Protecting and Supporting Breastfeeding in the First 24 hours of Life and Beyond

The MotherBaby Dyad in the Kangaroo Mothercare Habitat

To help protect and preserve the breastfeeding in the first 24 hours, it is important to understand baby's behaviour during that period. Babies who are "allowed" to remain within the habitat or context they were born to be in will demonstrate the neurobehaviour expected of them in these first few hours and days of life.[1] The habitat which is most natural for them is the mother; skin to skin, naked baby against naked mother. Within this context, babies will naturally crawl up the mother's body, find the breast and latch on. Though this journey may take many minutes even up to an hour or more, baby will be behaving in the way which is most natural and which will optimize good solid initiation of breastfeeding[2].

A baby taken out of this context or habitat will behave in a way which is protective and defensive in order to maintain and conserve its energy and preserve its life[3]. This baby may become dissociative, disaffected, s/he may "shut down", shake, cry. Furthermore, any baby protecting itself in this way may not at all be interested in latching, or may refuse the breast all together.[4,5,6] The "treatment" for a baby behaving in this way is to put her/him back in the correct habitat so s/eh can do what s/eh is supposed to do—attach to the mother. Therefore, continuous uninterrupted skin to skin care with the mother is indicated.

Incidentally, in a situation where a mother may choose not to breastfeed, the skin to skin contact is equally as important, in fact, probably more so, and should be supported.

The skin to skin contact required by baby in the first few hours, days, weeks of life is key not only to help maintain baby's respirology and metabolism, i.e. regulation of blood sugars, heart rate, breathing rate, body temperature, and increased oxygen saturation, but the skin to skin contact in the first few days helps her/his neurodevelopment and neurobehaviour.[7,8] This *Skin to Skin Care*, called kangaroo mothercare, provides the correct habitat in which the initiation of breastfeeding has already begun by virtue of the exchange of sensory information between mother and baby[9].

The First Latch

It is probably best that mother not be assisted in the first latching of the baby, unless of course mother is feeling very weak, disoriented or dopey from having been medicated during labour/delivery. However, she should not be left alone but instead be helped to get into a comfortable position where she can easily hold the baby in an unrestricted and safe way. The first latch is important mostly for establishing and securing this natural habitat for baby and mother. This latch is less so for nutrition and more so for baby

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1 Bergman, Nils, Kangaroo Mother Care: restoring the original Paradigm for infant care and breastfeeding. Presentation at Ottawa Valley Lactation Consultants conference, Ottawa, ON, 2005.

2 Newman, Jack Dr. Jack Newman's Guide to Breastfeeding, Rev Ed. Harper Collins, Toronto, 2005

3 Bergman, Nils, Linley, L. et al., Randomized controlled trial of skin-to-skin contact from birth versus conventional incubators for physiological stabilization in 1200 to 2199 gram newborns. Acta Paediatrics 93:779-785, 2004

4 Bergman, Nils, Bergman, Nils, Kangaroo Mother Care: restoring the original Paradigm for infant care and breastfeeding. Presentation at Ottawa Valley Lactation Consultants conference, Ottawa, ON, 2005.

5 Newman, Jack, Handout: When baby refuses to Latch, 2005

6 Kroeger Mary and Smith, Linda J., Impact of Birthing Practices on Breastfeeding: Restoring the Mother-Baby Continuum, Boston, MA: Jones & Bartlett Publishers, 2004

7 Ransjö-Arvidson, A., et al. Maternal analgesia during labour disturbs newborn behaviour: effects on breastfeeding, temperature, and crying. Birth 28:5-12 2001.

8 Bergman, Nils, Kangaroo Mother Care: restoring the original Paradigm for infant care and breastfeeding. Presentation at Ottawa Valley Lactation Consultants conference, Ottawa, ON, 2005.

9 McKenna, James, Presentation at INFACT Conference, Toronto, 2006

to begin her/his neurodevelopment outside the womb.[10] This first latch should not happen because baby has been pushed to the breast or even encouraged to take the breast if not first showing signs of interest. These signs include, but are not limited to, rooting, making sucking motions, opening her/his mouth, moving her/his head, opening and closing her/his hands.[11] And baby moving her/his way up the mother's body to the breast, this indicates her/his desire to latch. S/he may be helped by the mother to get there if necessary.

Once baby has self attached, mother may be encouraged to look for signs of a good asymmetric latch, chin in the breast , nose not touching the breast, wide open mouth, more areola showing near baby's upper lip—all this would be helpful for mother to note. Baby should be allowed unrestricted, not-timed, unscheduled access to the breast.[12]

Subsequent Latching In the First 24 Hours

As baby begins to show interest in latching the mother should be encouraged to position baby so her/his cheek is resting on the breast.[13] This will allow baby to begin movements toward the breast and while doing so, this is the ideal time for the Midwife/Doula/LC/Nurse/Physician/Support Person to help mother position her arms and hands to help support baby in the optimal way to facilitate good latching. It is suggested that mother try the cross cradle hold in these first few days of life until she has a good understanding of the asymmetric latch, unless of course she is ore comfortable with the cradle hold. The most comfortable position for the mother, however, is likely to be lying down—and still the same latching principles apply: asymmetric latch, chin in the breast, not the nose, the lower lip covering more of the areola then the upper, and the nipple aimed far back inside toward the roof of the mouth to the junction of the hard and soft palate. Switching to a cradle hold will be easier later on if desired. What is key is that regardless of the positioning, baby's body must be supported –either by the mother's arm where it acts like a shelf to baby's back and bottom, or by the bed. In a cross cradle position, mother may place her fingers under baby's face, making a pillow for her/his cheek, fingers together with the thumb coming around the base of the skull. It is critical that other not be holding baby at the back of the skull or pushing baby into the breast from the back of the head.

It is key that mother be shown what a large gape is as many mothers are so eager to have baby begin to latch that they will readily accept a tiny mouth as long as that mouth is open.[14] Also key is to help baby to breast quickly while baby's mouth is at the height of the gape. At times, allowing baby's chin to come into the breast will elicit the mouth opening very wide and then mother can gently bring baby's body into her[15]. The Support Person's hand, placed gently at the mother's wrist, can easily guide the mother to help baby get to the breast quickly so the chin comes into the breast and the nose never touches the breast at all.[16] It is imperative that neither the Support Person's hand nor the mother's hand push the back of baby's head. Remember, too, that mother should avoid holding down the breast tissue with her hand to clear a breathing space for the nose. This defeats the purpose. The point is that the nose should never come so close to the breast that mother feels the need to hold the breast away. Instead, baby's body should be in such a position that the nose does not come near the breast in the first place. The thing is to think of the baby as reaching for the breast by lifting her/his cheek and ensuring that baby does not flex

10 Bergman, Nils, Bergman, Nils, Kangaroo Mother Care: restoring the original Paradigm for infant care and breastfeeding. Presentation at Ottawa Valley Lactation Consultants conference, Ottawa, ON, 2005.

11 Lawrence, Ruth Breastfeeding: A Guide for the Medical Profession, 4th Ed. St. Louis: Mosby, 1994

12 Newman, Jack. Numbers on Demand. Presentation at Paediatric Rounds, North York General Hospital. Toronto, ON. 2004

13 Smilie, Christina. Baby led latching, presentation at the Humber/Infact Canada Conference, Toronto, ON. May 2005

14 Mohrbacher, Nancy, Kathleen Kendall-Tackett, PhD. and Jack Newman M.D. Breastfeeding Made Simple: Seven Natural Laws for Nursing Mothers. Oakland, CA, New Harbinger Publications, 2005.

15 Smilie, Christina, Presentation at the INFACT conference, Toronto, 2005

16 Glover, Rebecca, http://www.rebeccaglover.com.au/

the neck down[17]. Hyper extension of the neck is not advised, proper placement of the baby in front of the mother's chest, not too medial or lateral, will help facilitate good latching[18].

Sucking vs. Drinking

Understanding that just because a baby sucks at the breast does not necessarily mean that baby is drinking, we can help the mother to realize why timing of the feeding is unproductive. If milk flows baby will drink, if it doesn't, then baby is forced to just suck. Using compressions to help maintain the flow when baby starts to suck and not drink will prevent the baby from falling asleep from boredom.[19] Using compressions (along with good latching) at every feeding in the first few days will prevent engorgement. Follow the "Protocol to Increase Intake of Breastmilk by the baby".[20] It is helpful to encourage mother NOT to do a compression while baby has stopped to rest. Allow baby this rest and when s/he starts to suck again, if there is no drinking, THEN do the compression. Much confusion seems to arise around the sleepy baby who seems content to suck, a state which seems to foster many other labels like "lazy" or "just wanting to pacify". Permit me to say, I take great issue with these two statements. True, some babies are quite sleepy having arrived after a long journey, most likely medicated, etc. [21], and the thinking is if we get the baby's weight up, or we give the baby lots of food, then baby will have the energy to suck [22],[23]. Well, no doubt these statements are true, as well. However, I think it important not to discount the issue of flow[24].

The Baby Who Does Not Show Interest in Latching/Breast Refusal

If during labour mother had been treated with analgesics or any kind of pain medication, baby's behaviour may be found to be affected by such treatment.[25] S/he may be sleepy and even lethargic and often uninterested in latching.[26] Again, it seems that the best treatment in such a circumstance is to support the motherbaby dyad in achieving complete kangaroo mothercare, so that this correct habitat will facilitate the easy and early initiation of breastfeeding. Such a baby should not be forced to take the breast, and must definitely not be swaddled or wrapped at all[27]. S/he should have her hands allowed to move freely, unencumbered by blankets or mittens, and have uninhibited access to the breast.[28] Placing the baby skin to skin, chest to chest with the mother will ensure that access, and a blanket covering the two of them is fine if mother is more comfortable that way. Baby will feed when s/he is ready.[29]

If baby does show signs of hunger, yet does not latch at all even with constant skin to skin care, then a very short minute or two of finger feeding works wonders. This technique of training the baby to take the breast is used with a number 5 French 36" feeding tube placed on the finger (tape is completely

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17 Glover, Rebecca, http://www.rebeccaglover.com.au/

18 Levine, Mark, RMT, personal communications Toronto, 2006

19 Newman, Jack, Handout: Breast Compressions, 2005

20 Newman, Jack, Handout: Protocol to Increase Intake of Breastmilk by the Baby, handout on www.drjacknewman.com 2005

21 Kroeger Mary and Smith, Linda J., Impact of Birthing Practices on Breastfeeding: Restoring the Mother-Baby Continuum, Boston, MA: Jones & Bartlett Publishers, 2004

22 Smilie, Christina, Meeting of the Minds submissions, 2005

23 Fisher, Joan, Meeting of the Minds submissions, 2005

24 Newman, Jack, "Dr. Jack Newman's visual Guide to Breastfeeding", 2005

25 Hale, Thomas, Medications in Mother's Milk

26 Kroeger Mary and Smith, Linda J., Impact of Birthing Practices on Breastfeeding: Restoring the Mother-Baby Continuum, Boston, MA: Jones & Bartlett Publishers, 2004

27 Bergman, Nils, Presentation at the INFACT Conference, Toronto, 2006

28 Bergman, Nils, Presentation at the OVLC Conference, Ottawa, 2005

29 Mohrbacher, Nancy, and Stock, Julie: The Breastfeeding Answer Book. Rev. Ed. Schaumberg, Il: LLL International, 2003.

unnecessary) with the other end in EBM or EBM and D5W (sugar water: 5% dextrose solution)[30]. The finger is placed in baby's mouth, baby draws it all the way back and begins to suck[31]. The supplement should not be raised above baby's head to rely on gravity. The finger should not be pressed against the roof of the mouth, but rather it should be placed flat down on the back of the tongue[32], [33]. After baby sucks the liquid up the tube and drinks for a minute or two, then the baby can be tried at the breast. This process may need to be repeated a number of times by the Support Person and/or mother (though easier for the Support Person) until baby "gets" it.[34]

It is absolutely critical that baby not be forced to the breast. If baby cries then baby should be placed on mother's shoulder not at the breast.[35] If baby does not "get" it in the first few days, mother should be supported and told not to panic. Baby will eventually get it. Keep skin to skin, feed baby by cup (not by bottle or finger unless the other is completely uncomfortable with one modality over another) and then mother should express her milk[36]. Manual milk expression should begin within 12 hours of birth if baby seems to be refusing to take the breast[37],[38],[39].

The First Night

Baby's first (and/or second) night is usually baby's (and mother's!) roughest. Baby tends to do a lot of cluster feeding at this time, may be quite fussy, and seems to need constant comfort. Informing mother that this cluster feeding is normal and temporary will help her to get through this difficult period. Keeping baby close to mother skin to skin will help minimize this fussiness as babies tend to cry less when they are held next to mother skin to skin[40]. This cluster feeding may go on for 24-48 hours as/until the "milk comes in"[41]. Again, this is normal and to be expected. This is not the time to start introducing supplements, but rather, fix the breastfeeding, practice kangaroomothercare, and help mother to cope[42].

To Supplement or Not to Supplement

It is extremely unlikely that baby would require supplement in these first few days of life, and, when kept skin to skin with the mother, the likelihood is almost non existent. In fact, even with a mother who has

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30 It should be noted here that D5W supplementation vs. artificial baby milk supplementation is still very much in contention. Marsha Walker clearly states that D5W is not an appropriate supplementation in the early days of life "as it can adversely affect infant blood glucose levels. Because it is so rapidly metabolized, infants do not have time to mount counter-regulatory mechanisms to stabilize blood glucose, thus bouncing blood glucose levels from high to low. It also displaces the higher calorie and more nutritious colostrum from the infant's diet." (Meeting of the Minds communication, 2006.) ***It should also be noted that Jack Newman strongly disagrees wit this statement and feels that there is no research to support not using D5W and that formula may do the same thing , "Oral 5% glucose does not raise the blood sugar so quickly it causes a rebound",*** (personal communication with Jack Newman, 2006)

31 Important to note: There has never been a study done to research the efficacy, effectiveness, or safety of finger feeding. Though this lack of research does not in itself constitute a reason not to try it, caution should be used to ensure it is done correctly and with the explicit intent of getting the baby to take the breast, i.e.., as a temporary transitional tool to get baby to take the breast. It teaches baby: "if I suck I get food, therefore, if I suck on the breast, I will get food, too." See my section on Finger feeding in "Dr. Jack Newman's Visual Guide to Breastfeeding"

32 Palmer, Brian, http://www.brianpalmerdds.com

33 Newman, Jack, Handout: Finger Feeding, 2005

34 Newman, Jack, Handout: When the baby refuses to Latch on, 2005

35 Smilie, Christina. Baby Led Latching, presentation at the Humber/Infact Canada Conference, Toronto, ON. May 2005

36 If cup feeding is not a possibility for whatever reason, a spoon or dropper may be used. There is some suggestion that Paced bottle-feeding (Barbara Wilson-Clay) may be a safe option here, but again, the intent is to get baby back to the breast as soon as possible and not too used to faster flow from other modalities

37 Cathy Watson Genna suggests that hand expression/ pumping, should be started no later than 6 hours post partum if baby has not taken the breast. (Meeting of the Minds communication, 2005)

38 Fisher, Joan, Teaching Breastfeeding Mothers – DVD, Lactations Consulting services,

39 Kernerman, Edith, Handout" Expressing Milk", 2005

40 McKenna, James, http://streaming.nd.edu/artsletters/saturday05/mckenna.wmv

41 Riordan, Jan and K G. Auerbach. Breastfeeding and Human Lactation. 2nd ed. Toronto, ON: Jones and Bartlett Publishers, 1998

42 www.kangaroomothercare.com

gestational diabetes, the baby's blood sugar will rise automatically when kept skin to skin with the mother. Feeding should be established immediately in the case of the diabetic mother and mother should use firm breast compressions to keep baby drinking right at the first feeding.

If supplementation is deemed ***absolutely medically*** necessary, then expressed breastmilk is the best supplement in all cases. Again, in the case of diabetes, mother may choose to hand express colostrum in the weeks before her due date and freeze it and bring it to hospital with her when she goes into labour[43].[44] Otherwise, banked breastmilk is most appropriate if mother's EBM is not available. If breastmilk is not easily available, sugar water or formula would have to be substituted.[45]

Supplementation should always be at the breast on breast number three (really this is the first breast that baby is now brought back to after the baby has fed on the second breast). This way ***the gut has been coated with breastmilk first, and baby has had a chance to empty mother's breast so the milk supply is supported and encouraged. Then supplement only when*** baby is no longer drinking with compressions and switching sides. Mother should then be started on some galactogogues. Herbs, such as fenugreek and blessed thistle, (alfalfa possibly, eating oatmeal, nursing teas) taking enough fenugreek that she can smell it on her body.[46] The role of homeopathy should not be discounted as there is much anecdotal evidence and some research to support their role in milk production [47]

Finally, remind mother that skin to skin care, good latching, and firm compressions fixes and prevents almost all problems[48] Help her to sleep safely with her baby on a safe surface according to the guidelines of UNICEF[49] and ensure she gets the rest and support she needs to mother her new baby.[50],[51]

Edith Kernerman, IBCLC, RLC ©2005 revised 2006

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43 Fisher, Joan, Teaching Breastfeeding Mothers – DVD, Lactations Consulting services,

44 Kernerman, Edith, Handout: Expressing Milk, 2005

45 Newman, Jack handout: Breastfeeding, Starting out Right, 2005

46 Newman, Jack, Handout: Cabbage Leaves, Herbs, and Lecithin, 2005

47 Wylde, Tanya, ND, personal communication, 2005

48 Newman, Jack, Handout : Breastfeeding starting out Right, 2005

49 UNICEF, http://www.babyfriendly.org.uk/pdfs/sharingbedleaflet.pdf

50 Kroeger Mary and Smith, Linda J., Impact of Birthing Practices on Breastfeeding: Restoring the Mother-Baby Continuum, Boston, MA: Jones & Bartlett Publishers, 2004

51 McKenna, James, http://streaming.nd.edu/artsletters/saturday05/mckenna.wmv