Childbirth and Breastfeeding

Background Information for Leader Applicants and Supporting Leaders

http://www.llli.org/docs/lad/ChildbirthandBreastfeeding.rtf

Note: This booklet is not intended for use by mothers who contact LLL. Leaders can refer mothers to childbirth books in the Group Library, to LLLI pamphlets and tear-off sheets, to leaflets, brochures, and information sheets produced by their LLL entity, and to LLL online resources available in their location.
# Childbirth and Breastfeeding

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A mother’s personal birth experience informs and shapes her knowledge and awareness of how birth impacts breastfeeding. The Founders of La Leche League said:

\[\text{We learned early in La Leche League’s existence that a woman’s experience in giving birth affects the beginning of breastfeeding and many of her attitudes about being a mother. Alert and active participation by the mother in childbirth is a help in getting breastfeeding off to a good start.}\]

\((\text{The Womanly Art of Breastfeeding, 2003 English edition, page 18})\)

LLL Leaders need to have a comprehensive understanding of how different childbirth experiences and methods of delivery affect the start of breastfeeding. The Background Reading/Learning requirement helps the Leader Applicant develop this knowledge, enabling her to help mothers who have had many different kinds of deliveries, and to understand and apply LLL philosophy when discussing childbirth. This booklet provides basic background information that can be used to meet the childbirth aspect of this requirement.

Much of the information below is adapted from the resources listed at the end of this booklet. You might supplement your understanding through further reading, attending workshops, talking with Leaders in your Group or your Leader Accreditation Department (LAD) representative, or in some other way; or perhaps you have professional experience that will contribute to meeting the requirement. When you read \(\text{The Womanly Art of Breastfeeding}\), focus particularly on Chapter 2, “Plans Are Underway,” and Chapter 4, “Your Baby Arrives,” for LLL information about childbirth.

**CHILDBIRTH**

**How childbirth can affect breastfeeding**

Ideally, childbirth goes according to plan and the baby is delivered naturally, in a safe, relaxed environment celebrating the positive power of normal childbirth. Breastfeeding begins as a natural progression from the satisfying calm after the birth.

For many mothers, the experience can be very different: the labor and delivery may be long and painful or surprisingly short; mother and/or baby may be affected by medication administered during the birth; the baby may be whisked away for special care, or the mother may have surgery or some other intervention. These and many other factors can all impact the start of breastfeeding.

LLL believes that a mother’s active participation in childbirth can influence what happens during birth and afterwards. A critical point from this concept is that our focus on childbirth is in relation to breastfeeding. We know that when a mother is awake, aware, and actively involved she is better able to avoid procedures or interferences that can compromise the initiation of breastfeeding. It is important to recognize that “alert and active” does not refer just to an “ideal” birth experience:

- Women can learn about birth options and getting breastfeeding off to a good start during pregnancy by taking childbirth classes and attending LLL meetings.
- Mothers can be actively involved in making decisions before and during labor and delivery.
Mothers can remain alert through most medical procedures.
Challenges during the birth can make some mothers especially determined to breastfeed their babies.
With support and information, a mother can get off to a good start with breastfeeding, even if her delivery experience was not what she would have wished for.

Although some medical procedures may be performed routinely, and perhaps at times unnecessarily, at other times medical intervention can be lifesaving. When a mother understands more about the physiology of natural childbirth and early breastfeeding, she has more knowledge of what to do to minimize the effects of any interventions.

Mothers make the best decisions they can with the information and medical advice available to them. Sometimes, after having a baby, they may think of or learn of other alternatives and wish they had made different decisions. Our role as Leaders is to help a mother make sense of her birthing and breastfeeding experience, which may influence her choices when she has her next baby.

If a mother shares with us that she is unhappy with her birth experience, we cannot assume it was avoidable. We help mothers see how they can make breastfeeding work even after a cesarean birth, a medicated birth, an induced birth. This focus is important because we want to help mothers move from any feelings of regret, disappointment, or guilt to the positive feelings that come from bonding with their babies and having confidence that they can breastfeed and meet their babies’ needs. Your support through active listening can help a mother to move from her childbirth experience to making decisions about her present breastfeeding situation.

Remember that a mother may need time to deal with grief over a birth experience that was different from what she expected. If you think that a woman needs more support than you are able to give, or if the type of support she needs is outside your ability, you can refer her to others in your community, such as health care providers, other professionals, or support agencies/organizations.

**Alert, active participation in the birth experience**
The list below shows some of the options that may help mothers to experience alert, active participation in birth. An expectant mother can:

- Seek information (such as through childbirth classes, reading on her own, or by watching DVDs or videos showing active birth and exercises) that will help her learn about birth and ways to relax and be engaged and involved throughout her labor.
- Learn about different birth attendants (e.g., obstetrician or midwife) and how their childbirth philosophy may impact the birth experience. For example, a midwife might use more of a woman-centered approach to birth, while an obstetrician may be more medically oriented. However, some midwives may be more geared to medical birth, and many obstetricians believe in natural birth.
- Get to know her health care provider and ask questions so that she understands her provider’s approach to childbirth.
- Consider her options for birthing in a place where she will feel safe and relaxed, whether at home, in a birth center, or in a hospital.
- Learn if there is a local facility that has earned the designation of UNICEF Baby Friendly Hospital.
- Find out, when planning a birth center or hospital birth, about their policies regarding breastfeeding.
- Verify if there are any routine labor and delivery procedures, such as an enema or fetal monitoring, in her chosen place of delivery.
- Learn about specific medical interventions possible during birth and their potential impact on breastfeeding.
- Plan, when opting for a home birth, what her options are if there arises an emergency situation that necessitates moving to a hospital.
- Make a birth plan well before the birth and discuss it with her birth partner and health care providers.
- Consider employing a birth attendant (doula) to support her during the birth and in the early days with her baby.
- Build a support network of LLL Leaders and mothers in the Group.
A mother’s childbirth experience may affect the start of breastfeeding and the early days with her baby. For example, a difficult labor or medications used during a cesarean birth may make the baby sleepy for several days or decrease the effectiveness of the baby’s suck. A premature delivery is likely to affect every aspect of the baby's behavior and care. During labor, procedures such as an enema or routine fasting can affect a mother’s self-confidence and well-being. There may occasionally be a good reason for these procedures; mothers can ask for information to help determine if a procedure is necessary. A mother’s partner, friend, or relative who will be at the birth can be an advocate for her wishes.

**INTERVENTIONS AND MEDICATIONS**

**The effect of interventions on the birth experience**

This section discusses possible interventions that can ultimately affect the start of breastfeeding. Make use of *The Womanly Art of Breastfeeding, The Breastfeeding Answer Book* (if available), LLL pamphlets and other publications in your Group Library to learn more about how birth experiences affect the start of breastfeeding.

Often childbirth interventions can have a cascading effect: a seemingly small initial intervention can have consequences that may lead to more interventions. Even something that seems innocuous, such as inactivity during labor or being confined to bed, can interfere with the normal progress of childbirth and trigger a series of interventions. The list of procedures in the section “Induction” demonstrates some of the ways in which one intervention can lead to another.

However, Leaders need to be sensitive to the needs and feelings of mothers requesting support. Information about interventions and their effect on birth and breastfeeding can help us understand a mother’s situation and determine how to help her. This information may not be helpful to share with a mother, though, and could make her feel judged or criticized for her birth choices. It may be appropriate to indicate that more information is available if a mother wishes it; too much information at once may be alarming and create anxiety.

We encourage mothers to avoid unnecessary intervention, and, at the same time, we acknowledge that there may be valid medical reasons for specific procedures. In some situations, it can help a mother to know what she might expect if labor is induced, if she has a medicated or cesarean delivery, and to understand the possible consequences that can impact breastfeeding. Of course, not all interventions can be avoided, but knowing what to expect can help a mother be prepared to spend additional time and effort to help her baby breastfeed.

**Induction**

Induction, or artificially starting labor, is an option offered to many women in late pregnancy. Augmentation, or speeding up labor, may happen when labor has started but contractions are weak or have slowed down. Induction and augmentation methods may include:

- **Stripping or sweeping the membranes** - a procedure where a health care provider puts his or her fingers into the cervical opening and rotates them 360 degrees. This is done to facilitate the release of prostaglandins from the membranes and from the cervix, and to help the cervix to soften. This method may not be effective at starting labor and does have the potential to cause the bag of waters to break earlier than would happen naturally.

- **Breaking the waters (amniotomy)** - a procedure where the health care provider tears a small hole in the amniotic sac in hopes that the pressure of the baby's head on the cervix will stimulate or improve contractions. Without the protective cushion of the amniotic fluid, the baby’s head may be subject to greater pressure during contractions. The umbilical cord may be more likely to become compressed, resulting in oxygen deprivation and consequent respiratory distress, which may necessitate a cesarean birth. Cord prolapse (the umbilical cord enters the birth canal ahead of the baby) is also more common after amniotomy. Moreover, unruptured membranes often cushion not only the fetal head but also the mother's perineum, allowing for gentler stretching and reducing the likelihood of tears. The combination of rupture of the cushioning bag and oxytocin-augmented contractions often leads to more rapid and forced stretching of the perineum and so to more tears. If labor does not begin using this method, other interventions may become necessary.
• **Prostaglandins** - substances that are naturally produced by the body and act to soften the cervix and the lower part of the uterus; there are now several synthetic versions, supplied as a gel, pessary/vaginal suppository, or pill. Depending on the method of administration, the prostaglandin can sometimes be removed should contraction strength become overwhelming. Prostaglandin induction often leads to additional interventions, including oxytocin to augment the stimulation to the uterus. Prostaglandin induction increases the risk of assisted delivery and cesarean birth.

• **Misoprostol (cytotec)** - a synthetic prostaglandin that was approved for use in gastrointestinal problems. It is sometimes used in childbirth to initiate uterine contractions, administered at specific time intervals either orally or placed against the cervix. This method of induction is more effective at softening the cervix than prostaglandins, and is much cheaper. It may increase the risk, however, of overly strong contractions and fetal heart rate abnormalities. Once given, its effects cannot be stopped.

• **Oxytocin (Pitocin/syntocinon)** - a synthetic version of a natural hormone released from the mother’s pituitary gland, given in tiny amounts to induce labor and augment contractions. This can have the effect of generating longer, more intense contractions of the uterus. It can interfere with the flow of oxygen-rich blood through the placenta to the fetus, usually leading to fetal monitoring to assess the condition of the baby. When labor is induced with synthetic oxytocin, an intravenous drip is set up, possibly restricting a mother’s mobility (although drips are often connected to a stand on wheels that the mother can move around with her). Oxytocin induction may be more likely than a spontaneous labor to result in a vacuum-extraction or forceps delivery or a cesarean birth due to fetal distress from overly strong uterine contractions. This method of induction can increase a baby’s risk of being born in poor condition, and increase the likelihood of newborn jaundice. Increased fluid from the drip may cause a number of problems, including excessive edema of the breasts in the early postpartum period, making latching difficult. Oxytocin induction can have the potential to cause problems with breastfeeding initiation due to the disruption of the mother’s natural hormone levels, especially if used in conjunction with epidural anesthesia.

To minimize the effects induction can have on breastfeeding, a mother might consider natural methods of promoting contractions such as nipple stimulation, sexual intercourse (if the amniotic sac is still intact), acupressure or acupuncture, and walking or sitting during labor instead of lying prone. She should check with her health care provider before beginning a course of action.

Women tend to have harsher, stronger, significantly more painful contractions with chemically induced or augmented labors, which may make the mother feel she needs pain relief. Two common types of pain relief are analgesics (oral or intravenous pain medication) and anesthesia (such as an epidural). An induced or augmented labor can lead to a positive birth experience without further intervention; however, additional intervention is more likely to occur if the labor has not begun spontaneously. A woman considering an induction before her due date needs to know that a late preterm baby (37-39 weeks) may have some of the same types of problems breastfeeding as a very early preterm baby (such as weak or uncoordinated suck, and sleepiness at the breast).

**Fetal monitoring**
The aim of fetal monitoring is to ensure the well-being of the baby, for example that the baby is getting enough oxygen.

• Fetal monitoring can be carried out by intermittent listening with a fetoscope (a stethoscope-like device for use during pregnancy and labor) or with a Doppler (ultrasound) device.

• Electronic fetal monitoring (EFM) involves attaching the mother to a machine, either with two receivers held in place by belts around the hips (external monitoring), or by an electrode attached to baby’s scalp and a pressure catheter inserted alongside baby’s head (internal monitoring).

• EFM usually involves lying down, the most painful and least effective position for labor progression. Even if the mother is not lying down, movement is restricted.

• Routine EFM can make doctors and nurses believe that something is wrong when it is not, sometimes due to misinterpretation of the data from the machine.
- EFM has not been proven to improve outcomes for mothers or babies, and does increase the risk of interventions such as cesarean birth or assisted delivery.

- Laboring women being monitored by EFM sometimes feel that the machine becomes the center of attention during labor, instead of the mother and baby.

**Assisted delivery**

Instrument delivery with forceps causes compression of the baby’s head. Forceps can cause bruising and nerve damage to the sides of the cranium, causing the jaw to deviate. This can lead to jaw asymmetry, which can affect the baby’s suck. Use of a vacuum extractor can substantially increase the amount of force applied to the infant’s skull, causing compression of the baby’s head and increasing the risk of postpartum complications. Vacuum-assisted vaginal delivery may be a significant factor in the cessation of breastfeeding within the first two weeks of life.

The use of forceps or vacuum extraction may cause head pain and inhibit movement of the baby’s head and neck. Treating the baby as if he has a severe headache and reducing noise, light, touch (especially to the back of the baby’s head), and motion, can be effective comfort measures. “Kangaroo-style care” can also help, by holding the baby upright on his mother’s chest in a quiet, darkened place. Mothers might also seek help from practitioners trained in treating infants with gentle, noninvasive manual techniques. Chiropractors, osteopaths, physical therapists, occupational therapists, and massage therapists are some of the professionals who practice manual therapies.

Instrument delivery can cause the mother pain from an episiotomy (the surgical cut to enlarge the vaginal opening), which is sometimes performed in order to place/insert the instruments. The instruments themselves can sometimes injure the mother internally, causing pain. Being in pain can affect a mother trying to care for a newborn baby and may make it difficult to get breastfeeding off to a good start.

**Cesarean birth**

Cesarean birth is a major abdominal operation and carries well-documented risks for both mother and baby. A mother is likely to stay in hospital longer than she would otherwise, with a longer recovery time after the birth, which can have an impact on establishing breastfeeding. When a mother goes into labor and gives birth without intervention, her body releases hormones that help with breastfeeding (oxytocin and prolactin). A cesarean birth may interfere with the natural release of hormones in both mother and baby, making it more of a challenge to establish breastfeeding. Some experts describe earlier and more abundant lactation if the mother is allowed to experience labor before a cesarean delivery.

A Leader can encourage the mother to begin breastfeeding as soon as possible. The mother may need support to position her baby comfortably and avoid the area of her incision and stitches. Many mothers can go on later to have vaginal births after a cesarean (VBAC), thus avoiding the breastfeeding complications which might be caused by a cesarean birth. If a mother who has had a previous cesarean delivery talks with you about VBAC, you can encourage her to discuss it with her health care provider.

**Medication for pain relief**

There are several different types of medication used for pain relief during labor and delivery. Below is a summary of the range of typical options and some of their effects on mothers and babies; the list is not comprehensive.

- **Tranquilizers** are given to reduce anxiety and tension. However, they can cross the placenta and interfere with the baby’s ability to breathe, to suck, and to maintain a healthy muscle tension (tranquilized newborns tend to be limp).

- **Narcotics** (e.g., Demerol, pethidine) in doses high enough to lower pain may not be safe for mother or baby, so they are given in lesser amounts. Given intravenously or by injection, a relatively safe dose can cause sleepiness in the baby or mother, and often causes nausea, vomiting, and a drop in blood pressure in the mother. If narcotics cause nausea in the mother, the use of additional medications may
be necessary. These anti-nausea drugs can cause dizziness and drowsiness in the mother. Narcotics can affect the baby’s ability to suck, swallow, and breathe in a coordinated manner, lasting from several hours to several weeks after birth.

- **Inhaled pain medications** are used in some locations. Mothers inhale the gas through a mask attached with tubing to a gas cylinder. Nitrous oxide gas is used to dull labor pain, both in hospital and in home births. The effects are immediate and short-lived; some sources report that no obvious side effects have been found in babies or mothers.

- **Epidural anesthesia** numbs and weakens the lower part of the mother’s body. The mother remains conscious. A catheter remains in place for “topping up” of the anesthetic if required. For many women, it is an effective form of pain relief. However, epidurals don't always work, providing only partial pain relief (or none in 3% of cases). Possible side effects, such as maternal fever or a drop in maternal and/or infant blood pressure, may lead to further postpartum/postnatal intervention. Epidurals may be more likely to result in either cesarean birth or a forceps/vacuum-extractor delivery than an unmedicated labor. Research shows that after an epidural, babies are less alert, less able to orient themselves, and have less organized movements; these differences are measurable during the baby's first month. After an epidural, the mother’s back may feel stiff, achy, or sore.

- **General anesthesia** can be administered more quickly than an epidural, so it is still used when an emergency cesarean is required. It can cause nausea and vomiting in women after delivery and can produce breathing difficulties in babies.

- **Spinal anesthesia** is similar to epidural anesthesia, with similarly effective pain relief. However, a catheter is not left in place, so the duration of anesthesia is limited. The possible side effects caused by spinals are similar to those for epidurals. Spinals can cause a sudden and drastic drop in blood pressure. Some women have a spinal headache after birth. This headache can last for days after the birth, interfere with daily activity and baby care (including breastfeeding), and may require further medical treatment. A mother in this situation may need extra practical help and emotional support. Mothers may be told to lie flat for several hours following a spinal to avoid a headache. Doing that can make breastfeeding difficult unless the mother has help from someone knowledgeable about positioning and latch.

**Impact on breastfeeding from pain relief medication used during labor and delivery**
The sucking reflex of a healthy, full-term newborn delivered without the use of pain medications or anesthesia usually peaks about twenty to thirty minutes after birth. If this optimal time to begin nursing is missed, the baby’s sucking reflex may be less strong for about a day and a half.

Pain relievers or anesthesia can contribute to breastfeeding problems:

- The baby and/or mother may be sleepy or less alert and thus delay the first nursing.
- The baby's ability to suck, swallow, and breathe may be disorganized.
- The baby’s rooting and sucking reflex may be delayed and depressed.
- Pain medications (analgesia and anesthesia) do cross the placenta to the fetus, and the closer they are given to delivery, the more likely they are to remain in baby's system after birth. While the fetus is in the uterus, the mother's system and the placenta help the baby to eliminate toxins. Once the baby is born, his less mature liver will need to do this detoxification, hence it sometimes takes longer for babies to get rid of excess drugs.

**OVERCOMING CHALLENGES AFTER BIRTH**
**Post-birth choices that can affect the start of breastfeeding**

After a baby is born, the mother may have an expectation of what will happen next: the baby crawling up her abdomen to the breast or being gently lifted into her arms, in both cases enjoying maximum skin-to-skin contact and an early opportunity to breastfeed. However, the reality may be different, and it can be helpful for the mother to find out as much as she can before the birth so that she will be prepared for certain hospital/birth center procedures which may be thought necessary to determine and treat the condition of the baby.
Routine practice can include:

- **Newborn well-being assessments** (barring medical complications, these measurements can be taken while the baby is skin-to-skin with the mother):
  - **ABC testing**: Done immediately after birth, babies are assessed for Airways, Breathing, and Circulation to determine the need for resuscitation.
  - **Apgar score**: This assessment of the baby's Appearance (skin color), Pulse (heart rate), Grimace (reflex irritability), Activity (muscle tone), and Respiration is done after one minute and again at five minutes. This can be done quickly and need not disturb skin-to-skin contact time.
  - **How Ready Is This Child testing**: This reformulation of Apgar testing checks Heart rate, Respiratory effort, Irritability, Tone, and Color.

- **Suctioning**: Some hospitals remove mucus from the baby's airways by suctioning. It can be done more, or less, intrusively, depending on the baby's condition at birth. In some hospitals it is routine. Intrusive or deep suctioning (done for respiratory distress, or done routinely in some hospitals) can cause oral aversion in the baby, making him reject anything in or around his mouth, including the breast.

- **Postpartum routines such as washing and weighing the baby**: These can be delayed until after an unhurried skin-to-skin time; the mother and her partner may need to be assertive about this. For instance, the baby can be dried as they snuggle together. Bathing the baby may include washing the baby's hands. If this happens before offering the breast, it can confuse his sense of smell and make it harder for him to find his way to the breast.

- **Use of nurseries**: Some hospitals have a special room where babies sleep and are cared for by the nursing staff. This system relies heavily on busy nurses to recognize feeding cues and get a baby to his mother in a timely manner. Rooming-in (baby in mother’s room) may or may not be an option. Rooming-in allows a mother to get to know her baby and to respond early to hunger cues, such as fist sucking and rooting, which facilitates the early breastfeeding relationship.

- **Artificial nipples**: Routine baby care in the nursery may include dummies/pacifiers and supplementation, which can interfere with the establishment of breastfeeding.

- **Use of formula**: The hospital may routinely provide artificial milk if the baby is not nursing well within hours of birth. Instead, mothers can express some colostrum by hand and give it to the baby by an alternative method, such as spoon, dropper, or cup. Some hospitals may assume that every baby over a certain weight has low blood sugar and needs supplementation with formula. If a baby does have relatively low blood sugar, the mother may be advised to give glucose water and/or formula. A mother can ask her health care provider what test results indicate that her baby might have a need for supplementation, and work with him/her to develop a plan of action that maintains and values breastfeeding.

- **Water/glucose water**: The hospital may routinely provide water or glucose water if the baby shows signs of jaundice. Colostrum is more effective at flushing out meconium and preventing jaundice. Offering the baby water/glucose water can interfere with establishing the mother’s milk supply and increase the risk of jaundice.

- **Blood tests for newborn metabolic screening**: These tests may be required by government health authorities. They are routinely done by pricking the baby's heel; this takes place no sooner than 24 hours after birth. Painful medical procedures can affect a baby's ability and willingness to feed in the early days. However, breastfeeding during such procedures acts as a natural painkiller, alleviating the symptoms of pain, such as crying and grimacing.

- **Other painful medical procedures**: These can include administration of vitamin K, vaccinations, and circumcision. Like blood tests, these procedures can affect a baby's willingness to feed.
• **Test weighing:** Test weighing before and after a feed is not usually necessary and may not be an accurate assessment tool in the first few days of life. It can result in babies receiving supplementary bottles, which in turn can interfere with the mother’s milk supply. Mothers can be supported to dialogue with their health care providers about other signs of infant growth and well-being and ways to support breastfeeding.

• **Special care babies:** Some babies require additional care in a Special Care Baby Unit or Neonatal Intensive Care Unit. This can delay the start of breastfeeding; the mother can express her milk to establish her supply until her baby is well enough to be put to the breast. A mother in this situation may need the assistance of a knowledgeable LLL Leader or International Board Certified Lactation Consultant (IBCLC).

**Getting started with breastfeeding after a challenging birth experience**

When helping a mother, remember the basics of positioning and latch. After a challenging birth experience, a mother may have difficulty finding a comfortable position to breastfeed. She may feel disappointed, frustrated, or angry with herself or her body. She may be overwhelmed by the ordeal she has been through, exhausted and in pain or discomfort. She may also be afraid that the "window" for beginning breastfeeding has closed, or that breastfeeding will be another physical and emotional struggle. She may need support to gain confidence that she and her baby can breastfeed successfully. On the other hand, some mothers in this situation feel triumphant that they and their babies have survived the challenge; they look forward to breastfeeding.

Whatever her birth experience, a new mother is likely to benefit from feeling that she is being cared for and that she and her baby are safe and secure. She can then relax in the knowledge that all she has to do is look after her new baby. A mother who has had a challenging birth experience may need to share the story of her experience with you. She will value your listening ear and the support and information you can offer. If her situation is beyond the normal course of breastfeeding, you may need additional support from the Professional Liaison Department in order to help her effectively. You might also need to refer her to others for additional support, such as health care providers or a lactation consultant.

**When the mother is in pain**

The mother may be in pain from stitches in her abdomen (after a cesarean birth) or pelvic floor (after vaginal tearing or an episiotomy, the surgical cut to enlarge the vaginal opening), and struggling to cope. Many pain medications are compatible with breastfeeding. The mother can ask her health care provider about appropriate medications. A Leader can give the mother information about what to consider when the mother and her doctor evaluate a drug’s compatibility with breastfeeding (see the bullet points found in the LLLI FAQ online at [http://www.llli.org/FAQ/medications.html](http://www.llli.org/FAQ/medications.html) and/or “Questions about Medications while Breastfeeding,” Leader’s Handbook). If a baby exhibits excessive sleepiness or other side effects while a mother is using pain medication, she should inform her doctor immediately.

A mother may find it more comfortable to lie down to breastfeed or to try a different way of holding her baby, such as an under-the-arm or “clutch” hold. She may want to experiment using pillows to help support her arms and baby, or to protect her abdominal incision.

**When the baby can’t or won’t breastfeed**

Different factors can contribute to difficulties starting breastfeeding. For instance, a premature baby may have a weak suck due to an immature nervous system. A newborn baby can be very sleepy, especially after a medicated delivery. In these instances, getting started with breastfeeding can take some perseverance on the mother’s part. There may be other concerns or specific breastfeeding challenges unconnected to the birth experience. It is important for the mother to know that, even though breastfeeding may be delayed, she and her baby can still breastfeed.

A delay in establishing breastfeeding may require support for the mother to express her milk, and she will benefit from information about alternative feeding methods such as spoon, dropper, or cup if she wants to avoid bottle use. If the mother opts to use bottles, mimicking breastfeeding as much as possible can make the
eventual transition to breastfeeding go more smoothly. This might include holding the baby in a nursing position, using a “slow-flow” nipple that is soft and long enough for the baby to draw to the back of his mouth, touching the baby’s lips with the bottle nipple and waiting for him to open wide, letting him draw the nipple in himself, and keeping the bottle in a nearly horizontal position so that the baby has to work to get the milk from the nipple. Your support will be important while the mother works to get the baby to the breast and especially if her breastfeeding experience continues to be challenging.

BABY CARE

Skin-to-skin contact
Skin-to-skin contact can help the mother and baby learn about each other through touch, warmth, and smell, until the baby starts to breastfeed. This is the basis of “kangaroo care” for premature babies. The mother carries her baby against her body, skin-to-skin, building a bond of love and trust. The effect seems magical: the baby is better able to maintain body temperature; heart and breathing rates become more regular; the baby makes eye contact with his mother and may explore her nipple and perhaps attempt a few tentative sucks, which is especially gratifying to the mother. The principles of kangaroo care can be helpful for any mother and her breastfeeding baby.

Mother and baby can enjoy skin-to-skin contact at any stage; the mother’s chest is the normal habitat for a newborn baby. He will calm down and rest well whenever he is close to his mother in this way. If he bobs and slides down to a breast, the mother keeps his bottom close to her so that he feels secure. She can help him gently to latch on well. This method (sometimes called “biological nurturing”) is especially helpful if a baby has a sore head or has been pushed onto the breast by an overenthusiastic helper.

Mothers can find out if the hospital/birth center supports skin-to-skin contact and initiation of breastfeeding within the first hour. A healthy, unmedicated baby will generally show interest and initiate breastfeeding when he is ready and does not need to be rushed, especially if he has been skin-to-skin with his mother since birth. If the baby is too irritable or overwhelmed to take an interest in breastfeeding, skin-to-skin contact is sometimes enough to restore normal behavior within 15-30 minutes.

If skin-to-skin contact is delayed for any reason, the mother and her birth partner can advocate for this to begin as soon as the mother and her baby are ready. The mother will need to recline, with her chest area uncovered (she can wear a big shirt or pajama top, open at the front), and a cool drink nearby. The baby wears just a nappy/diaper and lies on the mother’s chest, between her breasts or slightly above, his whole body facing her and his head turned to one side. He has a blanket over his back and tucked round his feet, or he may be covered by the mother’s clothing. If there are concerns about the baby's temperature, he can wear a hat. If the mother is very tired or is affected by medications that make her sleepy, she will need someone to stay with her so that she does not worry about the baby slipping off the bed if she falls asleep.

Co-bathing
Taking a bath together can be relaxing for both mother and baby and provide an opportunity for skin-to-skin contact and easy access to the breast. It may be wise to remind mothers of commonsense precautions regarding water temperature (warm to the mother’s elbow, not hot), with most of baby’s body submerged to retain body heat. It is also a good idea to have another adult present to hold the baby as the mother gets in and out of the bathtub.

Baby carriers
Various kinds of baby carriers worn by the mother can provide a way of keeping the baby close and within easy reach of the breast. Wearing the baby in a soft carrier or sling facilitates breastfeeding in many ways: it’s convenient; movement can help calm the baby and help a baby having problems sucking to “organize” himself and nurse more effectively; the mother’s arms are free to care for older siblings. Babies who are slow weight gainers tend to nurse more and gain more when worn in a sling. Research shows that meeting a baby’s need for closeness will lead to more independence as the baby grows. Other research shows that “babywearing” reduces crying and provides the sensory stimulation that babies need to figure out the world around them. Keeping her baby close allows a mother to notice early hunger cues rather than waiting to be alerted by the late signal of crying. This early response helps maintain the mother’s milk supply, keeps the baby happy and secure, and helps the mother’s postpartum moods adjust more smoothly.
MOTHER SUPPORT
Supporting new mothers
After birth, support from relevant sources can be critical and can include family members and friends as well as La Leche League. Offering effective support includes knowing when and how to refer a mother to others for additional help. If a mother needs more than you can give her, or if her concerns go beyond the scope of breastfeeding support, you can suggest that she contact her health care providers or other professionals and support agencies as appropriate to her situation. It’s helpful to keep a list of resources in your community, such as breast pump rental stations, lactation consultants, and other professionals and agencies/organizations that offer support to mothers. Your supporting Leader or a Professional Liaison Leader can help you learn what’s available in your location. Offer the mother several options that are relevant to her situation so she can decide what will be best for her and her baby.

When childbirth is discussed in an LLL meeting, it is important for the Leader to keep the focus of the conversation positive as the Group discusses the wide variety of plans and actions that mothers can take to help get breastfeeding off to a good start regardless of the context of the birth. “Alert and active participation in childbirth” covers a broad spectrum of possibilities. A Leader can demonstrate what is meant by the LLL childbirth concept when she refers to *The Womanly Art of Breastfeeding* and to a variety of Group Library books on pregnancy, labor, and delivery.

A Leader can also invite different mothers at a meeting to discuss their varied birth choices and the effects those choices had (positive or negative) on the initiation of breastfeeding. It’s very important to facilitate a balanced discussion of experiences. If the discussion is dominated by those who have all had a particular type of birth experience (e.g., a particular labor medication or a particular birth setting), a mother may misunderstand LLL philosophy. She may not see herself fitting in comfortably with the Group if her experience has been different, or she may discount valid suggestions by the Leader or Group members if she sees the Group as too biased in some way. Including diverse experiences and perspectives demonstrates respect for the uniqueness of every childbirth experience. It demonstrates that LLL philosophy offers a workable approach to birth.

CONCLUSION
When mothers share their birth experiences, the discussion can be lively and sometimes emotional. Talk to your supporting Leader about her experience of providing support to mothers when talking about childbirth. Discuss ways to keep the focus on breastfeeding while allowing mothers to share their experience of a life-changing event. Talk about how to keep the discussion positive while not diminishing mothers’ childbirth challenges. The role of the LLL Leader is to listen, to support, and to provide information.

When we talk with a mother who is struggling with breastfeeding, finding out about her childbirth experience can shed light on the breastfeeding challenges she is facing. That knowledge can guide our response, so that we offer her information that will be helpful to her situation. We take care not to imply to the mother that she caused these problems by her choices during the birth. Our goal is to help the mother work with her present situation so she and her baby can get off to a good start with breastfeeding.

If you are looking for book titles to suggest to mothers or if you want to learn more about birth and breastfeeding, consider using the *LLLI Bibliography* as your guide. It can be accessed by going to the Book Evaluation Committee (BEC) Web page: [http://llli.org/BEC/BEC.html](http://llli.org/BEC/BEC.html) The books included in the Bibliography have been evaluated by Leaders worldwide, and reflect or support the LLLI mission, purpose, and philosophy.

If you have questions about any of the information in this booklet, contact your supporting Leader. She may know the answers to your questions and/or can refer you to other resources. She can also contact the Professional Liaison Leader in your location, who has access to more detailed information. Please keep in mind, however, that you don’t need to be an expert on childbirth in order to help mothers breastfeed.

You and your supporting Leader might discuss which childbirth scenarios are most common where you live, and what kinds of questions you are most likely to receive from mothers. By educating yourself about the options as well as risks and benefits of the different childbirth choices, you will be better able to support mothers who have had all types of birth experiences, and to help them have a satisfying breastfeeding relationship.
Resources

Selected references
Childbirth, pages 3-5

Interventions and medications, pages 5-8

Overcoming challenges after birth, pages 8-11
Genna: 65.
Kroeger & Smith: 136, 195.

Baby care, page 11
Genna: 272.
Mohrbacher & Stock: 27.
WAB: 78, 284-85.