Getting Breast-Feeding Started

This is the fifth issue of the regular feature on infant feeding practices. This article is from the book *Breast-Feeding in Practice: A Manual for Health-Workers* by Elizabeth Helsing and F. Savage King, published by Oxford University Press.

Frequency and Duration of Feeds

ALTHOUGH we can learn much from other mammals about lactation, we cannot learn from them what is a 'natural' feeding pattern for ourselves, because the frequency with which different animals feed varies so much. It varies between species from only one or two nursings a day in deer and antelopes to almost incessant feeding in bears. This variation between species depends partly on the solute and protein concentration of the milk (Ben Shaul : 1962). Species with *dilute* milks tend to feed more often. Woman has one of the most dilute milks of all—so if we are to deduce anything from that 'rule', we should expect the human infant to feed very often. But frequency also varies between individuals of the same species, and it even changes in the same individual mother—with a different baby and at different times during lactation.

When you look at human infants, you find that some are fussy, demanding, or seem to have a small stomach capacity. They want to feed every one or two hours throughout the day and night. Other babies have a larger capacity and a more peaceful temperament and demand to be fed only five times a day.

The only constant feature, among babies, is that none seem to be very hungry for the first few days. They may want to feed only two, three, or four times a day. But from the third day onwards, however, this changes. If a baby is given the opportunity to feed on demand, it may want to feed as many as ten to twenty times a day. There is nothing unusual about this, it only shows that the infant is waking up into the world. It needs to be reassured that closeness and cuddling are still available even though it has left the warm moving environment of the womb.

From the second week of life, most babies begin to demand less, and gradually settle into a routine of their own. Again there is a great individual variation. As a child grows, the feeding pattern should be a compromise between the child's and the mother's need.

Every infant has periods of sudden rapid growth, and at these times, it needs more food. These commonly occur around 3 weeks, 6 weeks, and 3 months of life (Waletzky: 1979). Some mothers find that their milk supply adjusts easily to the increased demand. Other mothers, however, experience a few days with a hungry, incessantly demanding baby, until their milk production increases in response to the increased sucking, and again becomes satisfactory.

These latter mothers need firm reassurance at this very difficult time that what they experience is normal, and that they have not 'lost' their milk, and that the building-up process will only require a few days of more frequent feeding.

The *duration* of each feed does not matter, even, probably, in the first few days. Health workers stress too much the risk of sore nipples if a baby sucks too long. Soreness may occur when a baby sucks in a bad position; it does not get enough milk; it is not satisfied, so it continues to suck. Most babies who suck correctly take 80-90 per cent of the food from each breast in the first four minutes (Lucas, Lucas, and Baum : 1979). Some babies take longer to finish. If a baby sucks for more than 10 minutes, check its position—then let it continue. But very *short* feeds—of 1-2 minutes—may leave the breasts engorged, and the baby unsatisfied.

The First Feed at the Breast

Some traditions do not allow a child to suck until a few days after birth. In many societies there is a superstition that colostrum is not good for the infant. The strong yellow colour of this fluid is sometimes associated with pus. Mothers simply wait for the mature milk to 'come in' before they put the baby to the breast.

In about the year AD 200, the fashionable Greek physician Soranus advised his upper-class lady patients not to put their infants to the breast until 20 days after birth. During this time, according to Soranus, her body was sick, her milk thick, indigestible, and raw, and not suitable for an infant (Rose : 1882). For the Greek upper-class ladies, this advice created no problem, since wet-nurses were readily available. But in the absence of wet-nurses, it is a very dangerous practice. Not only does the infant often starve for this period, but it makes it more difficult to establish lactation later on. Postponing suckling is an unnatural practice, which we should avoid and discourage.

There is no reason why a healthy, full-term baby cannot be put to the breast immediately after birth. There is good evidence that this increases the success and duration of breast-feeding (Salariya, Easton, and Cater: 1978). But although there are many reasons why a baby *should* suckle at this time, many supposedly 'modern' hospitals insist on a delay of 24 hours and even sometimes of two or three days before a baby is allowed to nurse. When we have asked why this should be, we have been given vague and conflicting answers—never a satisfactory one !

But, now, however, progressive health workers recommend putting the newborn to the breast immediately after birth (WHO/UNICEF : 1979). If possible, let the mother and child lie together for about an hour in a quiet room. They should both be naked, but covered together, and be able to hold, fondle, and suckle, and to *bond*. The father should also be there (Lozoff

et al : 1977). In due time this practice will, we hope, become general. During the initial bonding 'cuddle' do not bother them, let the mother try for herself. She may prefer to continue just to try for herself for another feed or two.

Soon, check to see how she is getting on and whether she can get the baby to suck the nipple. Many mothers try to put the nipple straight into the baby's mouth from the front. Often it is better to use the 'rooting reflex'. Let the nipple, or your finger touch the baby's cheek that is nearest to the breast. The baby will usually turn towards the nipple, trying to find it with its mouth. The baby may get the nipple between its lips—but then not suck properly. *You need to make sure that the nipple and areola are far into the mouth to stimulate the sucking reflex.* You may need to hold the baby quite firmly against the breast to make sure that enough areola goes in.

If the baby just sucks a little bit you have succeeded. Make sure the mother fully understands that these early 'feeds' are for learning to suck, and not for taking large amounts of milk. She must not expect any more —or she will not be satisfied with her baby's early efforts. All that is necessary for the first few feeds is to get the baby to take the nipple into its mouth, and give a few sucks.

Allow the infant to suck freely from the first day on —as often as is natural for each individual mother/child couple. Do not force them to follow a rigid institutional schedule. As early as 1952 Dr. Illingworth showed that if 'demand feeding' is allowed, mothers are less likely to develop sore nipples or breast congestion. It is high time this knowledge is put into practice ! (Illingworth and Stone ; 1952).

Cleaning the Nipples

Normal washing—when you wash the rest of the body—is all that is necessary. Human milk is bacteriostatic (it stops bacteria growing) so it is *not* necessary to wash or clean the nipples before a feed. If a mother insists on cleaning the nipples before a feed, she can use plain water (preferably boiled) on cotton wool—or even a few drops of her own freshly expressed milk on cotton wool. Never use soap, or lotions which contain alcohol to put on the nipples. These substances remove the natural oils and make the skin too dry, which makes it more likely to become sore.

The Health Workers' Role

Health workers have a role in *preparing* women to breast-feed, during pregnancy. Their role in helping new mothers to establish lactation is even more crucial. It begins with the person who helped the mother to deliver the baby—in or out of hospital—who must encourage her to put the baby to the breast immdiately, and make it possible for her to demand feed from that time.

It is the responsibility of all health workers—doctors, nurses, and midwives—to make sure that 'rooming in' is possible—with the baby beside the mother so that she can see and touch it.

Some mothers are in hospital long enough for lactation to be established there—others deliver at home or are discharged at 48 hours, so an important part of the process occurs at home. Wherever delivery occurs, the midwife should make it one of the most important of her duties to try to follow up and visit each newly delivered mother in her care regularly until breast-feeding is well established. If she cannot do this herself, she should make sure that someone experienced is at hand to give advice, and to help the mother seek appropriate help should problems arise.

Points to Mention After Baby is Born, in Hospital or during a Home Visit

Here is another 'checklist' to remind you about points that it is useful to discuss with the mother as soon as possible after she has given birth :

1. It takes a few days for the milk to 'come in' and for lactation to be established. She must expect her breasts to feel 'empty' for the first few days. It does *not* mean that she has no milk.

2. Most babies will get all that they need for these first few days in the colostrum—they are born with a food and water store to last until the milk comes.

3. Frequent sucking is necessary to get the milk flowing, and to establish lactation, even if the mother thinks that there is 'nothing' in her breasts. It is perfectly safe to suck both breasts 8-10 times a day, and even more frequently if the baby demands.

4. The duration of a feed is not important—let the baby suck until it releases the breast spontaneously.

5. Some swelling, or engorgement, of the breasts is *normal*, from the 3rd to the 7th day after delivery —when the milk first 'comes in' in a good amount. Frequent sucking may help reduce the engorgement. The engorgement of the breasts usually subsides after about one week. This does not mean that the milk production is less—probably there is more! The breasts feel smaller and softer, because some extra fluid in the tissues has gone.

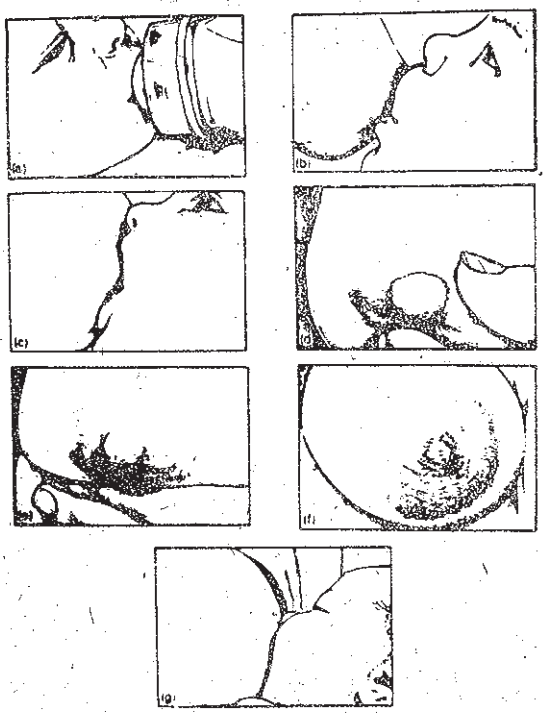
6. She should offer the whole breast to the baby, and ensure that it 'latches on' properly (Figure 1).

7. Remind mothers living under poor sanitary conditions of the *dangers of bottle-feeding.*

8. Also at this stage a mother may need to be taught about how she can increase her milk production (Fig. 1).

It is normal for babies to lose weight for the first few days. They are born with stores of water, glycogen, and fat to last until lactation is established. They regain their birth weight quickest if they are breastfed on demand from immediately after birth (Illingworth and Stone: 1952). There is great individual variation in the time it takes for an infant to regain its birth weight, but on average they take 10-14 days. A baby who loses more than 10 per cent of its birth weight, or who takes longer than 14 days to regain it, may need *temporary* supplementation.

The reason that you tell a mother these things is not so that she becomes an expert on all aspects of breast-feeding. It is to help her to understand what is happening in her own body, so that she is not alarmed by normal phenomena. Once she is 'initiated', that is,



(a) Both the sucking action and the position of the baby's lips are different with bottle-feeding. (b) The baby is sucking the nipple as if it was a bottle. It is pulling the nipple out, which can cause soreness. (c) The baby is sucking in a good position, with most of the areola in its mouth. Notice that its head is very close to the breast, and it is not pulling the nipple out unnecessarily. (d) The mother is holding the nipple out for her baby as if it was a teat on a bottle. She is only offering the nipple itself. (e) Here the mother is offering her whole breast to the baby, so it can take the nipple and areola into its mouth. (f) Sometimes the areola of a breast is very big, and then the baby cannot get the whole areola into its mouth. (g) Here is a baby sucking from a breast which has a very large areola. The baby cannot possibly get the whole areola into its mouth, but you can see that its head is in a good position (Fisher 1981). (Drawings by Ivanson Kayali from photographs by Margaret Bristol, ARPS, of the Oxford University Department of Medical Illustration.)

Fig. 1

once she has got her own milk supply flowing, the less she thinks about it the better.

Checking the Position of the Mother and Infant

We have seen mothers breast-feed in too many odd positions in which they claimed they felt completely comfortable, to feel like recommending any particular position as better than any other.

It is, however, important to check whether or not a mother is *relaxed* in her position. She may be so anxious to succeed that she sits or lies in a tense and uncomfortable position without knowing it. You should try to make her aware of what she is doing, and help to find a relaxed, comfortable position. The more inexperienced a woman is, the more likely she is to exhaust herself by sitting uncomfortably, holding back her breath, and straining her muscles. Also, check that her position allows the breast to fall *towards* the baby. If the breast is pulling or falling away from the baby, it makes it difficult for it to grasp the nipple. The extra stretching of and suction on the nipple skin can damage the skin and cause soreness. Helping a mother to find a comfortable position is an important part of the '*doula*' job. (Fig 2).

The *position of the baby* during feeding must also be correct to prevent sore nipples. The mother should hold the baby close enough to her body for its chin to touch her breast all the time. If the baby is not close enough to the breast, it may have to suck too hard on the nipple in order to keep it in its mouth. This excess suction can damage the sensitive nipple skin. A baby must be held close enough to the breast to keep the nipple *and* areola in place inside its mouth without much effort. Of course, you also have to make sure that the baby's breathing is not obstructed in any way. Sometimes a big, soft breast falls over a baby's nostrils. With a finger of her free hand, the mother can gently press this part of the breast out of the way. A poor feeding position occurs if a mother offers the nipple as if it were a bottle.

When the Mother Visits the Child Welfare Centre

Often it is not possible for the health worker who helps a mother to deliver her baby to continue to see her for long afterwards. Perhaps she can help her a week or two until lactation is established. But many problems may arise *after* that, during the phase of *maintaining* lactation. Health workers in child welfare centres have an important role to play here. Every time a mother comes to a child welfare centre—ask how breast-feeding is progressing, and if her breasts are in good condition. Say as many positive, encouraging things you can. Give each woman a chance to express her doubts and anxieties, but take great care not to sow any seeds of doubt that are not there already. When you weigh a child, and find that its weight gain is good, praise the mother—and her milk. If you find any problems, do whatever you can to follow up that mother and baby until the problem is resolved. If there is some kind of *doula*—a relative or friend, or a member of a local breast-feeding support group—you may find that they can help you a great deal. Share your ideas with them, and listen carefully to theirs !

Feeding positions with too much milk: (a) Mother has pillows under her head and a towel or nappy under her back to catch the dribbles of milk. She pulls the baby gently up to one breast, with its body lying across hers and supporting its forehead with the heel of her hand, positioning her elbow raised on a firm pillow or cushion to take the weight of its head. The mother should not try to support the baby by its shoulders as its head will drop down and its nose will become buried in her breast. (b) An alternative method of feeding with the baby propped up on pillows, head high, on its mother's lap so that it has to suck 'uphill', an older baby (c) can suck this way by sitting up on its mother's lap or straddling around her hips. (d) The 'twins' position. (e) A corner of a pillow can be tucked between the mother's shoulder and face on the side she wishes to offer. As the baby grows its legs will lie 'uphill' over her bent leg. The mother should lie in a relaxing position, top knee bent. (Courtesy Nursing Mothers' Association of Australia.)

Fig. 2

For information on better maternal and infant feeding practices, write to : Infant Nutrition Information Service, C-14, Community Centre, Safdarjung Development Area, New Delhi-110 016.