

## Commentary: Practical and Humanistic Lessons from the Third World for Perinatal Caregivers Everywhere

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This well-designed, carefully conducted, randomized controlled trial of female relatives as labor companions by Madi and coworkers was the work of culturally sensitive researchers. The powerful benefits of a female relative as a labor companion are demonstrated by the significantly reduced need for intrapartum analgesia, oxytocin, amniotomy, vacuum extraction, and cesarean delivery for mothers in the experimental group compared with those in the control group. The information obtained from this study has direct application to the care of laboring mothers in developing countries. This study, together with results from 13 randomized controlled trials of labor support in several different parts of the world, provides important lessons for caregivers in industrialized nations as well.

In a review of the Murdock and White anthropological sample of linguistically, geographically, and historically representative nonindustrialized societies, a woman was present with the mother during labor in 127 of 128 societies (1,2). In only one society did the mother labor alone. In North America and other industrialized nations, 100 years ago, childbirth occurred in the home with relatives and friends providing social, emotional, and physical support and often managing the delivery. However, as birthing moved into the hospital in the 20th century, the once universal practice of labor support was abandoned. Laboring mothers were routinely left in the unfamiliar confines of the hospital, away from the support of family, at a time of maximum stress and worry. Findings of studies on labor support published in the last decade provide retrospective insight into the probable cost of this

change in perinatal practice. The lack of continuous labor support may be linked to an increase in cesarean deliveries and other interventions, resulting in unnecessary pain, medical expenses, and complications. These mothers may have entered motherhood with feelings of low self-esteem, anxiety, and depression that may have made the relationship with their infants less satisfactory than they might have been otherwise.

Too many generations have passed during the 20th century to provide sufficient memory remnants of traditional home birth practices to reestablish them for mothers in industrialized nations. In North America, in particular, the father has been brought in to the labor and delivery unit as the supportive companion. The father's participation in the birth of his child may positively affect his parenting, and the laboring woman wants and appreciates his presence. A male partner or father does not provide labor support like that of an experienced female labor companion, or doula, however, and should not be expected to fulfill that role. A randomized controlled trial showed that the presence of a doula with a woman and her male partner resulted in significantly reduced cesarean deliveries and need for epidural analgesia, compared with women whose male partner was the sole source of continuous support (3).

Studies of supportive behavior during labor have demonstrated that fathers and male partners behave differently from doulas or other female companions. Delay et al used time sampling to study the behavior of doulas (4). Bertsch et al used a similar technique to study fathers who were the sole source of continuous labor support, and then compared the behavior of the fathers to the behavior of doulas (5). When the laboring woman was experiencing pain, the fathers were significantly farther from the mothers and talked and touched them significantly less than did doulas. Similarly, when Brooks et al examined the behavior of first-time fathers and female relations or friends, fathers did not automatically provide the type of support that female family

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members provided, and again remained significantly farther from the laboring woman (6). With increased pain, in general, the women moved in closer to the mother, and the father stayed where he was or moved back. When the laboring woman was in pain, the women used more phrases of a specific, active, supportive nature, while fathers did more general talking. In summary, women—whether female relatives or doulas—differed significantly from the fathers in their responses during labor.

The present study demonstrated that the traditional practice of having a female relative or friend with the mother during labor results in a labor and delivery experience that requires fewer interventions. Reviewing the birth customs in Botswana highlighted in this report may be particularly helpful for us in North America and other industrialized nations, where we have lost the details of traditional birth practices. Could the results of this study be replicated in United States hospitals? Women in the United States no longer have access to the body of birthing knowledge that used to be passed from one generation of women to the next. With the use of pharmacological forms of pain relief during labor over the last 60 years (first the combination of scopolamine and morphine known as “twilight sleep,” and now epidural analgesia), most women have little experience with nonpharmacological techniques to manage pain. If asked to support a female relative during labor and delivery, most women in the United States would have little experience and knowledge to bring to this demanding role.

When a woman in Botswana is pregnant with her first child, “traditional custom *demands* that her mother or other female relative looks after her.” Married or single, the expectant woman would spend her third trimester of pregnancy at her parents’ home, and stay until the baby is at least one month old. During the labor and delivery, the Botswana woman would be supported and encouraged by a female relative and a traditional birth attendant chosen by the family. After the birth, mother and infant are isolated to protect from infection. A responsible female relative cares for the new mother and infant until the baby is one to three months old. The mother is never separated from her

home, her family, or her baby. The isolation of the mother and infant together enables the mother to devote full attention to the infant to establish breastfeeding, and to start a pattern of interaction that is not disturbed and disrupted by outside pressures. The emphasis on support from family members continuing from the beginning of the third trimester to the third month is evident in these practices. This level of family support in the perinatal period is not typical in the United States, and would probably be viewed as an aberration. Yet these practices may be exactly what is necessary to reduce cesarean deliveries and to provide the new mother with the opportunity to focus on her infant in a way that encourages bonding, successful breastfeeding, and secure attachment.

In cultures where female relatives are accustomed to taking on the role of labor companion, this traditional practice should be permitted and encouraged. In North America and industrialized nations where customs and practices surrounding birthing have been lost and numbers of interventions during labor and delivery are increasing, doulas and more doulas need to be provided for every mother and every couple.

We hope that the readers of *Birth* will recognize the powerful lessons demonstrated by this study, and will share the information with their midwifery and obstetric colleagues, labor and delivery nurses, and all caregivers concerned with mothers and infants.

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