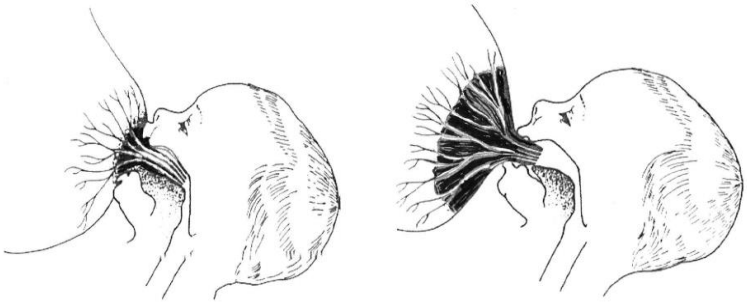
Positioning and Latching Baby:

POSITIONING & ALIGNMENT TO BREAST

To establish and maintain a good latch position it is important that:

- the mother is relaxed and comfortable.
- **baby alignment:** the head is straight, ear, shoulder and hips in a line. The whole body should be facing mother if the "cradle, transitional or football" holds are utilized.
- **baby's legs are tucked around mother's body:** clears nose
- **do not lift the breast:** bring baby to the natural position of the breast.
- **breastfeeding:** babies **breast**feed - not nipple feed - ensure baby achieves a deep latch of the breast - and listen for swallowing relative to the mother's lactation. If baby is only two days old the amount of colostrum available may be limited. Therefore, while there will be a few swallows one after the other, long periods of 'suck/swallow' are unlikely; once a milk supply has established the periods of suckling and swallowing will be apparent for a much longer period of time.
- **breast shaping:** this may be helpful if achieving a latch has been awkward for mother. If shaping to gain adequate latch the thumb or finger should "end up" a "moustache" for the baby! Release any pressure on the breast as soon as a latch has been achieved - remember not to lift the breast unless the mother is prepared to hold the breast throughout the full feed.
- **firm / full breast:** difficulty latching may occur as milk production establishes or after periods of long sleep - especially if baby has not established breastfeeding prior to fullness occurring.
- **transitional hold:** this may assist a mother to latch her baby - changing to "cradle hold" once a latch is achieved and baby is feeding well.
- **large breasts:** a face-cloth (or similar) underneath the breast could be helpful with the careful positioning of the infant. Mothers need to be able to "see what she is doing". Breast support may be necessary because breast weight can drag the nipple from latch during the course of the feed.
- **tender nipples:** seek help if this persists beyond the first few days of breastfeeding.
- **long nipples:** observe the full feed to ensure baby is effectively breastfeeding and transferring an adequate intake.
- **different nipples:** mother's commonly have unequal breasts and different nipple shapes. They are 'different' organs, 'different' breasts. A mother may find difficulty latching her baby on one of her breasts but not the other. Confidence and baby's intuition, over time, will generally ensure latching to both becomes easier.
- **milk removal is different:** breast to bottle – avoid the use of bottles, teats
- and pacifiers while establishing breastfeeding.

CORRECT ATTACHMENT TO BREAST



1 2

The diagram above shows how a baby takes the breast into his mouth to suckle.

Notice these points in picture 1:

- The baby has taken much of the areola and the underlying tissues into their mouth.
- The baby has stretched the breast tissue out to form a long 'teat'.
- The nipple forms only about one-third of the 'teat'.
- The baby is suckling from the breast, not the nipple.

Notice the position of the baby's tongue:

- The baby's tongue is forward, over the lower gum
- The tongue is cupped round the 'teat' of breast tissue. You cannot see that in this drawing, though you may see it when you observe a baby.
- The tongue 'presses' milk out of the ducts into the baby's mouth. If a baby takes the breast into his mouth in this way, they are well attached to the breast. The baby can remove breastmilk easily and that they are suckling effectively.
- When a baby suckles effectively, their mouth and tongue do not rub the skin of the breast and nipple.

Notice in picture 2, which shows a poor latch, how little breast the baby has in the mouth.

Visual images of positioning and latching can be seen on the following links:

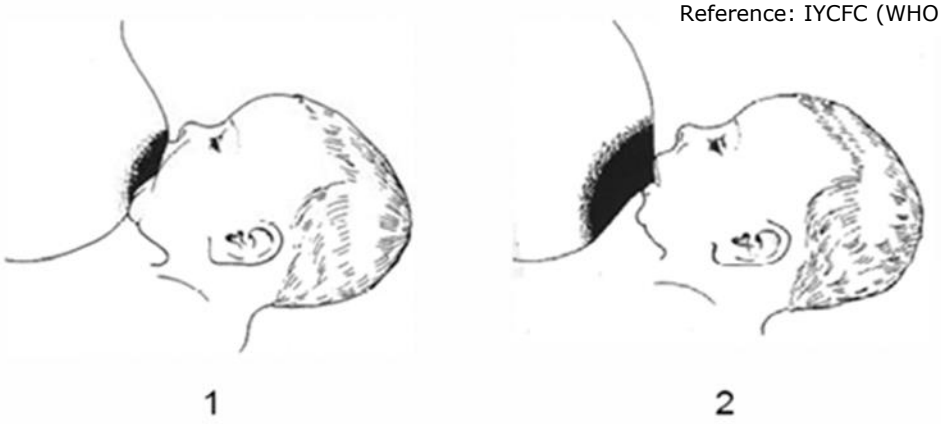
http://www.health.govt.nz/your-health/healthy-living/babies-and-toddlers/breastfeeding

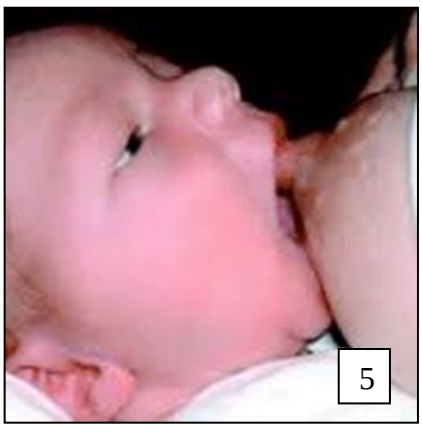
http://www.breastfeedingmadesimple.com/animatedlatch.html

GOOD & POOR ATTACHMENT TO THE BREAST

Below are six pictures of babies at the breast.
Those on the left (pictures 1, 3, 5) show babies well-attached to the breast.
Those on the right (pictures 2, 4, 6) show babies suckling in a different way.

Reference: IYCFC (WHO 2006)





In the **pictures to the left** showing a good latch (pictures 1, 3, 5) you can see:

- more of the areola above the top lip and less below his bottom lip. This shows

that the baby is reaching with his tongue under the ducts to express out the milk.
- the mouth is wide open.
- the lower lip is turned outwards.
- the baby's chin touches the breast.

These are some of the signs that you can see from the outside which tell you that a baby is well attached to the breast.

Seeing a lot of areola is not a reliable sign of *poor* attachment. Some mothers have a very large areola, and you can see a lot even if the baby is well attached. It is more reliable to compare how much areola you see above the baby's top lip and below his bottom lip.

In the **pictures to the right** showing a poor latch (pictures 2, 4, 6) you can see:
- 'nipple sucking' – baby does not appear to have a 'big mouthful' of breast. The nipple is in the baby's mouth with only a small amount of the underlying breast tissue.
- the same amount of areola above the top lip and below his bottom lip
- the angle between the top and bottom lips is 'pinched' – indicating perhaps that the baby did not have a wide open mouth when latching.
- the baby's tongue is likely to be back inside his mouth
- chin is not touching the breast
- In the top right hand picture the lower lip is not turned outwards.

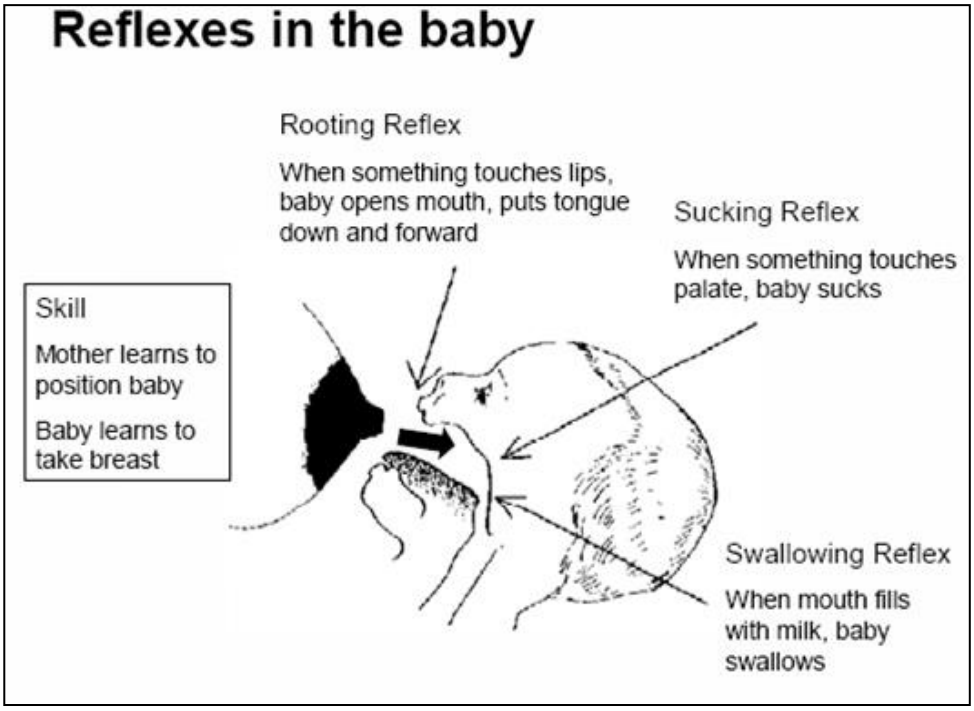
RESULTS OF POOR ATTACHMENT[1]

- Painful nipples
- Damaged nipples
- Engorgement
- Baby unsatisfied and cries a lot
- Baby feeds frequently and for a long time
- Decreased milk production
- Baby fails to gain weight

If a baby is poorly attached, and he 'nipple sucks', it is painful for his mother. Poor attachment is the most common cause of sore nipples.

- As the baby sucks to try to get milk they pull the nipple in and out. This makes the nipple skin rub against his mouth. If a baby continues to suck in this way, they can damage the nipple skin and cause cracks (also known as fissures).
- As the baby does not remove breastmilk effectively the breasts may become engorged.
- Because the baby does not get enough breastmilk, they may be unsatisfied and cry a lot. The baby may want to feed often or for a very long time at each feed.
- Eventually if breastmilk is not removed the breasts may make less milk.
- A baby may fail to gain weight and the mother may feel she is a breastfeeding failure.
- To prevent this happening all mothers need skilled help to position and attach their babies.
- Also babies should not be given feeding bottles. If a baby feeds from a bottle before breastfeeding is established, they may have difficulty suckling effectively. Even babies who start bottle feeds after a few weeks may also begin to suckle ineffectively.

BREASTFEEDING REFLEXES[1]



There are three main reflexes – the rooting reflex, the sucking reflex, and the swallowing reflex.

- When something touches a baby's lips or cheek, they open their mouth and may turn their head to find it. The baby puts its tongue down and forward. This is the 'rooting' reflex. It should normally be the breast that they are 'rooting' for.
- When something touches a baby's palate, they start to suck it. This is the sucking reflex.
- When the baby's mouth fills with milk, they swallow. This is the swallowing reflex.

All these reflexes happen automatically without the baby having to learn to do them.

Notice in the drawing that the baby is not coming straight towards the breast but coming up to it from below the nipple.
This helps baby to attach well because:

- The nipple is aiming towards the baby's palate, so it can stimulate its sucking reflex.
- The baby's lower lip is aiming well below the nipple so they can get their tongue under the ducts.

Reference:

1. *Infant & Young Child Feeding Counselling: An Integrated Course Session 3 - How Breastfeeding Works. WHO 2006*