# 4

# Breastfeeding Management

## Overview

4.1 Breastfeeding involves a physical process. The process of lactation starts during the pregnancy and culminates when the baby is either first put to the breast or the first milk, colostrum, is expressed. A mother needs to learn the technique of positioning and attaching a tiny, helpless infant, which may cause injury if not done correctly. There is also a strong emotional component. The effect of the skin-to-skin contact and the hormones released while breastfeeding are an important factor in the bonding process between the mother and baby.[1]

4.2 The process of breastfeeding is a very different experience for different women. For some it is an empowering experience that fills them with a sense of fulfilment.[2]

> Breastfeeding my baby also means that I have to stop and take time out, which relaxes me and allows me to connect with my baby - I believe that this helps to develop strong attachment between us. This helps to stop me being overwhelmed by my new role as a mum…[3]

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1 Levin M, sub 327, p 3.
2 Sirio N, sub 247, p 1.
3 Hodge R, sub 250, p 1.

4.3 For others there is no such experience; it is simply providing nutrition to their child.[4]

> Some women simply feel like they are tied to their baby with a ball and chain, particularly if their baby won't even take a bottle of expressed milk.[5]

4.4 Women have identified the following concerns about breastfeeding during their initial hospital stay:

- over-worked staff;
- lack of skills in assisting with attachment difficulties;
- inconsistent advice; and
- noise and embarrassment.

4.5 Most mothers do not anticipate problems with breastfeeding and health professionals may inadvertently contribute to this perception by focusing on the benefits of breastfeeding rather than the practicalities and problems that can be encountered in the early weeks.[6] The management of breastfeeding and breastfeeding issues needs to take into account the individual involved.[7] There are things that will help one woman greatly and have little or no effect on another woman. Breastfeeding should be learned and continued in a supportive environment and there needs to be an understanding that 'one size does not fit all'.

## The science of supply

4.6 During pregnancy a woman's breasts undergo changes and development to be ready to provide milk for the baby; this stage is called lactogenesis stage one. That milk is available even when a baby is born prematurely. The first milk in the breasts following delivery and often before delivery is called colostrum. It is thicker, yellowish milk which is more concentrated than mature milk. It is also rich in protein and in antibodies that help to protect the baby

4 Daniel A, sub 78 , p 2; name withheld, sub 439, p 1.
5 Daniel A, sub 78, p 2.
6 Government of Western Australia, sub 475, p 18.
7 Halpin S, sub 369, p 1.

from disease. During the first three to four days post-birth, copious milk secretion occurs, called lactogenesis stage two.[8]

4.7 By sucking at the breast, the baby stimulates tiny nerves in the nipple. These nerves cause hormones to be released into the mother's bloodstream. The hormone prolactin activates the milk-making tissues. The other hormone, oxytocin, causes the breast to push out or let down the milk. The amount of colostrum in the breasts is particularly suited to the baby's small needs in the first few days after birth. Mature breast milk, which is thin and bluish-white in appearance, gradually replaces colostrum over about ten days, although this changeover can take several weeks.[9]

4.8 Breastfeeding works on a supply, demand basis. The rate of milk production is regulated to match the amount of milk removed from each breast at each breastfeed. If milk withdrawal has not started within three days post-partum, the changes in milk composition with both stages of lactogenesis are reversed and the likelihood of the establishment of successful breastfeeding declines.[10] In the critical first six weeks of establishing lactation it is very important that babies are fed according to their needs not according to any kind of routine or schedule.[11] Most mothers find that they need to feed at least six times in 24 hours just to maintain their supply. Many new babies need eight to twelve or more feeds in 24 hours. However the frequency of feeds generally declines as the baby gets older.[12]

## Initiation – the early days

4.9 As shown in chapter 2, initiation rates in Australia are close to the recommended levels. However, in the early days of breastfeeding, many women can find it to be very difficult, painful and confusing.[13]

8 National Health & Medical Research Council, *Dietary Guidelines for Children and Adolescents in Australia* (2003), p 331.

9 Australian Breastfeeding Association website, 'Increasing your supply', viewed on 30 July 2007 at http://www.breastfeeding.asn.au/bfinfo/supply.html.

10 National Health & Medical Research Council, *Dietary Guidelines for Children and Adolescents in Australia* (2003), p 332.

11 Parker E, sub 54, p 1.

12 Australian Breastfeeding Association website, 'Increasing your supply', viewed on 30 July 2007 at http://www.breastfeeding.asn.au/bfinfo/supply.html.

13 BellyBelly.com.au, sub 441, p 24; name withheld, sub 381, p 2.

For many women the level of pain experienced is unexpected and they may find breastfeeding quite complex.[14] Even with the declared intent to breastfeed, damaged nipples, an upset, screaming baby and continuous, conflicting advice can jeopardise the breastfeeding relationship.

> For the first 3 months I felt like quitting every single day. It was painful. It was hard. It was time consuming. I was extremely drained and in poor physical condition. Extremely sleep deprived, in the first few weeks, having to breastfeed 24/7 every single 3 hours...[15]

4.10 Correct positioning at the breast and correct latching-on and milking action are vital for the efficient removal of milk from the breast without nipple pain and trauma.

**Box 4.1 Attaching and positioning at the breast: the key to successful breastfeeding**

- The mother should be seated comfortably in an upright position, so that her breasts fall naturally. She should have good support for her back, arms and feet. The infant should be unwrapped to allow easy handling and avoid overheating.
- If the nipple is erect, support the outer area of the breast with a 'C' hold, being careful not to alter the breast position. If the nipple is flat or inverted, move the 'C' hold under the breast and shape the breast between the thumb and index finger, well back from the areola.
- The infant should be supported behind the shoulders and facing the mother, with his or her body flexed around the mother's body. The position must be a comfortable drinking position for the infant.
- The infant's top lip should be level with the mother's nipple, and a wide gape should be encouraged by teasing the infant's mouth with the nipple.
- When the infant gapes widely, bring him or her quickly onto the breast. So that the infant will take a good mouthful of breast, it is always advisable to bring the infant to the breast, not the breast to the infant.
- The chin should be tucked well into the breast, and the infant's mouth should be wide open, with the bottom lip curled back. More areola will be evident above the infant's top lip than below the bottom lip. When positioning is correct it is not necessary to hold the breast away from the infant's nose.

14 Artlett C, sub 145, p 1; Name withheld, sub 374, p 1; Healy L, sub 423, p 1; Emery D, sub 429 , p 1; Thomme F, sub 430, p 1; Brown M, sub 432, p 1.

15 BellyBelly.com.au, sub 441a, p 23.

• After an initial short burst of sucking, the rhythm will be slow and even, with deep jaw movements that should not cause the mother any discomfort. Pauses are a normal part of the feed and they become more frequent as the feed continues.

• If the cheeks are being sucked in or there is audible 'clicking', the infant is not latched on correctly.

• The infant should stop feeding of his or her own accord by coming off the breast spontaneously. The nipple will appear slightly elongated but there should be no evidence of trauma.

*Source: National Health & Medical Research Council, Dietary Guidelines for Children and Adolescents in Australia (2003), p 336.*

4.11 Mothers clearly need a high level of support at this time and they need consistent advice.[16] The health system plays an important role in these early days, through provision of antenatal education and ongoing support and advice on how to initiate and continue breastfeeding (see chapter 6). One impact of the 'baby boom' on maternity wards means that midwives and lactation consultants have more patients and less time to sit, watch and help a new mother feed. Many inquiry participants reported that it was difficult to get help from busy staff.[17] Some mothers felt very upset by the technique of midwives physically bringing the baby to the breast; mothers did not appreciate strangers grabbing at their breast without asking for permission.[18] This technique also does little to promote proper attachment.[19]

4.12 Specific hospital practices such as skin-to-skin contact[20] can be very important for the mother and baby bonding process and is one of the 10 Steps of the Baby Friendly Hospital Initiative (see chapter 6). For example, early skin-to-skin contact has been shown to increase the length of time that mothers breastfeed by 42 days.[21] Mothers

16 Mahony J, sub 164, p 2; Parker L, sub 305, p 1.

17 See for example Gray N, sub 10, p 1; Dixon G, sub 30, p 1; Jeffery L, sub 34, p 4; name withheld, sub 232, p 1; De Lacey J, sub 285, p 1; Louis K, sub 325, p 1; West Australian Country Health Service South West Dietitians, sub 308, p 1; Ozanne S, sub 384, p 1; Richards H, sub 393, p 1; name withheld, sub 401, p 1; name withheld, sub 409, p 1; name withheld, sub 416, p 1; Attard H, sub 449, p 1.

18 See for example Simpson C, sub 16, p 1; Cheers A, sub 29, p2; Pile C, sub 38, p 1; Daniel A, sub 78, p 4; Carter N, sub 126, p 1; Hensby J, sub 269a, p 9; name withheld, sub 409, p 1; Corbett D, sub 466, p 1; Godfrey-Lea S, sub 468, p 1.

19 Bayside Breastfeeding Clinic, sub 318, p 2.

20 Walsh A, sub 20, p 1; Rothenbury A, sub 87, p 8, Edwards N, sub 107, p 2, Hensby J, sub 269e, pp 21-23.

21 NSW Health, sub 479, p 30;

with special needs such as those with type 1 diabetes are often routinely separated from their babies just after birth without this skin-to-skin contact and may need additional support to express after the birth.[22]

4.13 The variability of behaviour in the newborn infant needs to be carefully explained to the new mother. Infants may be sleepy or unsettled which can both impact on the initiation of breastfeeding.[23] They may want to feed frequently before the milk has come in and mothers need to know that these frequent feeds will help to stimulate the milk supply. It is important that health professionals and parents are aware that the use of bottles and dummies are usually inappropriate at this early stage of breastfeeding.[24] Infants will also cry and once the causes of hunger, heat, cold, noise or a clearly defined medical problem are ruled out, a crying infant can be a cause of deep distress and frustration for parents.[25]

4.14 The process of babies rooming in with their mothers, in contrast to the previous 'baby nursery', has assisted the initiation of breastfeeding. This is one of the ten steps of the Baby Friendly Hospital Initiative.[26] Some hospitals have a policy where a mother needs to sign a consent form[27] before infant formula can be given to their baby and the committee considers this should be mandatory in all hospitals. These forms will often clearly outline the reasons not to give infant formula and the acceptable medical reasons for supplementation.

4.15 With the increase in the rates of early discharge from hospital, many women are discharged before their milk has come in or before they have been able to successfully attach their baby to the breast.[28] Women are increasingly being sent home expressing using a pump and feeding the baby using a bottle and then are expected to reintroduce the breast at home, without any support.[29] Women are

22 Patton MA, sub 231, p 1.

23 Irvin N, sub 440, p 1.

24 National Health & Medical Research Council, *Dietary Guidelines for Children and Adolescents in Australia* (2003), p 343; Cassar S, sub 113, p 4.

25 National Health & Medical Research Council, *Dietary Guidelines for Children and Adolescents in Australia* (2003), p 367.

26 Australian College of Midwives, Baby Friendly Health Initiative, sub 185, p 8.

27 Ball R, Cairns Base Hospital, transcript, 4 April 2007, p 33.

28 Oliver T, sub 130, p 4; Kendall C, sub 240, p 1; Stephens C, sub 377, p 1; Sarah, sub 419, p 1.

29 Hendry H, sub 422, p 1.

expected to try to position and attach their baby in isolation. Although there is the advantage that the infant still receives breast milk through expressing, the infant feeding process then becomes more complex and time consuming as it includes expressing, feeding, bottle washing, sterilising and so on. It can also be difficult for many mothers to maintain supply when only expressing and not feeding at the breast.[30]

4.16 As well as the complexity of expressing another issue relating to early discharge is that women have barely learnt about attaching their baby to the breast and they may be sent home with less than optimal attachment, which gets worse with breast engorgement. Their nipples then get sore and insufficient milk is transferred to the baby as poor attachment means the baby cannot drain the breast well. The baby then is not getting as much milk as it would with optimal attachment. The weight gain of the infant then may be less than desirable and mothers are told 'your milk's dried up!' It is normal phenomenon for most babies to lose weight in the first week, surviving on low volume colostrum and interstitial body fluid, often voiding only once or twice in 24 hours over the first three days.[31] There is a lack of understanding of how this whole situation may have come about and also how to fix it. Relatives often put pressure on them to 'just switch to the bottle, it is easier that way'.[32]

**Box 4.2 One mother's recollection of the early days**

The lactation consultants at the hospital did their best with their limited time to try to assist me, but seeing them for 1 out of 16 feeds (in other words once every second day), the damage was being done and I didn't know how to fix it. I had this hand there, this chair, a pillow here and towel wrapped up under here, a finger pushing this part of my breast, trying to get a nipple shield to stay on and all the while doing this in the middle of the night with a screaming baby and no-one by my side.

It wasn't until I saw the Early Childhood Health Nurse when my son was 7 days old that I was finally told that it wasn't normal to have such intense pain when you are breastfeeding. I had developed mastitis, had cracked and bleeding nipples, and thrush on them too. Combined with the sleep deprivation, I was not coping with the pain and stress of it all. I was advised to cease breastfeeding for a few days to allow my nipples to heal. So in the meantime I had to express every 3 hours, feed my son

30 Volders E, Royal Children's Hospital, sub 85, p 2; Lenne S, sub 362, pp 1-2; name withheld, sub 444, p 1.

31 Thompson R, sub 19, p 8.

32 Walsh A, sub 20, p 1.

the bottle every 3 hours and then try to sleep for an hour in between. This was an all day cycle.

When it came time to try breastfeeding again I had associated feeding with pain and I was experiencing panic attacks half an hour before every feed, just anticipating how painful it would be. For this I went and saw a Clinical Psychologist because I'd had a couple of severe meltdowns and was in the high risk for Post-natal depression.

I so desperately wanted to breastfeed my baby, I had an abundant supply (that took 4 months to stop dribbling out of my breasts), but I was only able to breastfeed for 10 days, I expressed until my son was 6 weeks old and then couldn't cope with the extra work of expressing any longer and made the agonising decision to bottle feed.

I had very little support from health professionals, it seems that all the emphasis is on breastfeeding and yet for someone like me that couldn't handle to intense pain (which wasn't helped by 3rd degree tearing and 80 stitches down below), there was no support. I found it difficult to get any information about how to bottle feed, what was out there in terms of bottles, teats, formula, how to navigate outside of the house. So for the first 3 months of my sons life I was a recluse, staying at home, ashamed that I had failed to breastfeed my son. I was so disappointed.

*Source: Grindley A, sub 406, pp 1-2.*

## Duration of breastfeeding

4.17 There are many factors that can influence the duration of breastfeeding as seen in chapter 2. Rates of initiation are high but women do not breastfeed for as long as is recommended or even as long as they would often like. Many women feel that the reality of breastfeeding is quite different to their expectations. Research has shown that these expectations can affect breastfeeding duration. The clash between highly idealised expectations and early breastfeeding problems can lead to disillusionment and ultimately to early weaning.[33]

> Women do not make one decision to breastfeed; they make a decision almost every day to continue, particularly when they are having trouble. Most women in Australia are initiating breastfeeding. It is how long they keep going.[34]

33 Lactation Resource Centre, Topics in Breastfeeding, Set XVIII, O'Brien M, *Psychology, the mother and breastfeeding duration* (2006), p 2.

34 Escott R, transcript, 7 May 2007, p 20.

4.18 Many women experience some difficulties with breastfeeding particularly in the early days. These can include sore nipples, lack of milk, engorgement, fast milk flow and lack of weight gain of the infant. These can usually be readily overcome with advice, assistance and support.[35]

4.19 In the study 'Psychology, the mother and breastfeeding duration', two factors were identified which had an impact upon a mothers intention to wean. The first was how breastfeeding impacts the mother's comfort and wellbeing both practically and in respect to her confidence to succeed at breastfeeding. The second factor encompasses the mother's concern for the comfort and wellbeing of her baby, including concern over having enough milk for the baby and for the baby's night sleeping behaviour. Both these factors may reflect the mother's lack of confidence in breastfeeding meeting the needs of her baby. Interestingly milk supply and the baby's sleeping behaviour are common breastfeeding problems which could almost certainly be improved by the provision of skilled postnatal support.[36]

4.20 Duration of breastfeeding could be increased by identifying the factors which contribute to early weaning and finding a way to modify those factors or remove any negative effect. Unfortunately, most of these are difficult or impossible to modify. They are things like a woman's age, years of education or early return to paid employment. There needs to be more research which focuses on identifying and exploring the modifiable factors.[37]

## Low supply and perceived low supply

4.21 The 2001 National Health Survey found that the most common reason Australian women gave for weaning early was insufficient milk supply.[38] Low supply is often given as a reason for stopping breastfeeding in the first six to eight weeks or around four months. This perception of low supply may be due to the baby waking at night, having shorter feeds or having a weight gain that is perceived

35 National Health & Medical Research Council, *Dietary Guidelines for Children and Adolescents in Australia* (2003), p 354.

36 Lactation Resource Centre, Topics in Breastfeeding, Set XVIII, O'Brien M, *Psychology, the mother and breastfeeding duration* (2006), p 2.

37 O'Brien M, transcript, 17April 2007, pp 32-33.

38 Australian Bureau of Statistics, *Breastfeeding in Australia, 2001 (*2001), cat no 4810.0.55.001, p 4.

to be lower than it should be.[39] Additionally the mother may consider that her breasts no longer have the full, engorged feeling and may attribute this to a lack of milk.[40] Dummy sucking, timed feeding, topping up with formula and non-breastfeeding friendly medications are all commonly advised by medical professionals and can contribute to this problem.[41]

4.22 Research has found that a perception of insufficient milk supply may not be a real insufficiency but a result of misinterpreting infant behaviour such as the effect of restricting the frequency of breastfeeding or a mother's lack of confidence in the ability to breastfeed. Mothers may also report that they weaned due to low milk supply because this is considered a socially acceptable reason for weaning.[42]

4.23 As these issues may have nothing to do with actual milk supply, mothers require support and well informed advice from health professionals such as Maternal and Child Health Nurses, lactation consultants and GPs to help them through this period. Without appropriate assistance women may commence using infant formula. Many women are subsequently reassured by the volume they can mix, see, and deliver to their infant when using infant formula.

> In a world where having tangible outcomes and evidence is promoted in earnest, it is little wonder that new mothers also want to see exactly how much milk their infant is receiving.[43]

## Demand feeding and routines

4.24 Demand feeding or baby-led breastfeeding can leave some women feeling tied to the couch for hours on end and this can be enough to prompt some mothers to give up breastfeeding.[44] It is normal for young babies to feed eight to twelve times in 24 hours and for these feeds to be unevenly spaced; for example, evening 'cluster feeding' is very common.[45]

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39 NHMRC, sub 35, p 4; Poste C, sub 229, p 2.

40 BellyBelly.com.au, sub 441b, p 15.

41 Tutt S, sub 71, p 1; Nielsen L, sub 355, p 2.

42 Gribble K, School of Nursing, University of Western Sydney, sub 251, p 11.

43 Giglia R, sub 68, p 2.

44 Name withheld, p 413, p 2.

45 Hall T, sub 70, p 2.

4.25 Demand feeding can be very difficult for a new mother to manage and she may seek advice or suggestions from health professionals and relatives. Evidence suggests that this is often to get the baby into a routine. This can lead to mothers trying to limit their baby to three to four hourly feeds rather than stimulating supply by putting baby to the breast as the baby demands.[46] For some women the change to three to four hourly breast feeds can interfere with the supply-demand relationship and cause their breast milk supply to drop, encouraging the belief that breast milk supply is inadequate. The resulting practice of then introducing formula to supplement their breast milk has the effect of further reducing supply.[47]

> Many mums I speak to don't understand the very basics of how breastfeeding works and think if they wait longer between feeds then their breasts will be fuller and there will be more for baby when the opposite is true.[48]

4.26 Mothers may find that their supply is affected by something as simple as trying to establish a routine with their baby's feeding. 'Sleep, Feed, Play' routines are a common suggestion for parents with unsettled babies[49] but due to fewer feeding opportunities, the reduced demand can have an effect upon a mothers milk supply.

## Myths and misconceptions

4.27 There are many myths and misconceptions surrounding breastfeeding[50] and these can contribute to breastfeeding prematurely ceasing. These myths may come from health professionals, family members or even through advertising (see chapter 6).

4.28 Myths seem to be continually perpetuated in both the health system and the community. Myths and misconceptions, held by people years ago, appear to remain as prevalent today. The effects of these myths can be compounded by poor advice from health professionals and lack of knowledge about breastfeeding which may cause mothers to doubt their ability to breastfeed. The committee received

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46 See for example Boas T, sub 65, p 1; Hall T, sub 70, p 2; Larner, S, sub 117, p 3; Lording R, sub 186, p 9; Poste C, sub 229, p 2; Lewis D, sub 258, p 3; Nielsen L, sub 355, p 2.

47 Robinson L, sub 90, p 1; Poste C, sub 229, p 2; Alexander M, sub 289, p 5.

48 Hall T, sub 70, p 2.

49 Ng A, sub 127, p 2.

50 Greentree J, sub 93, p 1.

evidence of mothers of newborns who had given up breastfeeding within a week of leaving hospital for the following reasons:

- one mother with inverted nipples was told by a nurse that she would not be able to breastfeed;
- one mother was concerned that she couldn't get her one week old baby to settle;
- one mother was told by her paediatrician that she probably didn't have enough milk, so she should just switch to formula; and
- one mother was told by a baby health clinic nurse that she was overfeeding by breastfeeding on demand and needed to 'get the baby into a routine'.[51]

4.29 Some of the more common myths relate to the composition of breast milk and its quality as well as how long breast milk has a nutritional benefit.[52] Many mothers presume that genetic factors are responsible for their poor milk supply. When they have difficulties they may conclude that this 'runs in the family'.[53] Other myths relate to normal infant behaviour such as sleeping, crying and bowel movements. One of the most prevalent myths is that if you give a baby infant formula it will sleep through the night. This myth was extremely prevalent.[54]

4.30 When a breastfeeding mother becomes pregnant, she may be advised by health professionals to wean, without being told that she could continue breastfeeding. Often the mother may become pregnant and continue feeding during her pregnancy and then keep feeding her older child and the new baby, which is called tandem breastfeeding. This can be done safely if the mother eats well, gets enough rest and makes sure the new baby's needs are met first and mothers can find it enhances their breastfeeding relationship.[55]

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51 Chapman C, sub 94, p 1; Royds D, sub 370, p 1.

52 Werner C, sub 6, p 2; Bayldon J, sub 57, p 1; Colman C, sub 260, p 2; Moss M, sub 363, pp2-3.

53 Minchin M, Breastfeeding Matters (*1998),* 4th ed, Alma Publications, p 116.

54 See for example, Hartley M, sub 8, p 1; Dixon G, sub 30, p 1; Jeffery L, sub 34, p 3; Ward K, sub 56, p 3; Boas T, sub 65, p 1; Green S, sub 69, p 1; Daniel A, sub 78, p 4; Rothenbury A, sub 87, p 4; Carter N, sub 126, p 1; Smith S, sub 133, p 2; Groom S, sub 284, p 1; McKellar J, sub 303, p 2; Schafer D, sub 321, p 2.

55 Warner B, sub 14, p 1; Austin R, sub 49, p 2; Brycesson S, sub 96, p 1; Poggioli C, sub 100, p 1; Eldridge S, sub 214, p 2; Oates P, sub 245, p 1; Hendriks M, sub 262, p1; Heppell M, sub 291, pp 5-6; Roberts J, sub 469, p 1.

4.31 These myths, in conjunction with the lack of breastfeeding support and inconsistent advice, may lead women to feel they are left with no choice other than to use infant formula.

> One thing for sure is that as parents we are told what it is expected of us in relation to feeding our older children a healthy diet (ie healthy natural food not just processed foods) but it is not made clear that breastfeeding is the natural milk option and that choosing formula feeding is equivalent to offering a completely processed food diet. By educating women in this fact many may very well may look for different ways to solve the above issues without threatening their own ability to keep feeding.[56]

## Sleep

4.32 The physical demand that breastfeeding may place on a mother is often underestimated. Mothers may feel that if their baby is not sleeping through the night by three to four months of age, they have failed as a parent. If a mother is unable to express then they are the only one who can breastfeed and always have to be the one who gets up at night.[57]

> It is very, very difficult to stay focused on the benefits of exclusively breastfeeding your child for the first six months when you are absolutely at your physical and emotional limits, its four o'clock in the morning and you've just been up for the seventh time that night.[58]

4.33 Co-sleeping, where the baby and mother sleep together and night feeding can take place in bed without much disruption, can be a strategy[59] and can assist with maintaining supply. However, it needs to be done safely and is not an option that suits all mothers or parents.

**Box 4.3 How do you breastfeed your baby - Night feeding**

Particularly during the first half-year it is usual that the baby requires feeding 24 hours, day and night. Night breastfeeding stimulates milk production, and with a baby night feeds are a simple matter. With the lowest possible light, take the baby up

56 Mulheron S, sub 472, p 1

57 Name withheld, sub 411, p 1.

58 Daniel A, sub 78, p 5.

59 Love M, sub 322, p 9; Miller-Mustard S, sub 206, p 1.

to you in the bed when you breastfeed, and you should there sleep together if there are not any contraindications against it. The baby should have its own doona/quilt.

If the parents smoke, the baby should sleep in its own bed because of an increased risk for SIDS. Care and nappy changes should take place only if it is absolutely necessary. Some babies sleep through the night very early, others wake every night, whether they have mothers milk or not. Only if the baby has a satisfactory weight gain, is it alright to allow it to sleep through the night.

If you for a time have too little milk or the baby is not settling, you should breastfeed often and willingly add in a night feed or two. If you become tired and stressed with all the night waking and much night feeding, try to sleep a little yourself when the baby sleeps during the day.

*Source: Translated from the Norwegian Directorate for Health and Social Affairs publication 'Hvordan du ammer ditt barn?' (How do you breastfeed your baby? 'Night feeding' p 16), viewed on 30 July 2007 at http://www.shdir.no/vp/multimedia/archive/00004/IS-2092_4513a.pd.f*

## Infant weight

4.34 Mothers may be concerned that their baby is not gaining the appropriate amount of weight or be advised by health professionals that they need to complementary feed with infant formula. Information on weight and growth charts is covered in more depth in chapter 6. However, the committee noted the significant evidence of the impact that an infant's weight has on a mother and her feeding decisions particularly in the early days.[60]

## Extended breastfeeding

4.35 The WHO recommends breastfeeding exclusively for six months and then to meet their evolving nutritional requirements, infants should receive nutritionally adequate and safe complementary foods while breastfeeding continues for up to two years of age or beyond.[61] The Dietary Guidelines note that after six months,

60 Gray N, sub 10, p 2; Warner B, sub 14, p 2; Eldridge M, sub 25, p 1; Dixon G, sub 30, p 2; Pile C, sub 38, p 3; Cleghorn J, sub 46, p 4; Hall T, sub 70, p 1; Davis N, sub 124, p 1; Rose M, sub 139, p 1; Anderson B, sub 183, p 2; Ellis P, sub 197, p 2; McDonald R, sub 203, p 1; Austin P, sub 254, p 2; Ballantyne M, sub 261, p 1; De Lacey J, sub 285, p 1; name withheld, sub 380, p 1; Cuff S, sub 382, p 1; name withheld, sub 391, p 1; Pearce M, sub 394, p 1; Martin P, sub 395, p 1; Jeffree E, sub 403, p 1; name withheld, sub 405, p 1; name withheld, sub 416, p 1; Gibbens M, sub 418, p 1; Webb G, sub 425, p 1; Taylor K, sub 443, p 2; Blake R, sub 447, p 1; name withheld, sub 448, p 1; Phillips J, sub 460, p 7.

61 WHO Global strategy for infant and young child feeding Report, viewed on 30 July 2007 at http://www.who.int/gb/ebwha/pdf_files/EB109/eeb10912.pdf.

continued breastfeeding along with complementary foods for at least 12 months will bring continuing benefits.[62]

4.36 Breastfeeding a child over the age of one is considered to be 'extended' breastfeeding in the community. Mothers report that breastfeeding beyond 12 months elicits 'significant stigma and taboo' from the public.[63] Some mothers deliberately avoid feeding an older infant in public, and can feel quite sad at having to do this.

> The community views breastfeeding an older baby, let alone a toddler, as sick and 'child abuse'. I know of many women who are scared to breastfeed in public. I know of women who have been abused for doing so.[64]

4.37 There seems to be a curious dichotomy in the community where an infant of 18 months is still considered to be totally dependent on their parents for everything including food but is perceived to be too old to breastfeed. The committee would like to reaffirm its support for women being able to breastfeed for as long as they and the child wish to continue.

62 National Health & Medical Research Council, *Dietary Guidelines for Children and Adolescents in Australia* (2003), p 306.

63 Boswell D, sub 99, p 2; Jackson S, sub 11, p 2; Jones R, sub 13, p 1; Johnson L, sub 167, p 1; Tustian M, sub 189, p 1; Coombes A, sub 296, p 1.

64 Warner B, sub 14, p 2.