The Effect of Supportive Care for Pregnant Women During Labor on Breastfeeding Self-Efficacy and the Perception of Childbirth in a Central Region of Turkey

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Objective: This study aimed to evaluate the effect of support given to pregnant women during labor on their perception of childbirth and their breastfeeding self-efficacy.

Methods: This descriptive and relational study was conducted with 331 primigravid women who had a vaginal delivery in a maternity unit from December 15, 2018, to March 15, 2020. Data were collected using a descriptive characteristics form prepared by the researcher and based on the relevant literature, the Scale of Women's Perception for Supportive Care Given During Labor (SWPSCDL), the Perception of Birth Scale (POBS), and the Breastfeeding Self-Efficacy Scale-Short Form (BSES-SF)." The data were analyzed using descriptive statistics, a t test, a variance test, and Pearson's correlation.

Results: The mean total SWPSCDL, POBS, and BSES-SF scores of the participating women were 102.19 (±14.99), 54.75 (±9.39), and 76.24 (±11.37), respectively. A positive correlation was found between supportive care for women during delivery and both women's perceptions of childbirth and breastfeeding efficacy. In addition, training given in antenatal classes positively increased the perception of support during delivery among the women.

Conclusion: Supportive care given during delivery had a positive effect on the perception of childbirth and on breastfeeding self-efficacy. Interventions to encourage more couples to participate in training given at antenatal classes and to improve the working conditions of midwives working in delivery rooms would contribute to the support that pregnant women require during delivery and would provide a more positive delivery experience for these women. [*P R Health Sci J 2023;42(1):63-69*]

Key words: Childbirth support, Perception of birth, Breastfeeding self-efficacy, Childbirth

Childbirth is an experience that affects the baby as the birth proceeds as well as the mother and other family members. When this experience is perceived positively, the woman feels good and safe. However, a negative experience can cause postpartum depression and post-traumatic stress disorder, as well as impairing the parents' attachment to their baby (1–3). The impact of this experience may continue for about 10 years after the delivery (4).

The Parents' perception of birth are multidimensional and can vary depending on their expectations and experiences (5, 6). Pregnant women and their families perceive the childbirth experience positively when they are informed about the progress of the process, when they feel that the maternity nurse/midwife is with them during the process, when positive communication is established with clinicians, when they are included in the decisions about the childbirth, and in cases in which partner support is allowed (3, 6–9). However, a negative childbirth experience can occur when an emergency cesarean section is performed on the pregnant woman, if healthcare professionals do not adequately communicate with the pregnant woman, and if the pregnant woman's privacy is disregarded (7, 10–13).

Purpose of the Study

Supportive care is one of the most important positive factors that can affect the perception of the birth experience and the quality of the care provided (14). The supportive care given to a pregnant woman during delivery includes physical support (applying non-pharmacological methods for pain, considering her needs), emotional support (approaching with a smiling

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face, being encouraging and complementary), information (progress about the process of the delivery), and defense of rights (protecting the woman) (15). The effect of supportive care on birth results is currently the subject of study for the past few years. Supportive care given during childbirth is closely related to a reduced need for analgesia and anesthesia during delivery, lower rates of operative births, shorter durations of labor, and increased maternal satisfaction (16). A delivery experience without supportive care can be traumatic, which can have adverse effects on breastfeeding as well as on maternal health (17). Maternity nurses/midwives know that the support provided affects the health of the mother and the baby and that it is very important for a pregnant woman to have a positive childbirth experience.

This study aimed to evaluate the effect of support given to pregnant women during childbirth on their perception of the birth experience and their breastfeeding self-efficacy. The study also aimed to determine women's perceptions of birth and of supportive care and their breastfeeding self-efficacy levels.

Material and Methods

The study population consisted of all the pregnant women who presented to the Obstetrics and Gynecology Hospital from December 15, 2018, to March 15, 2020, who agreed to participate in the study, and who later underwent childbirth. The data were collected from the women in the postpartum unit who had had a vaginal delivery within the first 24 hours after childbirth; these women were chosen using a convenience sampling method. Convenience sampling is defined as a nonprobability sampling method adopted by researchers in which research data are collected from a pool of appropriate responders. This method was preferred because it allows fast and relatively inexpensive data collection from a relatively large group of participants. All the women who met the inclusion criteria and agreed to participate were included in the study.

Inclusion criteria

The study included women who were the age of 18 and older; were pregnant for the first time; had a vaginal delivery at the 37th to 42nd gestational week; had no high-risk conditions, such as preeclampsia or any kind of placental or presentation anomaly; and agreed to participate in the study.

Maternity unit in the institution where the study was conducted

The hospital's delivery practices include evidence-based practices for controlling pain (for all pregnant women) as well as non-pharmacological techniques (18). The number of vaginal deliveries in the center in 2019 was 8,145; 7 midwives are on duty every night.

The sample size of the study

The sample size of the study was calculated using G*Power 3.1.7 software. The sample was 327 people with a known score of 72.86 (±15.45) and a power of 95%, within 3 points of deviation (19). During the data collection process, 405 women were interviewed; 74 refused to participate. The study was carried out with 331 women.

Ethical consideration

Necessary permissions were obtained from the Selcuk University Faculty of Health Sciences Non-Interventional Research Ethics Committee and the hospital where the study would be conducted (2018/188). The women interested in participating were first informed about the study, after which their verbal and written consents were obtained.

Measurements

Data were collected using a descriptive characteristics form prepared by the researcher and based on the relevant literature, the Scale of Women's Perception for Supportive Care Given During Labor (SWPSCDL), the Perception of Birth Scale (POBS), and the Breastfeeding Self-Efficacy Scale-Short Form (BSES-SF). The data were collected by the researchers based on self-report.

Descriptive characteristics form

This questionnaire was prepared by researchers, who based it on the literature and the abovementioned measures; it included 25 questions about the sociodemographic and obstetric characteristics of the participating mother.

The scale of women's perception for supportive care given during labor

The scale was developed in Turkish by Uludağ and Mete (20) in 2013. It is applied within the first 24 hours after delivery and is used to determine the supportive care of women who have had a vaginal delivery. The scale consists of 33 items and has 3 subscales; the minimum score is 33, and the maximum score is 132. Higher scores indicate better supportive care. The content validity of the scale was assessed by a panel of experts and determined to be .94 Three factors—comforting behaviors, education, and disturbing behaviors—were exposed to exploratory factor analysis, and the factor loadings varied from .38 to .76. The factor structures were confirmed by confirmatory factor analysis. The Cronbach's coefficients were .94 for the scale, .92 for comforting behaviors, .85 for education, and .87 for disturbing behaviors.

The perception of birth scale

This scale, which evaluates the experiences and perceptions of mothers during delivery, was developed by Fawcett in 1996. The scale, a 5-point Likert-type measure, consists of 25 items; it was adapted to the Turkish language by Güngör and Beji (21, 22). The POBS has 5 subscales, each of which can be used independently. The items of the subscales are as follows: delivery experience, labor experience, delivery outcome, partner participation, and awareness. On the POBS, each item is rated

from 1 to 5. Increases in the total score, which does not have a cutoff point, mean that the mother had more positive experiences during the delivery. The total Cronbach's alpha coefficient of the original version of the scale was .90, and it was .84 in this study. In our study, the Cronbach's alpha was determined to be .85.

The Breastfeeding Self-Efficacy Scale-Short Form (BSES-SF)

The Breastfeeding Self-Efficacy Scale (BSES) was developed by Dennis and Faux and includes 33 items (23). The scale was adapted to the Turkish language by Aluş-Tokat and Okumuş (24). This scale evaluates postpartum mothers' breastfeeding self-efficacy. It is a 5-point Likert-type measure with scores ranging from 14 to 70 with responses that go from "not at all confident" (which receives a value of 1) to "always confident" (which receives a value of 5). The minimum score that can be derived from the scale is 14, and the maximum score is 70. The scale does not have a breakpoint, and higher scores indicate higher levels of breastfeeding self-efficacy. Original Cronbach's alpha value of the scale was .94, and Alus Tokat et al.'s Cronbach's alpha value was found to be .91 in this study.

Analytic plan

The data were analyzed using the Statistical Package for the Social Sciences, 25 (SPSS 25.0). Descriptive statistics, a *t* test, and variance analysis were used. The Kolmogorov–Smirnov test was used to determine whether the data were normally distributed. The relationship between the SWPSCDL and both the POBS and the BSES-SF was evaluated using Pearson's correlation analysis. Multiple linear regression analyses determined the level of relationship between the SWPSCDL and the POBS and BSES-SF.

Results

The mean age of the participating women was 27.08 (±5.17) years (min = 18.00; max = 43.00), the mean gestational period was 39.27 (±1.08) weeks (min =35.00; max = 41.00), and the mean weight gain during pregnancy was 11.40 (±4.89) kg (min = 4.00; max = 40.00). In terms of the participants, 64.0% had a secondary education, 67.4% had a moderate-level income, and 87.6% belonged to a nuclear family.

Concerning the obstetric characteristics of the women, 79.8% had their first-ever delivery as part of the study, 14.8% had previously undergone a spontaneous/voluntary abortion, 10.6% had not wanted to be pregnant, 8.8% had not gone for regular antenatal care, 83.7% had been checked by a physician, and 40.2% had experienced problems, such as nausea, vomiting, a urinary tract infection, or bleeding, during pregnancy. In addition, 28.4% of the participants had attended an antenatal class (Table 1). The mean SWPSCDL, POBS, and BSES-SF scores of the women were 102.19 (±14.99), 76.24 (±11.37), and 54.75 (±9.39), respectively.

On comparing the obstetric and descriptive characteristics of the participants, we found a significant difference between the education subscale of the SWPSCDL, the total and delivery experiences, the partner participation and awareness subscales of the POBS, and age group. As the age range increased, the mean scores obtained from the scales decreased. The statistically significant difference between the educational status of women and the total and labor experiences and partner-

Table 1. Descriptive and obstetric characteristics of the women

Property	n	%
Age groups		
18–30	255	77.0
31–45	76	33.0
Educational status		
Primary school	55	16.6
Secondary school	212	64.0
Higher education	64	19.3
Partner's educational status		
Primary school	30	9.1
Secondary school	202	61.0
Higher education	99	29.9
Employment status		
Employed	60	18.1
Unemployed	271	81.9
Partner's employment status		
Employed	325	98.2
Unemployed	6	1.8
Social insurance status		
Yes	311	94.0
No	20	6.0
Monthly income of the family		
Income is less than expenses	70	21.1
Income equals expenses	223	67.4
Income is higher than expenses	38	11.5
Family type		
Nuclear family	290	87.6
Large family	41	12.4
Number of pregnancies experienced		
1	264	79.8
2	55	16.6
3 and more	12	3.6
Presence of spontaneous/Voluntary abortion		
Yes	49	14.8
No	282	85.2
Number of spontaneous/Voluntary abortions		
1	44	89.9
2	5	10.2
Willingness to be pregnant		
Yes	296	89.4
No	35	10.6
Going to regular antenatal care		
Yes	302	91.2
No	29	8.8
Health professional providing antenatal care		
Midwife/nurse	54	16.3
Physician	277	83.7
Experienced problems during pregnancy		
Yes (nausea, vomiting, urinary tract infection, bleeding, etc.)	133	40.2
No	198	59.8
Exercised regularly		
Yes	77	23.3
No	254	76.7
Attended antenatal class		
Yes	94	28.4
No	237	71.6

participation subscale scores of the POBS were linked to responses from the members of the higher-education group.

There was a statistically significant difference between willingness to be pregnant and the total POBS score, the total and comforting behaviors, and the education subscale scores of the SWPSCDL. A significant difference was found between going to regular antenatal care and the total BSES-SF score, the total and all subscale scores of the SWPSCDL, and the total and delivery outcome scores of the POBS. The mean scores of the women who went to regular antenatal care were higher than those of the women who did not. A comparison between the healthcare professionals who carried out antenatal care showed that there was a significant difference between the total and education subscale of the SWPSCDL and the delivery experience subscale of the POBS. The mean scores of the women whose antenatal care was conducted by a physician were higher than were those of the women whose antenatal care was conducted by a midwife/nurse. For the regular exercise status of women, a statistically significant difference was found between the total BSES-SF, the education subscale of the SWPSCDL, and the total and all subscale scores of the POBS. There was a significant difference between attending antenatal classes and the total and labor experiences, delivery experiences, partner participation, awareness, comforting behaviors, and the education subscales of the SWPSCDL (Table 2). On examining the total and subscale scores, there was a relationship between all the mean subscale scores (r = 0.13, 0.42) except for the total SWPSCDL score and the partner participation subscale of the POBS. In addition, there was a relationship between all the mean scores (r = 0.25, 0.35), except for

Table 2. Comparison of descriptive and obstetric characteristics of the women and the mean scores of the scales

Scale	SWPSCDL				POBS				BSES-SF
	Total	Comforting behaviors	Education	Disturbing behaviors	Total	Delivery experiences	Labor experiences	Delivery outcome	Partner participation	Awareness	Total
	Mean±SD	Mean±SD	Mean±SD	Mean±SD	Mean±SD	Mean±SD	Mean±SD	Mean±SD	Mean±SD	Mean±SD	Mean±SD
Age groups											
18–30	102.85±14.68	45.65±9.08	22.64±3.70	33.56±6.20	77.16±11.01	19.06±3.86	20.49±3.72	16.63±2.43	11.83±3.86	9.12±1.96	55.25±9.54
31–45	99.97±15.87	44.13±9.58	22.48±4.24	33.35±5.59	73.14±12.08	18.65±4.41	19.27±4.10	16.31±2.59	10.28±4.41	8.60±2.20	53.07±8.76
P*	.141	.206	.022	.796	.007	.434	.015	.318	.007	.048	.077
Educational status											
Primary school	102.81±15.70	45.45±10.39	23.12±4.12	34.23±5.10	72.83±12.43	18.01±4.24	19.45±4.22	16.40±2.83	10.18±4.48	8.78±2.22	53.69±10.03
Secondary school	101.06±14.87	44.67±9.09	23.23±3.83	33.15±6.22	75.87±10.88	18.91±3.83	20.17±3.76	16.51±2.38	11.27±3.81	8.99±1.92	54.66±9.38
Higher education	105.42±14.47	47.25±8.34	24.07±3.70	34.09±6.26	80.37±10.99	19.98±4.11	20.98±3.68	16.85±2.44	13.28±3.83	9.26±2.18	55.96±8.89
P**	.118	.146	.268	.346	.001	.025	.094	.543	<.001	.422	.409
Partner's educational status											
Primary school	102.70±14.54	46.83±9.41	22.83±3.93	33.03±5.53	70.96±11.75	17.46±3.61	18.76±4.08	16.16±3.24	9.96±4.02	8.60±2.25	51.63±9.29
Secondary school	101.79±15.09	44.96±9.38	23.19±3.90	33.64±5.79	75.45±11.11	18.74±4.03	20.06±3.80	16.66±2.41	11.08±4.02	8.89±1.89	55.41±9.38
Higher education	102.85±15.04	45.54±8.82	23.91±3.72	33.39±6.76	79.44±11.00	19.89±3.83	20.94±3.73	16.47±2.33	12.74±3.78	9.37±2.17	54.34±9.34
P**	.832	.557	.223	.853	<.001	.006	.017	.533	<.001	.078	.105
Willingness to be pregnant											
Yes	102.93±14.86	45.74±9.20	23.63±3.75	33.55±6.09	76.53±11.14	19.01±3.91	20.30±3.81	16.66±2.35	11.54±3.97	9.01±1.98	55.18±9.28
No	95.97±14.83	41.60±8.51	21.22±4.15	33.14±5.85	73.74±13.09	18.65±4.66	19.45±4.12	15.74±3.21	10.94±4.59	8.94±2.37	51.11±9.70
P*	.009	.012	.001	.703	.170	.669	.219	.109	.406	.839	.015
Went to regular antenatal care											
Yes	103.10±14.60	45.76±9.05	23.58±3.78	33.75±5.98	76.73±11.42	19.07±4.02	20.34±3.78	16.66±2.48	11.57±4.08	9.07±1.99	55.32±9.18
No	92.68±15.90	40.48±9.55	21.20±4.03	31.00±6.38	71.06±9.53	17.86±3.44	18.89±4.28	15.48±2.08	10.51±3.42	8.31±2.23	48.79±9.69
P*	.001	.003	.001	.019	.010	.117	.053	.013	.180	.052	.001
Exercised regularly											
Yes	104.07±14.36	46.79±8.02	24.24±3.72	33.03±6.17	82.12±10.97	20.10±4.00	21.97±3.46	17.18±2.10	13.20±4.03	9.66±2.18	57.38±8.31
No	101.62±15.16	44.85±9.50	23.11±3.87	33.65±6.03	74.45±10.90	18.62±3.93	19.68±3.80	16.37±2.54	10.95±3.90	8.81±1.94	53.95±9.57
P*	.209	.106	.024	.434	.001	.004	.001	.012	.001	.001	.005
Attended antenatal class											
Yes	104.62±13.68	47.35±8.33	24.06±3.53	33.21±7.09	79.81±11.29	20.28±3.84	20.94±3.81	16.46±2.36	12.69±3.67	9.42±1.97	55.41±9.67
No	101.23±15.40	44.49±9.42	23.10±3.95	33.63±5.61	74.82±11.11	18.45±3.93	19.92±3.82	16.60±2.51	11.00±4.08	8.84±2.03	54.48±9.29
P*	.063	.011	.042	.608	.001	.001	.029	.654	.001	.018	.420

*t test for independent groups, **Variance test (ANOVA). POBS: Perception of Birth Scale; SD: standard deviation; SWPSCDL: Scale of Women's Perception for Supportive Care Given During Labor

the total BSES-SF and POBS scores and the disturbing behavior subscale of the SWPSCDL (Table 3).

The variables of the BSES-SF ($t = 2.767$; $P = .006$) and the delivery outcome subscale of the POBS ($t = 6.078$; $P < .001$) were predictors of the SWPSCDL and explained 22.3% of the variance. Conversely, the total and delivery experiences, labor experience, and awareness subscales of the POBS were not predictors of the SWPSCDL (Table 4).

Discussion

The results of the study show a dependence on primiparous women's levels of support received during labor and their perceptions of the birth and of breastfeeding self-efficacy, as well as the effect of perceived support on the perception of the birth and breastfeeding self-efficacy. The mean SWPSCDL, BSES-SF and POBS scores of the participants were 102.19 (±14.99), 54.75 (±9.39), and 76.24 (±11.37), respectively. Similar to this study, different studies conducted in Turkey reported that the perceptions of the pregnant women in their sample groups with regard to the supportive care offered by nurses/midwives during the process of labor were highly positive and their breastfeeding self-efficacy levels were high; however, their perceptions of the birth experience were only moderately positive (19, 25–28). Maternity nurses/midwives working in delivery rooms in Turkey work under similar conditions; Therefore, the supportive care that they provide would be expected to be similar, from delivery room to delivery room, from hospital to hospital.

This study found that the perception of the supportive care given during labor decreases as the age of the women receiving that care increases. However, women who had high levels of education, had become pregnant willingly, had received regular antenatal care, had exercised regularly (prior to giving birth), and had attended antenatal classes expressed higher levels of satisfaction with their supportive care than did their counterparts. Yılmaz and Nazik reported that there was no difference between age groups in terms of the support given by nurses and the women's perceptions of delivery (19). Other studies investigating the perception of birth and delivery satisfaction found that as age increased, women perceived care in delivery services more positively and that delivery satisfaction levels increased (29, 30). Unlike what was seen in other studies, in the present study, the levels of supportive care given during labor and the perceptions of birth decreased as age increased, which was thought to have resulted from the fact that the aforementioned studies were carried out in different provinces.

No difference was found between age and educational level in terms of breastfeeding self-efficacy score. Similarly, the previously mentioned studies reported that breastfeeding self-efficacy was not affected by the sociodemographic characteristics of the participating mothers (31, 32). However, willingness to be pregnant and going to regular antenatal care both had a positive effect on breastfeeding self-efficacy scores. There was no difference in terms of breastfeeding self-efficacy scores between the women who attended antenatal class and those who did not. Some published studies support the view that breastfeeding education given in the antenatal period has a positive effect on breastfeeding self-efficacy (24, 33, 34). In those studies, the participating women were given breastfeeding training, only, and its effect on breastfeeding was evaluated. Education given in antenatal classes covers pregnancy, delivery, and the postpartum process, and breastfeeding is included in some parts of these classes. The results of this study suggest that this general education did not affect breastfeeding self-efficacy and that more comprehensive and long-term breastfeeding education should be given in the antenatal period to increase breastfeeding self-efficacy and its success.

In the present study, the POBS scores were found to be higher in women who had attended regular antenatal care, who had exercised regularly, and who had attended an antenatal

Table 3. The relationship between the subscales of SWPSCDL and the mean and subscale scores of POBS and BSES-SF

Subscales of POBS	Subscales of SWPSCDL				
	Comforting behaviors	Education	Disturbing behaviors	Total SWPSCDL	Total BSES-SF
Delivery experiences	0.197	0.171**	-0.075	0.135**	0.123**
Labor experiences	0.308*	0,250	-0,081	0.221*	0.291*
Delivery outcome	0.392*	0.355*	0.229*	0.425*	0.308*
Partner participation	0.171**	0.164**	-0.163**	0.081	0.119**
Awareness	0.213*	0.192*	-0.030	0.168**	0.239*
Total POBS	0.357*	0.314*	-0.067	0.273*	0.293*
Total BSES-SF	0.315*	0.253*	0.081	0.291*	

*$P < .001$, **$P < .05$. BSES-SF: Breastfeeding Self-Efficacy Scale-Short Form; POBS: Perception of Birth Scale; SWPSCDL: Scale of Women's Perception for Supportive Care Given During Labor

Table 4. Regression analysis results of SWPSCDL and the total BSES-SF and the total and subscale scores of POBS

Dependent Variable	Independent variable	B	SE	β	*t*	*P*	Adjusted R^2 = 0.223
							F = 15.491
Total SWPSCDL	Constant	43.189	6.513		6.631	.001	Durbin–Watson = 1.768
	Total POBS	-0.139	0.201	-0.105	-0.688	.492	
	Delivery experiences	0.290	0.337	0.077	0.859	.391	**Model *P* ≤ .001**
	Labor experiences	0.524	0.385	0.134	1.359	.175	
	Delivery outcome	2.337	0.385	0.385	6.078	**.001**	
	Awareness	0.201	0.483	0.027	0.416	.678	
	Total BSES-SF	0.237	0.086	0.148	2.767	**.006**	

BSES-SF: Breastfeeding Self-Efficacy Scale-Short Form; POBS: Perception of Birth Scale; SE: standard error; SWPSCDL: Scale of Women's Perception for Supportive Care Given During Labor

class. Among the subscales of the POBS, the scores of delivery experiences, labor experiences, partner participation, and awareness were significantly higher in women who attended an antenatal class than were such scores in those who did not. One study found that structured prenatal education was effective in causing the participating women to perceive the labor experience positively (35). Boz et al. stated in their study that the delivery and labor experiences of women who received preparatory delivery training were more positive than were those experiences in the women who did not receive this training (25). Another striking result was that, as the education level of a woman's partner increased, that woman's general perception of birth, labor experiences, and delivery experiences, increased positively, as did the participation of said partner. As the education level of men increases, their awareness of the pregnancy, delivery, and postpartum period increases, and therefore they provide more support for their wives during antepartum and intrapartum care (36). Given the positive effects of partner participation on maternal and infant health, pregnant women and candidate fathers should be encouraged to participate in antenatal classes to increase partner participation (37, 38).

The results of this study showed a relationship between supportive care given to women during labor and both their perceptions of the birth experience and their breastfeeding self-efficacy. It was found in the study by Boz et al. that there was a strong positive relationship between the implementation of supportive care behaviors in the delivery room and the perception of the birth and labor experiences (25). The scores of the SWPSCDL subscales showed that there was a relationship between comforting behaviors and education and a given mother's perception of her birth experience and her breastfeeding self-efficacy. The comforting behavior subscale refers to such comforting behaviors as a midwife's having a smiling face and that individual's meeting the needs of the pregnant woman to make her feel good. The education subscale includes training provided for pregnant women by maternity nurses/midwives on straining during labor, breathing exercises, and information about the progress of the delivery (20). Women expect maternity nurses/midwives to communicate with them emphatically, show advocacy, provide continuous emotional support, and, at the same time, keep them updated about the delivery process (6, 39). International organizations such as the International Confederation of Midwives and the World Health Organization also emphasize that it is important for pregnant women and their families to participate in the decisions taken during labor (18). For women to perceive the delivery experience positively and increase breastfeeding self-efficacy, maternity nurses/midwives should focus on the behaviors that are aimed at comforting and informing these women, especially during delivery.

Conclusion

The perception of the birth experience has short- and long-term effects on maternal and infant health. A positive sense of breastfeeding self-efficacy also has an important effect on the success of breastfeeding (28). The results of this study showed that the support given to the women by the maternity nurses/midwives during delivery had a positive effect on the women's perceptions of birth and on their breastfeeding self-efficacy. Consequently, improving the working conditions of the maternity nurses/midwives working in delivery rooms will contribute to the necessary support of pregnant women during childbirth.

Limitations of the study

The study was carried out in a maternity hospital in the Central Anatolia region of Turkey, and the results cannot be generalized for the entire country.

Resumen

Objetivo: Este estudio tiene como objetivo evaluar el efecto del apoyo brindado a las mujeres embarazadas durante el trabajo de parto en su percepción del parto y la autoeficacia en la lactancia. Métodos: Este estudio descriptivo y relacional se realizó con 331 gestantes primarias que tuvieron un parto vaginal en una unidad de maternidad entre el 15 de diciembre de 2018 y el 15 de marzo de 2020. Los datos se recolectaron dentro de las primeras 24 horas después del parto mediante un formulario de características descriptivas, la Escala de Percepción de la Mujer para el Cuidado de Apoyo Brindado Durante el Parto (SWPSCDL, por sus siglas en inglés), la Escala de Percepción del Nacimiento (POBS, por sus siglas en inglés) y la Escala de Autoeficacia en la Lactancia Materna-Forma Corta (BSES-SF, por sus siglas en inglés). Los datos fueron analizados mediante estadística descriptiva, prueba t, varianza y correlación de Pearson. Resultados: Las puntuaciones medias totales de SWPSCDL, POBS y BSES-SF de las mujeres fueron 102.19±14.99, 54.75±9.39 y 76.24±11.37, respectivamente. Se encontró una correlación positiva entre la atención de apoyo a las mujeres durante el parto, así como la percepción de las mujeres sobre el parto y la autoeficacia en la lactancia. Además, la capacitación impartida en clases prenatales aumentó positivamente la percepción de apoyo durante el parto entre las mujeres. Conclusión: Las intervenciones para alentar a más parejas a participar en la capacitación impartida en las clases prenatales y para mejorar las condiciones laborales de las parteras que trabajan en las salas de parto contribuirán al apoyo necesario para las mujeres embarazadas durante el parto y brindarán una experiencia de parto más positiva para las mujeres.

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