



WOMEN'S KNOWLEDGE, SKILLS, AND ATTITUDES REGARDING THE BIRTH PLAN: A QUALITATIVE STUDY

CONHECIMENTOS, HABILIDADES E ATITUDES DE MULHERES SOBRE O PLANO DE PARTO: ESTUDO QUALITATIVO

CONOCIMIENTOS, HABILIDADES Y ACTITUDES DE LAS MUJERES SOBRE EL PLAN DE PARTO: ESTUDIO CUALITATIVO

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RESUMO

Objetivo: Compreender as mudanças percebidas nos conhecimentos, habilidades e atitudes de mulheres em relação ao plano de parto após participação em uma intervenção educativa. **Método:** Estudo qualitativo com intervenção educativa, realizado com mulheres em um município da Fronteira Oeste do Rio Grande do Sul, entre julho de 2023 e abril de 2024. A intervenção educativa abordou o plano de parto. A coleta de dados deu-se por meio de entrevistas semiestruturadas pré e pós-intervenção e diário de campo. Os dados foram submetidos à análise de conteúdo temática. **Resultados:** No momento pré-intervenção, evidenciou-se desconhecimento das participantes acerca do plano de parto e das rotinas da assistência obstétrica. Após a intervenção, observou-se ampliação dos conhecimentos, desenvolvimento de habilidades relacionadas à reflexão crítica e tomada de decisão, bem como atitudes mais favoráveis ao protagonismo e à autonomia no processo de parturição. Apesar disso, nenhuma participante utilizou o plano de parto durante a internação hospitalar. **Conclusão:** Conclui-se que os achados evidenciam que mesmo com a elaboração do Plano de Parto e o fortalecimento do conhecimento das gestantes, não foi possível modificar o cenário obstétrico no âmbito hospitalar.

Descritores: Obstetrícia; Parto; Plano de Parto; Saúde da Mulher; Trabalho de Parto.

ABSTRACT

Objective: To understand perceived changes in women's knowledge, skills, and attitudes regarding the birth plan after participating in an educational intervention. **Method:** Qualitative study involving an educational intervention, conducted with women in a municipality in the Western Border region of Rio Grande do Sul, Brazil, between July 2023 and April 2024. The educational intervention addressed the birth plan. Data were collected through pre- and post-intervention semi-structured interviews and a field diary. The data were subjected to thematic content analysis. **Results:** Before the intervention, participants showed limited knowledge of the birth plan and obstetric care routines. After the intervention, increased knowledge, development of skills related to critical reflection and decision-making, and attitudes more favorable to women's agency and autonomy during childbirth were observed. Nevertheless, none of the participants used the birth plan during hospitalization. **Conclusion:** The findings show that, even with the development of a Birth Plan and strengthened knowledge among pregnant women, it was not possible to change the hospital obstetric care context.

Descriptors: Obstetrics; Childbirth; Birth Plan; Women's Health; Labor.

RESUMEN

Objetivo: Comprender los cambios percibidos en los conocimientos, habilidades y actitudes de las mujeres en relación con el plan de parto tras participar en una intervención educativa. **Método:** Estudio cualitativo con intervención educativa, realizado con mujeres en un municipio de la Frontera Oeste de Rio Grande do Sul, Brasil, entre julio de 2023 y abril de 2024. La intervención educativa abordó el plan de parto. Los datos se recopilaban mediante entrevistas semiestructuradas pre y posintervención y un diario de campo. Los datos fueron sometidos a análisis de contenido temático. **Resultados:** En el momento preintervención, las participantes mostraron un conocimiento limitado sobre el plan de parto y las rutinas de la atención obstétrica. Tras la intervención, se observó una ampliación de los conocimientos, el desarrollo de habilidades relacionadas con la reflexión crítica y la toma de decisiones, así como actitudes más favorables al protagonismo femenino y a la autonomía durante el parto. No obstante, ninguna de las participantes utilizó el plan de parto durante la hospitalización. **Conclusión:** Los hallazgos muestran que, aun con la elaboración del Plan de Parto y el fortalecimiento de los conocimientos de las gestantes, no fue posible modificar el contexto de la atención obstétrica hospitalaria.

Descriptores: Obstetricia; Parto; Plan de Parto; Salud de la Mujer; Trabajo de Parto.

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What is already known:

- The birth plan is recommended by national and international guidelines as a tool for communication, autonomy, and the protection of rights in childbirth care.
- Evidence associates the use of a birth plan with greater satisfaction, women's empowerment, and more positive childbirth experiences.
- Despite these recommendations, the birth plan remains poorly known and underused in Brazilian health services, by both pregnant women and health professionals.

What this article adds:

- Prenatal educational interventions increase women's knowledge, develop skills, and strengthen attitudes that support autonomy regarding the birth plan.
- Even without formally using the birth plan, women demonstrated greater agency and a greater ability to express their preferences during childbirth.
- The limited incorporation of the birth plan reveals institutional and professional gaps that restrict its effective use in obstetric practice.

INTRODUCTION

Over time, the childbirth experience has undergone major transformations. Initially assisted by traditional midwives in the home setting, childbirth was regarded as a physiological event characterized by safety and supportive care. From the mid-20th century onward, scientific and technological advances led to its progressive institutionalization, with increasingly interventionist and medicalized characteristics focused on controlling obstetric risks and complications⁽¹⁾.

This model of care contributed to reducing women's agency and to the adoption of practices that often disregarded women's needs and preferences. In response, social movements and institutional initiatives began to advocate a new care paradigm grounded in evidence-based practices, respect for women's autonomy, and humanized care. In this context, notable initiatives include the World Health Organization (WHO) document *Care in Normal Birth: A Practical Guide*, published in 1996⁽²⁾, the Prenatal and Birth Humanization Program⁽³⁾, and Rede Alyne, launched in 2024 as a restructuring of Rede Cegonha within the Brazilian Unified Health System (SUS)⁽⁴⁾.

Strategies aimed at improving the quality of labor and childbirth care include health education activities, informative prenatal care, the presence of a companion, respect for freedom of position, encouragement of skin-to-skin contact, and development of a birth plan (BP). Educational activities promote the development of knowledge, skills, and attitudes, helping reduce uncertainty and empowering women throughout pregnancy and childbirth⁽⁵⁾.

The BP is recognized as a useful tool and is recommended by the WHO because it facilitates communication between women and health professionals and supports informed decision-making. It is a legally relevant document, preferably developed during prenatal care, in which the pregnant woman expresses her preferences, expectations, and values regarding labor, childbirth, and birth^(2,6). Its development may be facilitated by health professionals, especially nurses and physicians, thereby strengthening the therapeutic relationship and the woman's active participation in care⁽⁷⁾.

Among the settings that favor development of the BP, Primary Health Care (PHC) stands out because it provides continuous follow-up of pregnant women throughout prenatal care. PHC supports the development of relationships between women and health professionals, thereby fostering women's empowerment. It is therefore a strategic setting in

which to encourage, guide, and support the individualized and participatory development of the BP⁽⁶⁻⁷⁾.

The National Guidelines for Care in Normal Birth recommend that the BP be discussed with the woman while taking institutional conditions and resource availability into account. Evidence indicates an association between BP use and greater satisfaction, empowerment, and improved childbirth experience⁽⁷⁻⁸⁾.

In this context, nursing plays a key role in developing the BP. Prenatal nursing consultations are privileged settings for health education, supportive care, and strengthening pregnant women's autonomy, enabling discussion of their rights, preferences, and expectations regarding labor and childbirth. Thus, the BP can serve as an important educational and care tool, supporting nursing practice centered on each woman's individuality and improving the quality of prenatal care⁽⁶⁻⁸⁾.

Despite these recommendations, implementation of the BP remains limited in Brazilian health services. Studies indicate a lack of knowledge or only superficial understanding of the document among both pregnant women and health professionals, as well as negative perceptions regarding its use, which contributes to low uptake in obstetric practice⁽⁹⁻¹²⁾.

In light of these frameworks, the effective use of the BP is understood to depend not only on the provision of information but also on the integrated strengthening of the knowledge, skills, and attitudes of women and health professionals involved in care. From this perspective, knowledge corresponds to a set of information assimilated and organized by the individual, allowing reality to be understood. Skill refers to knowing how to act, that is, the ability to apply acquired knowledge productively in concrete situations. Attitude refers to the willingness to know how to act and involves social, affective, and value-based aspects that guide behavior in relation to care practices. Accordingly, consolidating the BP as a tool for improving the quality of obstetric care requires the integrated development of these three dimensions, since knowing about the document alone does not guarantee its development, use, or advocacy within care settings⁽¹³⁾.

This context highlights the need for educational strategies that strengthen BP use as a tool for improving the quality of prenatal and obstetric care. Accordingly, studies are needed to shed light on this prenatal education and communication tool and to support its validation as a necessary practice for improving prenatal and obstetric care. Thus, this study aimed to understand perceived changes

in women's knowledge, skills, and attitudes regarding the birth plan after participating in an educational intervention.

METHOD

This was a longitudinal qualitative study developed from an educational intervention, with data produced at two distinct time points (pre- and post-intervention), to understand changes in women's knowledge, skills, and attitudes regarding the birth plan. A qualitative approach was adopted because it enables an in-depth understanding of women's perceptions, experiences, and meanings attributed to the birth plan and to the educational process they experienced.

The study was conducted from July 2023 to April 2024 in three Family Health Strategy (FHS) units in a municipality in the Western Border region of the state of Rio Grande do Sul, Brazil. The study was linked to a university extension project focused on health education during the pregnancy-postpartum period and developed in partnership with the participating FHS units. The project aimed to promote educational activities related to pregnancy, childbirth, the postpartum period, and newborn care through educational groups, discussion circles, individual guidance, and the development of educational materials for pregnant women and their support networks. Activities were conducted monthly by a faculty member and nursing students affiliated with the university, in coordination with Primary Health Care teams. Topics addressed during the meetings included physiological changes in pregnancy, signs of labor, breastfeeding, women's rights during labor and childbirth, obstetric violence, postpartum care, and the birth plan. The educational intervention analyzed in this study was one of the activities developed within this university extension project.

Data collection for the research project occurred in two stages, corresponding to the pre- and post-intervention periods. Inclusion criteria for the first stage were: being 18 years of age or older, being registered with one of the participating FHS units, and receiving prenatal care during the data collection period. Women with verbal communication difficulties that prevented the interviews from being conducted were excluded. Discontinuation criteria were: not participating in the educational intervention, inability to establish contact during the postpartum period, or failure to complete the post-intervention interview.

Participants were included intentionally and progressively according to availability and fulfillment of eligibility criteria. The number of participants was determined according to the criterion of theoretical data saturation⁽¹⁴⁾, understood as the point at which accounts began to show thematic recurrence and no new elements relevant to the study objectives emerged. During the preliminary analysis of the pre-intervention interviews, repeated content was observed regarding lack of knowledge about the birth plan, questions about rights during childbirth, and perceptions of autonomy in the childbearing process. Theoretical saturation was therefore considered to have been reached with ten pregnant women. There were no refusals or withdrawals during data collection.

The study participants had not previously belonged to

a fixed or ongoing group within the university extension project. Recruitment took place during routine activities at the participating FHS units, which were open to pregnant women receiving care at these health services. Previous participation in other educational activities of the project was not an inclusion criterion. In addition, at the pre-intervention stage, participants showed limited or no knowledge of the birth plan, indicating that they had not previously received systematic guidance on the topic under investigation.

Before data collection began, participants were informed about the study objectives and signed the Informed Consent Form (ICF). They were also informed that, after the birth of their baby, they would be invited to participate in the second stage of the study, subject to renewed consent.

At the pre-intervention stage, an individual semi-structured interview was conducted by the principal researcher in a private setting at the participating FHS units. The interviews lasted an average of five minutes and were audio-recorded with the participants' authorization.

The interview guide included questions about prior knowledge of the birth plan, previous childbirth experiences, perceptions of autonomy in the childbearing process, and expectations regarding birth. Guiding questions included: "Have you ever heard of a birth plan?", "What do you understand by a birth plan?", and "What are your expectations for childbirth?"

The educational intervention was conducted in person at the three participating FHS units. Five group educational sessions were held monthly, each lasting an average of 60 to 90 minutes. The sessions were led by the principal researcher with support from nursing students affiliated with the university extension project, who had been previously trained in the content addressed and pedagogical strategies used to ensure standardization of the intervention.

Pregnant women affiliated with the FHS units, companions, postpartum women, and members of the health team participated in the sessions. Pregnant women's participation varied across sessions according to their availability and attendance at the group activities in the units. However, none participated in more than one session.

The intervention was structured according to a guide previously developed by the research team and based on World Health Organization recommendations, the National Guidelines for Care in Normal Birth, and scientific evidence on birth plans and good obstetric practices. The program content included: I) concept, purpose, and importance of the birth plan; II) women's rights during labor, childbirth, and birth; III) obstetric violence and unnecessary practices; IV) pharmacological and non-pharmacological pain relief methods; V) freedom of position and women's agency; VI) presence of a companion; VII) skin-to-skin contact and breastfeeding in the first hour of life; VIII) development and use of the birth plan in health services.

The pedagogical strategies included interactive presentations, discussion circles, problematization of situations related to obstetric care, sharing of experiences among participants, and practical guidance on completing the birth plan. Educational materials included: a) a printed booklet developed by the project team containing information on rights during childbirth, good obstetric practices, and guid-

ance for developing the birth plan; b) a printed birth plan template containing options related to women's preferences during labor, childbirth, and the immediate postpartum period; and c) audiovisual resources accessed via QR code, including educational videos and digital materials on labor, pain relief methods, and humanized obstetric care. At the end of each session, participants received the printed materials for consultation at home and were encouraged to discuss their preferences and questions during prenatal consultations.

The educational materials used in the intervention were developed by the lead author based on World Health Organization recommendations, the National Guidelines for Care in Normal Birth, and current scientific literature on humanized childbirth care and birth plans. The materials did not undergo a formal content or appearance validation process and were used exclusively as support tools for the educational activities.

At the post-intervention stage, a new individual semi-structured interview was conducted either at the participant's home or at the FHS unit, according to her preference. The interviews were audio-recorded, lasted an average of ten minutes, and addressed experiences related to development and use of the birth plan, perceptions of autonomy, communication with health professionals, and effects of the educational intervention. Guiding questions included: "Did you develop a birth plan?", "What was that experience like?", "Did the birth plan influence your decisions during childbirth?", and "Were you able to express your preferences to health professionals?"

This interview aimed to analyze postpartum women's experiences related to development and use of the BP. The principal researcher, the participant, and the newborn were present. In addition to the interviews, a field diary was used as a complementary source to record relevant observational aspects during the educational sessions, including interactions between participants and professionals, recurring questions, spontaneous comments, and the researcher's perceptions of the intervention context.

After data collection, the audio recordings were transcribed verbatim and subjected to thematic content analysis⁽¹⁵⁾. The first stage was pre-analysis, characterized by an initial and exhaustive reading of the empirical material to promote familiarization with the data and identify elements relevant to the study objective.

Next, the material was explored through thematic coding of the interviews and field diary records, identifying meaning units related to women's knowledge, skills, and attitudes regarding the birth plan. The codes were subsequently grouped according to thematic similarity, generating the analytical categories and enabling interpretation of the findings in light of the adopted theoretical framework.

The initial analysis was conducted by the principal researcher, who was responsible for organizing and systematizing the empirical material. The thematic categories and analytical interpretations were subsequently discussed with other researchers on the research team to increase analytical rigor, reduce individual interpretive bias, and promote consensus in defining the final categories.

Data organization and analysis were performed manually, without qualitative data analysis software. Method-

ological rigor strategies included exhaustive reading of the empirical material, triangulation between interviews and the field diary, analytical discussion among researchers, and continuous return to the original data throughout the interpretive process.

To ensure anonymity, participants were identified by the letter "P" followed by an Arabic numeral. The research project was approved by the Research Ethics Committee of the local university (CAAE: 68592023.7.0000.5323). The manuscript was prepared in accordance with the Transparent Reporting of Evaluations with Nonrandomized Designs and the Consolidated Criteria for Reporting Qualitative Research to ensure greater methodological rigor and transparency in reporting nonrandomized intervention studies using a qualitative approach.

RESULTS

Pregnant women's knowledge of the Birth Plan

In the first stage of the study, corresponding to the pre-intervention period, the BP was found to be unknown to most participants (n=8). All participants reported that they had never developed a BP. The participants who stated that they knew about it reported learning about the BP from other women.

I had heard about it before, but during my first pregnancy I had not made a birth plan. (M2)

I had heard about a birth plan. Other mothers told me about it. (M4)

Most participants (n=8) stated that they believed the BP to be an effective tool for planning and experiencing childbirth. They believed that developing the document could provide calm and a sense of security.

I think that if you do not plan, you may be unprepared for childbirth. (M2)

Maybe it can provide a sense of security, but it depends a lot on each person. (M7)

I think I would feel calmer if I developed a birth plan. (M8)

During the discussion with participants in the pregnant women's group, M4, M5, and M7 reported that, in previous births, they had undergone episiotomy and the Kristeller maneuver without prior consent. Two Community Health Workers (CHWs) who were participating in the activity also reported the same experience during their own births, as recorded in the field diary.

Most questions reported by participants concerned obstetric violence, particularly episiotomy and the Kristeller maneuver. They also expressed uncertainty about their autonomy in deciding on procedures and interventions performed during labor. Participants were unaware that they could participate in decisions regarding the use of non-pharmacological pain relief methods and freedom of position during childbirth. (Field diary)

During the educational interventions, the field diary recorded questions raised by some health professionals

regarding the implementation, use, and content of the BP. (Field diary)

These findings show that women's questions concerned the routines and procedures performed throughout labor and childbirth. While the pregnant women demonstrated limited knowledge of the BP during the interviews, the field diary records also revealed questions among health professionals regarding this document.

Postpartum women's skills and attitudes in developing and using the Birth Plan

At the post-intervention stage, four postpartum women reported having developed a BP. Those who developed it stated that they became interested in the document or wanted to take care of every detail of childbirth so that it would proceed as well as possible.

I became interested in the topic [...] through that session and the handouts you gave me; they really helped me plan for when I went into labor. (M1)

I wanted to do everything properly for the birth. (M3)

I learned what a birth plan was at that meeting and became interested in making one, because in my other pregnancies I did not look into these things [...] I made the birth plan, but I was not able to use it. (M5)

Two postpartum women reported using the materials provided during the educational intervention to develop the BP. One also reported clarifying some questions during prenatal consultations, while another said that she consulted her own mother when developing her plan.

Whenever I had a question, I also checked the handouts you gave me and asked at the health center; they helped me a lot during prenatal care too. (M1)

My mother helped me a lot; she would tell me about these things. (M2)

I used those handouts you gave us to mark my choices; that made it much easier. (M5)

Most participants reported that they found it easy to develop the BP. However, one participant reported difficulty because she had no previous childbirth experience and still had questions.

I found it difficult to develop the birth plan because I did not know what childbirth was like and I had many questions. (M1)

I found it easy to develop the birth plan, but you are always worried that you might be forgetting something. (M2)

It was easy because I already had the experience of my first pregnancy, so I had some idea of what I wanted and what would be good. (M3)

Participants emphasized that the BP helped them understand the childbirth experience. One participant stated that she had not known about the resources available for pain relief during childbirth.

I think it is important because it helps you understand many things and rethink things about childbirth. (M2)

It helped me a little. Because, at the time, you do not think much about everything you studied during pregnancy. You are in pain. (M3)

I thought it was important; I did not know there could be so many things to help relieve the pain. (M5)

In the BPs developed by the participants, the most common preferences were for the presence of a companion of their choice and breastfeeding within the first hour of the baby's life. They also emphasized early skin-to-skin contact between mother and baby, use of pain relief strategies, the possibility of choosing the birth position, and receiving information and guidance during labor.

I wrote that I wanted a companion, and they respected my decision. I wanted to feel my son when he was born, and they placed him on me right after he was born. They also put him to my breast, and then I went to the room. (M1)

I wrote that I wanted to have a companion, breast-feed my daughter, and not have to stay in bed to give birth. (M2)

I wrote that I wanted to have the right to a companion and to choose who it would be. I wanted to feel safe and for them to tell me everything that was happening and how my baby was doing. (M3)

I wanted to stay with a companion and use that ball to see if it would help with the pain. (M5)

The four postpartum women who developed the BP reported that they had neither handed it to nor informed any professional in the hospital setting that they had prepared the document. As reasons, they mentioned the unpredictability of events, forgetting the document, and not considering it necessary because of the birth outcome.

I did not hand it in at the maternity hospital because everything happened very quickly; I gave birth well before the expected date. So there was no time for anything. (M1)

I did not think it was necessary to hand it in because they told me I was going to have a cesarean section. I thought I would not need it. So I did not say anything. (M2)

I forgot it at home, but I told them about some things I wanted, such as having a companion and wanting to feel safe. (M3)

I was not able to take it to the maternity hospital. I went in for an examination and was admitted right away for a cesarean section. (M5)

Even though they did not hand in the BP, all participants reported discussing their wishes with health professionals. They considered that all their preferences had been respected.

At the maternity hospital, they were very good to me

and took very good care of me. Even when we do not understand some things, we end up trusting the doctors and nurses and just go along with it. So everything was calm and everything worked out. (M2)

I was able to have everything I asked for. I received very good care at the maternity hospital. (M3)

Three postpartum women stated that the BP contributed to their autonomy and agency, especially regarding the use of pain relief measures during childbirth. They also considered that developing the document gave them a better understanding of childbirth.

Developing the birth plan helped me use the best positions for giving birth and use the shower to help with the pain. (M1)

It made me more aware of some things that were happening, especially because it was my first time. (M2)

It helped me learn about childbirth and study more during pregnancy, because my first birth was bad; I felt very insecure and had questions. With the birth plan, I was able to understand and avoid many things during this last birth. (M3)

Although three participants did not develop a BP, the educational intervention was found to have sparked their interest in the document. They stated that they learned about the BP through the educational intervention.

I found out what it was at that session and even started one, but I did not finish it. (M4)

It was good; it was at the session that I found out what it was, because I had never heard of it before. (M6)

It was good to learn about some of the rights I had for the birth. (M7)

Participants who did not develop a BP stated that they did not do so because of lack of time or because they did not consider it necessary. One participant also emphasized that developing such a document was not part of what she regarded as the usual experience of pregnancy.

I did not have time because I had to work and organize things for my appointments. And everything happened very fast; I went in for MAP [antepartum cardiotocography] and they admitted me to the maternity hospital right away. (M6)

I think that, because it often is not part of the usual organization of pregnancy, I did not consider it essential, so I let it go and did not do it. (M7)

It should also be noted that all participants stated that health professionals at the maternity hospital did not ask whether they had a BP. They also reported that they had not received guidance during prenatal care about the possibility of developing the document.

Pre- and post-intervention analysis

The analysis of the pre- and post-intervention periods, presented in Table 1, shows improvements in women's perceptions after the educational intervention with regard to their knowledge, skills, and attitudes related to BP use.

Table 1 – Women's knowledge, skills, and attitudes before and after the educational intervention on the BP. Uruguaiiana, RS, Brazil, 2024

Dimension	Pre-intervention	Post-intervention
Knowledge	Limited or no knowledge of the BP, often associated with the idea of a bureaucratic or unfamiliar document. Reports of lack of information about rights during childbirth, obstetric procedures, and available choices.	Increased knowledge of the concept, purpose, and importance of the BP. Recognition of the plan as a tool for autonomy, communication, and protection of rights during childbirth.
Skills	Difficulty expressing preferences related to labor and childbirth. Limitations in developing the BP and insecurity when discussing choices with health professionals.	Development of the ability to prepare the BP more clearly and assertively. Greater ability to express wishes, negotiate care practices, and communicate preferences to health professionals.
Attitudes	Passive stance toward care, with uncritical acceptance of practices proposed by health services. Fear, insecurity, and limited perception of women's agency in childbirth.	A more active and participatory attitude during pregnancy and childbirth. Strengthened agency, increased confidence, and greater willingness to exercise autonomy and informed decision-making.

Source: prepared by the authors, 2024.

DISCUSSION

The results of this study show that the educational intervention on the Birth Plan contributed to increasing women's knowledge, skills, and attitudes regarding pregnancy and childbirth, fostering a more critical and reflective stance toward childbirth experiences. In light of the framework adopted, these dimensions are interdependent components of competence, indicating that the intervention not only increased information but also promoted the mobilization of knowing, knowing how to act, and willingness to know how to act within the context of obstetric care⁽¹³⁾. Therefore,

developing an individualized BP proved to be a valuable means of considering women's individual circumstances, strengthening women's agency and their pursuit of reliable information, which are fundamental aspects of a positive childbirth experience.

Regarding attendance at the sessions, participation by pregnant women and companions was low, a situation similar to that described in the literature. A qualitative study conducted in southern Brazil found that factors such as academic and work commitments, fatigue, discomfort associated with advancing pregnancy, health appointments, and preterm birth interfere with participation in educational

groups⁽¹⁶⁾. In addition, prenatal consultations are often brief and focused on technical aspects, tending to overlook pregnant women's prior knowledge and specific needs and resulting in fragmented care. In this context, educational groups are relevant strategies for addressing information gaps, promoting comprehensive care, and strengthening adherence to prenatal care⁽⁵⁾.

High-quality prenatal care, with regular consultations, examinations, and appropriate guidance, supports a healthy pregnancy and early identification of health problems. Prenatal care is also a privileged setting for supportive care, listening, and dialogue and is an appropriate time to introduce and develop the BP. Although participants' attendance at prenatal consultations was not assessed, this aspect is relevant for future research given its influence on the provision of guidance and on strengthening relationships with health services.

In the municipality studied, pregnant women's groups were predominantly organized and facilitated by Community Health Workers (CHWs). Although these professionals play a key role in early identification of pregnancy and in encouraging prenatal care, collective educational activities are a core responsibility of nurses in Primary Health Care. These settings foster the sharing of knowledge and experiences and strengthen relationships between women and professionals, thereby improving the quality of care provided⁽¹⁶⁾.

The educational intervention was an important driver of women's interest in developing a BP, particularly given their previous lack of knowledge about this tool. A study conducted in Portugal found that 68% of women did not develop a BP because they were unaware of its existence, showing that this information gap is not limited to the Brazilian context⁽¹⁷⁾.

In this context, health professionals, especially nurses, play an important role in encouraging development of the BP from reproductive planning and throughout prenatal care. Collaborative development of the document helps strengthen the relationship between professionals and pregnant women and promotes women's autonomy and active participation in decisions regarding labor and childbirth. Accordingly, the BP can be considered a relevant strategy for ensuring and strengthening women's rights throughout the pregnancy-postpartum cycle⁽¹⁸⁾.

Field diary records indicated that some health professionals had questions about the BP, particularly regarding its implementation and use in clinical practice; a similar finding has been reported in another study, in which the authors identified a lack of knowledge about the BP among prenatal nurses⁽⁹⁾. The limited knowledge identified at the pre-intervention stage reflects weakness in the knowledge dimension, which limits informed decision-making. This gap compromises the provision of reliable information during a period marked by major physical, emotional, and social changes in women's lives.

Health professionals need training in practices related to developing the BP, and they must be prepared both to guide its preparation and to understand its relevance in obstetric care. Authors have indicated that BP use can support nursing practice aimed at promoting women's autonomy during labor and childbirth, even in settings still characterized by

interventionist practices⁽⁹⁾. In this sense, the relationship established between professionals and pregnant women during BP development, together with the sharing of information and knowledge, can help transform this reality by strengthening women's agency and active participation in decisions related to the childbearing process^(9,18).

At the post-intervention stage, most participants showed interest in developing the BP and identified the educational materials provided during the intervention and the guidance offered by professionals at the FHS units as their main sources of information. These findings reinforce the role of PHC as a privileged setting for health education activities, promotion of self-knowledge, and strengthening links between women and the health care network.

Furthermore, development of the ability to prepare the BP and communicate wishes to professionals indicates progress in the skills dimension, which is essential for negotiating care practices in the hospital setting. The more active attitude observed after the intervention indicates strengthening of the attitudinal dimension, reflected in greater autonomy and a more critical stance.

However, none of the participants used the BP in the hospital setting during labor and childbirth. Reasons included being unprepared for the timing of birth, preterm birth, and forgetting the document. In addition, none reported being asked or advised by maternity hospital professionals about the BP, although most evaluated the care they received positively. In accounts that diverged from this positive assessment, participants emphasized a lack of information about the practices adopted, a situation that may generate insecurity and undermine the childbirth experience⁽¹⁸⁾.

The participants' accounts reveal asymmetric power relations in obstetric care, in which biomedical knowledge takes precedence over women's knowledge, perceptions, and wishes. The literature indicates that the discourse of risk is frequently mobilized by professionals to justify interventionist practices and is presented as a technical and moral imperative. In the face of this discourse, women tend to silence their preferences, contributing to the construction of the notion of the female body as potentially flawed or incapable, generating feelings of fear, insecurity, and submission and normalizing the medicalization of childbirth⁽¹⁹⁾.

This logic of care helps explain the findings of a study that analyzed compliance with BP requests within the SUS. Even when the document is developed, its effective use remains limited by organizational, institutional, and care-related barriers, as well as by the limited incorporation of the tool into health teams' work processes⁽²⁰⁾. This reinforces that failure to comply with the BP is not attributable only to women's lack of information but is also related to a care model that continues to privilege top-down decision-making.

The results of this study contribute to strengthening scientific knowledge about the BP and highlight the need to address it in health professional education, especially nursing education, to prepare students and future professionals for its application in clinical practice. Nursing in PHC plays an important role in fostering dialogue, building relationships, and developing the BP together with pregnant women, thereby promoting women's agency and respect

for women's choices in the childbearing process.

The importance of developing educational activities directed at both women and PHC professionals is also reinforced, with the aim of expanding BP use as a tool for improving the quality of obstetric care. Professional training can support the provision of safe, evidence-based information and contribute to collaborative development of the BP.

It is also important to reconsider the guidance provided in health services regarding obstetric care routines and procedures by expanding individual and collective health education activities that provide evidence-based information and foster the active participation of women and their support networks in decisions regarding pregnancy, childbirth, and the postpartum period. Study limitations include its exclusive conduct within PHC and the small number of participants, which precludes generalization of the results. In addition, the study considered only the perspectives of service users and did not include health professionals involved in care. Future research should therefore be conducted at other levels of care, including the private health care sector, and should incorporate the perspectives of professionals working in PHC and hospital settings to deepen understanding of the challenges and possibilities for BP implementation across different care settings.

In this context, the BP is a tool that can promote change in the traditional hegemonic model of obstetric care by challenging power relations historically established within the traditional obstetric model. By promoting access to information, dialogue, and explicit expression of women's preferences, the BP contributes to strengthening women's empowerment and expanding their active participation in decisions related to their bodies and the childbearing process.

However, as shown both in this study and in the literature, the effectiveness of this tool depends not only on pregnant women's knowledge but also on institutional recognition of the BP and its valuing by health professionals and services, which is essential for improving the quality

of obstetric care. The findings reinforce that educational interventions focused on the BP should address not only the transmission of information but also the integrated development of knowledge, skills, and attitudes, which is essential for consolidating competencies that support women's autonomy in childbirth.

CONCLUSION

This study made it possible to analyze the effects of an educational intervention on women's knowledge, skills, and attitudes regarding the BP and revealed prior lack of knowledge about both this tool and the routines, procedures, and rights involved in obstetric care. Observational records in the field diary suggest that questions related to the BP may also be present among health professionals, which may compromise its effective use in health services.

The educational intervention proved to be a resource that facilitated care by increasing knowledge, stimulating reflection on women's rights, wishes, and needs, and strengthening autonomy and women's agency throughout pregnancy and childbirth. Although the BP was not developed or used in the hospital setting by all participants, access to the information provided through the intervention contributed to greater understanding and ownership of the labor and childbirth process. However, the findings show that even when a BP was developed and pregnant women's knowledge was strengthened, the hospital obstetric care context could not be changed. Thus, the results reinforce that the educational intervention was effective at the individual level, particularly in increasing knowledge and awareness of rights, but was insufficient to transform institutional practices, professional skills, and attitudes that remain embedded in the current obstetric care model.

CONFLICT OF INTERESTS

The authors have declared that there is no conflict of interests.

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