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Effect of birth plan education on anxiety levels among third-trimester pregnant women prior to childbirth: A one-group pretest–posttest study

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Abstract

Background: Anxiety during the third trimester of pregnancy is a common psychological condition that may adversely affect maternal and fetal outcomes, including prolonged labor, increased obstetric complications, and negative birth experiences. Birth Plan education is a woman-centered educational intervention designed to improve childbirth preparedness, enhance communication with healthcare providers, and reduce maternal anxiety.

Purpose: To examine the effect of Birth Plan education on anxiety levels among third-trimester pregnant women prior to childbirth.

Method: A pre-experimental study with a one-group pretest–posttest design was conducted among 30 third-trimester pregnant women at the Independent Midwifery Practice (PMB) of Febi Yulistia, Bandar Lampung, Indonesia, between April and May 2025. Participants were recruited using total sampling. Anxiety levels were assessed before and after a 45-minute Birth Plan education session using the Hamilton Anxiety Rating Scale (HARS). Data were analyzed using the Wilcoxon signed-rank test with a significance level of $p < 0.05$.

Results: Before the intervention, the majority of participants experienced moderate anxiety (53.3%), with a mean anxiety score of 18.73 ± 4.36 . Following Birth Plan education, most participants reported no anxiety (60.0%), and the mean anxiety score significantly decreased to 11.67 ± 4.55 . The Wilcoxon signed-rank test demonstrated a statistically significant reduction in anxiety levels after the intervention ($p < 0.001$).

Conclusion: Birth Plan education effectively reduced anxiety levels among third-trimester pregnant women. Integrating Birth Plan education into routine antenatal care may enhance maternal psychological preparedness for childbirth and contribute to improving maternal health outcomes.

Keywords: Anxiety; Antenatal Education; Birth Plan; Pregnancy; Third Trimester.

INTRODUCTION

Pregnancy is a physiological condition that begins from conception until the birth of the fetus with a duration of pregnancy of around forty weeks and not exceeding forty-three weeks (Prawirohardjo, 2020). In the third trimester (twenty-eight to forty weeks), anxiety approaching labor increases, marked by the emergence of questions and concerns of the pregnant mother about the process of giving birth and the safety of her baby. Such anxiety can cause tension in the mind and body, and influence the course of childbirth (Setyaningsih et al., 2022). This condition can even trigger early contractions,

hypertension in pregnancy, and preeclampsia which have a bad impact on the mother and the fetus (Walyani, 2015).

The Maternal Mortality Rate is still becoming a serious problem. Globally, the World Health Organization (2024) reported that two hundred eighty-seven thousand women died during and after pregnancy in the year two thousand twenty, with a target of reducing the global Maternal Mortality Rate to fewer than seventy per one hundred thousand live births in the year two thousand thirty. In Indonesia, data from the Ministry of Health (2024) shows an

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increase in maternal deaths up to four thousand one hundred twenty-nine cases, with seventy-six percent occurring in the childbirth and postpartum phases (Rohati & Siregar, 2023).

Promotive and preventive efforts are required to lower anxiety as well as the risk of complications, one of which is through a Birth Plan (childbirth planning). A Birth Plan is a childbirth preparation service that encourages the mother to be more ready in facing the birth process, improving independence, training stress coping, as well as strengthening communication between the mother, family, and health workers (Notoatmodjo, 2018). Another study reported that providing childbirth preparation classes can lower the mother's anxiety level significantly (Wardhani et al., 2022; Setyaningsih et al., 2022). A preliminary study at the Independent Midwifery Practice of Midwife Febi Yulistia, Bandar Lampung in January two thousand twenty-five, shows that from thirty-five third-trimester pregnant women, as many as twenty primigravidas experienced anxiety approaching childbirth, whether related to the smooth process, pushing ability, or worry about an operation.

RESEARCH METHOD

This study employed a quantitative pre-experimental design using a one-group pretest-posttest approach to evaluate the effect of Birth Plan education on anxiety levels among third-trimester pregnant women. The study was conducted at the Independent Midwifery Practice (PMB) of Febi Yulistia, Bandar Lampung, Indonesia, from April to May 2025.

The study population consisted of all third-trimester pregnant women who attended antenatal care at the study site during the research period. Participants were recruited using a total sampling technique, resulting in 30 respondents. The inclusion criteria were pregnant women with a gestational age of 28–40 weeks, able to communicate effectively, willing to participate by signing informed consent, and having no obstetric or medical emergencies.

Pregnant women with severe pregnancy complications, diagnosed psychiatric disorders, or incomplete questionnaire data were excluded from the study.

The independent variable was Birth Plan education, while the dependent variable was maternal anxiety level. The intervention consisted of a structured 45-minute educational session delivered individually by a trained midwife using lectures, interactive discussions, and educational leaflets. The educational materials included the concept and benefits of a Birth Plan, recognition of labor signs, delivery preparation, pain management options, birth companion planning, communication with healthcare providers, and postpartum preparation.

Maternal anxiety was assessed using the Hamilton Anxiety Rating Scale (HARS), a standardized instrument consisting of 14 items with a total score ranging from 0 to 56, where higher scores indicate greater anxiety levels. Anxiety was measured twice: immediately before the intervention (pretest) and after completion of the Birth Plan education (posttest).

The collected data were checked for completeness, coded, entered into the Statistical Package for the Social Sciences (SPSS), and analyzed descriptively and inferentially. Descriptive statistics were used to summarize respondents' characteristics and anxiety scores, while the Shapiro–Wilk test was applied to assess data normality. Because the data were not normally distributed, differences in anxiety scores before and after the intervention were analyzed using the Wilcoxon signed-rank test with a significance level of $p < 0.05$.

This study received ethical approval from the Research Ethics Committee of Universitas Malahayati with number: No. 4908/EC/KEP-UNMAL/VI/2025). Written informed consent was obtained from all participants prior to data collection, and participant confidentiality and anonymity were maintained throughout the study.

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RESEARCH RESULTS

Table 1. Characteristics of Respondents (N=30)

Variable	Results	Mean Score	Min-Max
Age (Mean±SD) (Years) (Range)			
20–35	30/100		
<20 or >35	0/0		
Education (n/%)			
Senior High School	18/60.0		
Higher Education (University)	12/40.0		
Employment Status (n/%)			
Unemployed	17/56.7		
Employed	13/43.3		
Parity (n/%)			
Primigravida	22/73.3		
Multigravida	8/26.7		
Anxiety Levels (Pre-test) (n/%)		18.73	5–23
No anxiety	3/10.0		
Mild anxiety	11/36.7		
Moderate anxiety	16/53.3		
Anxiety Levels (Posttest) (n/%)		11.67	4–21
No anxiety	18/60.0		
Mild anxiety	10/33.3		
Moderate anxiety	2/6.7		

Table 1. illustrates the demographic and clinical characteristics of the study participants. All respondents (n=30, 100%) were within the healthy reproductive age range of 20–35 years. The majority of respondents had completed high school education (60.0%), were housewives (56.7%), and were primigravidae (73.3%). Regarding clinical status, the pretest assessment indicated that the majority of respondents (53.3%) experienced moderate anxiety prior to the Birth Plan intervention. Conversely, following the intervention, the posttest results demonstrated a significant reduction in anxiety levels, with 60.0% of respondents reporting no anxiety. The data range recorded was between 5 and 23, with 1 participant scoring at the minimum level (mild anxiety) and 4 participants scoring at the maximum level (moderate anxiety). The mean anxiety score decreased to 11.67, with a range of 4 to 21. Among the participants, one individual scored at the minimum level (mild anxiety), and one individual scored at the maximum level (moderate anxiety) post-intervention.

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Table 2. Normality Test

Variables	N	Shapiro-Wilk Value
Anxiety (pre-test)	30	0.000
Anxiety (post-test)	30	0.000

Table 2. shows the normality test results using the Shapiro-Wilk test for respondents before and after the Birth Plan intervention. The results indicate that the p-value for both pretest and posttest scores was < 0.05 , indicating that the data were not normally distributed. Consequently, the Wilcoxon signed-rank test was selected for the bivariate analysis.

Table 3. Wilcoxon Signed-Rank Test

Anxiety Status	Mean	SD	Min –Max	Mean Rank	p-value
Pretest	18.73	4.362	5–23	12.50	0.000
Posttest	11.67	4.551	4–21		

Table 3. demonstrates the change in maternal anxiety levels following the Birth Plan intervention. The mean anxiety score decreased from 18.73 (pre-intervention) to 11.67 (post-intervention). The Wilcoxon signed-rank test yielded a p-value of 0.000 ($p < 0.05$), indicating a statistically significant difference in anxiety levels before and after the intervention. Therefore, it can be concluded that Birth Plan education significantly influences and reduces anxiety among third-trimester pregnant women facing childbirth at the Independent Midwifery Practice (PMB) of Febi Yulistia.

DISCUSSION

Based on the research results, it is known that all respondents were aged 20–35 years, totaling 30 people (100%). This shows that the age of the respondents is within the productive range for undergoing pregnancy and childbirth.

Age influences the reproductive process. The optimal age for pregnancy and childbirth is between 20–35 years, while ages above 35 years and below 20 years are considered high-risk (Prawirohardjo, 2020). Another studies states that a person's age can influence the condition of their pregnancy. If a woman is pregnant during the reproductive period, there is a lower possibility of experiencing complications compared to a woman who is pregnant below or above her reproductive age (Manuaba, 2009).

Another results show that anxiety, when viewed from the age of mothers < 20 years old, resulted in 50% experiencing mild anxiety and 50% moderate anxiety. Healthy reproduction is in the age range of 20–35 years, and unhealthy reproduction is at the age of 35 years and above. The feeling of anxiety felt in the 20–35 years age category is not only due to the age factor but is also caused by the gravida factor; thus, in the 20–35 years age category, there were respondents who experienced severe anxiety (3% or 1 person) because they had not yet had experience with pregnancy and childbirth (Asih et al., 2021).

The education of the respondents was mostly Senior High School, namely 18 people (60%). This shows that all respondents were highly educated. Education influences a mother's ability to digest and absorb new information, which can influence the formation of attitudes toward pregnancy; the higher a person's level of education, the greater the opportunity to seek treatment at health services (Notoatmodjo, 2018).

High knowledge of pregnant women is related to the high education level of the pregnant women; adequate knowledge about pregnancy can help mothers obtain a lot of information about pregnancy and the changes experienced during pregnancy so that the mother will feel calm in facing the pregnancy, but conversely, if the mother's knowledge about pregnancy is insufficient, feelings of worry or fear in

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facing pregnancy and its changes will appear (Riniasih et al., 2020).

Based on employment, most respondents did not work, namely as housewives (IRT), totaling 17 people (56.7%). This shows that the pregnant women did not have jobs outside the home to support the family economy. Working mothers allow mothers to obtain information and experience about pregnancy from other people because mothers who have jobs will meet with other people more often. Besides that, mothers who have jobs will be influenced in determining stressors so that mothers can control anxiety better (Gary & Hijriyati, 2020).

The study explains that the employment characteristics of mothers giving birth from 34 respondents were mostly housewives (IRT), as many as 23 respondents (67.6%), while the remaining 11 respondents (32.4%) had jobs as private sector employees. Jobs influence a person's stressors, and those who have activities outside the house get many influences from friends and various information as well as experience from other people, which can change a person's way of viewing things in accepting and overcoming anxiety (Lilis & Lovita, 2021).

Whereas based on parity, most of the respondents were primigravida, or mothers currently pregnant for the first time, namely 22 people (73.3%). Primigravida pregnant women who will be experiencing the labor process for the first time tend to experience anxiety.

Another research provides a description of the high percentage of primigravida pregnant women who experience severe anxiety. Handling is required to minimize and overcome the anxiety experienced by pregnant women, among others, by providing good and comprehensive antenatal care by health workers, counseling, or providing information related to the health of the pregnant mother and the labor process for the pregnant mother and her family (Arikalang et al., 2023).

Based on the results of the research that has been carried out, before being given a birth plan (childbirth planning), most respondents experienced moderate anxiety, namely 16 people (53.3%) with an average anxiety score of 18.73, with a minimum value of 5 and a maximum of 23. This is proven by the respondents having the highest scores on question number 1 with symptoms such as feeling anxious and easily

offended; then question number 5, which is decreased memory, difficulty concentrating, and limited attention; question number 4, which is sleep disturbances; and question number 9, which is often experiencing heart pounding.

Another research moderate anxiety allows a person to focus on important things and put aside other things that are not priorities, which is marked by decreased attention, decreased problem-solving, being impatient, being easily offended, experiencing sleep disturbances, increased vital signs, moderate muscle tension, pacing, frequent urination, and headaches (Ningrum, 2023).

Factors that influence anxiety in pregnant women include lack of information about diseases, family support, financial sufficiency, stress from the environment, high frequency of nausea and vomiting (physical health factors of the pregnant mother), attitude toward pregnancy and the ability to master the pregnancy, the process of adjusting oneself to pregnancy, both physically and psychosocially, as well as information about scary childbirth experiences (Andriana, 2020).

During pregnancy in the third trimester (28–40 weeks), anxiety about approaching labor will appear with questions and shadows of whether the mother can have a normal delivery, how the pushing method works, whether something will happen when giving birth, or whether the baby will be born safely; these will appear more often in the mind of the pregnant mother. In third-trimester pregnant women, anxiety becomes more serious and intensive along with the approaching birth process. Feelings of worry can result in tension in the mind, body, pelvic muscles, and lower uterine segment muscles; this tension will later be able to interfere with the labor process (Setyaningsih et al., 2022).

The results of this study are in line with the another research which shows that out of 12 respondents, the average anxiety before attending labor preparation classes was 15.08 with a standard deviation of 2.937. Anxiety approaching labor seems to become part of the complex emotional experience description of women during pregnancy (Wardani et al., 2022)

This is strengthened by another study which showed that observations before the intervention showed the majority had moderate anxiety totaling 36

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people (52.2%), those who experienced severe anxiety totaling 26 people (37.7%), and 7 (10.1%) pregnant women experienced mild anxiety (Setianingsih et al., 2022)

An international study on the title "Effect of birth plans integrated into childbirth preparation classes on maternal and neonatal outcomes of Iranian women: A randomized controlled trial" mentioned that the vaginal birth rate was significantly higher in women who had a labor plan compared to those who did not (81.9% vs. 48.7%, $p < 0.001$). Apart from that, the length of the first and second stages of labor was significantly shorter in women who had a delivery plan ($p = 0.02$). Women in the labor plan group were significantly more satisfied with the labor and giving birth process ($p < 0.001$) and started breastfeeding after giving birth earlier than those who were in the control group ($p < 0.001$) (Mahmoodi et al., 2023).

Based on the research results, the findings suggest that the moderate level of anxiety experienced by most respondents is due to factors that influence anxiety in pregnant women; the results obtained were that pregnant women experience various levels of anxiety affected by several factors, namely age. The age of a pregnant mother can influence how the mother behaves in guarding her health and the fetus she is carrying. The more ideal the age, the more the mother will take notice in controlling anxiety during childbirth. In addition to age, researchers assume that primigravida pregnant women in the third trimester experience anxiety due to a number of factors, among others, the lack of exposure to information about preparation in facing childbirth. Primi pregnancy is the first experience that can cause feelings of anxiety, fear, and worry about the upcoming labor faced by most of the respondents.

Based on the results of the research that has been done after being given a Birth Plan (Childbirth Planning), most respondents did not experience anxiety, namely 18 people (60%) with an average anxiety score of 11.67, with a minimum value of 4 and a maximum of 21. The results of the research show that the anxiety level of most respondents became "no anxiety," which is proven in the questionnaire that has been distributed by the researchers, where pregnant women stated that they did not have symptoms on question number 1, which is "not anxious"; then number 2, "not shaking"; number 4,

"no sleep disturbances"; and question number 5, "the mother is good enough in centralizing concentration."

A birth plan (childbirth planning) is a note about what a pregnant mother wants during labor, birth, and after birth. A mother does not have to make a childbirth plan. A birth plan or birth plan is a simple, clear statement about a woman's preferences in facing birth. A birth plan is a written document about the choices of the mother and partner at the time of giving birth to their baby (NHS, 2024).

A labor plan not only empowers women to participate in making decisions about their own treatment but also makes them feel they can express their wishes early, without having to emit valuable energy during labor to repeat their views and argue with midwives or doctors. In addition, the plan can increase communication between women and healthcare service providers (Zulfita et al., 2025).

The results of this study are in line with another research which shows that after attending two labor preparation classes spaced a week apart and performing a re-evaluation, the average maternal anxiety results obtained were 9.67 with a standard deviation of 2.741 (Wardani et al., 2022)

The Influence of Birth Plan (Childbirth Planning) Against Anxiety in Facing Third Trimester Pregnant Women Labor. The Wilcoxon test results obtained a p-value of 0.000 (<0.05), meaning there is a meaningful difference between before and after being given the intervention, so it can be concluded that there is an influence of the birth plan (childbirth planning) on the anxiety of pregnant women in facing childbirth at PMB Midwife Febi Yulistia Bandar Lampung.

According to the NHS (2024), the benefits of a birth plan (childbirth planning) are to enable mothers to control their delivery with self-empowerment, provide a positive experience to the mother, obtain peace of mind, and get clear and easy information to convey needs.

A birth plan (childbirth preparation), which is one of the promotive and preventive efforts toward the incident of maternal death, is the delivery of information to pregnant women to be more open about their health, specifically complaints felt during pregnancy. This service can become an alternative for pregnant women to know how far the mother and fetus have progressed, increasing the mother's

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independence as well as practicing management of the mother's stressors. The educational approach is the most suitable approach to efforts in solving public health problems through behavioral factors compared to the coercion approach. Changes produced by education are based on knowledge and awareness through the learning process so that the behavior is expected to be long-lasting and persistent (Notoatmodjo, 2018).

Another study showed results that there is a decline in the anxiety scores of pregnant women before conducting childbirth preparation classes and after conducting childbirth preparation classes (Wardhani et al., 2022). Meanwhile, another study showed results that there is a significant difference in the level of anxiety between before and after being given labor preparation services with (p value = 0.000) or ($p < 0.05$) (Setianingsih et al., 2022)

The findings suggest that after being given Birth Plan (childbirth preparation) health education, the level of anxiety in facing childbirth in primigravida mothers in the third trimester experiences a decline because the health education provides clear and structured information regarding the birthing process, the stages that will occur, and actions that can be done to prepare oneself physically and mentally. With the existence of a better understanding, the mother feels more ready, confident, and able to control previous concerns that appeared as a consequence of ignorance or uncertainty. In addition, the Birth Plan also provides a chance for the mother to participate actively in planning childbirth, including choosing the place of delivery, the desired method, and who will accompany the mother at the time of childbirth. This increases the sense of self-control and the mother's involvement in the labor process, which can significantly lower the level of anxiety. This education is also capable of building better communication between the mother and health workers, so that the mother feels more supported and secure in undergoing childbirth.

CONCLUSION

Birth Plan education significantly reduced anxiety among third-trimester pregnant women. Integrating Birth Plan education into routine antenatal care may improve maternal psychological preparedness before childbirth.

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