



## Factors that Determine the Self-Efficacy of The Maternal Care in Postpartum Women: Data for Future Memory

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### ABSTRACT

**The birth of a child demands the provision of care. Mothers have different levels of safety or confidence when it comes to caring, which reveals the perception of self-efficacy. Our aim is to register, for future memory, the factors associated with self-efficacy in maternal care. Quantitative and cross-sectional study. It explores**

**sociodemographic factors, factors related to the pregnancy and labor history, the newborn's characteristics, and related care environment with self-efficacy in maternal care. The study population included postpartum women from two Turkish maternity hospitals, in convenient sampling, with a response rate of 93,4%. Prudent ethical principles. The criterion variable was observed through the Perceived Maternal Parenting Self-Efficacy (PMP S-E). The statistical analysis was carried out on the SPSS software. The participants had an average age of 27.81(DP=5.13), the majority were married (95.9%) and for 40.1% this was their first child. The majority of labors were vaginal (52.4%). When it comes to the criterion variable, about 70% had a high perception regarding self-efficacy in maternal care. The univariate analysis revealed eight variables, included in the logistic regression: maternal age ( $p=.050$ ), number of children ( $p<.001$ ), number of prenatal appointments ( $p=.006$ ), time that elapsed between the birth and the first episode of breastfeeding ( $p=.047$ ), maternal safety while breastfeeding ( $p<.001$ ), type of food given to the newborn  $p=.011$ ), midwife support for exclusive maternal breastfeeding ( $p<.001$ ) and maternal breastfeeding self-efficacy ( $p<.001$ ). In the binary logistic regression, the best predictors of self-efficacy in maternal care were: midwife support for exclusive maternal breastfeeding (OR=1.092; B=0,088) and the self-efficacy in the maternal breastfeeding (OR=13.187; B=2.579). When it comes to maternal breastfeeding, both from the perspective of self-efficacy and the support offered by professionals, are the most relevant factors in the perception of maternal skills recognized by mothers. This study fills an information gap about the phenomenon, looking at it in retrospect.**

**Keywords:** Self-efficacy, infant care, postpartum period, breast feeding, logistic models.

## INTRODUCTION

Motherhood is a physiological, psychological, and socio-familial fact, that modifies women's roles and behaviors, and guarantees assistance and care provided to the descendant for several years. Becoming a mother is a personal responsibility, but also a social gain, an inevitable behavior for the continuity of the species, given human altriciality.

The care of children in vast families was transmitted across generations, through culturally and socially defined models of mothering. Nonetheless, when analyzing the population indicators, especially the Synthetic Fertility Index (ISF), we notice that the opportunities for contact with newborns (NB) and, thus, for learning these models of maternal care have decreased. In many countries, namely in Turkey, the limit of the generation replacement was reached in 2015. The phenomenon has been worsening, as we observe a rate of 2,03 in 2021[Statista, 2021, Total fertility rate in Europe in 2021, by country].

But whatever the nationality, mothers, who are usually the main caregivers of the NB, anticipate the challenges of maternal care and seek skills to achieve self-confidence, that is, to achieve a high perception of self-efficacy in maternal care [1,2].

## CONCEPTUAL FRAMEWORK

This study is based on the Bandura's Social Learning Theory (SLT), which explains behavior through the regulation of cognitive processes and psychosocial experiences(Bandura et al., 2008). Such processes, determining the responses, influence the perception of the level of self-

efficacy. In this way, each person will understand their self-efficacy, assigning it a low or high level.

Self-efficacy focuses on the confidence or expectation of the person's ability to face or respond to a certain behavior [3, 4]. According to the potential that the person identifies in him/herself, it measures the investment, training, perseverance, to carry out the behavior with quality and satisfaction. The self-efficacy construct is, thus, a way of predicting behavior in the most diverse fields, namely in the exercise of motherhood [1], perhaps the most sublime life experience.

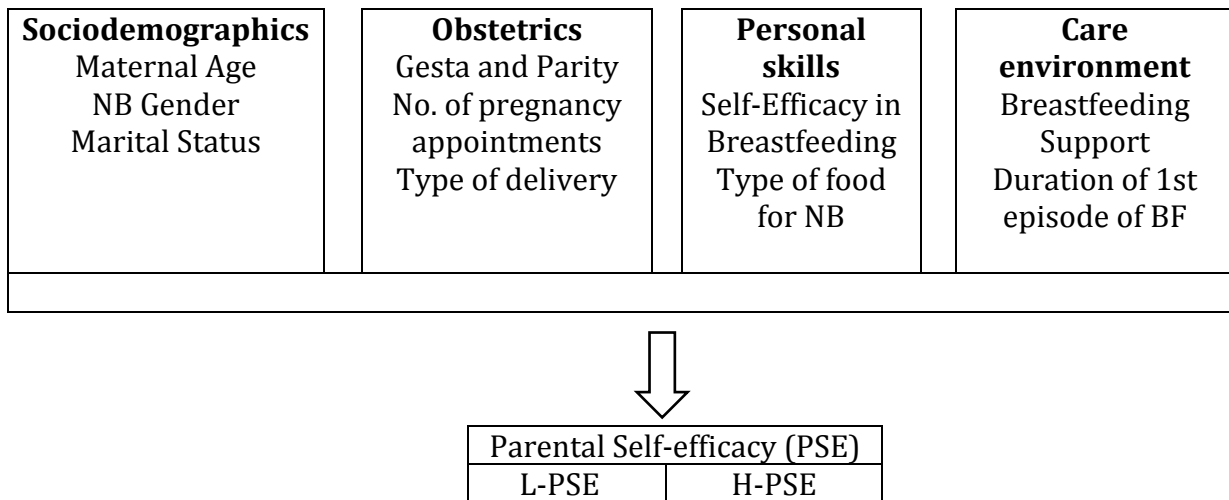
Self-efficacy in parental care, whether of the maternal or paternal figure, can be assessed through various models, but SLT is perhaps the most widespread theory [5]. Applied to maternal care, it describes the perception, belief, or confidence of mothers in their skills or abilities to carry out care behaviors that the child needs or depends on.

The mothers' perception of self-efficacy may be associated with sociodemographic variables such as education level [6], although without absolute agreement [7], but there is controversy regarding age [6-7] and some inconsistencies regarding with marital status [6-8]. In terms of obstetric variables, some authors identify a weak association with parity [6] and the type of delivery [7]. As for the child's characteristics, namely gestational age, there is a negative association in some studies [6], but regarding the gender and number of children, the results of the studies are contradictory [7-8]. Considering the factors of the care environment, the frequency of prenatal programs and pregnancy surveillance shows a positive association [9] and, on the other hand, the perception of support from professionals for EBF suggests that it has a positive effect on maternal self-efficacy [6]. Among the skills developed for maternal self-efficacy, the theme of breastfeeding (BF) and Exclusive Breastfeeding (EBF) are perhaps the most explored in prenatal classes, with revealing success [10] and a significant association between these variables [11]. Some studies report that greater success in the 1st episode of breastfeeding is associated with a greater perception of self-efficacy [7].

If, on the one hand, there are currently less opportunity for observation and training of maternal care in the family environment, on the other hand, countries such as Turkey have been offering successful education programs for maternal [12] and paternal figures [13]. To gain more knowledge, women turn to prenatal classes, where they train and simulate caring for the NB. In fact, studies based in Turkey show benefits, resulting in lower concern with childbirth, a faster adaptation to the postpartum process, early initiation of breastfeeding [12], suggesting the acquisition of maternal skills.

The perception that the maternal figure has about the care competence in relation to the NB, that is, self-efficacy in maternal care, constitutes the fundamental orientation in the interactions of the mother-child dyad [1]. The assessment of self-efficacy is done through instruments, which are useful for local and international studies, as they allow the assessment of the construct in different languages and in different cultures of maternal care [1].

Figure 1 shows the idea underlying the current study, assuming the variables that potentially influence self-efficacy in maternal care.



**Figure 1. Perception of parental self-efficacy**

The objectives of this study were 1) to investigate the level of self-efficacy in parenting and 2) to explore the factors that influence low or high self-efficacy in maternal care.

## METHOD

### Study Design

Quantitative cross-sectional study carried out in two hospitals in Turkey. The sample size was determined by the criteria of Krejcie and Morgan [14], based on the population of users who gave birth in two hospital units with about 2700 deliveries/year 724 women were invited in person. The recruitment, through convenience sampling, was of sequential type, according to the entrance of the participants in the postpartum service, until reaching the desired population portion, among those available [15]. Inclusion criteria were: 1) 16 years of age or older, 2) postpartum around 48-72h, 3) Turkish nationality, 4) non-twin birth and 5) uneventful postpartum. As exclusion criteria: 1) gestational age less than 37 weeks and 2) inability to read and write in the local language. A sample consisting of 676 women was reached after eliminating the incomplete questionnaires (response rate = 93.4%).

### Instrument for Data Collection

Data collection instrument consisting of four sections: 1) sociodemographic data (age, marital status, number of children), 2) obstetric data (type of delivery, gestational age, 3) Breastfeeding behavior (time from birth to breastfeeding, 4) Breast-feeding Self-Efficacy Scale - Short Form (BSES-SF), in the version validated for the Turkish language [16] and 5) the Perceived Maternal Parenting Self-Efficacy scale (PMP SE) [1], which in the current study revealed a Cronbach's alpha coefficient of .867. The additional archive 1 shows the data collection instrument.

The author of the PM S-E [1] was contacted, requesting permission to use the instrument, which was granted. The 20 manifest variables were subjected to a process of translation and back-translation with consultation with the original author. The publication of the validation of the instrument did not take place at the time of the study in 2016. Later in 2021, another team of authors validated the scale [2]. After contacting the authors of the 2021 publication, information was collected stating that the items in both versions had a 99% compatibility.

The PM S-E [1] assesses the perception of mothers regarding their confidence in performing parental care, that is, the perception of self-efficacy in caring for their newborn child (NB). It is an instrument with 20 items, all formulated in a positive sense, scored from 1 (strongly disagree) to 4 (strongly agree). The score is obtained through the simple sum of the items, ranging between 20 and 80 points. In this study, the Cronbach's alpha coefficient for the total of items was .961.

The PM S-E, through the sum of the items, presented a negative asymmetric distribution with a high value in the Skewness/SE quotient (asymmetry coefficient =  $-1.957/.094$ ). The ceiling effect, understood as the percentage of participants who reveal maximum scores (Sousa, 2015) was high ( $n=142$ ; 21.0%). The variable PM S-E was categorized using Visual Binning automatic recoding, considering the 50th percentile as the cutoff point. This variable, in categorical format, was designated as Low-High Maternal Self-Efficacy (L/H-MSE). The categories of this criterion variable were designated as High Maternal Self-Efficacy (H-MSE) and Low Maternal Self-Efficacy (L-MSE). The cutoff point was set at score 68 (L-MSE:  $\leq 68=0$  and H-MSE:  $>69=1$ ). Code 0 was assigned to one of the categories, reported to the acronym L-MSE (low self-efficacy in maternal care) and code 1, reported to the acronym H-MSE (high self-efficacy in maternal care).

### **Data Analysis**

Data analysis was carried out using the SPSS software (version 24) [17]. The characteristics of the participants were described through frequencies and percentages. In the comparison statistics between-groups, the Chi-square test ( $\chi^2$ ) was used for the categorical variables and the non-parametric Mann-Whitney test for the continuous variables.

A binary logistic regression analysis was performed to observe the relationship between the L-MSE and H-MSE criterion variable versus the explanatory variables, which in the univariate analysis showed statistical significance. Multicollinearity was observed through procedures that apply to linear regression [18], since SPSS does not have resources for this test in logistic regression. It is considered to be an existing multicollinearity a high Variance Inflation Factor coefficient ( $VIF>10$ ), tolerance ( $t<.100$ ) and correlation coefficients equal to or greater than .800 [18-19]. All methods were performed in accordance with relevant guidelines.

## **RESULTS**

### **Sociodemographic, Obstetric and Newborn-Related Characteristics**

Six hundred and seventy-six women participated, with a mean age of 27.81 (SD=5.13) and range of 16-45 years. Primiparous women ( $n=271$ ; 40.08%) are between 16 and 38 years old, with a mean age of 25.84 (SD=4.62). The average number of children is 1.88(SD=0.882). Most have a formal marriage relationship or live in a de facto union ( $n=648$ ; 95.9%)

The current pregnancy lasted between 37 and 42 weeks, with greater representation at 39 ( $n=441$ ; 65.2%) and 40 weeks ( $n=96$ ; 14.2%). Most newborns were male ( $n=141$ ; 52%) and most experienced the 1st episode of breastfeeding within their first hour of life ( $n=527$ ;78.0%). At the time when the questionnaire was answered, most had been fed only with breast milk ( $n=517$ ;74.6%). Both the perception of the participants and the support of the nurses associated with EBF, as well as the security felt by the mothers in breastfeeding, on a scale of 0-

9 points, had means of  $M=6.59(SD=3.09)$  and  $M=8.81(SD=0.693)$ , respectively. Table 1 summarizes the characteristics of the participants, as well as of the newborn children.

**Table 1. Sociodemographic and obstetric characteristics of participants**

Characteristics of the Participants		n	%
Age	≤ 20Years old	52	7.7
	21-25 Years old	179	26.5
	26-30Years old	247	36.5
	31-35Years old	145	21.4
	≥ 40Years old	53	7.8
Number of children	First child/daughter	271	40.1
	Second son/daughter	246	36.4
	Third son/daughter	126	18.6
	Four or more sons/daughters	33	4.8
Educational qualifications	8 <sup>th</sup> year of schooling	320	47.3
	12 <sup>th</sup> year of schooling	131	19.4
	Technical Course	19	2.8
	Higher Education	144	21.3
	Doctoral Education	23	3.4
marital status	Missing	39	5.8
	Single	21	3.1
	Married/Union in fact	648	95.9
Pregnancy surveillance	Divorced	7	1.0
	Doctor	333	49.3
	midwife	22	3.3
	Nurse-Midwife	41	6.1
	Doctor/Midwife/Nurse	237	35.1
Realization of Course for Preparing for Childbirth	Missing	43	6.4
	Yes	311	46.0
	No	354	52.4
Type of birth	Missing	11	1.6
	Vaginal	354	52.4
Gender of the baby	Cesarean	322	47.6
	Male	363	53.7
Feeding the baby in the hospital	Female	313	46.3
	Breast milk only	505	74.7
	Formula	31	4.6
	Formula & Breast Milk	138	20.4
Total	Missing	2	.3
		676	100

### Univariate Analysis of L-MSE and H-MSE and its Influencing Factors

A  $\chi^2$  tests were applied to observe the relationship between the L-MSE and H-MSE criterion variable and sociodemographic factors, obstetric characteristics of childbirth and the NB, as well as breastfeeding, both from the perspective of the woman's performance and the support

received. The results reveal that several categorical variables significantly influence the L/H-MSE ( $p < .05$ ) which are detailed afterwards.

Women who manifest L-MSE were mainly primiparous ( $n=105$ ; 52%), while the H-MSE was mainly in women with 2 or more children ( $n= 308$ ; 65%), with a significant relationship  $\chi^2_{(1,676)}=.16.961$ ;  $p < .001$ . Therefore, with a phi = 0.158, it is noticeable that the perception of self-efficacy increases by 2% ( $\Phi^2=0.0249$ ) in multiparous. We also observe that women with more pregnancy appointments, register a higher self-efficacy ( $\chi^2_{(1,676)}=6.608$ ;  $p=0.006$ ), with an association of  $\Phi=0.099$ . Thus, the largest number of appointments adds about 1% ( $\Phi^2=0.009$ ) in the variation of the score for the perception of self-efficacy. On the other hand, it appears that the greatest self-efficacy is mainly in women with EBF with significant association ( $\chi^2_{(1,676)}=5.80$ ;  $p=0.016$ ), having a value of phi=0.093, thus increasing the self-efficacy about 1% ( $\Phi^2=0.0086$ ). With a p-value close to the acceptance threshold ( $p=0.047$ ) the relationship between the two levels of self-efficacy and the time since the beginning of the 1st episode of breastfeeding is found ( $\chi^2_{(1,676)}=3.248$ ), suggesting greater confidence in the participants who started breastfeeding in the first hour of the child's life (table 2).

**Table 2. Univariate analysis of categorical variables versus criterion variable**

Characteristics		Low self-efficacy n(%)	High self-efficacy n(%)	Total	Chi-Squared	Phi
Order of children	1 <sup>st</sup> child	105(52.0)	166(35.0)	405(59.9)	$\chi^2_{(1,676)}=.16.961$ ; $p < .001$	-
	2 <sup>nd</sup> or more child	97(48.0)	308(65.0)	271(40.1)		.158
Marital Status	Unmarried/divorced [doesn't live in a couple]	10(5.0)	18(3.8)	28(4.1)	$\chi^2_{(1,676)}=.474$ ; $p=.310$	-
	Married/with partner [as a couple]	192(95.0)	456(96.2)	648(95.9)		
Time of the first episode of breastfeeding	>60 minutes	46(23.7)	81(17.6)	127(19.4)	$\chi^2_{(1,676)}=3.248$ ; $p=.047$	-
	≤60 minutes	148(76.3)	379(82.4)	527(80.6)		
Number of Pregnancy Consultations	<8 Consultations	26(12.9)	101(21.3)	127(18.8)	$\chi^2_{(1,676)}=6.608$ ; $p=.006$	-
	≥8 Consultations	176(87.1)	373(78.7)	549(81.2)		.099
Type of birth	Vaginal	106(52.5)	248(52.3)	354(52.4)	$\chi^2_{(1,676)}=.001$ ; $p=.519$	-
	Cesarian	96(47.5)	226(47.7)	322(47.6)		
Gender of the newborn	Male	100(49.5)	263(55.5)	363(53.7)	$\chi^2_{(1,676)} =2.037$ ; $p=.090$	-
	Female	102(50.5)	211(44.5)	313(46.3)		
Newborn food	Exclusive breastfeeding	137(68.8)	365(77.7)	502(75.0)	$\chi^2_{(1,676)}=5.80$ ; $p=.011$	-
	Other feed	62(31.2)	105(22.3)	167(25.0)		.093
Total				676(100)		

Other continuous variables showed influence on the L-MSE and H-MSE, namely the safety that the participant reports in breastfeeding ( $p<.001$ ), the support that midwives offer to EBF ( $p<.001$ ) and also the self-efficacy in feeding the NB ( $p<.001$ ). Maternal age has p-value values at the limit ( $p=0.05$ ) according to table 3.

**Table 3. Univariate analysis of continuous variables versus criterion variable**

Characteristics	Low n(%)	High n(%)	Mann-Whitney U Test
Maternal Age	202 (Mean Rank=316.29)	474 (Mean Rank=347.96)	U=52.360; n=676; p=.050
Safety in breastfeeding	202 (Mean Rank=300.61)	474 (Mean Rank=354.65)	U=55.528; n=676; p<.001
Nurse Support for BF	200 (Mean Rank=294.76)	470 (Mean Rank=352.83)	U=55.147; n=676; p<.001
Self-efficacy in BF	198 (Mean Rank=169.50)	455 (Mean Rank=395.54)	U=76.229; n=676; p<.001

### Logistic Regression Analysis of L/H-MSE and its Influencing Factors

The Binary Logistic Regression assumptions were observed, revealing Pearson and Spearman correlation coefficients between 0.86 and 0.553, as well as the value of  $t>.100$  or  $VIF<10$  between categorical variables and between continuous variables (tables 4 and table 5).

**Table 4. Multicollinearity analysis in categorical variables**

Position as dependent variable	Position as independent variable	Tolerance	VIF
Order of children	Time of the 1 <sup>st</sup> episode of BF	.985	1.015
	Number of pregnancy visits	.997	1.003
	Food to NB	.984	1.017
Food to NB	Order of children	.986	1.015
	Time of the 1 <sup>st</sup> episode of BF	.993	1.007
	Number of pregnancy visits	.992	1.008
Number of pregnancy visits	Food to NB	.972	1.029
	Order of children	.980	1.021
	Time of the 1 <sup>st</sup> episode of BF	.981	1.020
Time of the 1 <sup>st</sup> episode of BF	Number of pregnancy visits	.991	1.009
	Food to NB	.983	1.017
	Order of children	.977	1.023



**Table 5. Multicollinearity analysis in continuous variables**

Position as dependent variable	Position as independent variable	Tolerance	VIF
Safety felt by the participant in the BF	Midwife's support for BF	.991	1.009
	Self-efficacy in Breastfeeding	.979	1.022
	Maternal Age	.983	1.017
Maternal Age	Safety felt by the participant in the BF	.634	1.576
	Support from the midwife for BF	.993	1.007
	Self-efficacy in Breastfeeding	.633	1.580
Self-efficacy in Breastfeeding	Maternal Age	.974	1.027
	Safety felt by the participant in the BF	.972	1.029
	Support of The midwife for BF	.993	1.007

In the analysis of the Binary Logistic Regression, 8 variables were considered, of which four were categorical and four were continuous, according to the univariate analysis. The results showed two main predictors: a) EBF midwife support and b) BF self-efficacy.

**Table 6. Logistic regression for factors associated with the perception of self-efficacy in maternal care in postpartum women**

Variables in the Equation									
	B	S.E.	Wald	df	Sig.	Exp(B)	95% C.I. for EXP(B)		
							Lower	Upper	
Order of children (1 <sup>st</sup> child=1)	.049	.242	.042	1	.838	1.050	.654	1.687	
Time of the 1 <sup>st</sup> episode of BF (≤60'=1)	.008	.276	.001	1	.977	1.008	.587	1.730	
Number of pregnancy visits (≥8visits=1)	-.463	.306	2.291	1	.130	.629	.345	1.146	
Maternal Age	.007	.023	.099	1	.753	1.007	.963	1.054	
Safety when breastfeeding	.229	.192	1.418	1	.234	1.257	.863	1.831	
<b>Nurse Support at BF</b>	.088	.036	6.150	1	<b>.013*</b>	<b>1.092</b>	1.019	1.171	
Food to NB (breast milk=1)	-.507	.280	3.282	1	.070	.602	.348	1.042	
<b>Self-efficacy in BF</b>	2.579	.240	115.779	1	<b>.000*</b>	<b>13.187</b>	8.244	21.096	
Constant	-12.069	2.040	35.010	1	.000	.000			
<b>Model Information</b>									
Omnibus Tests of Model Coefficients	Chi-square=234.574; p-value <0.001								
Teste de Hosmer and Lemeshow	Chi-square=9.876; p-value =.274								
R <sup>2</sup> Nagelkerke									.443

Note: \* Significant at the level of  $\alpha=0.05$

Therefore, for each incremental nurse support unit for EBF, maternal self-efficacy increased by 1.09 (OR=1.09; B=0.088;  $p=0.013$ ). On the other hand, in BF self-efficacy, for each incremental unit of self-efficacy in feeding the NB, maternal self-efficacy increased by about 13.19 (OR=13,187; B=2,579;  $p<.001$ ), according to table 6. Bearing in mind the variability of the phenomenon under study, the models that were found explain about 44.3% of maternal self-efficacy, in accordance with  $R^2$  Nagelkerke. The model is well adjusted, according to the Hosmer and Lemeshow test ( $p$ -value=0.274).

## DISCUSSION

### Sciodemographic Characterisitcs

The sociodemographic profile of the participants shows greater representation of motherhood in the 26-30 age group (36.5%), a cumulative 29.2% which corresponds to the age of 31-45 years and an average age of 27.81 years, in agreement with the country's statistics in the year 2015, as to the average age of women who had children (28.6 in Turkey) [20-21]. However, participating primiparous women are younger compared to the average age at birth of the first child in European countries (25.8 versus 29.0). Most of the participants have one or two children ( $n=517$ ; 76.5%), or even three (19%), competing for the values of the Synthetic Fertility Index (ISF) of Turkey in 2015 (ISF=2.15). On this date, the country supported, at the limit, the replacement of generations. The average number of children in this study is very close to the results of a recently published international study, but reported to 2013 data (1.88 versus 1.75) [22]. The evolution over time has been showing a decrease in the ISF, standing in 2019 at 1.88, still above the European average (1.61), being the country with the highest rate in this region [21]. When it comes to the gender of the newborn, the results conform approximately the proportion of the typical gender ratio of humans, which presents about 102 to 106 male births per 100 females [23]. Turkish studies show that, given the preference for male children, couples have fewer children if the first is a man, as the probability of interrupting procreation arises when the goal is reached, that is, by having a boy as a child [24].

The results mirror relationships based on conjugality, reproducing the characteristics of the Turkish population, concurring with the OECD statistics, which refer that Turkey, Japan and Korea are the countries with the lowest representation of children outside of wedlock, specifically 2.8 of the marriages in Turkey [20]. The birth of children, in the context of formally registered and assumed relationship, with a monogamous orientation, happens mainly in the West. In these societies, marriage takes place based on the feelings of the betrothed and the passage of time and the birth of children, it seems to seek happiness. However, there is controversy regarding the relationship between the exercise of parenthood versus a satisfaction with the conjugal relationship. If, on the one hand, the emergence of children impairs the quality of the relationship and joint leisure [22-25] or worsens depression [22], on the other hand, the transition to parenthood and the children's childhood are phases of joy that strengthen conjugality [26]. In fact, the decision to have children needs to be matured in the couple, as marital discord causes children's psychosocial problems, these adults need education about healthy parenting styles [27]. Therefore, based on the positive intention of an intimate relationship for the rest of their lives, the pair will follow a path towards the neuroinvolvement of love and marriage, including children [28].

The representation of the educational qualifications of the participants conveys the completion of the 8-year compulsory education, which lasted until 2012/2013 [29]. Regarding the levels of

education beyond the 12th grade (n=186; 27.5%), it is observed that higher education had an expressive representation in 2015, perhaps corresponding to the effort of equity, underlining the reduction of disparity between genres [30]. Gender equity in access to education, girls' education, and health are sensitive issues. For some feminist currents, inequalities are mainly rooted in conservative social patterns [31]. Gender inequity in health drags on in time, despite the efforts of health professionals and institutions, signed agreements, recommendations stated by international entities or events in the past [32-34] and current [35]. It will perhaps be necessary to continue to reaffirm one of the WHO slogans "nurses and midwives improve people's health and well-being and reduce health inequalities" [36].

### **Obstetric Characteristics**

Considering the health surveillance during pregnancy, the greater representation of the doctor (49.3%) and the shared surveillance of the doctor/midwife/nurse (35.1%) suggest the accessibility of maternal and child care. In fact, statistics show that, in 2015, in Turkey a ratio of 40.4 professionally active midwives per 1000 live births [20] and maternal mortality from direct causes decreased between 2012 and 2015 from 15.4 to 13.7/100000 live births [37]. Although the coverage of care by midwives is higher, the idea arises that it is necessary to entice women into prenatal classes, as most do not attend (no=52.4%; yes=46.0%). This would be useful to clarify the advantages of vaginal delivery [38], as the preference for cesarean section is significant [39]. In fact, a quasi-experimental study in Anatolia highlights the effect of prenatal education, providing greater self-efficacy in Labor and better self-control [40]. The reasons usually invoked by women for preferring a cesarean are fear or maternal trauma, prolonged labor, or fetal well-being, but in Turkey, non-medical reasons prevail [38-40]. The representation of cesarean delivery is high, a fact commented on in reports that highlighted Turkey, Chile and Mexico, with rates between 45-50% [41] and specifically in 2015 around 53.1% in Turkey [42]. The numbers decreased a little, having a rate of 51.2% in 2021 [38]. Cesarean delivery is an urgent recourse and several efforts have been made to reduce its use. Since 1985, the WHO has recommended that it not go beyond 10% to 15% [43]. Recent moves in Turkey seek to reduce cesarean cases, through the Mother-Friendly Hospital Initiative [44].

### **Intrapartum Practices**

In intrapartum practices, early breastfeeding within the 1st hour of life is highlighted. This procedure is recommended by the WHO and is recognized as fundamental in several maternity hospitals. It is called the golden hour [45]. In fact, the stress of childbirth causes the release of adrenaline, reflected in the 45 to 60 minutes in which the NB is awake, enjoying intimate contact with the mother. Such contact evokes neurobehaviors that satisfy needs in this sensitive period, assuming that it can even determine the child's future behaviors [45]. It is important that the golden hour is respected and not occupied with procedures that are of particular interest to the professional, completing the tasks of dressing the NB, administering prophylactics among others.

### **Determinants of Maternal Self-Efficacy**

The logistic regression revealed two predictors in agreement with the literature that recognizes BF as the major difficulty in exercising maternal care [46]. The assumption that milk is insufficient or poorly nutritious and the interpretation of crying as the NB's dissatisfaction worry the mother. Fears, lack of self-confidence, low self-efficacy perception are strong allies of early weaning. This means that, compared to a majority of women under EBF, for each unit of

self-efficacy in breastfeeding behavior, maternal self-efficacy grows 13.18 times in the current model. In addition to the advantages and recommendations of the WHO [47-48], the annual campaigns, greater clarification for women, the care environment they are subject to during pregnancy, childbirth and puerperium, can stimulate intentions to breastfeed [47]. In the current model, the probability of greater maternal self-efficacy increases by 1,092, whenever the nurse's support for EBF increases by one unit. In fact, the hospital space where data collection took place is baby-friendly. The institutions that adhere to this chain of care develop policies to prepare employees, whether caregivers, administrative or logistical support. Turkey has been part of baby-friendly hospital programs since 1991, achieving good EBF rates [49], also adhering to other initiatives that strengthen mothers' decision-making [44].

### CONCLUSION

This study is a description related to a recent past, in which maternal self-efficacy was observed as a phenomenon within the puerperal phase. It is a sensitive phase for the mother/child dyad. Maternal self-efficacy can be fostered and nurtured by health professionals, namely nurses. Its predictors in the current model are mainly variables related to breastfeeding

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