Love, C., Pace, N., 2018. Consent. Anaesthesia & Intensive Care Medicine 19 (5), 263–266.
McKenzie-McHarg, K., Ayers, S., Ford, E., Horsch, A., Jomeen, J., Sawyer, A., Stramrood, C., Thomson, G., Slade, P., 2015. Post-Traumatic Stress Disorder Following Childbirth: An Update of Current Issues and Recommendations for Future Research. Journal of Reproductive and Infant Psychology 33 (3), 219–237.
Medeiros, R.M.K., Figueiredo, G., Correa, A.C.P., Barbieri, M., 2019. Repercussions of Using the Birth Plan in the Parturition Process. Rev Gaucha Enferm 40, e20180233.
Mei, J.Y., Afshar, Y., Gregory, K.D., Kilpatrick, S.J., Esakoff, T.F., 2016. Birth Plans: What Matters for Birth Experience Satisfaction. Birth 43 (2), 144–150.
Mirghafourvand, M., Mohammad Alizadeh Charandabi, S., Ghanbari-Homayi, S., Jahangiry, L., Nahaee, J., Hadian, T., 2019. Effect of Birth Plans on Childbirth Experience: A Systematic Review 25 (4), e12722.
Moher, D, Liberati, A, Tetzlaff, J, Altman, DG, Group, The PRISMA, 2009. Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The Prisma Statement. PLoS Med 6 (6), e1000097. doi:10.1371/journal.pmed1000097.
Morton, C.H., Simkin, P., 2019. Can Respectful Maternity Care Save and Improve Lives? Birth 46 (3), 391–395.
Nilsson, L., Thorsell, T., Hertfelt Wahn, E., Ekstrom, A., 2013. Factors Influencing Positive Birth Experiences of First-Time Mothers. Nurs Res Pract 2013, 349124.
Owens, K.H., 2009. Confronting Rhetorical Disability: A Critical Analysis of Women's Birth Plans. Written Communication 26 (3), 247–272.
Patterson, J., Hollins Martin, C., Karatzias, T., 2019. Ptsd Post-Childbirth: A Systematic Review of Women's and Midwives' Subjective Experiences of Care Provider Interaction. J Reprod Infant Psychol 37 (1), 56–83.
Peart, K., 2004. Birth Planning – Is It Beneficial to Pregnant Women? Australian Midwifery 17 (1), 27–29.
Preis, H., Lobel, M., Benyamini, Y., 2018. Between Expectancy and Experience: Testing a Model of Childbirth Satisfaction. Psychology of Women Quarterly 43 (1), 105–117.
Reed, R., Sharman, R., Inglis, C., 2017. Women's Descriptions of Childbirth Trauma Relating to Care Provider Actions and Interactions. BMC Pregnancy Childbirth 17 (1), 21.
Regan, M., McElroy, K.G., Moore, K., 2013. Choice? Factors That Influence Women's Decision Making for Childbirth'. J Perinat Educ 22 (3), 171–180.
Sanders, R.A., Crozier, K., 2018. How Do Informal Information Sources Influence Women's Decision-Making for Birth? A Meta-Synthesis of Qualitative Studies. BMC Pregnancy Childbirth 18 (1), 21.
Simkin, P., 2007. Birth Plans: After 25 Years, Women Still Want to Be Heard. Birth 34 (1), 49–51.
Soriano-Vidal, F.J., Vila-Candel, R., Soriano-Martin, P.J., Tejedor-Tornero, A., Castro–Sanchez, E., 2018. The Effect of Prenatal Education Classes on the Birth Expectations of Spanish Women. Midwifery 60, 41–47.
Suarez-Cortes, M., Armero-Barranco, D., Canteras-Jordana, M., Martinez-Roche, M.E., 2015. Use and Influence of Delivery and Birth Plans in the Humanizing Delivery Process. Rev Lat Am Enfermagem 23 (3), 520–526.
Veritas Health Innovation. 'Covidence Systematic Review Software', (Ed.)^(Eds.), Available at www.covidence.org.
Villarmea, S., Kelly, B., 2020. Barriers to Establishing Shared Decision-Making in Childbirth: Unveiling Epistemic Stereotypes About Women in Labour. J Eval Clin Pract 26 (2), 515–519.
Welsh, J.V., Symon, A.G., 2014. Unique and Proforma Birth Plans: A Qualitative Exploration of Midwives Experiences. Midwifery 30 (7), 885–891.
Westergren, A., Edin, K., Lindkvist, M., Christianson, M., 2020. Exploring the Medicalisation of Childbirth through Women's Preferences for and Use of Pain Relief. Women Birth.
Westergren, A., Edin, K., Walsh, D., Christianson, M., 2019. Autonomous and Dependent-the Dichotomy of Birth: A Feminist Analysis of Birth Plans in Sweden. Midwifery 68, 56–64.
White-Corey, S., 2013. Birth Plans: Ticket to the Or? MCN 38 (5), 268–273.
Alliance, White Ribbon, 2011. Respectful Maternity Care: The Universal Rights of Childbearing Women. White Ribbon Alliance (Ed.)^(Eds.).
Whitford, H.M., Entwistle, V.A., van Teijlingen, E., Aitchison, P.E., Davidson, T., Humphrey, T., Tucker, J.S., 2014. Use of a Birth Plan within Woman-Held Maternity Records: A Qualitative Study with Women and Staff in Northeast Scotland. Birth 41 (3), 283–289.
Whittemore, R., Knafl, K., 2005. The Integrative Review: Updated Methodology. J. Adv. Nurs. 52 (5), 546–553.
WHO Reproductive Health Library, 2018. Who Recommendation on Effective Communication between Maternity Care Providers and Women in Labour (February 2018). World Health Organization (Eds.).
Yuill, C., McCourt, C., Cheyne, H., Leister, N., 2020. Women's Experiences of Decision-Making and Informed Choice About Pregnancy and Birth Care: A Systematic Review and Meta-Synthesis of Qualitative Research. BMC Pregnancy Childbirth 20 (1), 343.