Journal for Health Sciences, Vol. 15, No. 2 (2025), pp. 41–54.
https://doi.org/10.32967/etk.2025.013

FACTORS AFFECTING THE SUCCESS OF LACTATION IN THE CONTEXT OF BIRTH QUALITY

GYÖNGYI PAPP, NÓRA SIMON
University of Miskolc, Faculty of Health Sciences

Summary: The initiation and maintenance of breastfeeding are influenced by a wide range of biological, psychological, and environmental factors. The objective of this study was to explore how childbirth circumstances, particularly the quality of the birth experience and the availability of institutional support, affect the success of lactation. The authors conducted an online questionnaire survey in October 2021, resulting in 1,000 fully completed responses. The sample primarily included women residing in urban areas who were highly educated, aged between 25 and 34 years, and had given birth to more than one child. The data collection was supplemented by semi-structured interviews conducted in the autumn of 2023 with mothers who had experienced difficult or noteworthy births. The findings of the study indicate that undisturbed birth and early skin-to-skin contact have a positive impact on maternal confidence and breastfeeding success. Conversely, traumatic childbirth experiences characterised by a loss of control have been more frequently associated with breastfeeding difficulties, maternal insecurity, and early weaning. Despite the quantitative analysis failing to demonstrate a statistically significant correlation between mode of delivery and breastfeeding problems, the qualitative data indicated a clear trend. The research also highlighted that the type of birth preparation, family background, and complex perinatal factors all contribute to lactation outcomes.

Keywords: *Breastfeeding, childbirth experience, maternal competence, undisturbed birth, perinatal care*

1. INTRODUCTION

The quality of labour and birth is one of the most significant experiences in the human life cycle. It has been demonstrated that this experience exerts a considerable influence on the health and developmental outcomes of the child. Furthermore, it is also essential for the mother's sense of competence, the development of attachment [1], and the initiation of breastfeeding. Recent research findings indicate that the development of the relationship between mother and child commences prior to birth, during pregnancy. At this particular stage of pregnancy, it has been observed that women gradually develop a mental representation of their foetus. This mental representation constitutes the foundation for the subsequent emotional attachment that is so integral to the development of the mother-foetus bond. This special relationship is defined in the literature as prenatal attachment and evaluated as an independent psychological phenomenon. [2] Breastfeeding as a biological norm is not merely a method of feeding; rather, it is a complex neuroendocrine and

psychosocial process, the starting point of which is closely related to the aforementioned process, as well as to the experience of childbirth and the environmental and psychological factors associated with it.

As demonstrated by numerous international studies [3, 4], the importance of undisturbed physiological birth is well-documented. This approach supports early skin-to-skin contact, facilitates the golden hour, and has a positive effect on the initiation of breastfeeding. [5] Undisturbuned birth has been shown to reduce anxiety and the development of postpartum depression, and to encourage mothers to be less likely to choose formula during initial difficulties. In addition, newborns are more likely to participate actively in feeding. [4]

The release of the hormone oxytocin during natural birth has been demonstrated to support uterine activity and the milk ejection reflex Furthermore, the neurobiological basis of mother-newborn bonding is formed by this hormone. [6, 7] Conversely, the medicalisation of birth, the large number of interventions, and the experience of birth as a loss of control or traumatisation can adversely affect breastfeeding attitudes, lactation self-confidence, and maternal mental health. These factors can have an impact on later physical and mental health. [8, 9, 10, 11]

Nevertheless, the effects of perinatal events extend beyond the newborn period. Recent advancements in developmental psychology and epigenetic research have demonstrated that early life experiences, particularly the stress surrounding birth, have the capacity to exert a long-term influence on a child's emotional regulation, stress response, and subsequent parenting competence. The quality of maternal care (including the commitment to breastfeeding) exerts a significant influence on the health behaviours of the current generation, while concurrently establishing transgenerational patterns. [12]

In the domain of perinatal sciences, it is imperative to investigate the factors that facilitate a positive birth experience and the efficacy of breastfeeding, particularly during the initial days and weeks postpartum, when mothers are most susceptible to complications. [13]

The selection of this topic is driven by the conviction that a more profound comprehension of the correlation between birth experiences and breastfeeding outcomes can facilitate the evolution of more compassionate, family-oriented care. This enhanced care is expected to not only promote the health of the mother-child duo but also lay the foundation for the establishment of secure attachment, effective stress management, and health-conscious lifestyles for future generations. In such an approach, health professionals – especially health visitors, midwives and birth attendants – can become pivotal in ensuring the positive quality of labour, birth and breastfeeding.

Education is pivotal in the promotion of breastfeeding and the support of lactation. [14] The objective of education is to impart the necessary knowledge to safeguard and support effective breastfeeding and lactation from pregnancy through childbirth until the conclusion of infancy. [15] In addition to preparing for

breastfeeding and childbirth, the responsibility of professionals around families is to influence attitudes and foster a positive atmosphere.

In recent years, there has been a paradigm shift in attitudes towards breastfeeding. Historically, in traditional societies, the sight of a breastfed baby was common; however, this practice is becoming increasingly rare today. Experiential support from immediate family members has proven to be an effective strategy for managing breastfeeding challenges and other problems associated with childbirth. In modern society, parent educators have taken on a role previously filled by women's communities, thereby compensating for the lack of such groups. [4] Individuals who have not had the chance to engage in childbirth preparation training frequently encounter challenges in the organisation and interpretation of information during prenatal care. Consequently, individual needs may be overshadowed in the context of hospital births, leading to a more impersonalised birth experience that adheres to standardised protocols. The absence of adequate caring, emotional and practical support has been demonstrated to engender feelings of insecurity in mothers regarding childbirth. This, in turn, has been shown to exert an indirect negative influence on the initiation and maintenance of breastfeeding. The period of prenatal care could be utilised as an optimal setting for preparing for childbirth and breastfeeding, thereby providing families with the necessary information to enable them to make informed decisions. [16, 17, 18] It is submitted that, in the event of adequate information being made available, a proportion of women may be in a position to eschew the option of caesarean section, which is frequently perceived as a more straightforward alternative. It is acknowledged that this procedure has the potential to engender significant physical, psychological and familial repercussions. A global perspective reveals a substantial increase in the prevalence of caesarean sections in recent years. Presently, surgical intervention is employed in more than a third of global childbirths. [19, 20]

The global caesarean section rate is approximately 21%, which indicates that one in five babies is delivered by caesarean section. This rate is substantially higher than the WHO's previous recommendation of 10–15%. Projections indicate that this rate may rise to 28–29% by 2030. [21] These data further substantiate the hypothesis that opting for the 'easier way' is not merely a matter of individual preference, but rather, is also indicative of a global trend. This trend has far-reaching health and social ramifications.

A review of the relevant literature was conducted the following research questions:

1. The level of experience and support gained during the days following childbirth in the hospital has a significant impact on mothers' attitudes towards breastfeeding.
2. The success of breastfeeding is contingent upon the absence of obstruction and disturbance during childbirth.
3. The presence of healthcare workers during childbirth, as well as the obstetric environment, have been shown to have a significant impact on the development of the mother's perinatal experiences and attitudes.

2. MATERIAL AND METHOD

The research used both primary and secondary data collection methodologies. Data from the authors' previously collected questionnaire were grouped according to specific criteria in the framework of secondary data collection. The target group of the study was mothers who had given birth in the past decade. Data collection was carried out using convenience sampling. Our questionnaire was shared in thematic groups on the largest social media platform (Facebook). Respondents were able to participate anonymously after consenting to complete the questionnaire, while the interview subjects were contacted personally. The research was conducted with the appropriate ethical approvals from the Health Scientific Council Borsod-Abaúj-Zemplén County Ethics Committee.

The online questionnaire includes questions on demographic data, circumstances of childbirth, intention to breastfeed, difficulties encountered during breastfeeding, and the level of information and support received. The questions asked in the study included both closed and open-ended items, with short text explanations to facilitate understanding. The data collection period took place in October, 2021. The survey generated more interest than expected, so the survey was closed after 1000 responses were received. The high number of responses also indicates the significant social relevance of the topic. In order to further interpret the quantitative results, the research was supplemented with semi-structured interviews. The aim of the qualitative phase was to explore the personal, often emotionally charged narratives of mothers' experiences of childbirth and breastfeeding. The eight interviewees were selected to participate in the study through a conscious recruitment process, with particular attention to identifying women who experienced challenges, unusual events or significant psychological distress during childbirth. The interviews were conducted in October and November, 2023. The interview phase was an important addition to the data collected through the questionnaire and contributed significantly to a deeper understanding of the research.

The quantitative data analysis was performed in Excel and a p value of ≤ 0.05 was considered significant. Data were presented as frequency values, mean and standard deviation. The χ^2 test was used to examine the association. The qualitative data were analyzed using thematic content analysis, with particular attention to the development of potential competence, processing of the childbirth experience and attitudes.

3. RESULTS

Table 1 presents the demographic data of the respondents for the 1000 completions, and *Table 2* shows the same datas for the 8 interviewees.

Table 1

Demographic data of the respondents (questionnaire, n = 1000)

Age (%)	
18–24	**4**
25–34	**66**
35–44	**29**
45–54	**1**

Marital status (%)	
married/registered partnership	**95**
unmarried	**3**
divorced/widow	**2**
Education (%)	
primary school or below	**1**
secondary education	**22**
vocational training diploma	**2**
higher education or more	**71**
currently study in higher education	**4**
Place of residence (%)	
capital city	**15**
county seat	**22**
town/city	**37**
village	**25**
farm or homestead	**1**
Number of children (%)	
1	**24**
2	**32**
3	**31**
4 or more	**13**
Mode of delivery (%)	
elective caesarean section	**13**
emergency caesarean section	**19**
vaginal delivery in hospital	**60**
vaginal birth after caesarean	**3**
planned home delivery	**3**
other	**2**
Success of lactation %	
there were no problem	**41**
there were problem	**59**

Table 2

Demographic data of the respondents (interviews, n= 8)

Age (years, mean ±SD)	29.5 ± 2.21
Marital status, %	
married/registered partnership	100
Education, %	
secondary education	25
vocational training diploma	12.5
higher education or more	62.5

The vast majority of participants in both the quantitative and qualitative components of our study consciously prepared for childbirth and breastfeeding and demonstrated a strong commitment to the prospect of a natural, undisturbed birth. This observation

is further supported by the data depicted in *Figure 1*, which shows that 74% of mothers rated the importance of maintaining an undisturbed labour and birth at the highest level on a five-point Likert scale. Additionally, 15% of respondents assigned a high priority to this aspect, whereas the proportions of those expressing a neutral (9%) or low (2%) valuation were minimal. These findings suggest that, for most mothers, childbirth transcends a purely biological event, representing instead a profound biopsychosocial process during which autonomous decision-making, a sense of security, and emotional support are critically important.

However, despite the perceived importance of undisturbed birth, less than half of the respondents (41%) endorsed the view that birth conditions significantly influence breastfeeding success. The proportion of respondents who do not perceive a correlation between the quality of birth and subsequent breastfeeding is relatively high (19%), particularly when contrasted with the proportion of those who regard the peace of birth to be an insignificant factor (2%).

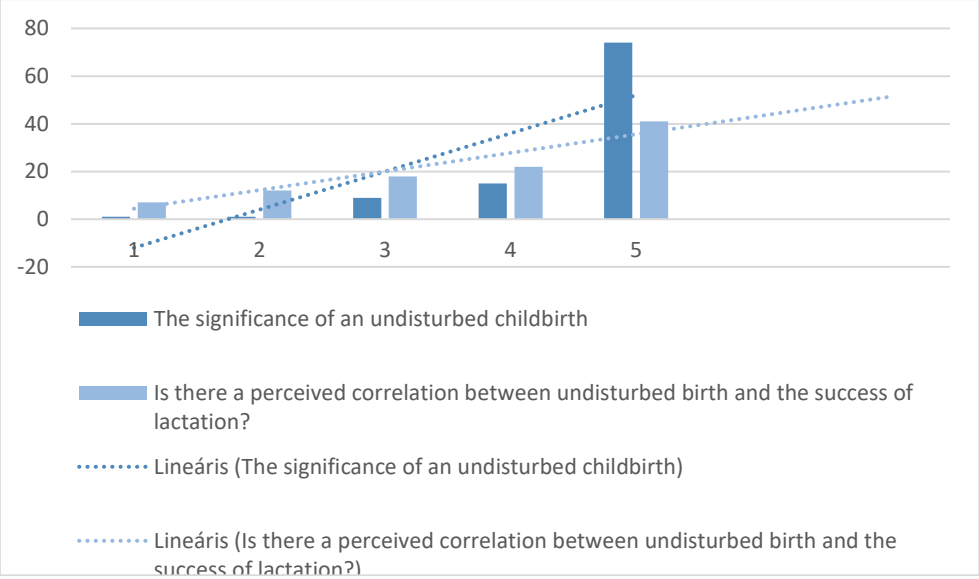

Figure 1. *Perceived Importance of Undisturbed Birth for the Successful Lactation (1 = not at all important, 5 = extremely important) (n = 1000)*

The statistical analysis of the questionnaire data indicated no statistically significant association between the mode of delivery and the occurrence of breastfeeding difficulties ($\chi^2_{(5)} = 2.80$, $p = 0.731$). However, findings from the qualitative data, interviews, and the distribution in *Table 3* suggest an observed association between the quality of the birth experience and breastfeeding success, particularly among primiparous women. *(Table 3)*.

Table 3
Distribution of mode of delivery and incidence of breastfeeding problems (N = 1000)

mode of delivery	no breastfeeding difficulties	breastfeeding difficulties	∑
PVN* in hospital	**64.1%**	**62.3%**	63.2%
emergency caesarean section	**19.8%**	**21.0%**	20.9%
elektive caesarean section	**9.4%**	**12.2%**	10.3%
VBAC**	**3.2%**	**2.1%**	2.7%
home birth	**3.3%**	**2.2%**	2.7%
home birth without professional assistance	**0.2%**	**0.2%**	0.2%
∑	**100%**	**100%**	100%

*PVN = Per Vias Naturales
** VBAC = Vaginal Birth After Caesarean

A considerable proportion of respondents who completed the questionnaire reported insufficient support during their postpartum hospitalisation. Their responses highlighted that the absence of the "golden hour", early maternal-infant separation, and lack of skin-to-skin contact frequently hindered the timely initiation of breastfeeding. Moreover, mothers who underwent labour induction with synthetic oxytocin or delivered via caesarean section reported breastfeeding difficulties with higher frequency. These quantitative findings are further elucidated and contextualised through detailed analyses of qualitative interview data.

"Oxytocin due to impatience, then non-dilation and 'the baby's heartbeat isn't that good', followed by a caesarean section. After which, due to lack of help, breastfeeding was unsuccessful." (32 years old, first child, caesarean section)

"I think I discovered a perfect parallel between breastfeeding and my birth. The failure of breastfeeding during the golden hour corresponds to the non-start of labour, and then the process that begins with great difficulty and with help – nipple shields for breastfeeding, oxytocin for childbirth – just doesn't go as it should, there are deficiencies and it stops – a tongue tie had to be replaced, which led to sucking difficulties, the baby didn't fit well, so the dilation stopped. Just as the birth that started in the spirit of naturalness ended in the operating room, breastfeeding was slowly replaced by formula" (27 years old, first child, caesarean section).

The quality of the birth experience is significantly influenced by the level of information provided to the woman, her decision-making autonomy, and the quality of communication with healthcare personnel. As illustrated in *Figure 2*, a significant proportion of the respondents (50%) did not receive any substantial information regarding the interventions that were performed during childbirth. Furthermore, 39% of respondents reported only partial information, while only 11% felt that they were provided with adequate support, information or decision-making opportunities. This

proportion is extremely revealing: the majority of mothers did not experience authentic involvement in decision-making around childbirth, or only to a limited extent.

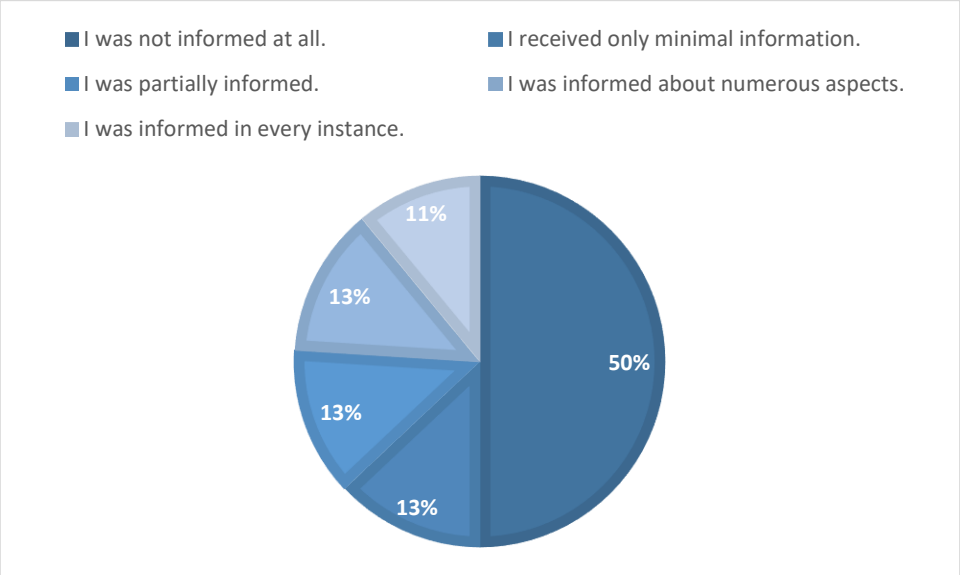

Figure 2. *Respondents' evaluations of the level of information received during childbirth (n = 1000)*

Similar results were obtained for breastfeeding support in the hospital. As illustrated in *Figure 3*, among the 1,000 participants who were surveyed, 419 (42%) reported not receiving any assistance in initiating breastfeeding during their hospitalisation, while an additional 180 (18%) indicated that they only received partial support. This indicates that 60% of mothers did not receive adequate support for breastfeeding, despite the fact that the initial hours and days following birth are of paramount importance for the initiation of lactation and the establishment of the bond between mother and infant. A multiple-choice format was employed in order to ascertain the source of any assistance, support or information received by the 581 participants who received help during their hospitalisation. The results indicated that the majority of respondents selected the baby nurse (552 people, 95%), followed by the hospital nurse (198 people, 34%), midwife (135 people, 23%), lactation consultant (119 people, 20%) and obstetrician (33 people, 5%).

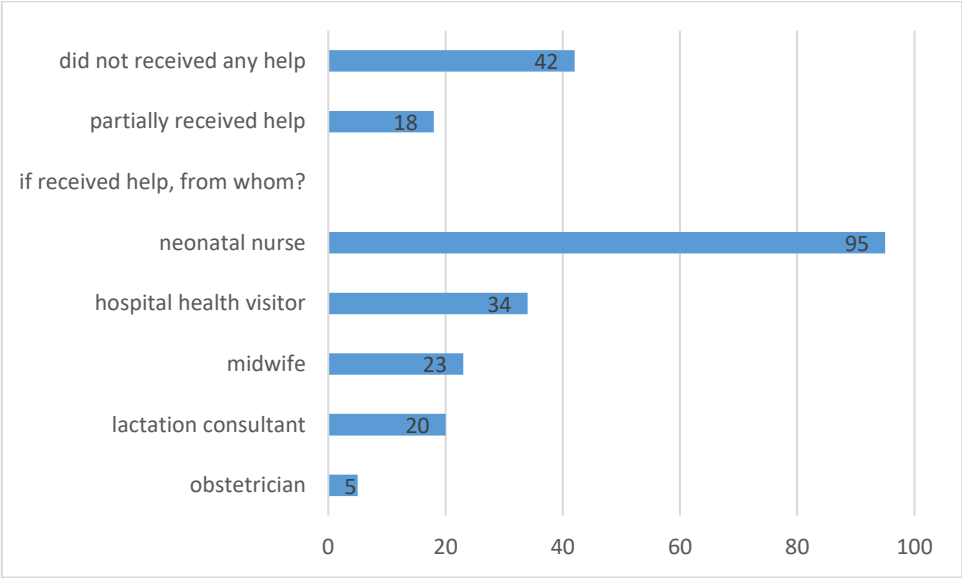

Figure 3. *Breastfeeding support in the hospital (n = 1000)*

The narratives provided by the interviewees reinforce the quantitative findings of the questionnaire-based study and, by contextualizing these results, contribute to a deeper understanding and a more vivid experiential interpretation. *"An opportunity for a golden hour in the caesarean section was present, yet the nurse working on the ward only arrived after several requests for assistance with the breast placement. Following the realisation that success would not be immediate, the nurse departed, resulting in the inability to breastfeed my infant son on the day of his birth." (26 years old, first child, caesarean section)*

"My first birth experience had a very bad effect on me and I experienced it as almost a trauma. I think the babies were the same trauma as me. Breastfeeding was difficult, it hurt, I didn't know how to latch on correctly, what was good and what was bad. The help with this was that they took her out and fed her from a bottle. I had to learn it all over again with my second baby, but this time they were very happy to help in the hospital, they were there with me. I didn't have a hard time. They monitored the breastfeeding, they also helped with the placement on the breast. At that time I had removable stitches, which healed much faster, I was able to breastfeed in several positions because it was easy to move around." (27 years old, 2 children, PVN)

4. DISCUSSION

The initial inquiry examined the extent to which postpartum experiences and the support received within the hospital setting influence maternal attitudes towards breastfeeding. Questionnaire responses indicate that both practical and emotional support provided during hospitalization play a critical role in the initiation and

continuation of breastfeeding, as well as in fostering a mother's sense of security. Interview findings further substantiate the hypothesis that the quality of experiences and the level of support received in the immediate days following childbirth significantly affect maternal attitudes towards breastfeeding. These results align with prior international research, which demonstrates that insufficient postpartum support—particularly following a distressing birth or one involving medical interventions—increases the risk of breastfeeding difficulties and early cessation. [4, 22] The literature consistently identifies elective caesarean section as a major contributor to breastfeeding challenges. [23]

Beyond the physical difficulties, inadequate support may undermine maternal self-efficacy, increase anxiety, and negatively impact the mother-infant relationship. Extant studies emphasize that the provision of authentic, comprehensive information, the adoption of assertive communication strategies, and the upholding of women's rights positively influence the birth experience, enhance maternal self-efficacy, foster trust, and facilitate the establishment of a secure mother–child bond. [16, 21] The findings of the present study corroborate these conclusions, indicating that the majority of women seek not only physical safety but also informational and emotional security during childbirth. Achieving a favorable birth outcome is contingent upon the mother's maintenance of composure and self-confidence, which fundamentally depend on comprehensive informational support, a predictable environment, and continuous emotional care. [24]

In particular, women undergoing caesarean section were more likely to experience delayed lactogenesis, painful breastfeeding, difficulties with infant latch, as well as heightened anxiety and diminished maternal self-efficacy. The results of this study corroborate previously established associations in the literature, demonstrating that birth circumstances—especially reduced maternal autonomy, absence of immediate physical contact, and impersonal care—significantly affect breastfeeding success and the quality of the initial mother–newborn bond. [22, 25] Qualitative analysis of our interview data revealed a pronounced parallel between the nature of women's birth experiences and their breastfeeding outcomes: participants reporting positive birth experiences exhibited greater confidence in breastfeeding and higher rates of successful on-demand feeding. It is well-documented that negative birth experiences, often characterized by loss of control and instances of obstetric violence, are frequently linked to breastfeeding difficulties, premature weaning, or reliance on formula feeding.

The findings of the present study emphasize that the perinatal period necessitates enhanced levels of preparedness, empathy, and attitudinal development—not only among pregnant women and their families but also among healthcare professionals involved in their care. As previously noted, emerging research on transgenerational effects, alongside epigenetic studies, increasingly underscores the imperative for early interventions to interrupt deleterious psychosocial trajectories. If the current state of obstetric care persists, there exists a substantial risk of perpetuating adverse outcomes, such as maternal insecurity and attachment disorders, across generations. [26]

The perinatal period is critically important for the identification and management of psychological challenges arising during pregnancy and the postpartum phase. Promotion and maintenance of optimal childbirth conditions – particularly minimizing unnecessary interference – have been consistently shown to exert beneficial effects on maternal experience, labour processing, and postpartum psychological well-being. [27]

This assertion is corroborated by the findings of contemporary longitudinal studies, which demonstrate a direct correlation between the experience of traumatic childbirth and the subsequent development of postpartum psychological disorders, including post-traumatic stress, depression, and impairment to the mother-child bond. [28, 29] These studies have demonstrated that maternal attachment skills are not merely established in the postpartum period, but also evolve during pregnancy through the formation of mental representations that are developed in conjunction with the fetus. The subjective experience of childbirth held by the mother has been shown to exert a significant influence on the quality of the subsequent mother-child bond, with the intensity of this influence being particularly pronounced in cases where the birth is processed as a negative or traumatic experience. [2, 30, 31] The health workers, by virtue of their unique role in offering ongoing support to families, have been identified as key players in the provision of timely intervention in this process. Health visitors can play a key role in timely intervention within this process, as their continuous presence offers a unique opportunity for providing long-term support to families.

5. CONCLUSIONS

Based on our quantitative and qualitative data, we found that a positive birth experience, particularly in a calm and supportive environment, promotes successful breastfeeding, enhances maternal confidence, and fosters secure early attachment. In contrast, breastfeeding difficulties, insecurity, and challenges in adapting to the parental role were more common following uncontrolled, traumatic birth experiences. Our survey also revealed that the preparation method, the amount of information received, and the attitude of hospital staff influenced mothers' perinatal experiences. This supports previous research concluding that the quality of the birth experience impacts not only the short term but also the long term, affecting the mother's mental health and her relationship with her child.

Health visitors bear significant responsibility in this area. A caring, trusting relationship creates opportunities for personalized information sharing and emotional support. During antenatal care, health visitors can provide women with up-to-date, evidence-based information to help them prepare for childbirth, breastfeeding, and health-related decisions. In the postpartum period, they can identify breastfeeding difficulties early and offer appropriate counseling.

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