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Original Article

Use of childbirth plans in high-risk obstetric pregnancies: nurses' perceptions*

Uso do plano de parto em gestantes de alto risco obstétrico: percepções de enfermeiras

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Juliana Amaral Prata[1]
Midian Oliveira Dias[1]
Ana Beatriz Brum da Penha[2]
Ana Carolina Ferreira Filipe[3]
Débora Cecília Chaves de Oliveira[1]
Tatiana Beatriz Leandro de Castro[1]
Laura Greco Gioia[1]

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[1]Universidade do Estado do Rio de Janeiro. Rio de Janeiro, RJ, Brazil.
[2]Secretaria Municipal de Saúde de São Gonçalo. Rio de Janeiro, RJ, Brazil.
[3]Hospital Municipalizado Adão Pereira Nunes. Duque de Caxias, RJ, Brazil.

Corresponding author:
Laura Greco Gioia
Blvd. 28 de Setembro, 157, 8 andar, sala 824.
Vila Isabel, CEP: 20551-030. Rio de Janeiro, RJ, Brazil.
E-mail: lauraggioia@gmail.com

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ABSTRACT

Objective: to understand nurses' perceptions of the use of childbirth plans with pregnant women classified as high-risk obstetrically. **Methods:** a qualitative study was conducted with 13 nurses from a public high-risk maternity hospital. Data were collected through semi-structured interviews and subjected to thematic content analysis. **Results:** nurses' perceptions reaffirm the childbirth plan as a document that promotes female empowerment, safety, and quality of care. However, only residents and specialists in obstetric nursing highlighted specificities and challenges related to its use in high-risk pregnancies. Furthermore, residents were the only ones who considered it a protective strategy against violence and unjustified obstetric interventions. **Conclusion:** nurse-midwives' and in-service training's potential to promote the use of childbirth plans and women's autonomy is evident, given the predominance of the technocratic model in high-risk maternity wards. **Contributions to practice:** investments are needed in the role of obstetric nursing in high-risk pregnancies, in prenatal care, to encourage the dialogical and shared construction of childbirth plans, and in maternity wards, to foster an institutional culture anchored in interprofessional collaboration and women's rights.

Descriptors: Pregnancy, High-Risk; Human Rights; Parturition; Nursing; Prenatal Care.

RESUMO

Objetivo: conhecer as percepções das enfermeiras sobre o uso do plano de parto com gestantes classificadas como alto risco obstétrico. **Métodos:** estudo qualitativo, com 13 enfermeiras de uma maternidade pública de alto risco. Os dados foram coletados por meio de entrevistas semiestruturadas e submetidos à análise de conteúdo temática. **Resultados:** percepções das enfermeiras reafirmam o plano de parto como um documento que promove o protagonismo feminino, a segurança e a qualidade da assistência. Entretanto, somente residentes e especialistas em enfermagem obstétrica destacaram especificidades e desafios relacionados à sua utilização nas gestações de alto risco. Ainda, residentes foram as únicas que o consideraram como uma estratégia protetora de violências e intervenções obstétricas injustificadas. **Conclusão:** evidenciam-se potencialidades das enfermeiras obstétricas e do ensino em serviço para impulsionar o uso do plano de parto e a autonomia das mulheres, diante da predominância do modelo tecnocrático nas maternidades de alto risco. **Contribuições para a prática:** são necessários investimentos na atuação da enfermagem obstétrica no âmbito das gestações de risco, no pré-natal, para incentivar a construção dialógica e compartilhada do plano de parto, e na maternidade, para fomentar uma cultura institucional ancorada na colaboração interprofissional e nos direitos das mulheres.

Descritores: Gravidez de Alto Risco; Direitos Humanos; Parto; Enfermagem; Cuidado Pré-Natal.

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Introduction

A childbirth plan is a document, written or online, prepared by women during pregnancy, in which they record their expectations and preferences regarding childbirth and birth care such as: the presence of a companion of their choice; positions during labor and childbirth; fluid and food intake; the environment; means to promote comfort and well-being; the procedures they agree to undergo; and newborn care[1-3].

This document is also recognized as a strategy that promotes communication with healthcare professionals and contributes to care improvement and safety, as it favors individualized care provision and woman empowerment in childbirth[1,4]. Concerning this last contribution, a childbirth plan is particularly important, given the predominance of the technocratic model in Brazilian obstetric services, expressed in procedural, interventionist, medicalized, and doctor-centered care, permeated by discourses of risk that interfere with women's participation in decisions about their care[2,5].

This worldview gained traction in contemporary Western society through new therapeutic and diagnostic resources, coupled with advances in medicine, which are essential for managing situations of maternal and fetal risk. However, these changes have intensified medicalization of life, culminating in pregnancy pathologization, childbirth institutionalization, female body appropriation by biomedical knowledge, obstetrics masculinization, and woman heteronomy[5].

Over the years, obstetric care, anchored in the technocratic model, has presented negative results related to the indiscriminate use of interventions, giving rise to criticism regarding medical authoritarianism. This situation has led to publications based on scientific evidence, which recommend the humanization of care and the promotion of women's human rights through the adoption of "best practices" in childbirth and birth[6-7].

These practices encompass the development of actions to promote the physiology of childbirth such as: the presence of a companion; the role of nurse-midwives; the use of non-pharmacological methods for pain relief; encouragement of upright positions during labor; timely umbilical cord clamping; skin-to-skin contact; breastfeeding within the first hour of a newborn's life; and rational use of obstetric interventions, such as amniotomy, uterotonics, lithotomy position, and venous catheterization[7-8].

In the context of "best practices," the creation of a childbirth plan should be encouraged regardless of women's obstetric risk stratification. However, this recommendation has not always been followed by healthcare professionals, who value the creation of this document, especially among pregnant women with usual risk pregnancies[9]. In this regard, the present study is justified by the gap in literature regarding studies that address the childbirth plan use and specificities in the context of high-risk obstetrics, especially due to its potential to contribute to demedicalization, since it can be seen as a non-invasive nursing care technology[2,7,9].

Defined as care actions developed by nurse-midwives that constitute a care process with minimal invasiveness to women's bodies, these technologies are widely used in the care of low-risk women in labor, associating themselves with the promotion of best practices, person-centered care, a positive childbirth experience, and women's human rights[7].

It is important to clarify that these rights, in the field of sexual and reproductive health, encompass the right to: life, survival, safety, and sexuality; reproductive self-determination and free choice of motherhood; dignity, health, and the benefits of scientific advances; and access to information for decision-making free from discrimination. Applied to the context of childbirth and birth, these rights translate into the right of all women, regardless of obstetric risk stratification, to safe, dignified, and respectful maternal care[10].

Given these observations about the potential of a childbirth plan for exercising women's rights during childbirth, and considering the particularities of pregnancy, childbirth, and birth for women with associated obstetric risks, the following question arose:

what are the nurses' perceptions regarding the use of a childbirth plan with high-risk pregnant women? It should be clarified that the choice to use the feminine to refer to nurses throughout this study is based on gender issues that permeate nursing, a profession historically associated with feminine attributes and composed predominantly of women. Thus, this article aimed to understand nurses' perceptions of the use of childbirth plans with pregnant women classified as high-risk obstetrically.

Methods

Study design and participants

This is a qualitative study that followed Consolidated Criteria for Reporting Qualitative Research recommendations. Participants were 13 nurses from a high-risk maternity ward of a university hospital in the state of Rio de Janeiro.

Nurses working in an obstetrics center, where the childbirth plan is presented by women in labor or requested by professionals, and who have been providing care in that sector for at least one year, were included. Nurses who were on leave or vacation during the data collection period were excluded. In the case of resident nurses, the exclusion criterion was being in their first year of training, as they are beginning the process of acquiring knowledge and practices specific to the sector specialty and dynamics at this stage.

It should be clarified that the study setting included ten nurses in the obstetrics center, of whom six met the eligibility criteria. During the data collection period, seven second-year obstetrics nursing residents were assigned to that sector and were included in the research.

Data collection

Data were collected from August to October 2020 through semi-structured individual interviews, which followed a script containing closed-ended questions for a brief characterization of participants and the following open-ended questions: what is a childbirth plan? What are your perceptions about the use of a childbirth plan by high-risk pregnant women? How do you feel when assisting a high-risk pregnant woman who has a childbirth plan?

Intentional participant recruitment occurred through in-person contact made by nurses from the unit's obstetrics center, who provided a brief explanation about the research, followed by an invitation to participate. Upon acceptance, interviews were scheduled according to participants' availability and conducted by two authors, obstetrics nursing residents at the time of data collection, who were not assigned to the studied sector and who received prior training on the individual interview technique, offered by the first author, a researcher with extensive experience in qualitative research.

All interviews took place in the presence of a researcher and a participant, during the work shift in the obstetrics center, in a room that ensured privacy, without interfering with daily care and respecting the COVID-19 pandemic context health regulations. With due authorization, the interviews were digitally recorded. They lasted an average of 25 minutes and were transcribed in full after completion. It should be clarified that the transcribed material was validated by participants, without any indication of adjustments to the content.

As an indication of data collection completion, the thematic saturation technique was adopted[11], identified in the eleventh interview and confirmed with the completion of two more, thus ending in the thirteenth interview carried out. It should be noted that there were no refusals or losses during the data collection process. Furthermore, it is highlighted that a pilot interview was carried out, which confirmed the data collection instrument adequacy and, therefore, it was included in the study.

Data analysis

Data underwent thematic content analysis, going through the pre-analysis, exploration, and ca-

tegorization phases, with the identification of recording and context units, followed by the selection of significant excerpts and their grouping into two thematic categories, and data treatment and interpretation[12]. This process was developed by two authors and reviewed by a third, with the interpretative synthesis and inferences based on scientific literature on the subject and women's human rights in childbirth, in dialogue with Brazilian public policies focused on women's reproductive health.

Ethical aspects

Participants signed the Informed Consent Form, with anonymity ensured through the use of the terms "Nur.", referring to generalist nurse, "Nur.-Mid.", referring to nurse-midwife, and "NR", concerning obstetric nursing resident, followed by a number corresponding to the order in which the interview was conducted. The study respected the ethical and legal aspects of research with human beings developed in healthcare services, and obtained approval from the *Universidade do Estado do Rio de Janeiro* Research Ethics Committee, under Opinion 4,029,184/2020 and under Certificate of Presentation of Ethical Consideration 29736920.8.0000.5282.

Results

Of the 13 professionals interviewed, all identified as female; two were generalist nurses, four were nurse-midwives; and seven were obstetric nursing residents. Nurses' age range varied from 35 to 48 years, and that of the residents from 24 to 32 years.

Meanings attributed to the use of a childbirth plan in the context of high-risk obstetrics

Encompassing seven registration units and 17 text fragments, this category reveals that all participants understand the childbirth plan as a document that: expresses women's wishes for care during the labor and birth process; promotes communication between the team and the high-risk pregnant woman; provides security to obstetric care; and contributes to restoring female empowerment: *That is what she wants during childbirth! We offer what's in the childbirth plan, as much as possible. It makes care much easier, especially because I'm a generalist nurse. I can provide more confident guidance when the woman comes with a childbirth plan* (Nur.9). *It's her wish! The way she wants the childbirth to be conducted, but within her conditions to meet her desires, considering her pathologies. So, we have to try, as far as possible and within her conditions, to carry out those activities there* (Nur.11). *It's a way of bringing to the professionals who will assist with childbirth what the woman wants and doesn't want for childbirth. It would be a form of communication between the team of professionals and the pregnant woman. I think it's an attempt to make childbirth more hers and less the professional's* (Nur.-Mid.12).

Furthermore, residents and nurse-midwives pointed out some specific aspects that should be included in the childbirth plan for pregnant women classified as high-risk, highlighting comfort and tranquility promotion, emotional support offering, and respect for best practices. Additionally, regarding the need for obstetric interventions that contradict the provisions of the aforementioned document, they considered it important to provide explanations and obtain prior consent: *I believe that ways should be considered to make the woman feel comfortable during the process so that the team can assist her in the best possible way... timely clamping and skin-to-skin contact, especially when she needs a cesarean section so that she can experience a pleasant moment that will positively mark her life!* (NR5). *Emotional issues must be considered in order to provide a peaceful labor! ... she is a high-risk pregnancy, but she doesn't need so many interventions!* (NR3). *This is a letter written to the team that will assist the pregnant woman, in which the couple lists everything they want or don't want during labor and childbirth, which must be respected. In case any intervention is necessary, the woman must be informed and have her authorization! It is important that the woman has information on how to build this childbirth plan according to her risk factor* (NR1). *I think it's important that the woman is aware that, in an emergency, if it is necessary to intervene in childbirth, this intervention will be done, regardless of whether there is anything in her childbirth plan that says she doesn't want a particular intervention.*

Many have this knowledge and know what can happen, but others end up listing things that are unrealistic, and it becomes impossible to provide assistance (Nur.-Mid.10).

Based on specific perceptions from the interviewed residents, there is recognition that the use of a childbirth plan in high-risk pregnancies is a protective strategy against obstetric violence and a resource to mitigate clinically unjustified interventions, contributing to the development of qualified, individualized, and humanized care that provides positive childbirth experiences: *We can understand a woman's perceptions of labor and what she wants because she goes to "childbirth land"* [referring to the moments preceding the expulsive phase]*, and she can't express her desires and becomes very vulnerable! So, I think it's a very important tool that prevents obstetric violence!* (NR2). *It's a tool that can improve childbirth care and ensure a satisfactory experience. Extremely necessary in high-risk pregnancies so that the team doesn't fail to offer individualized care to the woman, who is already concerned about her pregnancy being different from the usual situation. I believe this is a way to clarify communication between the pregnant woman and the team, avoiding routine interventions and providing individualized care, where interventions are only performed if necessary* (NR5). *The use of a childbirth plan is important because high-risk women will be assisted primarily by obstetricians, a category that most often disrespects women's rights and the physiology of childbirth. The childbirth plan ends up being a defense for them! It should include things that will guide care towards something more humanized and respectful, avoiding obstetric violence* (NR6).

Challenges related to the use of a childbirth plan in the context of high-risk obstetrics

In this category, consisting of four registration units and 12 text fragments, it is evident that one of the major challenges is the medical team, which, when faced with a pregnant woman who has a childbirth plan, often fails to recognize the value of this document, displaying attitudes of sarcasm and contempt: *I think the biggest obstacles are with the medical team! They still have a certain barrier... they don't look at it favorably! In general, when they come with a childbirth plan, they already want to make fun of it. Sometimes they don't even want to read it; they say it's nonsense, that a childbirth plan is for low-risk pregnancies* (Nur.-Mid.8). *What we have as an obstacle is the medical team, which sometimes doesn't put into practice what the woman requests. Many doctors don't accept it, they think it's nonsense, that they know what they're going to do and it's not the woman who has to lead this! ... many times, they take the childbirth plan and say, "What a joke! I'm not going to follow this. It will be like this if I think it has to be"* (Nur.11). *We provide care as the woman wishes, to the extent possible. But here, since obstetric nursing doesn't manage childbirth, I realize it's difficult for doctors to understand that a childbirth plan can be followed as the woman progresses. I've seen many doctors mocking it, and when we tell them the woman brought it, they say it's nonsense and aren't interested in looking at it. When they read it and see that it's not how they do things, they say it can't be done that way. They say the woman wants to choose too many things* (Nur.-Mid.13). *I had never seen anyone from a high-risk pregnancy arrive with a childbirth plan! But normally, the medical team isn't very open. They don't want to do it; they don't consider it... we feel bad because we know the focus of care is the woman! We want to do it for her, but they don't cooperate* (NR2).

As another limitation to the use of childbirth plans in high-risk maternity wards, residents and nurse-midwives cited low adherence by women, as few present this document at the time of admission and, even then, only when questioned by a professional. For these participants, this perception suggests that pregnant women do not view the childbirth plan as a document for the effective exercise of their rights: *Upon admission, the nursing staff asks if the woman has a childbirth plan. Some say they don't, that they don't know about it. Some say they have one, but forgot to bring it. Generally, those who bring a childbirth plan are more empowered, have more autonomy, and are more aware of the situation they are going through. But I think they don't give this document the importance they should* (Nur.-Mid.12). *Often, the woman doesn't present it at the time of admission, and the doctors don't ask. We only know that the woman has a childbirth plan if she remembers to hand it over or if we, the nursing staff, ask about it at her admission* (Nur.-Mid.13). *To date, I have only received one patient with a childbirth plan, and my approach was to read everything and talk to her about what was described, her intentions, and understand if what was there was really what she wanted, if she understood everything, and we conducted the labor according to what was in the childbirth plan* (NR4).

Discussion

The analysis process revealed that nurses' perceptions regarding the concepts and contributions of using a childbirth plan with women in labor classified as high-risk are similar to those found in national and international research conducted in services that provide care for low-risk pregnancies[2,13-14].

Hence, all participants recognized its importance, understanding it as a document that outlines postpartum women's preferences for obstetric care, and is presented to professionals upon admission to the maternity ward. Furthermore, they identify it as a resource that facilitates communication with the healthcare team, contributing to the development of individualized care and promoting female empowerment.

Developing a childbirth plan improves women in labor's understanding of the processes involved in childbirth and birth, and its use in guiding care results in: strengthening the bond with professionals; promoting a welcoming environment; reducing anxiety, stress, and fear; fostering a sense of trust and emotional support; a feeling of control; and participation in decisions[3,13,15]. Thus, incorporating a childbirth plan into obstetric services contributes to care safety and quality, minimizing, among other things, acts of malpractice, negligence, disrespect, and abuse[3], which constitute violence, as they violate women's human rights.

It is known that, unfortunately, many women in labor have their rights violated during obstetric care, especially given the asymmetrical relationships established in hospital childbirth[16]. In the context of high-risk obstetrics, the possibility of complications, the centrality of medical conduct, and the predominance of clinical decisions by professionals can culminate in situations that interfere with the exercise of women's rights to autonomy, self-determination, dignity, and physical and psychological integrity[17].

Within this healthcare setting, pregnant women, women in labor, and postpartum women are more susceptible to interventions and have reduced bargaining power, as they are considered patients and classified as high-risk. Therefore, encouraging the development and use of childbirth plans in this context is considered a strategy to promote person-centered care and women's participation in decision-making processes, globally recognized as strategies to improve obstetric outcomes and ensure women's rights[17-18].

However, considering that complications are common in high-risk pregnancies, the approach to a childbirth plan during prenatal care has specific characteristics, since it needs to be more flexible to support the dialogical construction of said document, accompanied by clarifications about the possibility of complications that require interventions not initially desired by women[1-3,13,15].

However, there is a clear scarcity of educational activities that address and problematize pregnant women's preferences, since they are often limited to the top-down transmission of information about pregnancy, childbirth, breastfeeding, and baby care. Furthermore, understanding that pregnancy is a reproductive life event that brings with it intense changes and a certain emotional lability[19], health education actions should promote discussions that support the shared construction of an individual childbirth plan[1], and not structured models that disregard the subjectivities, particularities or even the obstetric risk stratification of each woman.

In addition to the childbirth plan's flexibility, another specific aspect of using this document in the context of high-risk pregnancies is the importance of considering the ambiguous feelings that arise during pregnancy amidst obstetric risk situations, such as fear, guilt, frustration, worry, insecurity, low self-esteem, and negative expectations related to the pregnancy. Therefore, it is essential to offer emotional support and promote tranquility to these women in labor, as this care minimizes suffering, provides well-being and comfort, favors better psychological adaptation to the events, and contributes to achieving better perinatal outcomes[17,19].

It is worth noting that, in the results of this study, the recognition of these specificities was only

identified among resident participants and specialist nurses in obstetric nursing, indicating the existence of distinctions in the being-knowing-doing of the specialty in relation to generalist nurses. Supporting this inference, there is the relevance of the role of nurse-midwives in the care of pregnant women, women in labor and postpartum women with associated risks, due to the contributions of their care process to the exercise of women's human rights, with respect for their diversity, and to the safety and quality of childbirth and birth care[3,7], recently ratified by the Brazilian Ministry of Health through the creation of the Alyne Network (*Rede Alyne*), in 2024[20].

Also, according to the ordinance that establishes the Alyne Network[20], and in line with the recommendations for good obstetric practices[6], a childbirth plan must be developed with the support of a healthcare professional, preferably a nurse-midwife or obstetrician, through the establishment of a bond and dialogue with women and their family during prenatal care[9]. However, it is observed that many pregnant women are unaware of childbirth plans, and few present it upon arrival at the maternity ward, revealing low adherence to its use, as evidenced in a narrative review on the use of this document in obstetric services in Brazil[1], identified as a challenge in the context of high-risk pregnancies, specifically by the nurse-midwives and residents participating in this research.

Therefore, it is necessary for prenatal care professionals to be trained to encourage and support the creation of a childbirth plan, understanding its importance in ensuring women's rights during childbirth[14]. At the same time, it is essential that maternity teams inquire about this document upon admission and, upon identifying complications[13-14], provide information about the situation, using culturally appropriate and accessible language, offer options regarding therapeutic possibilities, and obtain prior consent, thus encouraging shared decision-making[13,21], regardless of postpartum women's obstetric risk stratification.

As another barrier to the use of childbirth plans in high-risk maternity wards, all nurses in this study highlighted that when a pregnant woman with this document is admitted to the obstetrics center, a large part of the medical staff does not value it and displays derogatory attitudes, suggesting that part of this category still shares the technocratic model's worldview and does not adhere much to best practices, in line with the results of national and international studies[4,16,22].

Despite official recommendations and scientific evidence, this finding also reveals the persistence of hierarchical relationships, especially in high-risk obstetric maternity wards, where medical professionals position themselves as scientific authorities, anchored in the principles of legitimacy—based on the woman's acceptance that doctors possess knowledge superior to her own—and dependence—which stems from the fear that women will suffer negative consequences if they infringe upon such authority[23-24].

This rationality, a product of medicalization of life, culminates in female body appropriation and woman heteronomy, seen as passive and objects of manipulation who require control and active guidance from a professional to achieve a positive outcome in childbirth[5]. In this context, the discourse of risk is used as a tool to subjugate women to medical practices, since fear of death is the main anchor of their authority. On the other hand, they submit to biomedical dominance in an attempt to meet professionals' expectations and receive good treatment, behaving according to the standards established by them[23,25].

As a result, obstetric care is often characterized by unnecessary interventions, where "compensation" is the birth of a healthy baby, this being the prerogative for the exercise of medical power above women's wishes and rights[23]. From this perspective, situations of obstetric violence arise, defined as a type of structural gender violence that compromises women's integrity and physical, psychological, and social well-being during pregnancy, childbirth, and the postpartum period[16,26].

From this perspective, it was found that a childbirth plan was identified as a protective mechanism against obstetric violence only by the residents in this

study. This finding may possibly be related to the fact that it is a concept that is still under construction and its dissemination is recent[16]. However, as professionals in training who move between teaching and research institutions, residents interact with professors and researchers in the academic field, and participate in debates about the recognition and confrontation of this type of violence in the obstetric field, while witnessing this problem in the daily care provided in maternity wards. In this teaching and learning process characteristic of health residencies, they incorporate provisions that guide them to identify obstetric violence and develop approaches to its prevention, such as childbirth plan use[16,26-27], with the potential to promote the qualification of care and protection of women's human rights in practical training settings.

Considering the meanings attributed by nurses to use a childbirth plan and recognize the specificities regarding its use with pregnant women classified as high obstetric risk, the findings of this research reveal that one of the strategies for overcoming the challenges related to the use of this document in maternity wards with a high-risk care profile lies in encouraging nurse-midwives' participation.

Nevertheless, in addition to the importance of prenatal care in encouraging the dialogical and collaborative construction of a childbirth plan, the persistence of the technocratic model highlights the need for actions to foster an institutional culture anchored in interprofessional collaboration and person-centered care.

Study limitations

Limitations of this research relate to the fact that data collection was only carried out in one unit of a single urban center, in addition to the low adherence to using a childbirth plan by the women assisted in the studied setting, which restricts professionals' experience at the institution studied regarding the use of this document. Furthermore, the difficulty faced in the participant recruitment process due to the workload overload resulting from the COVID-19 pandemic context is noteworthy.

Contributions to practice

This study confirms the importance of a childbirth plan as a strategy to ensure the exercise of women's rights in the processes of childbirth and birth. However, by highlighting the specificities and challenges of using this document with pregnant women classified as high-risk obstetrically, it also contributes to reflections on the relevance of nurses' role in this area of care, especially specialists in obstetric nursing. These professionals, by valuing the use of this non-invasive care technology, promote the demedicalization of high-risk maternity wards, in contrast to the medicalization and heteronomy imposed by the technocratic model in obstetric care.

Conclusion

Nurses' perceptions regarding the use of childbirth plans with pregnant women classified as high-risk are similar to those identified in usual-risk pregnancies, reaffirming that this document is a resource for promoting women's rights. However, only residents and specialists in obstetric nursing highlighted the specificities and challenges of its use in high-risk maternity wards. At the same time, it was found that residents were the only participants who considered it a strategy for protecting women from violence and unjustified obstetric interventions.

Authors' contributions

Conception and design, data analysis and interpretation: **Prata JA, Penha ABB, Filipe ACF**. Manuscript drafting and critical review of relevant intellectual content, final approval of the version to be published, and agreement to be responsible for ensuring that all aspects related to the accuracy or integrity of any part of the manuscript are properly investigated and resolved: **Prata JA, Dias MO, Penha ABB, Filipe ACF, Oliveira DCC, Castro TBL, Gioia LG**.

Data availability

The authors state that the data is available in full in the body of the article.

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