

Birth Plan: knowledge among postpartum women admitted to two reference maternity hospitals in a municipality in Paraná

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ABSTRACT

Objectives: to analyze the knowledge of postpartum women assisted in two maternity hospitals in Paraná, Brazil, regarding the Birth Plan. **Methods:** field-based, exploratory-descriptive research conducted in two maternity hospitals in Paraná. Data collection employed a questionnaire containing closed-ended questions designed to obtain sociodemographic information and to assess participants' understanding of the Birth Plan and their preferences. **Results:** the study included a total of 210 postpartum women, predominantly aged 26–35 years (43.3%), identified as White (60.0%), homemakers (41.0%), and with high-risk pregnancies (55.2%). Most postpartum women showed no knowledge about the topic, reporting being unaware of what a Birth Plan is (76.2%), not using the document due to lack of knowledge (67.1%), or lacking information (19.0%) during prenatal care. **Conclusion:** the vast majority of postpartum women were unfamiliar with the Birth Plan, even though it is a crucial document that enables women's freedom of choice and the expression of their preferences during childbirth.

Descriptors: Parturition; Obstetric Delivery Planning; Prenatal Care; Humanization of Assistance; Nursing Care.

INTRODUCTION

The origin of the Birth Plan (BP) dates back to the 1980s⁽¹⁾, aiming to foster better relationships between pregnant women and health professionals, thereby aiding decision-making, risk assessment, and developments in the childbirth process. Since its inception, the BP has gradually gained prominence in Western countries, bolstering female empowerment, enhancing care for the mother-fetus dyad, and receiving endorsement from the World Health Organization (WHO)⁽²⁾. The BP constitutes a document that the pregnant woman and her partner can draft and present to the health team providing care to that family unit, or it can be jointly developed with professionals delivering prenatal services⁽³⁾; regardless of its preparation method, it must capture the women's preferences, expectations, and fears concerning their own birthing process⁽¹⁾. Joint preparation of the BP by the pregnant woman and a health professional yields positive outcomes^(3,4).

Elaboration and discussion of the BP during prenatal care prove essential, since this document facilitates priority setting from the woman's viewpoint, thereby averting unnecessary practices and procedures that heighten risks to the pregnant woman and newborn. Similarly, it encourages partner involvement in its creation and attendance at prenatal consultations throughout pregnancy, while boosting the woman's confidence through a sense of support during key childbirth moments⁽⁵⁾.

In the care process, the nurse plays a pivotal role in guiding and developing the BP, thereby establishing a partnership that strengthens the bond and trust between professional and pregnant woman. Furthermore, this document enables deeper in-

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sight into the patient's needs and preferences, allowing nurses to properly guide pregnant women and their partners, rendering them empowered, respected, and motivated to seek specialized care. In this context, nurses must schedule health education sessions during prenatal care to address doubts from both pregnant women and their partners⁽⁶⁾.

From the perspective of ensuring safe prenatal care, the Program for Comprehensive Women's Health Care (In Portuguese: Programa de Assistência Integral à Saúde da Mulher, PAISM) highlighted policies on female empowerment concerning rights over their bodies, independence, and choices in gestation and contraceptive methods. PAISM implementation in 1984 marked a vital milestone for women, introducing health principles and rights while integrating education, prevention, and treatment activities through care actions focused on prenatal services, labor, postpartum period, family planning, prevention, and treatment of sexually transmitted infections (STIs), breast cancer, and cervical cancer^(7,8).

To reinforce women's rights outlined in PAISM, Federal Law No. 11.108 took effect on September 19, 1990, mandating that health services allow a companion's presence throughout labor, birth, and immediate postpartum⁽⁹⁾. This regulation substantially improved care for women during these critical moments, benefiting both the pregnant woman and the fetus.

Although these advances emerged in the 1980s and 1990s, the medical landscape with surgical techniques had already become firmly entrenched in Brazilian society's cultural context. This trend reduced the incidence of natural/physiological births due to cesarean section characteristics, which offer painless and rapid delivery alongside scheduling flexibility for the procedure.

To restore emphasis on natural/physiological birth and expand women's care access, PAISM evolved in 2004 into the National Policy for Comprehensive Women's Health Care (In Portuguese: Política Nacional de Atenção Integral à Saúde das Mulheres, PNAISM), which established integrated actions for disease and harm prevention, health promotion, and recovery, aiming to promote comprehensive female health care, advance empowerment, and autonomy in health-related decisions within social, community, or political spheres⁽⁶⁾. Since then, PNAISM has contributed to lowering women's morbidity and mortality while elevating care quality and humanization for this population⁽¹⁰⁾.

Within PNAISM⁽⁶⁾, the Birth Plan (BP) finds inclusion, and its implementation during prenatal care holds utmost relevance for planning care delivered to pregnant women, as it promotes women's autonomy, encourages selection of birth type (physiological or surgical), fosters empowerment and agency among these patients during labor (L), and consequently heightens their safety while diminishing trauma. Additionally, it ensures birthing women's choice options and preferences during labor (L), such as ingesting fluids and food, birthing positions, companion presence, newborn-related actions, and non-pharmacological pain relief methods^(11,12).

From these considerations, the importance of BP elaboration and use by pregnant women and their partners, along with its ap-

plication in Primary Health Care prenatal consultations, becomes clear, particularly so nurses can deliver tailored care to each family unit. Despite its significance, no mapping exists regarding its use in Brazilian municipalities. Thus, the following question arose: Is the Birth Plan elaborated and discussed with pregnant women during prenatal care at reference maternity hospitals in the state of Paraná, Brazil?

To address this research question, the present study aimed to analyze knowledge of postpartum women with habitual and high-risk pregnancies, assisted at two maternity hospitals in the state of Paraná, Brazil, concerning the birth plan.

METHODS

This study constitutes field, exploratory-descriptive research with a quantitative approach, conducted at two public reference maternity hospitals for habitual and high-risk cases.

Postpartum women assisted at these maternity hospitals during the immediate postpartum period qualified for inclusion. The study excluded postpartum women not registered in the *Rede Mãe Paranaense* Program.

Data collection took place between June and August 2023 through individual and private approaches, during which researchers administered a questionnaire developed based on scientific articles, manuals, guidelines, standards, and legislation found on the Scientific Electronic Library Online (SciELO) platform and the Virtual Health Library (acronym in Portuguese, BVS). The questionnaire with closed-ended questions included sociodemographic variables (age, skin color, schooling, family income, marital status, profession, religion); obstetric and prenatal data (gestational history, number of children, prenatal care attendance, number of consultations, gestational age at prenatal initiation, participation in pregnant women's groups, abortion occurrence, complications during previous births, gestational risk, personal history, and family history); knowledge about Birth Plan (BP): what BP means, Companion Law, Doula Law, participation in pregnant women's groups; BP elaboration, who informed and guided about BP, difficulties encountered during BP elaboration, and reasons for not elaborating BP (if applicable).

Data entry occurred in an Excel[®] spreadsheet (version 16.0, 2019, Microsoft Corporation, United States). Subsequently, analysis involved absolute and relative frequency distributions using the Statistical Package for the Social Sciences - SPSS (version 25.0, 2007, International Business Machines Corporation, United States).

The research received approval from the Human Research Ethics Committee (CEPEH) of the Universidade Paranaense (UNIPAR), under Certificate of Presentation for Ethical Appraisal (CAAE) No. 69894023.7.0000.0109.

RESULTS

The study included 210 postpartum women with habitual and high-risk pregnancies, showing prevalence in the 26–35 years

age range (43.3%), self-reported white skin color (60.0%), married marital status (65.7%), family income from one to two minimum wages (40.5%), complete high school education (44.8%), homemaker occupation (41.0%), and Catholic religion (69.0%), as described in Table 1.

In relation to gestational characteristics, 31.0% had one to two pregnancies, gave birth to one to two children (59%); 71.0% never experienced abortion; 52.9% reported unplanned pregnancy; 97.6% attended prenatal consultations, of which 94.3% completed six or more consultations; 82.4% initiated prenatal care at gestational age < 12 weeks; and 55.2% of postpartum

women had their last pregnancy classified as high risk, as described in Table 2.

Most postpartum women lacked knowledge about BP (76.2%) and the Doula Law (78.1%), whereas 52.4% knew the Companion Law; a significant portion of pregnant women (76.2%) did not participate in pregnant women's groups and did not elaborate BP (96.2%). Among the latter, 67.1% reported a lack of information about the document. Of those who reported elaborating BP (3.8%), 50.0% received guidance from nurses, and 37.5% completed the document independently. All who completed BP reported no difficulties in its elaboration, as described in Table 3.

Postpartum women's preferences regarding the birthing process, with frequency > 75.0%, included freedom of movement and hydration (76.2%), use of non-pharmacological methods for pain

Table 1 - Sociodemographic profile of postpartum women in immediate postpartum period (n = 210) at two maternity hospitals in Southwestern Paraná, Brazil, 2023

Variables	n	%
Age (years old)		
18 – 25	86	41.0
26 – 35	91	43.3
> 35	33	15.7
Self-reported skin color		
White	126	60.0
Black/Brown	84	40.0
Marital status		
Single	72	34.3
Married	138	65.7
Family income (minimum wages)		
≤ 1	63	30.0
1 – 2	85	40.5
3 – 4	55	26.2
> 5	7	3.3
Schooling		
Incomplete elementary school	8	3.8
Complete elementary school	27	12.9
Complete high school	94	44.8
Incomplete high school	35	16.7
Complete higher education	16	7.6
Incomplete higher education	30	14.2
Profession/occupation		
Homemaker	86	41.0
Seamstress	15	7.1
General Services	10	4.8
Farmer	9	4.3
Others	90	42.9
Religion		
Catholic	145	69.0
Evangelical	50	23.8
No religion	11	5.2
Others	4	2.0

Table 2 - Obstetric characteristics of postpartum women in immediate postpartum period (n = 210) at two maternity hospitals in Southwestern Paraná, Brazil, 2023

Variables	n	%
Number of pregnancies		
One	65	31.0
Two	65	31.0
Three	39	18.6
Four or more	41	19.4
Parity		
No children	35	16.7
One to two children	124	59.0
Three or more	51	24.3
Abortion		
None	149	70.9
One	52	24.8
Two or more	9	4.3
Was the pregnancy planned?		
Yes	99	47.1
No	111	52.9
Attended prenatal care?		
Yes	205	97.6
No	5	2.4
Number of prenatal consultations?		
Less than 6	12	5.7
6+	198	94.3
Gestational age at prenatal initiation (weeks)		
< 12	173	82.4
12 – 24	30	14.3
24	7	3.3
Gestational risk		
Habitual	65	31.0
Mean	29	13.8
High risk	116	55.2

relief (84.3%), fetal heart auscultation (84.3%), skin-to-skin contact with the baby (92.4%), breastfeeding immediately after birth (91.0%), being informed about baby care procedures (95.7%), companion staying with the baby (95.2%), and participating in the baby's first bath (85.7%) (Table 4).

Conversely, lower occurrences involved dimming lights (33.8%), awaiting membrane rupture (45.7%), avoiding episiotomy (53.8%), and awaiting umbilical cord pulsation cessation before clamping (47.6%) (Table 4).

Most had no opportunity to record preferences (93.8%). When asked about the word summarizing their greatest desire for birth and baby's delivery, 15.7% responded "health and happiness" (Table 4).

Table 3 - Knowledge of postpartum women in the immediate postpartum period (n = 210) about the Birth Plan at maternity hospitals in a municipality in Southwestern Paraná, Brazil, 2023

Variables	n	%
Knows what is		
Birth Plan?		
Yes	50	23.8
No	160	76.2
Companion law?		
Yes	110	52.4
No	100	47.6
Doula law?		
Yes	46	21.9
No	164	78.1
Participated in a pregnant women's group?		
Yes	50	23.8
No	160	76.2
Elaborated Birth Plan?		
Yes	8	3.8
No	202	96.2
If elaborated, who guided you?		
Nurses	4	50.0
Physician	3	37.5
Media (internet-newspapers-television)	1	12.5
If elaborated, who helped elaborate the Birth Plan?		
No one	3	37.5
Partner	2	25.0
Friends/family	1	12.5
Health professionals	2	25.0
If elaborated, experienced difficulty elaborating the Birth Plan?		
No	8	3.8
Reason for not elaborating Birth Plan during prenatal care:		
Lack of information	141	67.1
Lack of knowledge	40	19.0
Did not want to	16	7.6
Others	5	2.5

Table 4 - Preferences of postpartum women in the immediate postpartum period (n = 210) at two maternity hospitals in a city in Southwestern Paraná regarding the birthing process, Brazil, 2023

Postpartum woman's preferences	n	%
Freedom of movement		
Yes	150	71.4
No	60	28.6
Freedom of movement and hydration		
Yes	160	76.2
No	50	23.8
Dimming lights		
Yes	71	33.8
No	139	66.2
Await membrane rupture		
Yes	96	45.7
No	114	54.3
Avoid episiotomy		
Yes	113	53.8
No	97	46.2
Minimum vaginal examinations		
Yes	134	63.8
No	76	36.2
Medication administration upon explanation and approval		
Yes	154	73.3
No	56	26.7
Auscultate the baby's heart		
Yes	177	84.3
No	33	15.7
Use of non-pharmacological pain relief methods*		
Yes	177	84.3
No	33	15.7
Skin-to-skin contact with the baby		
Yes	194	92.4
No	16	7.6
Await cord pulsation cessation before clamping		
Yes	100	47.6
No	110	52.4
Breastfeed baby immediately after birth		
Yes	191	91.0
No	19	9.0
Informed and clarified about baby procedures		
Yes	201	95.7
No	9	4.3
First examinations on the lap or nearby		
Yes	155	73.8
No	55	26.2
Companion staying with the baby		
Yes	200	95.2
No	10	4.8
Participate in the baby's first bath		
Yes	180	85.7
No	30	14.3
Record of preferences		
Had record	13	6.2
No record	197	93.8
Words representing desire for birth/baby's delivery?		
Health and happiness	33	15.7
Love	25	11.9
Tranquility	20	9.5
Health and love	12	5.7
Others	120	57.8

Note: *Massage, shower, relaxation with ball, deep breathing, among others.

DISCUSSION

The lack of information and knowledge about the Birth Plan reported by a substantial proportion of postpartum women cared for in reference maternity hospitals indicates possible weaknesses in health professionals' understanding of BP relevance, or insufficient appreciation of its use as a tool for female empowerment, resulting in violation of rights to active participation in pregnancy and childbirth.

This scenario underscores the need to revise continuing education policies in health within municipal service networks that assist pregnant women, parturients, and postpartum women, as well as to create quality indicators for prenatal and childbirth care that include Birth Plan elaboration and use.

Elaborating BP during prenatal care can strengthen the quality of care on both individual and collective levels, providing women with calm and effective experiences that contribute to safe, natural/physiological birth, with a humanized approach and without unnecessary interventions.

Preparing BP is a woman's right and a tool available to facilitate communication between health team members and pregnant women, highlighting their preferences and choices regarding obstetric interventions. Therefore, during labor, women must receive information about procedures planned for their care and, whenever applicable, their consent must be obtained⁽¹³⁾.

The primary purpose of BP is to safeguard women's choices concerning childbirth practices and to prevent obstetric violence, that is, behaviors by health professionals during reproductive care based on interventionist actions, unjustified medication use, and omission of care⁽¹⁴⁾.

The sociodemographic profile in this study, with predominance of White, Catholic, married women with family income from one to two minimum wages and a complete high school education, reflects typical characteristics of Paraná, located in Southern Brazil^(15,16).

Predominance of homemakers may be explained by the city's profile, an inland municipality with approximately 100,000 inhabitants, although it is the most populous city in Southwestern Paraná. This setting may more clearly express Brazil's historical cultural pattern in which women traditionally assumed the role of home caregivers, while men were responsible for financial provision⁽¹⁵⁾.

Within the framework of Law No. 9.263 of January 12, 1996⁽¹⁷⁾, family planning comprises a set of health, information, and support actions that promote free choice by individuals, couples, and families regarding the timing and number of children. Although these actions were officially implemented in Brazil in the 1990s, mean number of children per woman has declined since the 1960s, with projections of 1.5 children per woman by 2030, below the recommended replacement level⁽¹⁸⁾, a pattern aligned with this study, in which postpartum women reported having one or two children, yet even those experiencing a second birth stated not knowing what BP is and not using this tool.

Most postpartum women reported unplanned pregnancy, which may have significant clinical implications for both mother and

baby, since such a condition relates to a higher incidence of complications during pregnancy⁽¹⁹⁾, reinforcing BP relevance.

In this study, most pregnant women attended six or more consultations, with the first visit before 12 weeks, in line with recommendations by the Brazilian Ministry of Health set forth in Ordinance No. 569 of June 1, 2000, which stipulates at least six prenatal consultations during pregnancy, one in the first trimester, two in the second, and three in the third⁽²⁰⁾. Thus, there were at least six opportunities to present BP to these women, which apparently did not occur in the context studied; lack of information about BP was the main reason cited for non-use, a situation also reported in studies⁽⁸⁾ from different Brazilian regions, including a study in Pernambuco, Northeastern Brazil, where 91.1% of 203 postpartum women reported receiving guidance about BP⁽²¹⁾.

Gestational risk stratification by physicians or nurses must begin at prenatal initiation and be duly recorded in medical records and maternal booklets, in order to ensure appropriate and specialized care and hence contribute to reduced maternal, fetal, and neonatal mortality⁽²²⁾.

Nurses play an essential role in guiding women during prenatal care through detailed consultations and joint BP elaboration, as BP use is directly associated with empowerment, greater satisfaction with childbirth experiences, and improved communication between professionals and users⁽⁶⁾.

Primary Care nursing is responsible for promoting and applying pregnant women's knowledge about BP; however, this knowledge-building process is not being effectively implemented or, when applied, proves ineffective, with insufficient emphasis during prenatal consultations, as evidenced by the low percentage of women (3.8%) who elaborated on BP.

A study with 15 nurses working in the Family Health Strategy (In Portuguese, *Estratégia Saúde da Família*, ESF) in Rio Grande do Sul revealed a lack of knowledge or misconceptions about BP, often restricting it to prenatal care and disconnecting it from the childbirth process⁽²³⁾.

Law No. 11.108/2005 guarantees pregnant women the right to one companion, regardless of doula presence, yet slightly more than half of this study's participants were unaware of that right. The companion freely chosen by women promotes safety and comfort, in addition to supporting good practices in care for this group⁽⁹⁾.

Municipal Law No. 4.517 of October 6, 2017, in Francisco Beltrão, ensures the right to doula presence during labor, childbirth, and immediate postpartum in maternity units, birth centers, and hospital environments in public and private networks whenever requested by parturients⁽²⁴⁾; although this law supports doula participation, 78.1% of interviewees were unaware of this regulation or its implications for their particular situation⁽²⁵⁾.

Regarding postpartum women's preferences, freedom to move and hydrate during labor and birth relates to reduced pain perception, dystocia, and surgical interventions, thereby increasing the likelihood of vaginal birth and enhancing women's sense of control over their bodies⁽²⁶⁾. Recognition of these practices by

postpartum women reflects both their level of knowledge and the influence of educational actions during prenatal care and intrapartum assistance, pointing to the need to strengthen institutional policies that guarantee structural and professional conditions for effective implementation⁽²⁶⁾.

As for dimming ambient lights during labor to promote comfort, 66.2% of participants reported not desiring this measure, likely due to a lack of information about benefits of a dim environment during childbirth. Excess light activates the neocortex, the brain region responsible for rational thought, so creating a comfortable, private, and low-light setting may be crucial to support childbirth physiology and promote well-being⁽²⁷⁾.

Episiotomy, a procedure used during vaginal birth since the eighteenth century, constitutes obstetric violence when performed without patients' consent⁽²⁸⁾; in this study, 53.8% of participants preferred not to undergo episiotomy. Episiotomy should only occur with informed consent and under specific circumstances, yet it remains routine in many maternity services, often without appropriate approval⁽²⁹⁾.

Unnecessary episiotomy can cause lasting harm beyond childbirth, including persistent pain, dyspareunia, bleeding, local inflammation, and late-postpartum psychological repercussions such as shame, embarrassment, and impaired maternal experience, so when analyzing postpartum women's knowledge about BP, clear inclusion of information on episiotomy and its indications becomes crucial to promote informed choices, strengthen female autonomy, and prevent experiences of disrespect and obstetric violence⁽²⁸⁾.

Another frequently reported preference involved limiting digital vaginal examinations to those strictly necessary for safe assessment of labor progression; while recommended by the Brazilian Ministry of Health, these examinations can be unpleasant, invasive, and embarrassing, infringing on privacy and potentially triggering physical and emotional discomfort⁽²⁹⁾.

Within analyses of BP knowledge, recognizing the need to limit vaginal examinations is essential, since BP offers women a means to clearly express preferences and foster practices aligned with evidence-based care and respect for individual needs, thus serving as a strategic tool to prevent abusive interventions and strengthen communication⁽²⁹⁾.

In relation to preference for fetal heart auscultation, this practice began in the 1960s to evaluate fetal heart rate and uterine activity during labor and remains a principal method for assessing fetal cardiac activity in utero, together with fetal movements and uterine contractions as key health indicators⁽³⁰⁾, thereby enhancing women's confidence in fetal well-being as labor progresses.

For pain relief during labor, options such as ambulation, shower baths, exercise with balls, and similar techniques are recommended by the World Health Organization due to their multiple benefits, including greater pain control and comfort for most women⁽³¹⁾.

Skin-to-skin contact and early breastfeeding immediately after birth offer several advantages for newborns, including more effective first feeding with better sucking. Prolonged skin-to-skin

contact during breastfeeding in the first four months after birth fosters positive attachment and affective bonding, alongside feelings of happiness, love, calm, and comfort for both mother and baby⁽³²⁾.

The low indication of preference for delayed umbilical cord clamping until pulsation ceases likely stems from insufficient information about its benefits, a gap that can be addressed through prenatal guidance. Delayed clamping enables placental blood transfer to the newborn and may increase neonatal iron stores by up to 50%⁽³³⁾.

Parturients remain constantly vigilant about their newborns and want to know their health status and all procedures performed; screening such as heel prick, hearing, eye, tongue, and heart tests play a crucial role by identifying potential conditions that may affect development⁽³⁴⁾, and nurses must offer explanations and facilitate timely completion.

Preference for companion presence next to the baby, expressed by 95.2% of participants, may relate to the need for support in postpartum self-care and newborn care⁽³⁵⁾.

Preference to perform the first baby bath, reported by 85.7% of participants, may signal a desire for mutual affective exchange between mother and baby. According to WHO recommendations, first bathing should be delayed for at least twenty-four hours after birth, allowing extended skin contact with the mother and reducing the risk of hypothermia⁽³⁶⁾.

When mothers were asked which word summarized their greatest wish for childbirth and baby's birth, "health and happiness" predominated; pregnancy is a unique, often eagerly anticipated period, involving physical and psychological transformations, and parents' emotions at birth are frequently described as profound happiness and enchantment⁽³⁷⁾, underscoring the need for nurses to support fulfillment of this desire through birth planning with women during prenatal care.

Scientific literature on BP remains scarce, which may have limited discussion, yet this does not diminish emphasis on BP applicability in clinical obstetric practice in both public and private services. Further studies are recommended on pregnant women's and professionals' knowledge about BP, including elaboration processes, use, and impact on childbirth experiences.

CONCLUSION

Reports from a substantial proportion of postpartum women regarding lack of knowledge about BP and failure to elaborate or use it reveal possible weaknesses in multidisciplinary care during prenatal services in Primary Health Care and in maternity settings, since women's preferences were not investigated in those contexts.

Most women demonstrated a lack of information on this topic, regardless of gestational risk, which compromises health promotion and prevention of complications during care delivery in childbirth, and undermines their empowerment during labor and birth.

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NAN: conceptualization; data curation; investigation; methodology; resources; validation; writing – original draft and writing – review and editing.

NCSB: investigation; methodology; validation; writing – original draft and writing – review and editing.

AP: investigation; methodology; validation; writing – original draft and writing – revision and editing.

GPB: investigation; methodology; validation; writing – original draft and writing – revision and editing.

LRS: investigation; methodology; validation; writing – original draft and writing – revision and editing.

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FCR: conceptualization; formal data analysis; investigation; methodology; validation; and writing – review and editing.

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Conflict of interest

None.