

Experience report

Educational groups for pregnant and postpartum women in a rural primary health care unit: an experience report

Grupos educativos para gestantes e puérperas em unidade básica de saúde rural: relato de experiência

Grupos educativos para mujeres embarazadas y puérperas en una unidad de atención primaria de salud rural: informe de experiencia

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Abstract

Objective: to describe the organization and interprofessional implementation of collective care activities for pregnant and postpartum women in a rural Primary Health Care Unit in the Federal District, Brazil. **Method:** experience report conducted between February and June 2025, based on four educational meetings involving pregnant and postpartum women and, in one of them, relatives and partners. The activities were carried out by Physical Therapy and Nutrition residents in collaboration with the Primary Health Care team, using participatory methodologies and field diaries. **Results:** 37 participations were recorded, with greater adherence to open-format activities, increased interaction between users and the health team, and inclusion of family members. The meetings promoted clarification regarding prenatal care, newborn care, and social rights, in addition to referrals to support networks. **Conclusion:** the experience proved to be feasible and replicable for strengthening care and bonds within Primary Health Care.

Descriptors: Primary Health Care; Pregnant People; Postpartum Period; Patient Care Team; Rural Population

Resumo

Objetivo: descrever a organização e a execução interprofissional de ações coletivas de cuidado a gestantes e puérperas em uma Unidade Básica de Saúde rural do Distrito Federal. **Método:** relato de experiência realizado entre fevereiro e junho de 2025, baseado em quatro encontros educativos com gestantes, puérperas e, em um deles, familiares e parceiros. As atividades foram conduzidas por residentes de Fisioterapia e Nutrição em articulação com a equipe da Atenção Primária, utilizando metodologias participativas e diário de campo. **Resultados:** registraram-se 37 participações, com maior adesão em atividades abertas, ampliação da interação entre

usuárias e equipe e inclusão de familiares. Os encontros favoreceram esclarecimentos sobre pré-natal, cuidados com o recém-nascido e direitos sociais, além de encaminhamentos para a rede de apoio. **Conclusão:** a experiência mostrou-se viável e replicável para fortalecer o cuidado e o vínculo na Atenção Primária à Saúde.

Descritores: Atenção Primária à Saúde; Gestantes; Período Pós-Parto; Equipe de Assistência ao Paciente; População Rural

Resumen

Objetivo: describir la organización y la ejecución interprofesional de actividades colectivas de cuidado dirigidas a gestantes y puérperas en una Unidad Básica de Salud rural del Distrito Federal, Brasil. **Método:** relato de experiencia realizado entre febrero y junio de 2025, basado en cuatro encuentros educativos con gestantes, puérperas y, en uno de ellos, familiares y parejas. Las actividades fueron desarrolladas por residentes de Fisioterapia y Nutrición en articulación con el equipo de Atención Primaria, utilizando metodologías participativas y diario de campo.

Resultados: se registraron 37 participaciones, con mayor adhesión a las actividades abiertas, ampliación de la interacción entre usuarias y equipo de salud e inclusión de familiares. Los encuentros favorecieron aclaraciones sobre atención prenatal, cuidados del recién nacido y derechos sociales, además de derivaciones a la red de apoyo. **Conclusión:** la experiencia se mostró viable y replicable para fortalecer el cuidado y el vínculo en la Atención Primaria de Salud.

Descriptor: Atención Primaria de Salud; Personas Embarazadas; Periodo Posparto; Grupo de Atención al Paciente; Población Rural

Introduction

Maternal mortality remains an indicator of health inequity, reflecting disparities in access to and the quality of women's healthcare. In Brazil, despite progress, significant regional disparities persist, with poorer indicators among vulnerable populations, particularly in rural areas, where geographic and social barriers hinder timely access to health services.¹ In Primary Health Care (PHC), longitudinal and territory-based care is crucial for reducing adverse outcomes during the pregnancy-postpartum period, especially in rural settings.² By organizing care around the local territory, the Family Health Strategy (FHS) enables the incorporation of social determinants and the development of more comprehensive, context-specific practices.³ In this context, the use of "light technologies", such as embracement care, relationship-building, and skilled listening, combined with collective strategies like educational groups, represents a valuable approach to maternal healthcare.³ These methods foster the exchange of experiences, strengthen women's autonomy, and facilitate the early identification of care needs.

Interprofessional practice, understood as the collaborative integration of various health professionals in delivering care, is recognized as a key strategy for improving the quality of PHC services. This approach enhances the system's ability to meet users' needs, reduces care fragmentation, and strengthens the principle of comprehensive care by integrating diverse forms of knowledge and practices into the care process.⁴

However, implementing collective actions in rural settings presents challenges related to access, service organization, and the territory's specific sociocultural characteristics. Despite the importance of these initiatives, there is a scarcity of literature describing experiences with interprofessional collective practices for maternal health in rural PHC, particularly concerning care organization and the adaptations required for the local context.⁵

Given this scenario, it is important to systematize experiences that integrate collective care, interprofessional collaboration, and territorial specificities. Thus, this study aims to describe the organization and interprofessional implementation of collective care actions for pregnant and postpartum women at a rural Basic Health Unit (BHU) in the Federal District (FD).

Method

This is a qualitative and descriptive experience report conducted at a BHU located in the rural area of the Fercal Administrative Region (AR), part of the North Health Region of the FD, Brazil. The experience was carried out by two residents, one in Physiotherapy and one in Nutrition, participating in the Multiprofessional Residency Program in Family Health with an emphasis on Rural Population Health (PRMSF Campo). This program is linked to the Oswaldo Cruz Foundation (Fiocruz Brasília) and operates in partnership with the FD State Department of Health under the Unified Health System (UHS).

The study was structured according to methodological guidelines for experience reports,⁶ adopting the Charles Maguerez Arc as a framework. This arc comprises five interrelated stages: observation of the context, identification of key points, theorization, formulation of solution hypotheses, and application to reality.⁷

The systematization of the experience relied on records produced throughout the activities, including residents' field journals, descriptive notes from the meetings, institutional records from the BHU, and educational materials used. These data were organized chronologically and subjected to a descriptive-reflective analysis guided by the stages of the Maguerez Arc. This process involved identifying significant situations, defining core needs, linking findings to theoretical frameworks, and interpreting the potential and challenges associated with the actions taken.

The activities took place between February and June 2025, consisting of four in-person meetings focused on collective care for pregnant and postpartum women linked to the unit. Meetings were held on a roughly bi-weekly basis, with adjustments made according to local dynamics, participant availability, the team's schedule, and the residents' training requirements.

The meetings were organized around themes related to the pregnancy-postpartum cycle, covering both clinical and psychosocial aspects of care. Key topics addressed included: preparation for childbirth; guidance for women in early pregnancy; strengthening support networks and partner involvement; newborn care and first aid basics; mother-baby bonding and child development; and attention to maternal mental health.

The participants were pregnant and postpartum women registered in the BHU micro-areas who resided within the Family Health Strategy (FHS) coverage area and were monitored by Community Health Agents (CHA); women at any stage of pregnancy and of any age could participate, provided they were receiving prenatal care within the local public health system. Partners and family members attended one of the sessions, aiming to expand the support network.

Participants were identified using records from the e-UHS system and the unit's internal spreadsheets, which contained information on age, gestational age, and expected delivery date.

Given the specific characteristics of the rural area, logistical aspects regarding the pregnant women's travel were incorporated into the planning of the initiatives. Consequently, public transport schedules, the unit's patient flow, and scheduling

arrangements were analyzed to identify the most suitable times for the meetings, thereby minimizing access barriers and encouraging participation.

The initiatives were organized under the project titled *“Cuidar, Apoiar, Preparar: Ações Coletivas voltadas para a Saúde Integral de Gestantes e Puérperas na BHU 03 Lobeiral – Fercal”* (Caring, Supporting, Preparing: Collective Actions Focused on the Comprehensive Health of Pregnant and Postpartum Women at BHU 03 Lobeiral – Fercal, free translation), which guided the conduct of activities in the area.

The organization of the meetings is presented in Chart 1, detailing the target audiences, topics addressed, and pedagogical strategies adopted, all structured according to the needs identified in the area and the stages of PHC monitoring.

Chart 1 – Description of the meetings held at BHU

	Meeting	Main Objective	Used Methodology	Content Worked	Materials / Resources	Target Audience	Type of Group
1	Preparation for childbirth	To provide guidance on body changes in late pregnancy, recognize warning signs, and strengthen autonomy for childbirth	Interactive presentation; hands-on experience; active listening	Physical changes; pelvic floor strengthening; warning signs; social rights	Educational booklet; exercise mat; brochures	Pregnant women in the 3 rd trimester	Closed
2	Initial care and active listening Initial care	To address Questions and initial sensations of pregnancy; reinforce the importance of prenatal care	Discussion circle; active listening; light physical activity	Early pregnancy changes; prenatal care and bond with the BHU	Explanatory brochure; ambient sound; Swiss ball	Pregnant women in the 1 st and 2 nd trimesters	Closed
3	Partner/family involvement	To raise awareness among the support network regarding active participation in pregnancy and care.	Video screening; moderated discussion circle	Emotional support; active presence; fatherhood and masculinity	Thematic video; poster; group activities	Partners and family members	Closed
4	Baby care and first aid	To prepare caregivers For everyday situations and emergencies in baby care	Practical demonstration; guided dialogue	Newborn care; accident prevention; first aid	Simulation mannequins; illustrated leaflets; educational video	Pregnant women, puerperal women, and family members	Open

Each session lasted an average of one hour and twenty minutes and was held in an indoor space at the Basic Health Unit (BHU), which had been prepared beforehand to foster dialogue and bonding among the participants. To this end, chairs were arranged in a circle to create a welcoming, intimate atmosphere, enhanced by printed invitations and simple decorative elements like flowers, making the space more inviting. There were measures to ensure thermal comfort, guaranteeing suitable conditions during the activities. These aspects encouraged active participation and strengthened the bonds between pregnant women, women in the postpartum period, and the healthcare team.

Before each session, the pregnant women underwent a nursing screening that included checking vital signs and updating their clinical records, with individual referrals made as needed.

The first session covered the bodily and postural changes associated with the third trimester, such as cardiovascular, respiratory, and gastrointestinal adjustments. Strategies for breastfeeding and pelvic floor strengthening were discussed, as well as warning signs requiring immediate medical attention. Additionally, the women were informed about their social rights, including maternity leave, the right to have a companion present during childbirth, pre-delivery visits to the maternity ward, and social benefits linked to prenatal care.

The second session addressed early pregnancy changes, such as weight gain, edema, and nausea, and the importance of prenatal care, including the schedule of appointments and essential tests. Emphasis was placed on the relationship with the BHU and the role of the CHA, reinforcing the importance of ongoing communication with the team. The third session focused on emotional support during pregnancy, highlighting the partner's participation and shared responsibility for care. Discussions covered aspects of fatherhood, masculinity, and the division of responsibilities, alongside the debunking of myths through a participatory activity. The possibility of partner participation in prenatal care was also addressed.

The fourth session focused on newborn care, including safe positioning, the prevention of household accidents, and basic first aid. Warning signs such as fever and seizures were discussed, and guidance was provided on how to handle choking incidents, including airway clearance techniques, as well as how to contact emergency services.

Action planning was carried out in coordination with the FHS team and the multiprofessional team (e-Multi), ensuring a comprehensive and interprofessional approach. The project was primarily led by residents, with continuous monitoring through weekly meetings for evaluation and adjustments.

Evaluation was conducted continuously, based on listening to the participants, systematic observation of the residents, and meetings with the health team, during which impressions and proposals were discussed with the preceptors and the unit coordinators.

The study adhered to current ethical standards, in accordance with National Health Council Resolutions N. 466/2012 and N. 510/2016, and received institutional approval from the BHU and the Residency Program's preceptorship. Verbal consent was obtained from the pregnant women prior to the activities, ensuring participant autonomy, confidentiality, and anonymity. As this was an experience report rather than a study involving systematic research data collection, submission to the Research Ethics Committee was not required, in compliance with current ethical guidelines.

Results

Four meetings were held involving pregnant women, women in the postpartum period, and their partners or family members linked to the FHS. A total of 37 participations were recorded, representing the aggregate attendance count, given that some individuals attended more than one meeting and the audience composition varied according to the topic addressed. The number of participants fluctuated across meetings based on service users' availability and service scheduling; thus, the group did not constitute a fixed sample. Residents primarily led the activities, supported by e-Multi professionals and other FHS team members. The experience was evaluated formatively, drawing on residents' records, team observations, and spontaneous feedback provided by participants at the end of the meetings.

The organization of the groups underwent adjustments throughout the process. Initially, the meetings followed a closed format, with no repeat participants, which enabled outreach to a larger number of pregnant women at various stages of gestation. Subsequently, an open format was adopted, allowing for repeat participation by service

users. This shift was prompted by a growing demand for closer monitoring, particularly among women in the later stages of pregnancy. Although individual participation data were not systematically compiled, greater engagement and return attendance were observed during the open meetings; this fostered the continuity of guidance, strengthened bonds, and enhanced interaction between participants and the team, aligning with Primary Health Care (PHC) principles.

Regarding participation rates, higher attendance was noted at meetings held at the facility on days with lower service volume, a relevant factor given the specific characteristics of the rural territory. Conversely, participation was lower among pregnant women living in more remote micro-areas, a trend linked to the difficulties involved in traveling to the facility. To minimize these barriers, meetings were scheduled for days and shifts with lower clinical demand, such as periods when no laboratory sample collection took place, aiming to ensure greater facility availability and a more welcoming environment for participants.

The unit's infrastructure, considered adequate for a rural setting, with spacious areas, climate control, and multi-purpose rooms, facilitated the activities. Nevertheless, operational adjustments were necessary; for instance, residents created their own educational materials using available unit resources, as institutional booklets were unavailable.

Residents played a central role at every stage of the process, including planning, community outreach, facilitating discussion circles, and systematizing experiences. Meeting facilitation was carried out in partnership with CHAs, who contributed significantly to inviting pregnant women from their respective micro-areas. Coordination with the FHS team was characterized by collaboration and mutual recognition, although the level of participation varied among professionals.

Team meetings served as important forums for monitoring activities and discussing adopted strategies. These sessions allowed for specific contributions from various professionals—such as the dentist, who noted low attendance at dental appointments among pregnant women, particularly those in their third trimester. In response, it was suggested that the dentist participate in the meetings to emphasize the importance of oral health care during pregnancy and facilitate access to services. This

interaction highlighted the potential of educational groups to better identify needs and strengthen coordination across different professional disciplines.

Despite the effective coordination among residents, CHAs, and part of the team, certain challenges were identified. The facilitation of activities fell largely on the residents, occasionally leading to an excessive workload. Furthermore, difficulties arose regarding the integration of the entire team, stemming from clinical demands and the unit's operational dynamics. Specific questions also emerged concerning the objectives and execution of the activities, indicating a need for more effective communication strategies and shared planning.

Other challenges included the low participation of the pregnant women's partners, especially in cases where there was no ongoing relationship with the biological father, with family members such as grandmothers and aunts being more frequently present. This dynamic highlighted the need to adapt activities to the diverse family structures found in the local area.

Adjustments were made to the activities as the sessions progressed. During the final meeting, for instance, the practical foot-soaking activity was scaled back because the pregnant women spontaneously shared more thoughts on the mother-baby bond, thereby fostering an exchange of experiences among the participants.

The systematization of the experience relied on records kept by residents, team observations, and participant feedback. Although a digital evaluation form was made available, the data collected via that form were not used in this report, as the study had not been submitted to the Research Ethics Committee beforehand. Nevertheless, spontaneous comments allowed for the identification of key aspects of the experience.

Notable outcomes included increased autonomy among the pregnant women in recognizing warning signs, a better understanding of social rights, a strengthened bond with PHC services, and greater team engagement in educational practices. In some instances, the meetings also served as a forum for addressing social needs, such as difficulties accessing benefits like *Bolsa Família*. Based on these accounts, referrals were made to network services, such as the Social Assistance Reference Center (CRAS - *Centro de Referência de Assistência Social* in Portuguese), and registration details were updated, thereby enhancing comprehensive care and intersectoral coordination.

As a follow-up measure, a WhatsApp® group was created to ensure continuity of care, facilitating communication between meetings and maintaining the connection with the service users. This initiative enabled information sharing, invitations to future activities, and an expansion of the strategy's reach, supported by unit staff who promoted the group during consultations. Overall, the results highlight the potential and challenges associated with implementing collective actions in primary health care within rural contexts, underscoring the need for flexible organizational strategies, professional integration, and the strengthening of intersectoral actions.

Discussion

Implementing educational groups for pregnant women in the rural area of Fercal-DF proved to be a strategy aligned with PHC principles, particularly regarding the promotion of comprehensive care and the emphasis on educational practices during the pregnancy and postpartum period. In line with the guidelines of the National Primary Care Policy and Primary Care Handbook N. 28 (Women's Health), these initiatives contribute to strengthening interprofessional care and enhancing the quality of prenatal care.⁸ In this regard, the experience not only facilitated the dissemination of information but also fostered stronger bonds between pregnant women and the health team, a key element for the continuity of care.⁹

This strengthening of the bond was directly linked to the pregnant women's active participation in the meetings, highlighting the importance of collective spaces that value the sharing of experiences and knowledge. Literature indicates that exchanging lived experiences contributes to building support networks and empowering women during pregnancy. Furthermore, including family members—such as grandmothers and aunts, underscores the importance of considering the extended support network when planning interventions, especially in rural areas, where family structures play a central role in care.¹⁰

The residents' facilitation of activities, grounded in an interprofessional approach and participatory methodologies, fostered a welcoming environment based on dialogue. Furthermore, the use of strategies such as discussion circles and hands-on activities contributed to greater participant engagement and the co-

construction of knowledge, aligning with evidence highlighting the potential of active methodologies in health education.¹¹⁻¹² This process also underscores the value of multiprofessional residency programs as spaces for both training and intervention, enabling the integration of education, service delivery, and the community in the development of context-specific practices.

However, the implementation of these practices revealed significant challenges linked to the rural setting. Difficulties regarding travel for pregnant women living in areas far from the BHU affected the meeting attendance, pointing to a need for organizational strategies that are more flexible and adapted to local realities.¹³ This aspect represents a limitation of the initiative, as it restricted participation from certain micro-areas and, consequently, the overall reach of the activities.

Additionally, there were weaknesses regarding shared responsibility within the multiprofessional team; activities were largely concentrated among the residents, with difficulties in integrating other unit professionals. This scenario reflects structural challenges within Primary Health Care (PHC), such as heavy workloads and high service demand, that can compromise the implementation of collective, interprofessional initiatives.¹⁴ These findings indicate a need to strengthen work process management and to institutionalize these practices within daily service operations.

Another relevant aspect concerns the low participation of the pregnant women's partners in the proposed activities. Although including partners is recognized as a key strategy for strengthening support during pregnancy, sociocultural factors can influence participation, thereby limiting a family-centered approach to care.¹⁵ This limitation highlights the need to develop specific strategies that take local particularities into account and increase engagement among this group. The experience also highlighted the importance of incorporating themes related to maternal mental health into educational groups, taking into account the emotional transformations experienced during pregnancy. Creating spaces for attentive listening helped identify subjective needs and promote the well-being of pregnant women, broadening the understanding of care beyond biomedical aspects.¹⁶

Finally, systematizing this experience helps demonstrate the feasibility of interprofessional collective actions within the context of rural PHC, offering insights for

organizing care in areas with similar characteristics. Despite the identified limitations, the results point to the potential of these strategies to foster bonding, expand access to information, and strengthen the active role of service users, making this a practice that can be adapted and replicated in other PHC settings.

Conclusion

The experience enabled a description of the organization and implementation of interprofessional collective actions aimed at pregnant and postpartum women in a rural setting. It highlighted that conducting educational groups within PHC fostered broader participation in collective activities, strengthened the bond between service users and the team, and increased women's autonomy in identifying warning signs and recognizing their rights throughout the pregnancy and postpartum period.

The meetings served as spaces for listening and exchanging experiences, where the target audience participated actively, contributing to the shared construction of care and the tailoring of actions to their specific needs. Furthermore, these activities facilitated the identification of social needs and referrals to other points within the care network, thereby enhancing the comprehensiveness of care.

At the service level, the experience led to the adoption of more flexible organizational strategies, such as combining open and closed groups and using communication tools to ensure continuity of care, which supported the longitudinal monitoring of service users.

Interprofessional collaboration contributed to the integration of diverse forms of knowledge in developing the initiative, although there were challenges regarding shared team responsibility, access for pregnant women living in remote areas, and low participation by partners.

The systematization of the actions undertaken, including thematic planning, mobilization strategies, and meeting organization, provides a framework applicable to other rural PHC contexts, since local territorial specificities are taken into account.

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