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Research

SÍNDROME DE *BURNOUT* EM ENFERMEIRAS OBSTETRAS E OBSTETRIZES QUE ATENDEM PARTO DOMICILIAR PLANEJADO NO BRASIL

*Burnout Syndrome in obstetric nurses and midwives who attend planned home births in Brazil**Síndrome de Burnout en enfermeras y parteras que atienden parto domiciliario planificado en Brasil*Talita Lima Corrêa de Pinho¹ Júnia Aparecida Laia da Mata² Joice Moreira Schmalfluss³ Nayara Girardi Baraldi⁴ Clara Fróes de Oliveira Sanfelice⁵ 

RESUMO

Objetivo: identificar a prevalência da Síndrome de Burnout em enfermeiras obstetras e obstetrizes que atendem parto domiciliar planejado no Brasil. **Método:** estudo transversal, com amostragem não-probabilística por conveniência. As participantes foram recrutadas em ambiente virtual e os dados foram colhidos com uso de questionário sociodemográfico e escala Oldenburg Burnout Inventory. As relações entre o escore da escala e as variáveis sociodemográficas foram avaliadas por meio de teste de comparação e coeficiente de correlação. **Resultados:** participaram 73 profissionais atuantes em 11 estados brasileiros, predominando 98,6% de mulheres e 79,4% de enfermeiras obstetras. Identificou-se 45,2% das participantes com Síndrome de Burnout, 30,1% sem nenhum acometimento, 17% com esgotamento e 6,8% com distanciamento do trabalho. **Conclusão:** os dados apontam para elevada prevalência da Síndrome de Burnout na população estudada e taxas menores de esgotamento e distanciamento com o trabalho.

DESCRITORES: Enfermagem obstétrica; Parto domiciliar; Estresse ocupacional; Esgotamento profissional; Burnout.

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ABSTRACT

Objective: to identify the prevalence of Burnout syndrome in obstetric nurses and midwives who attend planned home births in Brazil. **Method:** cross-sectional study, with non-probabilistic convenience sampling. Participants were recruited in a virtual environment and data were collected using a sociodemographic questionnaire and the Oldenburg Burnout Inventory scale. The relationships between scale scores and sociodemographic variables were assessed using a comparison test and correlation coefficient. **Results:** 73 professionals working in 11 Brazilian states participated, with a predominance of 98.6% women and 79.4% obstetric nurses. 45.2% of the participants were identified with Burnout Syndrome, 30.1% without any impairment, 17% with exhaustion, and 6.8% with depersonalization at work. **Conclusion:** the data point to a high prevalence of Burnout Syndrome in the studied population and lower rates of exhaustion and distance from work.

DESCRIPTORS: Obstetric nursing; Home childbirth; Occupational stress; Burnout, professional; Burnout.

RESUMEN

Objetivo: identificar la prevalencia del Síndrome de Burnout en enfermeras y parteras obstétricas que atienden partos domiciliarios planificados en Brasil. **Método:** estudio transversal, con muestreo no probabilístico por conveniencia. Los participantes fueron reclutados en un entorno virtual y los datos se recogieron mediante un cuestionario sociodemográfico y la escala Oldenburg Burnout Inventory. Las relaciones entre la puntuación de la escala y las variables sociodemográficas se evaluaron mediante una prueba de comparación y coeficiente de correlación. **Resultados:** participaron 73 profesionales que actúan en 11 estados brasileños, con predominio del 98,6% mujeres y el 79,4% enfermeros obstétricos. El 45,2% de los participantes se identificó con Síndrome de Burnout, el 30,1% sin ningún impedimento, el 17% con agotamiento y el 6,8% con alejamiento del trabajo. **Conclusión:** los datos apuntan a una alta prevalencia del Síndrome de Burnout en la población estudiada y menores índices de agotamiento y distanciamiento del trabajo.

DESCRIPTORES: Enfermería obstétrica; Parto domiciliario; Estrés laboral; Agotamiento profesional; Burnout.

INTRODUCTION

Planned home birth (PDP) is a type of childbirth care that has been recognized since the 1990s by the World Health Organization (WHO)¹ and is expanding in several countries, such as the Netherlands, Denmark and Germany.² According to the WHO, women have the right to choose their place of birth and can opt for the environment in which they feel safest and most comfortable, after having received all the necessary information.¹

The literature points to positive outcomes for women and babies, which supports the safety of this choice.³⁻⁴ According to a systematic review carried out in Brazil, a comparison between PDP and hospital births showed that some interventions are significantly less in the home environment, which contributes to increased maternal satisfaction with the experience.⁵

Home birth care is indicated exclusively for low-risk pregnant women who wish to give birth at home, in a scheduled manner and in the presence of qualified professionals.⁶ In Brazil, some of the women who opt for home birth care are motivated by individualized care; little or no obstetric intervention; exercising autonomy; early and prolonged skin-to-skin contact with the newborn (NB); the possibility of having more than one companion and opposition to the predominantly technocratic obstetric model in force in most health institutions.^{5,7}

Although there is no official register of professionals who provide PDP care in the country, this practice is carried out almost exclusively by obstetric nurses (ONs) and midwives, since these professionals have regulations for this type of care (Technical Opinion No. 003/2019 of the Federal Nursing Council (COFEN)).⁸

However, home birth care has not been incorporated into public health policies in Brazil, and is an option for women who can afford it⁵, as it is a service offered privately by professionals. According to the literature, this current configuration of work implies different practical and social challenges, both for the women who choose this option and for the professionals involved in the care.⁹

Among the challenges faced by the professionals, we can mention social prejudice against the care; society's lack of information on the subject; stigmas and obstetric violence in the event of a transfer to hospital; difficulties in acquiring the necessary supplies and services for safe and quality care, as well as the lack of protocols that guide the work at home.⁹ Thus, it is possible that the difficulties faced by professionals in maintaining this model of care may represent a stress factor and contribute to the development of work-related burnout, such as Burnout Syndrome (BS).

According to the WHO, BS results from chronic stress in

the workplace that has not been successfully managed.¹⁰ The syndrome, included in the 11th Revision of the International Classification of Diseases (ICD-11)¹⁰, can cause cognitive, emotional and attitudinal damage, which translates into negative behavior towards work, peers and one's professional role.¹¹ When maintained over time, the consequences of BS can also affect the individual's physical health.¹¹

The literature is vast with research on BS in different professions, in the most diverse labor institutions. It is therefore essential to investigate the prevalence of BS in workers who are not linked to institutions (self-employed), as is the case with ONs and midwives who assist in planned home births. Thus, given that the health sector is one of the most affected by BS¹¹ and that the literature points to constant challenges in the work of ONs and midwives in PDP care⁹, this study aimed to identify the prevalence of BS in this population.

METHOD

A cross-sectional study carried out with ONs and obstetricians who attend PDP in Brazil, recruited in a virtual environment after the survey was publicized on social media. The description of this study was based on the recommendations of the STROBE (Strengthening the Reporting of Observational Studies in Epidemiology) roadmap.

In order to broaden the reach of the research, a specific research account was created on the social networks Instagram and Facebook. The research was disseminated with the help of various institutions and nursing associations, such as the Brazilian Association of Obstetricians and Obstetric Nurses (ABENFO National and Sections) and the Interdisciplinary Group of Studies and Research on Planned Home Birth (GIEPDP) at UFRGS.

Non-probabilistic convenience sampling was used, since it is not possible to estimate the universe of professionals who currently attend PDP in Brazil (there is no official record of this information) and, therefore, no sample calculation was carried out to determine the sample size. Professionals were invited to take part by sharing the survey pages on the internet and those who met the inclusion criteria and expressed interest had access to the survey instruments in the virtual environment. The inclusion criteria were: ONs or obstetricians; with at least 12 months' experience in PDP care in Brazil; and being active in PDP care. Professionals who had attended at least one (1) PDP in the last 30 days

prior to collection were considered active. Data was collected using two instruments: 1) a sociodemographic questionnaire prepared by the authors, and 2) the Oldenburg Burnout Inventory (OLBI) scale.¹²

The sociodemographic questionnaire included the following variables: identification (initials); age (years); gender; city/state of residence; monthly income from PDP (in minimum wages); training (obstetric nursing or obstetrics); length of time working in PDP care (years); presence of another employment relationship (yes or no); average number of consultations per month and presence of a back-up team (always, in most consultations, only in some consultations, never).

The second instrument used was the OLBI scale, created in 1999 in Germany.¹² Its creation was aimed at overcoming psychometric flaws identified in scales previously used to measure BS. The OLBI scale is made up of two domains (disconnection from work - DT and emotional exhaustion - EE), has no restrictions on professions and can therefore be applied in any occupational context.¹² This characteristic was fundamental for the authors to choose to use it in the context of this research, since the target audience of the study has no institutional ties.

The DT domain refers to detachment from the object and content of the work, particularly with regard to personal identification with the work and the desire to continue in the profession. The EE domain can be defined as a consequence of intense pressure, both affective and physical, i.e. as a long-term consequence of certain unfavorable work demands.¹²

The original version had 16 questions. After the validation process for Brazil in 2018, three variables with mea-

surement power problems were excluded from the final instrument, which now has 13 variables in its Brazilian version.¹²

The variables related to the DT domain are: I often do new and interesting things in my work; I talk more and more often negatively about my work; Lately, I have been doing my work in an almost mechanical way; I consider my work to be a positive challenge; Over time, I have become disinterested in my work; I feel increasingly committed to my work; and I often feel fed up with my tasks.¹²

The variables related to the EE domain are: There are days when I feel tired before I even get to work; After work, I need more time to feel better than I used to; I can cope very well with the pressures of my work; During my work, I feel emotionally drained; After work, I have energy for my leisure activities; and After work, I feel tired and without energy./.

The OLBI scale uses a likert structure for the answers, with scores ranging from one point (strongly disagree) to four points (strongly agree), and some variables have their scores inverted for the sum of the means in the dimensions.¹² For the purposes of the results, the following guideline was followed: mean scores ≥ 2.25 in the EE dimension and mean scores ≥ 2.1 in the DT dimension were considered high.¹² The individuals were classified as shown in Table 1.

Chart 1 - Classification of individuals according to Burnout status, as proposed by Peterson.¹³ Campinas, SP, Brazil, 2022

Domains		
Emotional Exhaustion (EE)	Termination of employment (DT)	Classification
Low	Low	Without Burnout
Low	High	With distance
High	Low	With exhaustion
High	High	With Burnout

The reliability of the scale was measured by composite reliability, with the EE dimension having a reliability of 0.92 and the DT dimension 0.88, which means that the two dimensions had excellent reliability.¹²

To collect the data, the scale was fully transcribed into an online form, using the free Google Forms® tool. On accessing the virtual research environment, the participant was initially presented with the Informed Consent Form (ICF). If they agreed, they signed it digitally (with a copy sent to their registered e-mail address) and then answered the sociodemographic questionnaire and the OLBI scale. The data was collected over four months in 2022. The data was automatically transferred to a Microsoft Excel® spreadsheet.

For comparisons involving a two-category qualitative variable and the Burnout score, the unpaired Student's t-test was applied. Data distribution was assessed using the Shapiro-Wilk test. Internal consistency was assessed using the Cronbach's alpha coefficient. This coefficient ranges from 0 to 1, where values greater than 0.7 indicate reliability between the measures. The Cronbach's alpha value for the scale was 0.86,

and the analysis by domain identified values of 0.8 in the DT dimension and 0.79 in the EE dimension. The statistical software SAS version 9.4 was used for all the analyses and a 5% significance level was considered.

The study was approved by the Research Ethics Committee, report no. 5.489.112/2022.

RESULTS

A total of 73 health professionals who provide PDP care took part in the study, 79.4% (n=58) of whom were ONs and 20.5% (n=15) obstetricians. 98.6% (n=72) were female and the average age was 35 years, ranging from 24 to 56 years.

Participants came from four regions of the country (Southeast, Northeast, Central-West and South), in 11 Brazilian states (São Paulo, Minas Gerais, Rio de Janeiro, Federal District, Bahia, Rio Grande do Norte, Maranhão, Paraíba, Rio Grande do Sul, Santa Catarina and Paraná). The characteristics related to working in PDP care are described in Table 1.

Table 1 - Characteristics related to work in planned home birth care (n=73). Campinas, SP, Brazil, 2022

Variable	n	%
Monthly income		
From R\$1,000.00 to R\$5,000.00	31	42,47
From R\$5.001,00 to R\$10.000,00	26	35,62
From R\$10.001,00 to R\$15.000,00	12	16,44
From R\$15.001,00 to R\$ 20.000,00	4	5,48
Time working with PDP		
From 1 to 2 years old	12	16,44
From 3 to 5 years old	24	32,88
From 6 to 10 years old	26	35,62
From 11 to 15 years old	8	10,96
Over 16 years old	3	4,11
Other employment		
No	42	57,53
Yes	31	42,47
Average number of visits per month		
1 to 5 appointments/month	66	90,41
From 6 to 10 appointments per month	7	9,59
Back-up team		
Always	17	23,29
In most cases	16	21,92
Only in some cases	28	38,36
Never	12	16,44

The results on the identification of SB are shown in Table 2.

Chart 2 - Prevalence of Burnout Syndrome among obstetric nurses and midwives (n=73). Campinas, São Paulo, Brazil, 2022

Domains		Results		
Emotional Exhaustion (EE)	Termination of employment (DT)	Classification	(n)	%
Low	Low	Without Burnout	22	30,1%
Low	High	With distance	5	6,8%
High	Low	With exhaustion	13	17,8%
High	High	With Burnout	33	45,2%

The comparisons made between the scale scores and the variables "income", "professional training", "time working at the PDP", "other employment relationship" and "back-up team" did not show statistically significant results, i.e. they were not related to the identification of BS. The variable "average number of appointments/month" was not evaluated in the statistical tests due to the small number of participants in the "6 to 10 appointments/month" category.

All participants identified as having BS were notified of the results by electronic communication (e-mail). The e-mail included the individual result, a brief explanation of BS and guidance on the importance of seeking care for this condition.

DISCUSSION

This study found a high prevalence of BS among ONs and obstetricians attending PDP in Brazil. The literature points out that health profes-

sionals work with issues directly related to health and/or illness, which entails a high degree of responsibility and makes them more prone to developing stress and other related illnesses, increasing their vulnerability to BS.¹⁴⁻¹⁵

All over the world, studies have been carried out to identify the incidence and prevalence of BS in the occupational environment, using different instruments.

In nursing, a study carried out in Uganda showed a similar result to the one found in this study, in which 49.1% (n=194) of the nurses in a hospital had BS.¹⁶ In contexts of high stress, as occurred during the COVID-19 pandemic, several studies have pointed to higher rates of BS among health workers, with prevalence reaching rates close to 70% in some places.¹⁷⁻¹⁸

In the maternal and child area, a cross-sectional study of American nurses working in maternity hospitals revealed that 25% of the participants (n=384) had BS.¹⁹

A large-scale study of certified nurses and midwives in the USA found a prevalence of BS of 40.6%.²⁰ However, this investigation found a

significant relationship between the syndrome and workload, which is not consistent with the findings of this study, since the most prevalent average number of visits in this study was one to five per month. In the American study, one of the main drivers of burnout was the practice environment²⁰, which reinforces the impact of this variable on the development of the syndrome.

In this respect, it is important to consider the practice environment of professionals who provide PDP care in Brazil, since one of the main challenges currently pointed out in the literature is related to the daily clash with health professionals opposed to the practice, a fact which requires constant reaffirmation of the abilities and ideals of those who provide PDP care.⁵ In addition, the literature shows that professionals experience daily prejudice from various layers of society, mainly due to a lack of information about this model of care.⁹

The search to work in the field of PDP is often due to the devaluation of ONs and midwives in obstetric services and dissatisfaction with the obstetric model practiced. In this context, a study that aimed to describe the trajectory of ONs' entry into PDP care in Rio Grande do Sul, Brazil, identified that ONs had witnessed and experienced situations of obstetric violence and limitations to act with autonomy and freedom in labor and birth care in the hospital context, which were determining factors for their entry into the home care service.²¹

Even so, the quest to perform their duties with autonomy and freedom, through the PDP, has not been a guarantee of a practice environment free of judgments and restrictions in the Brazilian context, since this type of labor and birth is on the margins of the health system. There are many reasons listed in the literature that can cause BS. Aspects that lead to, trigger and/or maintain people with the syndrome can be classified into two broad categories: (1) organizational factors, such as workload or the emotional demands involved; and (2) individual factors, such as the worker's personality or coping strategies.¹¹

A national study aimed at identifying the difficulties faced by professionals working in PDP care pointed to social and practical aspects that weaken and hinder care, which, according to the study, seem to be related to the lack of regulation of this model of care in the country's public health policies.⁹

Among the organizational aspects related to PDP care that can negatively impact the work of professionals are the difficulties in acquiring basic supplies for care, as well as ordering laboratory tests and/or imaging tests, in addition to the lack of a protocol available to guide and support the conduct practiced in the home environment.⁹

It is believed that these aspects, among others, can contribute to the development of burnout, since the literature emphasizes that the syndrome is mainly a consequence of exposure to certain working conditions and not an individual characteristic of the worker, such as a personality trait.¹¹

The repercussions of installed BS are numerous and can lead to a series of adverse consequences for both individuals and organizations. These consequences are initially psychological in nature, but if they are maintained over time, they translate into adverse effects on the physical/biological health and behavior of workers.¹¹

It is therefore essential that affected professionals are identified early and seek treatment and coping strategies as soon as possible. In this respect, it is considered that professionals who treat PDP are doubly fragile, since they do not have an employment relationship with health institutions, which could favor screening for this condition, as well as referral for support and monitoring of the condition.

CONCLUSION

This study found a high prevalence of BS among obstetric nurses and midwives who attend PDP in Brazil and lower rates for burnout and detachment from work. No statistical correlation was found between the variables studied and a positive result for the syndrome.

It is hypothesized that the difficulties pointed out in the literature faced by these professionals may be contributing to work-related exhaustion and, consequently, to the development of bur-

nout. It is therefore suggested that further studies be carried out to investigate the cause and effect relationships in this context.

Due to the physical and emotional damage caused by BS, it is possible that the care offered to parturients and their families by professionals with BS may suffer some kind of impact. This highlights the need to think about regulating the work of these professionals, as a strategy for monitoring working conditions and promoting measures to prevent or monitor those affected by BS. As a limitation, the lack of an official source for identifying and recruiting professionals working in the PDP meant that it was not possible to calculate the sample for this investigation.

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