Letter from the Editor

Research and Public Policies Help Advance the Benefits of Breastfeeding and Natural Childbirth

Abstract

As more and more research recognizes the benefits of breastfeeding and natural childbirth, public policy steps up its efforts to protect these benefits.

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Policies protecting breastfeeding began in 1919, when the International Labor Organization held a Maternity Protection Convention to focus on the needs of employed childbearing and breastfeeding women. This action was in response to the industrial revolution. Prior to that time when 95% of the population lived and worked on farms, the work of women was less likely to interfere with childbearing and breastfeeding.

Now, 82 years later, the U.S. Surgeon General has called for facilitating breastfeeding or breast milk expression in the workplace (see pages 45–47). The document “Blueprint for Action on Breastfeeding” should be recognized as the result of national and international efforts by many hardworking, dedicated health advocates for children.

For many of these 82 years, the advocates worked to protect breastfeeding on the faith that Mother Nature knew what she was doing when she created breast milk. Since then, the multiple benefits of breastfeeding have been documented by research, and the pace of progress on policies to protect breastfeeding have picked up.

One area that is seldom addressed is the importance of childbirth education in the bringing together of a mother and infant who are ideally prepared to initiate breastfeeding. This includes a mother who knows when and how to launch breastfeeding and, prenatally, has built a good support system at the place of the birth, in her family, and in her work place. Equally important, it includes an infant who is not impacted by labor and birth medications in a way that impairs launching breastfeeding. And even when medications are interfering, the cause is recognized and both mother and infant are given extra care to help them overcome a poor start.

The place of labor medications in impacting early and, hence, later breastfeeding rates is not well documented and has not made it to any national policy statements. However, as demonstrated in the above example, research has only accelerated the protection of breastfeeding. Advocacy based on common sense has been a first step leading to early policies that have eventually been accelerated by the support of research findings.

So it is with supporting mothers through no- and low-medicated births. Only a small amount of research shows problems with breastfeeding subsequent to epidurals, and the research is not detailed enough to demonstrate which epidural medications and under what circumstances (Steiner, 2000). Yet, many nurses anecdotally talk about the difficulty of helping epidural babies in some hospitals to latch on in the early days of life. It is time for research to document the details of this phenomenon more thoroughly.

While waiting, however, childbirth educators should continue to do what they do best: Teach pregnant women how and why both they and their infants will benefit from the most natural birth possible in their situation.

—Sharron S. Humenick, RN, PhD, FAAN

Reference

Steiner, S. H. (2000). Medication/Anesthesia. In F. H. Nichols and S. H. Humenick (Eds.), *Childbirth education: Practice, research and theory* (pp. 416-434). Philadelphia: W. B. Saunders Company.

Letter to the Editor—Respect

Anthony DeLellis's guest editorial, "Respect in the Perinatal Experience," in the Volume 9, Number 4 issue of the journal stretches my perception of the meaning of the word as well as my understanding of its significance in the perinatal experience. Dr. DeLellis pulls some illusive threads together and weaves the concept of respect into concrete principles that can be taught and fostered.

If we, as childbirth educators, incorporate these gentle, affirming guidelines in the way we communicate and into our teaching styles and curriculum, we can gain more trust, self-confidence, and openness from the participants—critical components of effective learning.

Sincerely,
Kay Raheja, RN, LCCE, FACCE

Letter to the Editor—Promoting Natural Childbirth

I enjoyed the article in *The Journal of Perinatal Education* (Vol. 9, No. 4, 2000) by Judith Lothian where she answers the question, "Why natural childbirth?" I would also like to refer journal readers to pages 80-81 of my book, *Special Women: The Role of the Professional Labor Assistant** where I succinctly list the following advantages of natural childbirth:

- Natural birth is difficult, but a woman's body is designed for this function. When a woman births without drugs, anesthesia, or medical interventions, she learns that she is strong and powerful. She learns self-confidence. She learns to trust herself, even in the face of powerful authority figures.
- Once she realizes her own strength and power, she will have a different attitude for the rest of her life

about pain, illness, disease, fatigue, and difficult situations.

- When a mother births without drugs, anesthesia, or medical interventions, she will approach mothering differently. She will realize that it took hard work to bring this child into the world and it will take hard work to raise this child into an adult.
- Through all of this, she will grow as a person, becoming more confident in her abilities to handle any situation that she might face and more responsible for her own destiny.
- Natural birth allows the mother a larger range of options in terms of caregiver, places to birth, positions for birth, and the conduct and delivery of birth. This allows a woman an internal locus of control (she makes decisions and accepts the challenge of labor as her challenge) versus an external locus of control (caregiver or hospital makes decisions and the challenge of managing the labor).
- Natural birth is medically safer for mother and baby. Anesthesia and other interventions, when used without medical indication, present risks to their health, which may include: drop in maternal blood pressure; drop in fetal heart tones; decrease in uterine contractility; increased incidence of labor dystocia; increased need for pitocin augmentation; rise in maternal temperature; difficulty for mother in voiding; impairment of maternal pushing ability; increased use of forceps or vacuum extractor for delivery; increased use of episiotomy and greater perineal trauma; increased need for cesarean section; increased incidence of fetal hypoglycemia; increased need for sepsis work-up for baby (e.g., spinal tap, IV, prophylactic antibiotics, 3- to 7-day stay in nursery); more maternal/infant separation; increase in breastfeeding problems; greater incidence of anesthesia headache for mother; increased likelihood of separation from family; greater likelihood of postpartum back pain for mother; and increased chance for nerve palsy or paralysis for mother.
- If mother or baby is not healthy or if the progress of labor is clearly not normal, the use of drugs, anesthesia and other interventions may be justified.

I would gladly let the readers of *The Journal of Perinatal Education* use the above information in *Special Women* as a handout in their classes. I would ask that the handout include my name and the book's title.

Sincerely,
Paulina G. Perez, RN, BSN, FACCE

* Perez, P., & Snedeker, C. (2000). *Special women: The role of the professional labor assistant*. Johnson, VT: Cutting Edge Press.