breastfeeding Today

Vitamin D & Breastfeeding
Birth & Sex
Jaundice & the Breastfed Baby
Vitamin D & Breastfeeding

Mom To Mom: Nursing On Show

What's Cooking? Apple and Cinnamon Muffins

MOTHERS’ STORIES:
• Breastfeeding with a Tracheostomy
• Working and Breastfeeding My Babies
• What Breastfeeding Really Is

Book Review: Birth & Sex

Jaundice and the Breastfed Baby
Knowledge about breastfeeding and health is growing all the time with new scientific research. And personal opinions about breastfeeding, birth and babies are varied, numerous and colored by our culture and experience. In this edition of Breastfeeding Today we examine a few hot topics by taking a look at Vitamin D and questions regarding supplementation; jaundice in the healthy newborn; the obstetric view of childbirth as a medical event that disturbs the sexual nature of giving birth; and how people react to seeing breastfeeding in public spaces.

La Leche League meetings provide a welcoming environment in which to nurse our children comfortably, talk about breastfeeding and all sorts of aspects of parenthood, openly together or one to one, while making good friends over a cup of tea and slice of cake. Take a look in the “What’s Cooking?” column at the delicious recipe for the apple and cinnamon muffins that one LLL Leader baked recently to welcome moms to her group’s meeting.

LLL is famous for sharing stories (as well as cake!) and here mothers from Northern Ireland, UK, Ethiopia, Africa, and Washington DC, USA recount their own poignant tales about learning to breastfeed a baby born without a nose; combining work with breastfeeding, and discovering what it is to be a breastfeeding mother. Please consider telling your story and sharing your photos with other moms around the globe.

Our organization benefits from each individual’s help while we provide a community where we and our families can find life-long friends and support.

Welcome to the LLL family!

http://store.llli.org/memberships

(Photos for publication need to be well lit, at around 300dpi, and have no photo modifications such as borders/frames, textures, or filters such as sepia tone.)

Barbara

teditorbt@llli.org

Barbara Higham has been a La Leche League Leader since 2004 and is the managing editor of Breastfeeding Today. She lives in the spa town of Ilkley in Yorkshire, England, with Simon and their three children, Felix (15), Edgar (12) and Amelia (8).
Why do we need vitamin D?

Vitamin D is a hot topic, especially for exclusively breastfeeding families. The American Academy of Pediatrics (the AAP) recommends that families provide a vitamin D supplement for their babies regardless of how they are fed. The AAP, whose guidance is respected throughout the world, states:

“A supplement of 400 IU/day of vitamin D should begin within the first few days of life and continue throughout childhood. Any breastfeeding infant, regardless of whether he or she is being supplemented with formula, should be supplemented with 400 IU of vitamin D” (Wagner, Greer, American Academy of Pediatrics Section on Breastfeeding, & American Academy of Pediatrics Section on Nutrition, 2008.)

As breastfeeding mothers and advocates, we naturally believe that breastmilk, the superior infant food, confers every nutritional need our babies have, and the idea of giving our babies anything else during the first half of their first year may feel out of sync with that belief. When we turn to our trusted healthcare providers, mothers of older children, or other resources, the information we receive about vitamin D may confuse us even more.

What is vitamin D?

Even though we call it a “vitamin,” vitamin D is actually a pre-hormone we secrete that doesn’t immediately do anything, but our bodies convert it into the active hormone so it can do its various jobs. The body’s vitamin D status is measured by a test for 25-hydroxy-D 25(OH)D. (It is important to note that this is NOT the same as the test for the active hormone 1,25(OH)D, which is often elevated in people with insufficient vitamin D. If you are tested, ensure that your physician is ordering the correct test: 25(OH)D.) When we take a vitamin D supplement, it is either ergocalciferol (vitamin D2) or cholecalciferol (vitamin D3). When we are exposed to the sun, a cholesterol in our skin converts specific rays of the sun into cholecalciferol.

There is currently no consensus about exactly what vitamin D does and doesn’t do. We know vitamin D is necessary for proper calcium absorption, important for bone and dental health (since if we’re not getting enough calcium, our bodies will take what they need from our bones and teeth). Too much or not enough calcium in the body can cause more immediate problems, too, such as irregular heartbeat, loss of appetite, and a general inability to stand, walk, and function normally. We definitely know when calcium gets that far out of whack, but our bodies do such a good job of drawing it from our bones and teeth that things rarely get that serious. Sufficient vitamin D in the body helps ensure we are able to absorb and use the calcium we get from our diets.

We also know that vitamin D is necessary for beta cell function. Beta cells are the cells in our pancreas that make insulin. Insufficient vitamin D in the body may lead to problems with sugar metabolism and manifest as diabetes and insulin resistance (pre-diabetes). There is also evidence for the role of vitamin D in immune function; however, it is unclear how much vitamin D is sufficient to bolster the immune system against respiratory infections and other illnesses (Rehman, 1994; Belderbos et al., 2011; Bergman, Lindh, Bjorkhem-Bergman, & Lindh, 2013).

There is some research to suggest that insufficient vitamin D may play a part in the development of certain cancers. Insufficient vitamin D may be associated with the development of autoimmune disorders, such as rheumatoid arthritis (Christakos et al., 2013). There is emerging research that supports previous observations that higher levels of vitamin D during pre-conception and pregnancy are necessary to prevent pre-eclampsia and pre-term labor and delivery (Wagner, Taylor, & Hollis, 2010; Bener, Al-Hamaq, & Saleh, 2013).

When the Institute of Medicine prepared its guidelines for Recommended Daily Intake (RDI) of vitamin D in 2010, it could consider only the most valid and reliable studies in the research literature about vitamin D: randomized, controlled studies. Much of the published data about vitamin D was observational—not illustrative of a cause and effect relationship between vitamin D status and a particular condition—and therefore, not strong enough to define wide-sweeping public health recommendations at the time of the report’s publication. The current RDI for vitamin D for all persons between the ages of 12 months and 70 years is 600 IU/day; 800 units/day are recommended for those 70 and older and infants should take in 400 IU/day. The Institute of Medicine states that these recommendations apply to 97.5% of the population, and “are not intended to preclude individual, clinical recommendations by doctors to their patients.” Additionally, the reviewing committee acknowledged that further research—more randomized, controlled trials—is needed (U.S. Department of Health and Human Services, 2010).

How is sufficiency defined?

What is an optimal level of 25(OH)D? This is perhaps the area of greatest controversy between governmental public health guidelines and some members of the research community. For bone health, 20 ng/mL seems to be sufficient. Most people are able to achieve this 25(OH)D level by taking in 600 IU/day of vitamin D. Some suggest 32 ng/mL is optimal, while others assert that 50 ng/mL should be the minimum 25(OH)D level in humans. Still other research suggests that levels at or above 50 ng/mL can be harmful. Vitamin D toxicity—too much vitamin D—is rare, but it is possible, especially in those with such rare conditions as sarcoidosis (a chronic inflammatory condition) and Williams syndrome (a neurodevelopmental disorder).

It is worth considering that the optimal 25(OH)D level for one person may differ from that of another person. As well, arguments can be made for the biologic
normalcy of a seasonal rise and fall of 25(OH)D levels. Only with additional research can the medical and science communities approach a consensus about what target 25(OH) levels should be for optimal health.

Where do we get vitamin D?

Calling vitamin D a vitamin or nutrient leads us to believe that we should get it from our diets, and this is part of the controversy over how much (or even whether) we should be adding vitamin D to our diets. Humans were designed to have their vitamin D needs satisfied through regular and frequent exposure to the sun. In lightly pigmented individuals, 15–20 minutes of full sun exposure (most skin uncovered, such as with a swimsuit on, no sunscreen, during the season when the sun’s rays are the strongest) stimulates the body’s production of 10,000–20,000 IU of vitamin D during the following 24 hours. Those with darker skin tones require longer periods of exposure, perhaps as long as an hour.

Many healthcare providers erroneously advise their patients that the daily sun exposure most of us receive year-round (hands and face while we go to and from our homes, workplaces, and cars; perhaps the occasional day outdoors) is enough for vitamin D synthesis. In many places in the world, for much of the year, the sun’s rays are not strong enough to stimulate vitamin D synthesis in our skin. Only the tropics, those areas of the planet between the 35th parallels (north and south), receive the sun’s rays year-round. For Americans, this means only those who live south of Atlanta can rely on the sun to satisfy their vitamin D needs year-round.

In addition to location, other factors can have an effect on how we receive vitamin D from the sun. For those who spend most of their lives outside of those 35th parallels, the season of the year matters. The quality of sun exposure in February will not be the same as the quality in July. Cloud cover and air pollution are variables that can change daily, as well. Obviously, when we remain indoors, the sun’s rays don’t reach us; lifestyle is definitely a factor that affects our sun exposure.

The promotion of sunscreen and clothing/shade that minimizes the risk of skin cancer is a major public health initiative that makes sense for many people. A family’s comfort level with any unprotected exposure to the sun is important when considering whether/how much that family needs to think about vitamin D supplements. Keep in mind, also, that sun exposure for vitamin D doesn’t have to be all or nothing. A family may be comfortable with some unprotected time in the sun, and consider supplements or vitamin D-rich foods, such as fatty fish, fortified dairy products, and mushrooms to make up the rest of what they need to optimize their 25(OH)D stores.

So, what does this all mean for breastfeeding mothers?

The critical issue for breastfeeding mothers and their infants is that many mothers do not enter pregnancy or lactation with sufficient vitamin D. Two recent studies identified high percentages of pregnant women with vitamin D insufficiency—25(OH)D between 20 and 32 ng/mL, or deficiency—25(OH)D less than 20 ng/mL (Hamilton et al., 2010 & Merewood et al., 2010). When women with low levels of vitamin D become pregnant, their babies are more likely to be born with low vitamin D, as well. However, this isn’t the only problem. A mother’s 25(OH)D level directly affects the amount of vitamin D that is transferred to her baby through her breastmilk. Recent research demonstrates that even when a mother’s vitamin D status is “sufficient,” her milk doesn’t contain the amount of vitamin D necessary to prevent rickets (and possibly other health conditions) in her baby. In the absence of adequate sun exposure, the mother requires a dose of vitamin D that is more than ten times the RDI (Wagner, 2011). When this regimen of vitamin D supplementation for mothers has been found to be effective in fortifying their breastmilk with enough vitamin D to meet their babies’ needs, further research is necessary to determine that it is safe for women to take such high doses during lactation.

But I thought breastmilk was the superior infant food and contained everything my baby needs?

Yes! Your milk is still the very best you can feed your baby. Perhaps, in an ideal world we would all still be living in the tropics with regular exposure to the sun every day. However, if our locations and the conditions under which we live simply don’t set the stage for adequate vitamin D, then, to compensate, we need to make a conscious effort to ensure we either manufacture or take in enough vitamin D. It doesn’t just happen naturally for us when we live further away from the equator and spend most of our time indoors.

How do I make sure my baby is getting the vitamin D he needs to be healthy?

The answer to this question will be different for each family, but the following options may be worth considering:

Offer your baby a daily vitamin D supplement of 400 IU, in accordance with the recommendation of the American Academy of Pediatrics.

This option is ideal for those mothers and babies who cannot (because of location, season, lifestyle, or other factors) or choose not to (because of possible health risks) expose themselves to the sun on a regular basis, because it ensures the baby is receiving the recommended daily dose of vitamin D. While most pediatricians in the United States are still prescribing multi-vitamin preparations for their infant patients, regardless of how they are fed, an increasing number are becoming aware that exclusively breastfeeding mothers often prefer not to supplement their babies with vitamins and minerals that are readily available and better utilized from their own milk. If vitamin D supplementation seems like the best option for your baby, talk to your pediatrician about using a vitamin D-only preparation. These often come in tasteful, colorless, oil-based drops that can be placed on your nipple before you latch your baby on for a feeding.

Ensure the mother is replete in vitamin D.

As stated above, research supports that supplementing a mother with high doses of vitamin D is an effective—and probably safe, method of raising the amount of vitamin D that is available to a baby in mother’s milk (Wagner, 2011; Haggerty, 2011; Thiele, Senti, & Anderson, 2013). However, additional research is needed to confirm this. This option may suit the family that is uncomfortable with offering any kind of supplement, even D-only, during the time that the infant is being exclusively breastfed, and where sun exposure is not...
possible or desirable to the mother. It is important to consider that a mother's 25(OH)D level may vary depending on her milk status during pregnancy or immediately postpartum. She should talk to her baby's doctor about how much or how frequently to offer a supplement to her baby while she works on increasing her own stores. (This mother should keep in mind that "replete" for the purposes of conferring adequate vitamin D via breastmilk may be a much higher level of 25(OH)D than is considered sufficient for other reasons.)

Expose mother, baby, or both to the sun's rays.

In some parts of the world, it may be possible to get enough sun exposure to build robust stores of vitamin D. Lifestyle is a vital factor here: the family needs to spend enough time, unprotected, out in the sun. It is also important to consider that it is not recommended that babies be exposed to the sun without clothing, sunscreen, or other protection, because sunburn can be severe on a baby's delicate skin, with effects that could last a lifetime.

Talk to your pediatrician about the factors that matter: your family's skin color, family history of skin cancer, where on the globe you live, the season, and how much time you'll be spending outdoors. Perhaps it might be safe for you to bring your baby outside wearing only his diaper for 15–20 minutes before you apply sunscreen and dress him in protective clothing and a hat. While the risks of sunburn are real for mothers, too, most adults know better how much sun exposure they can responsibly get before they burn. A mother who spends time outside daily may feel comfortable relying on the sun's rays to sustain her vitamin D sufficiency. To be sure, a blood test (25(OH)D) can be requested, perhaps twice a year—once during the season of best exposure and again when geography or lifestyle prevents optimal sun exposure. Remember that a lab report of "normal" doesn't necessarily represent the vitamin D status that is necessary for breastmilk to confer adequate vitamin D to an infant.

Take a combination approach to vitamin D sufficiency.

Maybe you're a family that lives within 35 degrees of the equator and likes to spend some time outside, but often it's just too hot to be out for very long. Or, you are outside a lot, but most of your body is covered by clothing. (If you could only live at the beach and wear only our swimsuits all the time!) Perhaps you know that, in the summer, you tend to burn after more than a few minutes in the afternoon sun, and you wear a hat or sunscreen more often than not. Maybe you feel assured by the reliability of a vitamin D supplement for your baby, but you don't remember to give it to your baby every day—and maybe you have a similar feeling (and problem) with your own supplements—you want to take the necessary daily dose to ensure your milk provides enough vitamin D to your baby, but you sometimes forget. Balancing the risks and benefits of sun exposure and supplements may require unique solutions for every family: what works for you might not be the best option for your neighbor. Do your research, consider your preferences, and talk to your baby's doctor as you figure out the vitamin D solution that's best for you.

Diana Cassar-Uhl, MPH, IBCLC

has been the La Leche League leader in New York City since 2005. A regular contributor to Breastfeeding Today, Diana is the author of the La Leche League's tear-off information sheet on Vitamin D http://store.llli.org/internal/profile/505 and her writing about breastfeeding is featured on several blogs/websites, including KellyMom and The Leaky Boob. Mother to Anna (2002), Simon (2004), and Gabriella (2007), Diana served for 17 years as a clarinet player in the U.S. Army before beginning her career in public health.

References


MOTHER’S SITUATION

NURSING ON SHOW
I’m expecting my second baby in a few months and really want to breastfeed this time around. One of the reasons I was reluctant to persevere last time was my fear of breastfeeding in front of other people. None of the mothers in my close family—my mom, sisters, aunts or cousins—have breastfed their babies and I have heard some of them say negative things about nursing mothers we have encountered when we have been out and about together. How have other moms found the confidence to breastfeed when members of their family are unsupportive? And how often do moms meet with negative responses from the general public when they are breastfeeding in public spaces?

Response
Before I had my first baby, I expected to be harassed at some point when nursing in a public space: I even had the appropriate state law bookmarked in my phone. What I encountered was quite the opposite. Many mothers have come up to me and talked about how they loved nursing their babies and complete strangers have told me their stories. In my three plus years of nursing, I have never had a comment that made me feel uncomfortable. I think that has helped build my confidence and knowing that I am doing the best for my child, who has the right to eat wherever we are.

Megan Miltz, Valparaiso, Indiana

Response
I breastfed both my babies even though my husband and our families were unsupportive. Every time we ran into problems (sleep, teething, illness), their first response was, “Maybe it’s time to quit breastfeeding.”

It is important to be confident in yourself and your choice. Find other mama friends who breastfeed and can support you: look for a local LLL group.

Using a cover made my husband’s family uncomfortable, so I nursed in a bedroom, and it was nice to have some quiet time. In fact, when visiting family, my babies were passed around so much it was the only time I really got to spend holding them!

The general public cares less than you imagine. With my second baby, I decided that people who got offended could turn around or leave. I used my cover only when I felt it was appropriate. Nothing is more fulfilling things you can do as a mom, don’t let fear deprive you of the chance to experience this. Figure out what works for you and your baby, and don’t allow naysayers to interfere.

Krisa S. White, Bastrop, TX, USA

Response
 Barely anyone notices when you are feeding a small newborn. I would try, when possible, to sit facing a wall if somewhere busy, such as a café, to give myself some privacy. I built up confidence so was then more prepared to feed an older infant in public.

Emily Andrews, Northampton, UK

Response
You’ve obviously found La Leche League, which would have been my first suggestion: surround yourself with pro breastfeeding people to help re-balance the potential challenges nearby. I’ve found comfort and support from various online and local groups, as well as friends who have breastfed.

Educate yourself so you feel equipped to inform your family should they have questions about breastfeeding. I began to read The Womanly Art of Breastfeeding while pregnant and I can recommend getting it on a Kindle App to read while nursing.

I’ve only ever had positive comments about feeding my son in public; I’ve never noticed any negativity, although you can be so engrossed in your baby at times you’d never know!

Melissa, Bedfordshire, UK

Response
Maybe think about employing a postpartum doula? Most will accompany you on outings to public places to sit and enjoy a coffee and help you get used to nursing away from home. They can help with educating your family about breastfeeding and provide a buffer for any negative comments.

Afton Shearer, Northampton, UK

Response
I sought out help before my baby was born, which then gave me confidence to persevere even though members of my family were not supportive. It still makes my mum uncomfortable, but she is beginning to get used to the idea. When we went to a café and she wanted to feed my baby with a bottle of expressed milk, I let her as I was looking forward to a treat of waffles and maple syrup in peace. She was then surprised when we saw another mum breastfeeding there. She hasn’t commented since! I recently breastfed in church at my nan’s funeral. I found out afterward that my mum had asked the vicar if it was OK. I pointed out that if God had a problem with it, I don’t think he would have given us breasts to feed babies. I think the more I do breastfeed around her (particularly in public) the more she gets used to it. But as for the confidence, just look for support elsewhere.

Maisy, UK

Response
I had a little mantra “I am feeding my baby. My baby needs to be fed.” I used to say it to myself in preparation for any challenge that may have arisen. I used to feel that people were commenting about me breastfeeding, but very rarely found this to be the case. I breastfed my first three children and attempted to breastfeed my fourth, but unfortunately this time it hasn’t worked out (long story) and so I am formula feeding. On a first trip out in public, I felt I was being judged as a bad mum when I had to get the bottle and formula out. So maybe sometimes it’s simply a matter of perception.

Katie Williams, Northampton, UK

Response
The only comments I have received breastfeeding my three have been positive with people wanting to show their admiration for my doing something so lovely for my child.

Theresa Wright, Northampton, UK

Response
None of the women in my family breastfed either, not even a grandma. It actually made me more determined to be the one to change the trend. I got the usual comments about how tying it would be, but the complete opposite was true; it gave me a huge amount of freedom. Later, I ignored all the “When are you finally going to give up?” comments. Ultimately, I knew breast was best for my baby.

I didn’t breastfeed under a cover as I didn’t want to hide. I met with two negative incidents. The first
was when a man stared at me in a posh restaurant in a “What on earth are you doing” kind of way. The second was when a woman in IKEA told me where the Mother and Baby area was in the café, to both of which I responded by keeping calm and carrying on nursing just a bit longer. The more we normalize breastfeeding, the easier it will become for others. Good luck with the new baby and with the breastfeeding!
Laura Neville, Northampton, UK

Response
I’ve never had negative comments and have breastfed my baby whenever and wherever she has wanted. I sometimes felt slightly uncomfortable with an older baby, probably because you don’t see many other toddlers being breastfed. Meeting other mums in person and online through LLL, reading lots to understand how good, natural and normal in an evolutionary sense breastfeeding is, even if it’s not the cultural ‘norm,’ has really helped me.
My family was initially supportive but challenged me constantly after 12 months, usually with the best of intentions because they wrongly thought nursing was tiring me out. Changing the subject instead of debating might have helped. Surprisingly, my grumpy, who is usually easily offended about all sorts, was cool about my breastfeeding, shocking my family who couldn’t believe it. People do surprise you and if you can get comfortable with it, very few people even notice. Stories in the press can worry you unnecessarily. Sometimes people may be embarrassed so your reaction is key as people take their lead from you.
Lisa Hurst, Northampton, UK

Response
No one in my family has breastfed either. Initially I wore a scarf, which I could quickly use to drape over any exposed bits, until we developed our technique. After a while, family members have gradually become more curious and asked questions. I’ve had no criticism at all. My huby’s grandad is still housebound when she was breastfeeding us. The first time I nursed in public, she tried to drape a scarf over me! I just said, “Let me do it my way, please” and she backed off. My little girl breastfed beautifully and there was no issue. Another time, we were at a neighbor’s house and my mum had told me I’d need to ask to use another room if I intended breastfeeding because the neighbor didn’t have children, so she felt it was inappropriate. When I asked permission the neighbor was outraged at the suggestion that I should leave the room and miss out on the conversation! Very slowly I’ve started to demonstrate there’s no reason to make a big deal out of breastfeeding.
LLL meetings have been invaluable for me. It’s so reassuring to see mums feeding babies of varying ages, in all sorts of positions, even in the sling. Helps remind me that what we’re doing is normal, acceptable and absolutely the right thing for our family. Good luck, and enjoy the new addition to your family.
Amanda Baldwin, Northampton, UK

Response
I’ve never had a negative experience when out but have had quite a few with family. I found reading

The Womanly Art of Breastfeeding and The Politics of Breastfeeding helped me feel I was making the right decision for me and my child. LLL meetings are also a great way to boost that confidence. The first few times, I felt nervous I focused on my baby intently. Now, of course, my head is held high!
Cheryl North, Northampton, UK

Response
I’ve never met with any negative attitudes and I breastfeed on the bus, in shops, anywhere I need to. If I catch people looking or staring I just smile at them.
Akaana, Edinburgh, Scotland, UK

Response
I didn’t breastfeed my older two for similar reasons because my ex and his family were against it and this is one of my biggest regrets. I have cherished every moment of breastfeeding my little one. It would be such a shame for both you and your baby not to experience this!
Sera, Edinburgh, Scotland, UK

Response
I’m sorry you’ve heard negative comments about nursing from your own family. It’s baffling that people see anything wrong with feeding a baby. My mum, who is supportive and breastfed her four children is quite ‘old school.’ She believes in covering up and moving away from the social gathering to feed the baby. I’m pretty sure she must have been embarrassed! She even nurse the baby from the pew and no one noticed. I wouldn’t have considered myself particularly unobservant but I had never noticed! That was a watershed moment for me.

Negative comments can feel really personal but are frequently more about how the commentator is feeling and not an objective assessment of your actions.
Rebecca, Edinburgh, Scotland, UK

MOTHER’S NEW SITUATION

POSTPARTUM BLUES

I have suffered from depression in the past and after the birth of my first baby, four years ago, I had a fairly serious bout for which I required medication. I gave up breastfeeding after only a few weeks because of sore nipples and I was worried about the medication I was taking getting through my milk to my baby. I have been well for the last 18 months but am concerned about the possibility of baby blues. I really want to give breastfeeding a go this time. What have other mothers done to cope when facing the prospect of birth and potential depressive illness?

I suggest taking it slowly; gain confidence at home first and then quietly stand your ground, leading by example. I have never had negative comments. I even nursed standing up in the menswear section of a department store recently, and no one batted an eyelid!
Claire, Edinburgh, Scotland, UK

Response
I’m sorry your family seems unsupportive. Perhaps they may change their views about one of their own. In any event, you have the support of many mothers across the globe! I found it more difficult at first because we weren’t experienced—who is the first time?!—and I felt a bit self-conscious.
I’ve never found my cover-up shawl useful and I only end up attracting more attention trying to use it! I like my large, wrap-around cardigan because it is a much easier way to cover up, when my baby has settled into the feed, but I only use it if I need to keep the wind or sun off her.

I asked a friend who has breastfed all four daughters how she managed in church. She said she just fed them in the pew and no one noticed. I wouldn’t have considered myself particularly unobservant but I had never noticed! That was a watershed moment for me.

Send your responses to editorbt@lli.org
A WINNING RECIPE

Good nutrition means eating a well-balanced and varied diet of foods in as close to their natural state as possible

Johanna Rhys-Davies from Silsden, West Yorkshire, UK learned this delicious recipe from some wonderful breastfeeding moms while she was traveling recently with her family in Australia. On her return, she baked a batch to share with the mothers at her local LLL group’s meeting.

Jo says you can exclude the sugar if you prefer and/or use sweeter eating apples in the recipe instead of baking apples and/or sprinkle a tiny amount of sugar on top of each cake as they leave the oven (as shown in photo).

### Apple and Cinnamon Muffins

- 300 g (2 cups) plain flour
- 1 tablespoon of baking powder
- 2 teaspoons of ground cinnamon
- 150 g (3/4 cup firmly packed) brown sugar
- 2 medium (about 400 g) of cooking or eating apples cored, peeled and chopped
- 125 g (3/4 cup) sultanas (raisins)
- 125 g (4 oz) butter
- 2 eggs lightly whisked
- 185 ml (2/4 cup) milk

Preheat oven to 180°C/350F and either add muffin cases to a muffin pan (they usually hold 12) or lightly grease the indentations in a non stick muffin pan with some additional melted butter.

Peel, core, chop and weigh the apples.

Sift the flour, baking powder and cinnamon together in a large bowl.

Stir in the apples, sultanas and sugar (if sugar is desired) until well combined with the flour/baking powder/cinnamon mix.

In a separate bowl, whisk the eggs. Add the milk and butter. (I heat my butter for 10 seconds in a microwave first so that it melts and combines well with the other wet ingredients).

Blending the wet ingredients before adding them to the dry mixture makes it easier to evenly combine the two.

Add the milk/eggs/butter mixture to the flour/fruit/spices mixture and stir with a large metal spoon until the ingredients are only just combined.

It is important that the ingredients are only just combined as if the mixture is over mixed the cooked muffins will have a tough texture.

Spoon the mixture evenly into the muffin cases/pan. My mixture usually makes about 15–18 muffins.

Bake the muffins in the pre-heated oven for 20 minutes or until golden and cooked through. (Use a metal skewer or knife to test for readiness: if it comes away clean from the centre of a muffin, they are done, if not try another 2–3 minutes).

Allow to stand for 2–3 minutes when cooked before resting on a wire rack. Serve warm or at room temperature or store in an airtight container for up to one day.
Breastfeeding with a Tracheostomy
Gráinne Kerr, Northern Ireland, UK

I fought hard to be able to attempt a vaginal birth after two cesareans, but after I had that natural birth, my “I did it” moment was very different from the triumph it might have been. My baby has what’s known as Complete Arhinia: she was born without a nose.

Despite concerns about her facial profile at our 20-week scan and subsequent amniocentesis, no one was expecting this. So when I lifted my tiny miracle out of the water in the birthing pool and the medical team saw her face, alarm bells, literally, started ringing, and people started shouting and running and crying. The midwife hastily severed my baby’s cord and whisked her away before I could even speak. My whole world had been snatched from me. I wish someday I might forget how painful it was. I was allowed to see her for one brief cuddle before they took her to the neonatal intensive care unit (the NICU).

I wasn’t able to feed her. A baby needs two airways to breastfeed. I was a breastfeeding advocate supporting other mothers to breastfeed and still nursing her big sister. Breastfeeding was a huge part of my life.

That night alone in my room after my husband had gone home to our other two children, who were just two and three years old, I remember crying so hard I couldn’t breathe. How it hurt not to have my baby, not to know if she was, or ever would be, OK. The pain was so raw and heavy I didn’t think I’d ever recover.

When they wheeled me down to the NICU to see her, it was shocking, as I’m sure it is for every mother who has to see her newborn lying behind a plastic wall with all those wires and tubes. Her face that I love so completely now, looked strange to me then, and the layers of tape holding her breathing and oro-gastric (OG) feeding tube in place, didn’t help. I was very scared.

My head hurt with questions. Would I love her enough? Would she be OK? Would I ever be able to feed her? Would I be able to cope? Would anyone else love her? Would she forgive me for leaving her in that box with strangers every night? Would she ever be happy? Would I? The list seemed endless.

I cried while the consultants explained what they could do. They admitted they had never even seen this condition before. We were told that a total of 37 cases had been recorded in medical literature. Thirty-seven. That’s historically. Worldwide! That feeling of being alone was magnified by this information. We were very alone. We were 1 in 500 million alone. There was no website for this, no support group for us, no charity championing our cause, no glossy leaflet about what we might expect.

Apart from a small hole in her heart that we were told was not uncommon and not to worry about, thankfully tests revealed otherwise she was healthy and normal. I clung to that information while doctors scrambled to provide us with any other insights.

I cried when they explained that she would need a tracheostomy so she could breathe while sleeping and eating. [A tracheostomy is a surgically created hole through the front of the neck and into the windpipe. A tube is inserted into the opening and connected to an oxygen supply and ventilator to assist with breathing.] It would mean a massive change to our family life and huge amounts of care. We wouldn’t be able to hear her cry or coo or giggle. I couldn’t imagine how we’d cope and I was sure you couldn’t breastfeed a baby who didn’t have a nose and breathed through a hole in her neck. It was devastating news: any hope I had was disappearing. But I was wrong.

Finally, one consultant said she couldn’t see why we shouldn’t at least be able to try to breastfeed and some further research suggested we had every reason to be hopeful. It took a little digging, but I did find a short thread online discussing breastfeeding babies with a tracheostomy. Theoretically it was possible. We would just have to wait and see if her sucking and swallowing coordination were up to the task. Until then she would be tube-fed. I was told to take comfort in the fact that she would be getting my breastmilk. It was a small consolation but I knew where she needed to be and every cell in my body ached to feed her. I expressed my milk for her. I found the pumps kept causing me pain. I already knew how to hand express and quite quickly established a good supply. I continued hand expressing every two to four hours. I couldn’t bring myself to leave the hospital without her so I stayed in a family room in the ward. Walking down the corridor at night to make a milk delivery was so important to me. It was the least I could do. Walking back to my bed without her never got easier.

She had her tracheostomy [the term for the surgical procedure to create the opening] when she was eight days old. I felt sick to my stomach during the whole operation, but it would mean she would no longer need to be in the incubator and that the large intubation tube, which was so cruelly taped to her mouth, could come out. It meant we’d get to see her sweet little face. She was admitted to the pediatric intensive care unit following her operation and now I could see her and kiss her little lips and hold her tiny body. And I hoped against hope that I could feed her.

The staff wanted her to recover from surgery before our attempting to breastfeed so I waited. I was now able to hold her. So much of this waiting was done while she slept in my arms. How much faster the time went now I was holding her. It felt amazing and I never wanted to put her down. It was healing and, not surprisingly, my milk supply took a giant leap. Oxytocin for the win.

When we did get a chance to try a breastfeed, it was awkward and tense. I was terrified of hurting her by pushing on the tracheostomy, which, as she was so small, came out further than her face. Positioning was difficult and circumstances were far from optimal. Sitting in an upright, armless chair, watching this wire and that one, trying to get her face close enough to latch without touching her new neck accessory with my swollen postpartum breasts, it’s no wonder we struggled. I told myself to give it time, that it was to be expected after her being tube-fed for this long.

After much fumbling and failing, late at night on her tenth day, we did celebrate our first breastfeed, a moment I will treasure forever. “She’s doing it, she’s doing it,” I whispered to a nearby nurse, not daring to breathe or move in case the magic stopped. We would struggle to repeat this moment in the coming days and weeks but every now and then it would happen and my world would feel right again. They were scattered moments of bliss throughout some of the worst days of my life.

It would take us another four weeks of OG tube feeds and three more of bottle feeds, before our dream of exclusive breastfeeding became a reality.

You can read the second part of Gráinne’s breastfeeding journey in her blog here: http://birthingandbreastfeeding.wordpress.com/2013/08/10/breastfeeding-tracheostomies-tears-and-triumphs-part-two/
I am a working mother of three: a six-year-old, a two-year-old, and a baby of four months.

When I had my first baby, I had high blood pressure and the doctor told me to be ready for surgery earlier than my due date, at 32 weeks. To start breastfeeding my baby for the first time, after I returned from the cesarean section, was very hard because I was in a lot of pain and could not move easily. But deep inside I had the desire and determination to breastfeed. The nurse told me that my son was in the intensive care unit as he was premature, weighing 2.5kg, but she promised to show me my baby that night. When I saw my little baby at last he was so very, very small.

After I was discharged from the hospital, my breasts were sore and engorged. I couldn’t move my arms and I was in pain. With the help of my family, I pumped the first milk for my baby because he was so small and couldn’t suck. I pumped my milk for three days. After three days, I decided to stop pumping and give him the breast directly. That was a challenging moment for me. He cried a lot because my nipples were hard for him and he tried but couldn’t suck for long. But I refused to give him anything other than my breastmilk. He tried again and again to breastfeed until he got it, such a happy moment for me and for him. I continued breastfeeding every two hours day and night.

In our country’s law a female employee is entitled to maternity leave of 90 consecutive days. I had heard about pumping and putting breastmilk in the refrigerator but in reality I didn’t know how. I felt strongly that I had to continue breastfeeding my baby. How much milk does he need? How will he react? Is it enough? These kind of questions were in my mind and deep inside I had a strong feeling that I would feed him only my breastmilk.

My office was 2km from my home. I asked my boss to convert my annual leave to give me two hours per day for three months. Fortunately he agreed. Additionally, I have a one-hour break at lunchtime, so from 11:30 am to 2:30pm I got time to breastfeed my baby. I was a very happy mother. I checked how much milk my baby was taking during those two hours. At night I pumped and put my milk in the refrigerator. In the morning I pumped again and those supplies of milk were enough for my baby until I returned from work. After I returned from work, at 12:30, I breastfed him and pumped again for the afternoon session. When he started solids after six months, I didn’t stop breastfeeding. I pumped breastmilk until his first birthday and continued until he was two years and six months old.

After four years I got pregnant and had the same blood pressure problems. I gave birth to a baby boy at 34 weeks and he weighed only 2kg. This time I was familiar with how to breastfeed and had learned much from my previous experience.

I started work after three months and again got a chance to breastfeed my baby for six months like before.

I got pregnant when my second boy was 33 months old and I breastfed him until the end of my pregnancy without any difficulties.

At 37 weeks of pregnancy I gave birth to a baby girl weighing 3.35kg and started to breastfeed her at the hospital. When I returned home, my baby boy wanted to share my milk with his sister and I allowed him to continue nursing for two months. This time, too, I got two-hour breaks to feed my baby. I followed my previous experiences of pumping and putting milk in a refrigerator.

With all this experience, I have had many challenges but I considered my babies’ health and growth. I followed their milestones and made a record of most with photographs, a notebook and videos.

I am a proud mother to have breastfed my three children. I know and believe all about the benefits of breastfeeding. Breastfeeding made my children healthy, bright and happy, and so much more. I myself have benefitted too, I am healthy and had no problem losing weight. I believe that we mothers can give to our babies the most important and valuable food, the only food they need to grow!

What Breastfeeding Really Is

Dani Clark, Washington, DC, USA

I don’t think I match the stereotype of a woman who breastfeeds her child until he is five. And yet, that was me, until my son, Matteo, stopped asking for “milky” just a few months ago.

Despite being a full-time professional, striding daily down Washington’s streets to face jargon-filled meetings and publishing deadlines, I still labor under the delusion that breastfeeding moms who sustain nursing must be unemployed women living in communes with husbands who are community organizers. Or something like that. It’s funny that I still harbor such a notion, because I know, deep down, that it has nothing to do with the reality.

Breastfeeding was hard won. In the first eight weeks of my son’s life I suffered from cracked-open, MRSA-infected breasts and had days and nights of torture. I’ll spare you the details. Suffice it to say that I thank God for my persistence: from whence it came I still do not know. But the victory of surviving is not why I flew past year one and into year two without batting an eye and then, a little more hesitantly, into the covert operations of years three, four, and five.

My mother breastfed all five of her children until we were two. One comforting memory I have is of her body splayed on our worn out brown couch, eyes closed, and one of my siblings suckling happily. It was normal. My mother’s example is not why I continued though. By year three every other phone call with her included the question of whether I had weaned him yet. By the fourth year she was openly exasperated with me for “still letting him.”

But continued breastfeeding was not about me being a pushover, or about some subconscious desire to hold on to babyhood. Breastfeeding was about coming home from my first eight-hour day of work, when he was ten months old, and lying together on our mattress floor bed while he nursed and I patted his chubby, curious arms. It was opening my shirt right in front of the doctor after my son’s 18-month immunizations and both of our heart rates going down. It was his waking up in the middle of the night, sick with fever, at two years, and rocking softly together as I crooned folk songs that catapulted into my brain straight from the 1980s.

It was seeing him look up at me, at six months, 12 months, two years, three years, four, his face growing and changing but his smile, a reflection of pure joy and trust, staying the same. Breastfeeding was relationship. And it was knowing, because of this relationship, that even though he did not have the words, the assurance of my body and presence through the breastfeeding was something he needed, right until the exact moment when he didn’t need it any more.
Birth & Sex: 
The power and the passion

by Sheila Kitzinger
London: Pinter & Martin 2012
Reviewed by Naomi Stadlen, London, UK

The seventh of the ten concepts which sum up the philosophy of La Leche League states: “Alert, active participation by the mother in childbirth is a help in getting breastfeeding off to a good start.”

Sheila Kitzinger, the English social anthropologist and woman-centred childbirth educator, has fought to enable women to enjoy “active participation” in giving birth. Her many books are in harmony with La Leche League values, and she has been a speaker at LLL conferences. Her contribution to our understanding of childbirth has been, and continues to be, unique.

The final words of her new work, Birth & Sex are: “We are on the threshold of reclaiming spontaneous childbirth.” What does she mean? Isn’t childbirth safer than it ever has been, with most women going to hospital and giving birth under the supervision of well-trained medical health professionals?

Kitzinger challenges this perception: “Birth is usually treated as a medico-surgical crisis. Women are fed into the hospital system at one end, are processed through it, and come out at the other with a baby.” [1] She adds later: “The obstetric view of childbirth is that it is a medical event conducted by a team of professionals, in an intensive care setting.” [2]

Succinctly, Kitzinger describes the effect of this view: “Women became treated as containers to be opened and relieved of their contents within strictly limited time constraints, and attention was concentrated on a bag of muscle and a birth canal rather than a person.” [3] Technical innovations to monitor the birth made it easier to ignore the person of the mother. “It is almost as if it is the monitor which is having the baby, and all eyes are fixed on it.” [4]

These technical innovations have had a negative effect on mothers giving birth. “It meant that women could no longer trust their bodies…. Spontaneous feelings are rejected, as women in labour are required to put on a performance in an alien environment, often in front of total strangers.” She adds: “For those who have been through that ordeal, references to the sexuality of birth must sound like the ravings of someone who is seriously mentally disturbed.” [5]

Kitzinger offers a completely different paradigm. “When a woman is helped to do whatever she feels like doing in the second stage of labour, adopting positions, moving and breathing in any way she wants, the second stage can become an intense sexual experience.” [6] She explains: “In the second stage of labour each contraction can bring a series of orgasms as each one climaxes in pushing and release, mounts again, culminates in another, and so on.” [7] Kitzinger describes a woman’s orgasm in language both simple and lyrical: she shows how a woman uses the same muscles and the same breathing rhythms that are used in sexual intercourse in giving birth. This kind of birth-giving creates a special moment for the first meeting of mother and baby. “A peak sexual experience, the birth passion, becomes the welcoming of a new person into life.” [8]

However, Kitzinger is quick to point out that a woman whose birth was different, a painful ordeal, “has not failed to be a ‘real mother’.” [9] She wants to demonstrate how fulfilling the experience of giving birth can be, but at the same time she shows compassion to those women who suffer in giving birth. She writes: “I was fed up with women being blamed for everything that happened to them.” [10]

But if birth can be so wonderful, why do so many women have births that are painful, terrifying and humiliating? In Birth & Sex, Kitzinger offers a very simple answer.

Women, she writes, have a pattern of childbirth imposed upon them. “‘Push! Push! Don’t waste your contraction!...Take a deep breath, hold it. Now come on, you can do better than that. Don’t let your breath go! Take another one...’ The idea behind this is that she should be pushing right through a contraction, using every second of it, and putting her utmost strength into it. It is the exact opposite of the female orgasm. What has happened is that a male model of physiological activity is being imposed on women in childbirth.

The pattern of male orgasm—stiffen, hold, force through, shoot!—is distorting her own spontaneous psychosexual behaviour. Instead of the wave-like rhythms of female orgasm, bearing down is treated like one long ejaculation.” [11] This is an important assertion. Kitzinger may be the first person to have thought of it.

But how accurate is Kitzinger’s description of male orgasm? Wilhelm Reich, who published his now-classic, The Function of the Orgasm in 1927 [English translation, 1942], describes the sexual sensations of men and women, not as two different patterns, but as similar. He was clear that men did experience wave-like sexual feelings. However, he deplored what he called “compulsive characters” who would produce “violent frictions” in contrast to sensations “mutual, slow, spontaneous and effortless;” this was printed in italics, so he obviously thought these gentle sensations were important. [12] Perhaps the more violent pattern so vividly described by Kitzinger corresponds to Reich’s “compulsive character” rather than being characteristic of all men.

Mothers are also often urged to push their babies out as if they were having a bowel movement. “Push down! Go to the toilet!” Straining and pushing don’t seem optimal ways of going to the toilet.

Kitzinger shows that women (and surely their male partners too) have been confused by images derived from aggressive ways both of defecating and of reaching an orgasm. Kitzinger says these practices, very common in hospital births, constrain women from giving birth gently and spontaneously.

Kitzinger has written many books on childbirth. Her first, The Experience of Childbirth published in 1962, opened with a chapter called “Childbirth With Joy.” The book contains many quotations from mothers’ own birth stories which describe a variety of joyful experiences. For half a century, Kitzinger has worked consistently both to show that childbirth can be
a time of sexual fulfillment, and also to name and explore the many impediments which make this difficult for so many mothers.

Her unique achievement is evident if one reads comparable works, for example, *The Function of the Orgasms* (2009) by her near contemporary, Dr Michel Odent. This, too, is a fine work, describing centuries of “powerful negative cultural conditioning” which interfere with childbirth and the period immediately after. Yet Odent frequently seems to lose sight of the autonomy of an individual mother. “From a practical perspective...a labouring woman needs to be protected from any sort of stimulation of her neocortex,” he states on his penultimate page. Isn’t this something for a mother to decide for herself?

Kitzinger by contrast is always personal. In this way, she and we are always present throughout her work. Where others who write to inform mothers are often didactic and overpowering, Kitzinger succeeds in being informative, while brimming with humanity, and so she is truly empowering.

During the first week following birth more than half of all newborns become jaundiced. In most cases, this is a normal part of adjusting to life outside the womb. Jaundice may infrequently be a sign of more serious health problems and is more prevalent in premature babies.

**What is jaundice?**

Most babies are born with more red blood cells than they need for life outside the womb. When these cells break down after birth, they produce a yellow pigment called bilirubin, which circulates in the blood. When bilirubin reaches the liver, it is changed into a form that can be transported to the intestines and passed out of the body in the baby’s feces. A newborn baby’s immature liver cannot process all the bilirubin at once. Excess bilirubin is deposited in the skin, muscles, and mucous membranes of the body, which creates the jaundiced yellowish or golden appearance. When blood levels are too high, bilirubin may enter the brain and damage the nervous system.

Blood tests can identify problems early. Babies who have high bilirubin levels on the first or second day of life, or levels that are rising quickly, and as well as premature or sick infants, will be more closely monitored.

When bilirubin levels rise slowly over the first three or four days, a baby probably has normal physiologic jaundice. This is harmless and some experts think it may even be beneficial.

**Jaundice & the Breastfed Baby**

**Continue breastfeeding**

Babies with jaundice should continue to breastfeed.

Frequent breastfeeding during the first days of life will help clear bilirubin from your baby’s body.

Don’t give water

Bilirubin is eliminated in a baby’s feces and a baby who is frequently breastfed will have plenty of bowel movements. Giving water or other breastmilk substitutes makes things worse as your baby will nurse less often.

**Prolonged or Breastmilk Jaundice**

If a baby is gaining weight well, with breastfeeding alone, having lots of bowel movements, passing plentiful, clear urine and is generally well but still jaundiced he has what some call “breastmilk jaundice.” (On occasion, infections of the urine or an under functioning thyroid gland, as well as a few other even rarer illnesses may cause the same picture.) Breastmilk jaundice peaks at 10–21 days, but may last for two or three months.

Dr Jack Newman says www.nbci.ca/:

“Breastmilk jaundice is normal. Rarely, if ever, does breastfeeding need to be discontinued even for a short time. Only very occasionally is any treatment, such as phototherapy, necessary. There is not one bit of evidence that this jaundice causes any problem at all for the baby. Breastfeeding should not be discontinued ‘in order to make a diagnosis.’ If the baby is truly doing well on breast only, there is *no reason*, *none*, to stop breastfeeding or supplement even if the supplementation is given with a lactation aid, for that matter. The notion that there is something wrong with the baby being jaundiced comes from the fact that the formula feeding baby is the model we think is the one that describes normal infant feeding and we impose it on the breastfed baby and mother. This manner of thinking, almost universal amongst health professionals, truly turns logic upside down. Thus, the formula feeding baby is rarely jaundiced after the first week of life, and when he is, there is usually something wrong. Therefore, the baby with so called breastmilk jaundice is a concern and ‘something must be done.’ However, in our experience, most exclusively breastfed babies who are perfectly healthy and gaining weight well are still jaundiced at five to six weeks of life and even later. The question, in fact, should be whether or not it is normal *not to be jaundiced* and is this absence of jaundice something we should worry about? *Do not stop breastfeeding for ‘breastmilk’ jaundice.*”

**Not Enough Breastmilk?**

Higher than usual levels of bilirubin or longer than usual jaundice may occur because the baby is *not getting enough milk*. See http://viewer.zmags.com/publication/fd9eb27c#/fd9eb27c/20

When your baby is getting little milk, bowel movements tend to be scanty and infrequent so that the bilirubin that was in the baby’s gut gets reabsorbed into the blood instead of leaving the
body with the feces. If the baby is breastfeeding well, more frequent feedings may be enough to bring the bilirubin down more quickly. If your baby is not breastfeeding well, helping him latch on better may allow him to breastfeed more effectively and thus receive more milk. Compressing the breast to transfer more milk into the baby may help: a lactation aid may be used to supplement feedings.

A helpful way of knowing how much milk your baby has taken in is to look for what comes out. Beginning on the third or fourth day after birth, babies should have at least six to eight wet cloth nappies (five or six disposables) and at least three bowel movements in 24 hours.

High bilirubin levels can make your baby sleepy and lethargic and less interested in breastfeeding. If your baby is sleepy and not waking often, express your milk to help establish milk production and reduce breast engorgement. You can give your expressed milk to your baby by cup or syringe. See “Waking a Sleepy Newborn” www.llli.org/toolkit for suggestions to encourage a sleepy baby to nurse well.

A baby who breastfeeds well and often is less likely to have a problem with jaundice. Encourage your baby to nurse very often, at least 10 to 12 times in 24 hours. This will help clear bilirubin from his intestines more quickly.

Seek skilled help positioning and attaching your baby at the breast if you are struggling. If you are feeling overwhelmed, an LLL Leader can provide a listening ear.

Once your baby has the food he needs, he will have more energy to nurse well.

It is very important to let your doctor know if your baby has dark colored urine or pale colored feces.

Treating Jaundice
Breastfeeding can continue if diagnostic tests are needed. Most babies won’t need treatment. You might want to ask how necessary it is to treat the jaundice at this stage; whether instead you can continue to monitor the baby’s bilirubin levels, encourage him to breastfeed more frequently, and re-evaluate the situation in 24 hours. And, if phototherapy is deemed necessary ask how you can ensure frequent breastfeeding during the treatment.

If your baby finds blood tests distressing it can help calm you both to breastfeed during or immediately after the test.

Sometimes phototherapy is recommended to treat newborn jaundice. Phototherapy uses special blue-green lights to break down the bilirubin stored in a baby’s skin so that it can be eliminated more easily. A baby lies under the “bili-lights” wearing just a diaper, with his eyes covered to protect them. He stays under the lights continuously for a day or two, although parents may remove him from the lights for feeds. Once his bilirubin levels begin to fall, the lights are no longer needed.

Phototherapy restricts the time you can spend holding and nursing your baby. So if phototherapy is needed, it’s important to do everything you can to stay close to him and continue to breastfeed frequently. If you are still in the hospital, the phototherapy unit can usually be set up at the bedside, so that you can talk to your baby, touch him, and breastfeed him frequently.

More frequently now, babies can receive phototherapy using a fibreoptic blanket that wraps around the baby’s body and provides continuous light treatment. Your baby’s eyes will not have to be covered, and you can hold and breastfeed him during treatment.


Jaundice In Healthy Newborns Information Sheet LLLGB 2009 Quickfind: 2802

* Breast compression. This technique can help your baby to breastfeed actively and take more milk.

1. Hold your breast with one hand—thumb on one side, fingers on the other.

2. Wait while your baby breastfeeds actively (his jaw is moving all the way to the ear). When he is no longer swallowing, squeeze your breast firmly. Hold it squeezed until he stops nursing actively and then release.

3. Rotate your fingers around the breast and repeat step 2 as needed on different areas of the breast. Go gently—this should not hurt.

* Lactation aid. A supplemental nursing system/nursing supplementer is a bottle with thin tubes that attach to the nipple. When the baby sucks at both the breast and the tube, she gets milk from the bottle while the suckling stimulates the mother’s breast.
Global LLL

A look at what is happening in LLL around the world

LLL USA

Members of LLL Greater Pittston displaying their new logo umbrellas at a recent meeting.

Umbrellas are available from LLL of Eastern PA.

LLL Nebraska

LLL of Nebraska, USA, won a $12,500 grant from the U.S. Centers for Disease Control & Prevention to enhance peer support programs. It will use the funding for continuing education programs and materials for Leaders, a new professional display board, outreach materials, and to become an organizational partner of the Nebraska Breastfeeding Coalition.

LLL Hungary

Coming soon The Womanly Art of Breastfeeding translated into Hungarian.

LLL Japan

In the News

On September 17th an LLL Meeting was held in Kamashi, Iwate Prefecture which is in Tohoku - the area hit hardest by the devastating earthquake and tsunami of March 2011.

The theme of the meeting was “Gather together! Talk together! Anyone Can Breastfeed Meeting.”

The meeting was attended by breastfeeding mothers, a grandmother and three healthcare professionals. Mothers said they enjoyed the meeting very much and felt encouraged by listening to other mothers and sharing their own breastfeeding experiences and stories. LLL Japan is hoping to hold similar such meetings again in areas affected by the Tohoku earthquake and tsunami in the near future.