

AIMS JOURNAL

Thinking about breastfeeding



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Editorial: Thinking about breastfeeding

By Alex Smith



Welcome to the September 2025 issue of the AIMS journal. The theme for this quarter is breastfeeding.

An important issue that emerged as we read through people's accounts, was the lack of breastfeeding support available for new mothers. This made me go and search out the only photograph I have of my first baby being breastfed. She is eight weeks old in the picture and already being 'topped up' with formula milk. By eleven weeks, I had stopped breastfeeding.

This was fifty years ago. According to the [1975 Infant feeding survey](#), only 51% of all mothers initiated breastfeeding, and just [36% of mothers under 20](#), which was me by a whisker. By six weeks only 20% of babies were still breastfeeding, so I suppose I wasn't doing too badly. But I hadn't wanted to stop breastfeeding, I simply didn't get the right support.

When I look at the picture I want to cry. "I am not even holding her properly", I wailed as I retrieved it from the album. (You try putting your head to one side and swallowing twice.) My kind son said that perhaps I was trying to get her face in the photo, and I grasped at that possibility hoping it was the case. I was 'demand feeding', which was very cutting-edge at the time, but my baby wasn't very demanding. I was worried that her slow weight gain, and the mucus that appeared in her nappies, had a serious underlying cause such as cystic fibrosis. I reasoned that if she gained more steadily with formula top-ups I would know that wasn't the case. I mentioned my concern to the health visitor who squeezed my breast and announced that I didn't have much milk, and, even though

I knew that she couldn't possibly tell that way, her words sealed my decision and that was the beginning of the short and slippery slope towards replacing my milk with formula milk.

My last ditch attempt to maintain breastfeeding was to try 'supplementing' with apple puree. I still remember her sigh of relief as she savoured the first spoonful and then wolfed down the whole bowl. But bottles, solids *and* breastfeeding was taxing and soon it just felt easier to drop the dwindling breastfeeds. Of course I still loved feeding my baby and I have a deeply happy memory of watching my mother feed her, but even after fifty years I wish I had done better by my dear little girl. I didn't even call the NCT breastfeeding counsellor, but then we didn't have a telephone in those days, and I didn't drive.

There is one funny part to our breastfeeding story though. About six months after we had stopped breastfeeding I lifted her out of her cot one morning, all warm and sleepy from a daytime nap, and as I went to sit with her on the sofa, she turned to her breastfeeding position as if to have a feed. Just as she was opening her mouth, we made eye contact and she suddenly realised what she had done. There was that moment of recognition and then she burst out laughing. Deep in her core she hadn't forgotten her early breastfeeding weeks and clearly they were a happy memory for her.

When I spoke with my daughter yesterday to ask if it was okay that I was including these memories in my editorial (it was) she reminded me that she always preferred 'food' and never did like milk. She also said that the natural ease with which she breastfed her four children was probably implanted in her as a tiny breastfed baby. That was a lovely thing to hear, thank you darling.

By the time my daughter had her happy forgetful moment, I was already expecting my second baby and I borrowed '[The Womanly Art of Breastfeeding](#)' from the NCT library. Having read that, I couldn't imagine any problem that would stop me breastfeeding the new baby and, despite inevitable challenges of one sort or another, my other four children were exclusively breastfed. Even as I write this, though, I wish more than ever that I could turn back the clock and for this to be true for my firstborn as well.



Someone once explained to me that regardless of our cognitive reasoning as to why we find ourselves formula feeding, our body 'notices' that the call on the milk supply was either never made, or ceased earlier than expected. As far as our body is concerned

there is only one possible explanation for this; something must have happened to the baby. This is why, I was told, women often feel a deep sense of grief when breastfeeding stops very early on - even when this was their decision. For some women, the events that led to early breastfeeding disruption can even result in ongoing feelings of trauma. In this issue of the journal [Nicola de Sousa](#) remembers her own experience of breastfeeding trauma and how this led her to train as a breastfeeding counsellor, and [Emma Laurinaviciene-Connor](#) looks back at her breastfeeding journey, highlighting the missed opportunities and limitations of the support she received. Midwives are usually the first people that new mothers look to for support, but in her article independent midwife [Lucy Moggridge](#) explains just how little training midwives receive in breastfeeding, and [Anne Hemsley](#), a former midwife, backs this up in her account of spending a lifetime learning about breastfeeding, but having to initiate and organise this herself.

If midwives have a gap in their knowledge, doctors have an even larger one. Normal physiology is not a big part of their training, and like the rest of us, they are unwittingly swayed by the misleading knowledge propagated by the formula milk industry. We count ourselves hugely privileged to have an article by [Gabrielle Palmer](#), the author of 'The Politics of Breastfeeding', filling us in on the factors that sabotage breastfeeding.

The issue of profits before health is still ongoing as this recent [BBC article](#) shows. Even when breastfeeding has not been sabotaged, there is money to be made by undermining women's confidence that they already have all that they need to feed their babies - that their bodies know what to do. In this issue, Birth doula and breastfeeding counsellor, [Berlin Krebs](#), warns us about the ever-growing business in birth and breastfeeding technology, and [Kathryn Kelly](#) shares a recent discussion at an AIMS workshop where she invited people to share their thoughts about technology in the perinatal period. While the vast majority of new mothers are capable of breastfeeding, there are a few exceptions. [Claire Barlow and Jenn Kenworthy](#) introduce their support group for mothers suffering with pituitary gland problems, and explain how a heavy blood loss following a birth can affect the milk supply.

On the whole though, the reason why the UK has one of the lowest breastfeeding rates in the world is because we grow up not seeing it (not even in Peppa Pig's family) and therefore we do not absorb this knowledge naturally. Suzanne and Joelle Colson have dedicated their careers to studying what natural human breastfeeding probably looks like before being overlaid by cultural impositions. We include two articles by Joelle and Suzanne Colson, one about [Biological Nurturing](#), and one proposing that newborn babies are able to [feed while asleep](#) and that breastfeeding might be easier and more successful if they did. Following the Colsons, we flag up the effect that [IV fluids](#) given to

the mother in labour may have on her baby's initial weight loss, and rounding up the themed section of the journal on a lighter note, AIMS volunteer [Catherine Hart](#) interviews Kate Evans the author of the very popular book, 'The Food of Love'.

We are really happy with the variety of opinion and perspective shared between the articles in this issue. **If any of these stir strong feelings for you, the editor will be pleased to receive letters for publication in December at: alex.smith@aims.org.uk**



Also in our non-themed section, [Nicole Schlögel](#) continues to reflect on how the 'mechanics of birth' she learned by heart as a student midwife, is at complete odds with the organic dynamics of physiological birth. [Scott Mair](#) puts the case for fathers as central, active parents with their own needs, strengths, and challenges, and [Jenny Cunningham](#) and [Dr Jude Field](#) share the results of their project aimed at establishing future priorities for midwifery research. In this issue we pay our last respects to [Jean Robinson](#) and [Margaret Jowitt](#), both old friends of AIMS, and next time we will be remembering the inspirational [Michel Odent](#) who passed away in August. Last, but never least, the [AIMS Campaigns team](#) updates us on their activities since June. We are very grateful to all the volunteers who help in the production of our Journal: our authors, peer reviewers, proofreaders, website uploaders and, of course, our readers and supporters. This edition especially benefited from the help of Anne Glover, Jo Williams, Katherine Revell, Salli Ward and Josey Smith.

In the December issue of the journal, AIMS is pleased to be drawing on the excellent work of the research project known as [Mum-PreDiCT](#). We hope that this issue will share useful information about how the NHS can support women with multiple health conditions as they seek to navigate their way through pregnancy, birth and the postnatal period. If you have a personal experience of this and would like to share it, please contact me at: alex.smith@aims.org.uk

Beguiling Baby Tech, Bewildering Bodies: Technological Creep Into Sacred Space

By Berlin Krebs



Author Bio: Berlin is a birth doula, breastfeeding counsellor, yoga teacher, culinary school drop-out, writer and mother of one. She lives near Baltimore with her family.

I went into labour a little after midnight on June 7th. By late morning, my contractions were strong and quite close together, so I called my midwife. She instructed me to download an app to track my contractions. That tracking data would then be sent to her iPhone automatically via the app. Once I started swiping and tapping on the bright screen, I was gone from my body (*search app store, learn that app is not sending data because I did something in the wrong mode, redo, rate intensity with a colored smiley face, attempt to drop back into the felt sense*). After a while, she asked me to hop on a video call (*find charger, set up laptop, search for meeting link, text her to resend meeting link, talk to floating head on screen*). She wondered aloud why, if contractions were as strong and as close together as I claimed they were, I was able to talk during them. I didn't have an answer for her. *Maybe I'm tracking them wrong?* I wondered, doubt setting in as the app flashed messages at me that said *time to go to the hospital! Baby is coming!* My daughter wasn't born until late in the afternoon on June 9th.

We spend so much of pregnancy and postpartum *counting*, wondering about enoughness. Fundal height, due dates, glucose measurements, weights, percentiles, blood panels, heart rates, centimeters dilated, length of contractions, length between contractions, blood pressure readings, pain scales. Then: how big is the baby when they're born, and how about now, and how about now? How long did they sleep for, and how long was their first wake window? Wait, how much do I weigh now? What week are we on and what does Google say they are supposed to be doing this week, and are they doing that thing? It continues into breastfeeding: we want to know exactly how much milk

we're making, exactly how much baby *needs*— and we really can't know this (remember, the amount of milk you are able to pump is not indicative of how much milk you are making, or how much your baby can remove!) Us Westerners like data. We like information. We find comfort in what the evidence says, we take solace in the numbers. But the process of growing, birthing and feeding a baby is subsumed in mystery, and though we try our darnedest with ultrasound, fetal monitoring, robot bassinets, smart socks and bluetooth milk trackers, there is no eradicating it. The whole thing requires a certain degree of surrender. Dr. Sarah Buckley said it best when she wrote, "We diminish our own authority in birthing and in mothering—we disempower ourselves—when we put more faith in information from the outside (tests, scans, others' opinions) than our internal knowing of our bodies and of our babies."

That early app-tracking had a subtle but significant effect on my labour. The 'information' it provided was just enough to seed distrust, just enough to sprinkle the fairy dust of confusion and disembodiment over us.

It was the first of many instances in parenthood which would highlight the near-impossibility of trying to integrate cold, unfeeling technology into these warm, iridescent moments meant for presence and connection; how the "intelligence" of technology dulls our requisite relational sensitivity and hardens that which requires such softness. When parents are habitually conditioned to idolize the apps, stats and machines over all else within the sacred events of birth, breastfeeding and mothering, it can be hard to stop. There's an app for everything, and baby tech is marketed to new parents as a must-have, promising safety and peace of mind. Nowadays, a Snoo is regarded as a postpartum essential. It'll not only put your baby to sleep for you, but "tend" to them in the night when they wake— and fascinatingly, [insurance might be covering it soon](#), despite the risks of torticollis and plagiocephaly,¹ which occupational therapists and IBCLCs (International Board Certified Lactation Consultants) are beginning to report more and more frequently in babies who are strapped down and whose movement is restricted during sleep. Carrying and tending to our babies all day is seen as inconvenient. We worry it's spoiling them and creating bad habits – enter the Babocush, meant to mimic the irreplaceable safety and comfort of mom's chest, so she may be free to go about her day, unfettered! No need to learn your baby's tired cues when Huckleberry's SweetSpot will tell you exactly when they should be put to sleep! Worried about SIDS? Track your baby's vital signs and sleep trends by slipping them into an Owlet Sock!

All of these products are problematic, but there are a couple new breastfeeding gadgets poised to hit the market soon that have me especially concerned. One is a yet-to-be-named “[soft, wearable device](#),” developed by researchers at Northwestern University, which is said to measure milk volume via bioimpedance. The results are available immediately via your tablet or smartphone. The other is called Coro. Essentially a nipple shield, Coro is another wearable bluetooth device that supposedly will tell us how much milk we are producing and how much milk a baby consumes, then send that data to a handy app on our phones. Somehow, for years and years, women have been breastfeeding without fancy gadgets and smartphone apps, but these companies convince us we need more than just our soft, animal bodies. The allure is hard to pass up. These devices promise to make new motherhood not just easier, but *clearer*, more *precise*, more *accurate*, more *certain*. And that accuracy equates to responsibility, which we equate to “Good Mother Status.”

Unfortunately, and ever-so-inconveniently, there is no “right number” of ounces that every breastfed baby should consume.

On the Coro device, lactation consultant and former NICU dietician Sanja Nel [writes](#):

“Knowing how many milliliters of breast milk your baby consumed is not actually particularly useful. How do I know this? From years of working in NICU, where most babies can’t breastfeed, but get expressed breast milk. As the dietitian, it was my job to calculate how much milk the babies needed – and that figure could be anywhere from 150 to 220 ml per kg, a huge range. How did we know what was the right amount? We took an educated guess, based on baby’s health profile, and then monitored weight gain to know whether we needed to increase or decrease the feeding volume. So we judged adequate milk intake not on milliliters consumed, but on weight gain over time. Which is exactly what you do if you’re breastfeeding “the old fashioned way.”

This is why lactation professionals ask questions like: how many diapers is baby wetting? Do they seem content after a feed? What are their hands doing, are they squeezed tight into fists or are they open and relaxed? Do your breasts feel softer after you nurse? While milk intake can be measured by weighing baby pre- and post-feed with lactation scales (which cost, for a very accurate one, around \$2,000) that number still doesn’t erase the fact that every baby is different, every day is different, every week is different, your baby is growing rapidly and their needs are changing rapidly, and your milk composition and quantity are impacted by those factors. Breastmilk is *alive*, and changing all the time.

There are a few issues with these breastfeeding devices. One is that babies do not eat exactly the same amount every time they nurse. Sometimes they nurse because they are hungry, sometimes they nurse because they are thirsty, sometimes they nurse because they are seeking comfort. There is no specific number of milliliters or ounces that we are trying to hit every time we nurse our baby. The breasts produce milk constantly, even when the baby is drinking. Developers at Northwestern [describe testing their device](#) by having mothers wear the sensors while pumping to know “precisely the amount of milk mothers expressed.” We know that the amount we pump does not always correspond to how much milk a baby can remove at the breast; that actually, mothers often pump less than their babies are able to remove because our bodies don’t respond as enthusiastically to the pump as to our babies. There are also other fluids moving around in the breasts (blood, lymphatic fluid, Montgomery gland secretions) not just breastmilk, so I am curious how these devices distinguish milk from other fluids? To me, these products feel disrespectful to the perfect intelligence of breastmilk, in the sense that it says that an ounce is just an ounce is just an ounce. In other words, they don’t account for the variances in fat, hormonal, nutritional, immunological (and so on) content of breastmilk. They just say that milk is food, and here is how much your baby ate today. All of these devices – the Snoo, the Huckleberry app, Coro – weasel their way into, and between, the mother-baby dyad. They chip away at a new mother’s maybe already fragile trust in herself and prey on her anxiety for profit. They encourage mom to farm out her intuition and pay more attention to an app than to her baby (like me, with my not-so-textbook contraction patterns). I imagine this misdirection of attention could also make reading and intuiting newborn cues more difficult, which is a big part of the bonding process. We don’t know the neurological or developmental implications of a baby sucking on a bluetooth device. And not insignificantly: another thing to wash, charge, learn, troubleshoot and remember during the marathon that is postpartum? No thanks.

When introducing anything that promises to provide you with information, whether it be a cervical check in labour, an ultrasound during pregnancy, an electrode that tracks your baby’s sleep trends and vital signs, or a smart nipple shield, we must ask ourselves: *what do I plan to do with this information?* Often, there is actually nothing to *do*, no action to be taken, just numbers to obsess over.

I understand the appeal. A lot of this stuff seems innocent enough— practical, even!— but I see a problem blossoming here. Opportunities to lure us deeper into our devices, coax us out of our own brains, and dismiss the quiet importance of heart-centeredness in birth and mothering abound. There is a pernicious insistence that we outsource our instincts to others before checking in with ourselves, that we rely on apps to tell us how

to feed solids, sleep train, breastfeed, track labour contractions, and then, to obsess over our bodies and babies when they land outside the algorithm's recommended range, but within the very wide range of normal— and now we can look forward to having a smart little piece of silicone available to track our milk production and comfort us with probably-lacking data.

Of course we gravitate towards the ease, validity, mastery and logic that shiny new baby tech promises us— but when it comes to pregnancy, birth and parenting, perhaps we are becoming a little too data-driven. We revere the black-and-white nature of numbers and downplay the luminosity of our intrinsic mothering capabilities.

Data provides us with good info, but it doesn't tell us the whole story. Data is information stripped of its humanness. All of these devices are touted as things that will support breastfeeding, that will bring peace of mind to new mothers, that will protect and encourage nursing and help new moms last longer in their breastfeeding journeys. But how many moms using these devices will stop breastfeeding early, when actually, everything is fine— because they provided them with only one piece of the whole lactation picture? How many women will actually *feel comforted* by the numbers they see on their phones enough to continue breastfeeding *longer* than they might have *without* this gadget, and how many women will use the numbers as a reason to quit? Does the Owlet actually bring peace of mind, or does it increase the likelihood of postpartum anxiety? What are the consequences of letting an 8-week old sleep through the night in the Snoo? How many ways can we data-fy birth, pregnancy and parenthood? How many ways can we get women to second-guess themselves? How many ways can we dampen the feminine flame of intuition?

We are really good at overcomplicating things. I worry that in all of our earnest, borderline obsessive efforts to be good parents, we wind up making things harder, more exhausting, more confusing for ourselves; that our insatiable *need to know* just leads us further and further into the deep dark woods of disconnection. The practical guidance of our instincts should hold the same weight, if not more, as the linear, unfeeling sharpness of the numbers.

The best way to measure that your baby is getting enough milk is that they are swallowing when drinking, producing plenty of wet and dirty diapers, gaining weight, and seem happy and healthy in other respects. That's pretty much it. Pay attention. Keep your baby close. Trust. And if something *is* wrong? If baby *isn't* getting enough? There will be signs. Trust yourself to recognize them, and get help from a human, not an algorithm.

Intellectualizing our way through pregnancy, muscling our way through birth and tracking our way through parenthood seems to be our preference as Westerners. But the external seeking of tests, scans, apps and plans will only get us so far. The more difficult, limbic work of this season of life is surrender. When we reach the edge of predictability and

understanding— and we always will— an invitation to drop inward lies on the other side. Becoming a mom is a wild ride. We're not going to know everything. We can't! Leave some space and some quiet to allow those maternal spidey-senses to prick up, though, and we might find ourselves surprised at how much we *do know*.

We don't need smart bassinets, or bluetooth on our breasts.

We need to let go.

¹ Editor's note: Torticollis in babies, also known as "wry neck," is a condition where the neck muscles are tight, causing the head to tilt to one side and the chin to turn to the other. Plagiocephaly is a disorder that affects the skull, making the back or side of a baby's head appear flattened.

Feeding your baby? Don't let them lie to you.

by *Gabrielle Palmer*



Gabrielle Palmer, wrote her inspirational and eye-opening book, 'The Politics of Breastfeeding', in 1988 (3rd edition 2009). I bought it immediately and, even to this day, if I forget why I still care about how babies are fed, I open her book and instantly remember. It changed the way I viewed the world and when that happens, there is no going back. The importance and continued relevance of 'The Politics of Breastfeeding' means that it has never been out of print in 37 years. It has since been accompanied by its 'mini-version', 'Why the Politics of Breastfeeding Matter' (2018), and by what some people consider to be her best book, 'Complementary Feeding: Nutrition, Culture and Politics' (2011). When Gabrielle agreed to write for AIMS I knew in my bones that her words will be a rallying call to the next generation of breastfeeding activists. Thank you Gabrielle.

Author Bio: Gabrielle Palmer was once a breastfeeding counsellor. Reading 'The Baby Killer' in 1974 catapulted her into campaigning. In 1979 she set up Baby Milk Action. When working in Mozambique colleagues urged her to apply for the MSc in Human Nutrition at the London School of Hygiene & Tropical Medicine. To her amazement she got a place (1985/86) and this changed her life. Childbirth guru, Sheila Kitzinger, asked her to write her book, 'The Politics of Breastfeeding'. She was never out of work or worry thereafter. She has two children and three grandchildren. She claims to be retired.

“ We live in a society in which there is too much information, but very little knowledge and even less wisdom.”

(Elif Shafak)

In this article I want to address issues that sabotage breastfeeding, globally and in the UK, and why that matters.

Culture and belief is powerful

If we grow up being told that something is very hard and many people cannot do it, that becomes the case. Conversely, if we grow up seeing that thing happening all around us we absorb that ability and think nothing of it.

My school singing teacher was strict, humiliating anyone who got a note wrong. My sister was told to sit at the side and keep quiet because she 'didn't have a voice'. She didn't sing again for over 50 years. Then the warm-hearted Gareth Malone appeared on TV persuading us that we could all sing. He transformed the nation and choirs popped up everywhere. My sister joined a choir in her 60s and loved it. I also thought I couldn't sing. In Mozambique where I lived in the early 1980s, everyone sang. Work meetings were punctuated with a song; the President sang, often out of tune, during his speeches; work celebrations involved songs composed for the occasion ... "*We're going to conquer diarrhoea*" ... being a most relevant one, harmonised beautifully by health workers. One day while teaching, I found myself singing solo to start the class. I had forgotten my fear. My students were brilliant, harmonising spontaneously and I knew that no one would be thinking, 'she's got an awful voice', 'did you hear that flat note'.

So too with breastfeeding. In the 1980s, Mozambique suffered conflict, a collapsed economy and food shortages. As volunteers, my family and I (children 9 and 11) lived on meagre rations, but we were all healthy. During those years I never came across 'failure to breastfeed'. Life was tough. All women worked hard, as farmers, factory workers, economists, teachers, soldiers, policewomen etc. Women did the bulk of the water carrying. Many carried a 30 litre container of water on their heads for over a mile. That's 30 kilos! Here we pay a gym subscription to become that strong.

Most of those women were lactating. All my knowledge and training as a mother and as a nutritionist pales beside my breastfeeding education in Mozambique. When teaching, I noticed women unconsciously pressing their arm against their breast with a circular movement. I realised they were suppressing a let down reflex - maybe they'd been thinking of their child - but they did it obliviously just like I might scratch my head. The special tip I'd solemnly learned in breastfeeding counselling training was common knowledge here, passed from woman to woman. I never met anyone who doubted she could breastfeed. That's why some years later when I told my Mozambican friends that I was writing a book about breastfeeding, they burst out laughing.

The UK is a society where most women get in a tizz about breastfeeding, unless they happen to come from a breastfeeding culture and also manage to evade the sabotage of ill-informed health workers and marketing. Scottish data reveals that at the 6 to 8

week review 90% of babies of Black, Caribbean or African ethnicity were breastfeeding compared with 39% of white Scottish babies ([ScotPHO 2025](#)). This intrigues me. Could more of these women be persuaded to become breastfeeding supporters?

Most of us unconsciously submit to the social norms of our age . We also ‘govern’ each other.¹ Women struggling to play football were once met with scorn, ignorance and dismissal, *by other women* as much as by men. They were actually banned from playing in FA grounds until the 1970s. Just as it was with football, it is hard to breastfeed in a social, cultural and economic climate that still views breastfeeding as difficult and weird. One of the most effective ways of supporting breastfeeding and breastfeeding continuation is to provide the mother with a ‘breastfeeding community’. Inviting pregnant mothers to breastfeeding groups so that they absorb breastfeeding as being ‘the normal thing’ and not weird at all, and providing early peer support after the birth is known to be very helpful.²

Writing for AIMS I don’t have to explain the importance of birthing practices and their impact on breastfeeding. While skin to skin contact immediately after birth is now an accepted and approved practice, it is often brief and tokenistic - not yet an intrinsic part of our culture. Extended skin to skin contact improves breastfeeding success³ and may also increase breastfeeding uptake. I know personally an ambitious academic who had her first baby at 42. She planned to breastfeed for just four weeks and to return to work early before maternity leave ended. She knew the midwives because she designed research protocols with them. After the birth she had eight hours’ skin contact with her baby. She breastfed for two years, extending her maternity leave to eight months and returning part-time, which meant using up some savings. Against even her own predictions, she was a happy and devoted mother who enjoyed her baby. And she still soared the academic ranks without a problem. I’m convinced it was the skin contact.

The well-meaning and unintentional saboteurs

I once attended an on-line global conference on breastfeeding run by The World Health Organization (WHO). The lead speaker introduced the subject with the following words: “I always knew I would breastfeed, my mother was Hispanic and she breastfed me, but my mother never told me how difficult it was.” Thus in a forum intended to promote breastfeeding she made the whole world believe that breastfeeding was difficult, deterring thousands of women and confirming the assumptions of many participating doctors. How could a professional physician be so unaware of their words?

Sincere people inadvertently destroy confidence every time they speak or write. A common mantra is: “Do breastfeed if you can, but don’t feel guilty if you can’t.” It drives

me crazy. Whatever their own experience, would any competent teacher emphasise difficulty or suggest failure when introducing their subject? Confidence is the first principle for learning and a teacher's first step is to make their pupil believe they can do it. Do we say to our children on starting school, "Don't feel guilty if you can't learn to read"?

Women who wanted to breastfeed and 'failed' can feel upset, hurt or extremely angry. They may believe their bodies let them down. There are, of course, situations when breastfeeding is not possible: a double mastectomy, active breast cancer or [Sheehan's syndrome](#) where the pituitary gland is damaged. Inevitably though, women stop breastfeeding sooner than they had hoped because they didn't get the care, information and support they needed. Health professionals may not be fully trained in breastfeeding and may project their own baggage of unresolved problems. They truly believe that the kindest thing is to help the woman change to artificial feeding. If that woman's family thinks so too, then it's almost impossible for her to resist. We live in a fog of well-meaning ignorance, or worse, cognitive dissonance.

In the 1990s a doctor attending the Breastfeeding Practice and Policy Course at the Institute of Child Health (ICH), London, declared, "When I arrived I thought I knew 90% about breastfeeding, now I realise I only knew 10%". He was head of his national paediatric association and very pro breastfeeding. Most of the medical attendees had never observed a breastfeed from start to finish and were unfamiliar with mother-baby interaction and behaviours. We invited mothers and babies into the classroom to teach them. Many doctors came from countries where outdated medical text books taught harmful protocols. Their power as doctors can override good, traditional knowledge.⁵ Every doctor I've ever worked with has told me that Medical School taught them nothing about how to help women to breastfeed. "We leave all that to the midwives" one said. In the UK many doctors' own negative experience biases their attitudes.

Mothers got the wrong advice for 40 years

For decades WHO based its child growth standards on the [US National Health Survey](#) growth charts. Most countries adopted them as their national guidelines. Since the 1920s, weight and height measurements were gathered from American children, mostly white, artificially fed and given early solids.⁶ During this time, the concepts of 'growth faltering' and 'insufficient milk syndrome' were adopted by scientists and the baby food industry. Nutritionists working to combat severe childhood malnutrition developed life-saving strategies, but they got the basics wrong. Research into 'lactation performance' abounded. I recall a study in Africa where they separated mothers and

babies, restricted feeds and then test weighed the baby to assess breastmilk supply. So unethical. It must have been torment for babies and their mothers, but then most scientists were western educated, culturally biased and misunderstood how breastfeeding worked. They saw a mother like a dairy cow who was either a good or poor milker. They saw the breast as a bladder, not a gland, stimulated by the baby.

These clever people were mostly men who did not have intimate knowledge of real breastfeeding behaviour. They pronounced that after three months mothers could not produce enough breastmilk to support adequate growth, that is, growth like that of artificially fed, overweight American babies. Mothers were instructed to add oil or sugar or both to the traditional staple food (e.g. maize porridge or rice) at three months, to compensate for the allegedly failing breastmilk supply.⁷ Everyone believed they were doing the right thing. Decades later nutritionists reinvestigated and realised that this practice not only reduced breastmilk stimulation (a baby full of high calorie pap does not have a big appetite for her mother's milk) but the 'empty calorie' sugar and oil reduced the availability of the useful nutrients in the cereal and lowered the quality of the diet. Moreover the foods were likely to carry infection to the baby at an age when the immune system is not fully developed.

Fortunately, towards the end of the 20th century, WHO embarked on the splendid Six Country Study which followed children from birth onwards in six different cultural settings. They discovered that the US growth standards were misleading; that the growth slow-down after three months was not 'growth faltering' but normal; that six months' exclusive breastfeeding was ideal and that early solids were harmful. WHO stated: *"Arguably, the current obesity epidemic would have been detectable earlier if a prescriptive international reference had been available 20 years ago"* (WHO 2004). We had been feeding our children so inappropriately that the manufacturers had to change their recipes, reducing the calorie and protein content of infant formula. Too high levels were linked to later health problems such as cardiovascular disease and diabetes. When it came to complementary food labels, the industry fought hard and dirty against WHO and UNICEF's aim to change age instructions.

Does breastfeeding matter in the UK?

Breastfeeding has a powerful effect on a nation's health. It protects babies and their mothers from a broad range of health problems.^{8,9} It affects intergenerational health. Our health is influenced by our parents' and grandparents' diet,¹⁰ and so breastfeeding is likely to benefit our children's children. Breastfeeding influences health in later life and its adoption could save the NHS substantial sums.

UK breastfeeding rates are among the lowest in the world. In affluent areas, such as the East of England, 59.3% are breastfeeding at 6 to 8 weeks and in poorer areas such as the North East 38%. When I know how hard the skilled health professionals and the breastfeeding support groups work I find this depressing. Overall rates have risen slightly and we're all supposed to be positive, but I ask why as a society are we so unambitious? Why does the UK ignore the WHO recommendation for '*exclusive breastfeeding for six months, continuing with family foods for two years and beyond*', which the UK signed up to at the World Health Assembly?¹¹

“A millionaire’s baby who is not breastfed is less healthy than an exclusively breastfed baby whose mother is in the poorest social group.”
(Prof J Stewart Forsyth 2006)

Professor J Stewart Forsyth led the research team that found that formula fed babies in cool, clean Dundee had the same rates of pneumonia and diarrhoea as formula fed babies in the poverty stricken slums of tropical Manila in the Philippines where death rates were high. The Dundee babies did not die because when they became ill, they had rapid access to good health services and were diagnosed and treated quickly. Our artificial feeding culture is dependent on an ever present, skilled and expensive back-up service. Without antibiotics, oral rehydration salts and rapid response health professionals our infant mortality rate would rise alarmingly. For years the focus was on mothers' hygiene competence, but young babies don't die just because of poor feed preparation, they die because they are deprived of the immunological protection of breastmilk.

Women's right to choose

Before I continue, let me quote childbirth guru, the late Sheila Kitzinger, who said:

“The only reason for a woman not to breastfeed is if she doesn't want to.”

I agree. Every woman has the right not to breastfeed. But she also has the right to know the risks and to get unbiased information about feeding products. When vulnerable newborns in Europe and the USA died from infection due to intrinsic pathogens in infant formula was this headline news? Are all parents informed that powdered infant formula is not sterile? Codex Alimentarius, the UN authority which sets global standards for food safety and nutritional adequacy, requested a committee of learned scientists to advise on the safety of additives in infant formula. After extensive investigation, they recommended that artificially fed babies under 12 weeks should only be fed freshly made products without additives. Codex did not build this edict into [their rulings](#). The

baby food industry is skilled at manipulating the Codex committee and governments who participate. The UK government is as much in a headlock by the food industry as any other nation.

This is a serious issue. Antibiotic resistance is increasing. Former UK Chief Medical Officer Dr Sally Davies calls it '*a catastrophic threat*'. She talks about fatal infections after minor surgery, but she does not mention the inevitable rise in baby deaths. Our NHS buckles under the pressure of an unhealthy population, in part due to our terrible diets, lack of physical activity and pollution. In the UK over 30,000 babies and children under five are hospitalised with RSV (Respiratory Syncytial Virus) annually at a cost of £91,000 to the NHS. Twenty to thirty babies die.¹² If all those babies had been breastfed, hospital admission and mortality would have been [significantly reduced](#). When breastfeeding babies get an infection it is usually far less severe and they're less likely to be hospitalised.

The baby food industry

With any big issue, first follow the money! The market for infant formula and follow on milk is worth more than \$55 billion (2022). Its marketing budget is [\\$3-5 billion a year](#). Every penny or cent of this marketing is paid for by families who use infant formula, follow on and toddler milks. We pay for companies to tell us lies.¹³ This compares with the entire operating budget of WHO. This is despite the [WHO Marketing Code](#) that bans promotion of formula milk while permitting scientific information to be disseminated for health professionals. This year, 2025, a digital marketing resolution has been added to the Code. Teams of highly paid lawyers will be advising companies like Nestle and Danone on how to evade these rules.

Industry marketing is not just advertising. The companies have for decades infiltrated the health professional bodies and influenced medical and midwifery education around the world. Vast sums are spent on sponsorship, research grants and educational forums. Described by the late Dr Derrick Jelliffe as '*manipulation by assistance, endorsement by association*', this harmful relationship between commerce and health professionals persists.

In 2000 I was employed by UNICEF. We were working with WHO on The Global Strategy for Infant and Young Child Feeding. A joint meeting was planned with a signed Memorandum of Understanding (MOU) that neither the baby food industry nor the campaign groups (such as [IBFAN](#) the International Baby Food Network) would attend. I was in the group addressing the timing of the introduction of solids. Industry was fighting to keep the advice on their labels as being at four months. To my surprise, an

International Labour Organisation representative (of employers, not employees) was in the group arguing the case for early solids (i.e. four months). A WHO employee also prevaricated, even though he knew the scientific evidence advised exclusive breastfeeding ([or formula](#)) for [six months](#). I discovered at the end of the meeting that people from the baby food industry were eavesdropping in on the whole meeting from the Director General's office. The fox had not just designed the hen coop, it was sitting in with the chickens. I now have more faith in WHO's integrity. It has employed many individuals who act honourably and care passionately about these issues. It is usually a question of underfunding and financial pressure that pushes institutions into the arms of the baby food industry. The Code exists to curb these relationships.

One successfully marketed product is 'follow-on' milk. I have to inform you that follow-on and toddler milks are entirely unnecessary. It is healthier for your child to drink fresh whole cows' milk as part of their mixed diet. Current UK DOH advice is, if you're not breastfeeding, to continue with standard infant formula until 12 months. Behind the scenes many infant feeding experts think it's [safe to give cow's milk from six months](#). Throughout the 21st century there's been a steep rise in prescriptions of expensive [specialised formula milks for infants](#) thought to be suffering from medical conditions such as colic, reflux or even Cow's Milk Allergy (CMA). Mothers often attribute common problems of babies such as crying, vomiting or rashes to CMA, and some breastfeeding mothers exclude cows' milk from their diet. A team of paediatricians assessed [the evidence](#) and found that in 99% of infants with CMA, the mother's breastmilk did not contain sufficient CM allergen to trigger a reaction. In the vast majority of babies there was no need for the mother to avoid cows' milk. As one of the authors of this research explained to me, 'The cow's milk molecule is too big, it can't get into the breastmilk.' The blood/milk barrier is amazingly clever at keeping out bad stuff and letting in good stuff such as bespoke antibodies for the infections that besiege both mother and baby in everyday life. Meanwhile, the formula manufacturers are unashamedly profiting on the anxiety of mothers who simply need reassurance and support.^{[14,15](#)}

When Nestle dressed up their [saleswomen in nurse's uniforms](#) and went to the rural clinics in Africa, the sickness and death that ensued triggered me into a life's purpose that I had not foreseen. They have since honed their marketing into the subtle strategies they use today. They have captured the power networks and too often the mindsets of the professionals. I learned that Nestle paid for 60 Indian paediatricians to fly to Switzerland for a conference on CMA. They produce a [special chart](#) to aid diagnosis. Nestle could not run such a conference in India because India's version of the WHO Code would make such training illegal. Industry is banned from training health professionals but it happens all over the world where the Code is not in law or is weakly

implemented. Globally, too many of the professional bodies for doctors, midwives and nurses still have baby food industry financial support. Even as they make good statements about breastfeeding, they absorb distorted information just as the babies absorb the artificial milk.

We must remember that for over a hundred years the combination of medical ignorance and commercial greed has destroyed easy breastfeeding and it continues to do so. Breastfeeding is a universal demonstration of women's skill and strength. Indeed, some philosophers and anthropologists have theorised that the origin of misogyny, men's demeaning of women, arises from a fundamental jealousy of their greater powers to give birth and breastfeed.



What can you do?

You're doing a lot already I'm sure, but here are a few ideas.

1. Once giving a talk in a hospital, I mentioned the lifetime costs of type 1 diabetes (breastfed children have a lower risk), unaware that the financial manager was listening. I learned later that it changed his decisions, especially as his wife had type 1 diabetes. Money talks. Look at your local economics. What is the commonest reason for admission to your local paediatric ward? It could be respiratory infection. Calculate if those babies had been breastfeeding, how many would have needed admission? Likewise with GP appointments and prescription costs (GPs rarely see breastfed babies). Get your figures checked, make alliances, don't make enemies. I would hazard a guess that the savings might equal the cost of an extra infant feeding advisor to support mothers in the community.
2. Calculate the plastic pollution from artificial feeding and inform your local environmental groups. Young environmentalists are often bowled over by the facts of breastfeeding. What we learn long before we have children has a lasting effect.
3. Share my books with people who care about the world. Friends would say, "Oh I'll buy *The Politics of Breastfeeding* for my pregnant niece", I'd reply, "No, buy it for your nephew, it's got jokes and pictures and it affects him too, it's not a 'how to' book." I'm aware younger people avoid longer books hence, 'Why the Politics of Breastfeeding Matter'. And, 'Complementary Feeding: Nutrition, Culture and Politics' is a rapid run through food issues which are rarely discussed in the media.



Additional AIMS suggestions for becoming a breastfeeding activist:

- Gain knowledge and skills by training as a breastfeeding supporter, breastfeeding counsellor or lactation consultant.
- Engage or volunteer with organisations that support and promote breastfeeding.
- Advocate for breastfeeding by supporting policies and campaigns that protect the rights of breastfeeding mothers, and by promoting breast-feeding friendly environments ([watch this short film](#)).
- Report UK Code violations to [The Baby Feeding Law Group](#).
- Remember just one fact as to why this matters. For me (the AIMS editor) it is that, globally, over [800,000 deaths](#) of children under five, each year, can be attributed to suboptimal breastfeeding practices. That is akin to one and a half 'Titanics' of babies being lost *every single day*!

Further reading:

Rachel Reed - Information and a course about birth physiology can be found on [her website](#).

Alex Smith - A lay-person's description of physiological birth can be found [here](#).

Gemma McKenzie - **Undisturbed Physiological Birth: Insights from Women Who Freebirth in the United Kingdom.**

Gemma McKenzie - **Quest Narratives and Heroine Journeys: the road to freebirth and the joy of undisturbed physiological birth.**

Hutton EK, Reitsma A, Simioni J, Brunton G, Kaufman K. Perinatal or neonatal mortality among women who intend at the onset of labour to give birth at home compared to women of low obstetrical risk who intend to give birth in hospital: A systematic review and meta-analyses. *EClinicalMedicine*. 2019 Jul **25**;14:59-70. <https://pmc.ncbi.nlm.nih.gov/articles/PMC6833447/>

^[1] Sara Wickham (2020) A Tribute to Tricia's Lab Cats www.sarawickham.com/fun-stuff/a-tribute-to-tricias-lab-cats

^[2] Image source: www.rawpixel.com/image/12706629/png-teacup-porcelain-saucer-coffee-generated-image-rawpixel

^[3] I attended a meeting recently where the Chair, an obstetrician who had herself had a baby at home, told us that obstetricians have hardly any training in physiological birth and probably only ever see one (if ever) by accident. Their training is almost solely in pathology.

^[4] Henshall B.I., Grimes H.A., Davis J., East C.E. (2024) What is 'physiological birth'? A scoping review of the perspectives of women and care providers, *Midwifery*, Volume 132, 103964, ISSN 266-6138. <https://doi.org/10.1016/j.midw.2024.103964>.

^[5] Downe S., Kingdon C. (2025) Caesareans are rising fast in the UK – but giving birth is getting worse for women. *The Conversation*. <https://theconversation.com/caesareans-are-rising-fast-in-the-uk-but-giving-birth-is-getting-worse-for-women-246211>

- ^[61] Tew M (1998) Safer Childbirth? a critical history of maternity care. (2nd Edition). London. Free Association Books Ltd.
- ^[71] NPEU (No date) Birthplace in England Research Programme www.npeu.ox.ac.uk/birthplace
- ^[81] Wickham S. (2025) Is home birth safe? www.sarawickham.com/research-updates/is_home_birth_safe
- ^[91] The Farm Midwifery Center (2010) Preliminary Report of 2,844 Pregnancies: 1970-2010 <https://thefarmmidwives.org/preliminary-statistics>. All the transfers were completed safely.
- ^[101] Ed. Nancy Caldwell Sorel (1984) Extract from the journal of Mary Walker (1800s) In: Covered Wagon Confinements. Ever Since Eve: Personal reflections on childbirth. New York. Oxford University Press.
- ^[111] This communication, and the following one, were shared with me during an antenatal class about 30 years ago. I asked the group of about 12 people what they knew (if anything) about their own births. Half of the group had been born at home and half in hospital. The difference between the accounts was striking. All of the hospital birth stories were about procedures and shift changes, whereas all of the home births involved food.
- ^[121] Tuva Falch Skrondal, Trine Bache-Gabrielsen, Ingvild Aune (2020) All that I need exists within me: A qualitative study of nulliparous Norwegian women's experiences with planned home birth. **Midwifery Volume 86**, July, 102705
- ^[131] Author's note: The obstetrician mentioned in footnote 2 said that she too had not told many friends and colleagues about her home birth plans because she did not want to be exposed to their fear - a fear arising from simply not knowing about physiological birth.
- ^[141] Reed R. (2025) Understanding and Assessing Labour Progress www.rachelreed.website/blog/understanding-labour-progress
- ^[151] Reed R. (2025) Vaginal Examinations: stuck on the cervix www.rachelreed.website/blog/vaginal-examinations-in-labour
- ^[161] Goldkuhl L., Dellenborg L., Berg M., Wijk H., Nilsson C. (2022) The influence and meaning of the birth environment for nulliparous women at a hospital-based labour ward in Sweden: An ethnographic study, Women and Birth, Volume 35, Issue 4, Pages e337-e347, ISSN 871-5192, <https://doi.org/10.1016/j.wombi.2021.07.005>
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- ^[211] Biley F.C. (2010) The 'Sickening' Search for Health: Ivan Illich's revised thoughts on the medicalization of life and medical iatrogenesis. <https://citeseerx.ist.psu.edu/document?repid=rep1&type=pdf&doi=5ae20b369fc95ac4a343a6da7560905ceb2593a2>
- ^[221] Olza I, Leahy-Warren P, Benyamini Y, et al (2018) Women's psychological experiences of physiological childbirth: a meta-synthesis. BMJ Open 2018;8:e020347. doi: 10.1136/bmjopen-2017-020347 <https://bmjopen.bmj.com/content/8/10/e020347>

Breastfeeding over the decades.

by Anne Hemsley



Author Bio: Anne Hemsley is a nurse, midwife, lactation consultant, mother, wife and proud and grateful grandmother x 4.

I often say that in life I never stop learning, when it comes to the subject of breastfeeding, I have taken almost a lifetime to acquire my learning and it's still not complete.

What I saw in 1978

Allow me to take you back to the start of my learning process which began in 1978 .

In **1978**, in the North of England, I started my 12 month midwifery training. Notice that I said it was a training in midwifery and not an education in midwifery. In many aspects of my midwifery training, lifelong skills were acquired, unfortunately this was not the case in acquiring skills in supporting breastfeeding mothers.

The antenatal period – During the first booking-in visit at the antenatal clinic the pregnant women were asked “breast or bottle?” It appeared that most women replied, “bottle”.

Of those that replied breast, at some point during their first antenatal check-up they would have an examination of their breasts with attention focusing on their nipples. If their nipples were not obviously prominent, they would be advised to rub them briskly with a rough towel and occasionally I heard midwives suggest scrubbing the nipples with a nail brush to prepare them for feeding the baby.

I now know that, in this period, breastfeeding rates were around 28% in the United Kingdom, but this included babies who only went to the breast once or twice.

Labour and pain relief - During labour it was often the case that a mother would have had 2 doses of the narcotic Pethidine. The side effects of Pethidine are drowsiness in both mother and baby. There are several other factors which influenced the rather low rate of breastfeeding during the post-natal hospital stay of 7 days following a normal, vaginal birth and 10 days following a caesarean section.

At birth: no skin to skin contact - Mothers were not immediately given their newborn baby. The attending midwife took the baby to a corner of the birthing room to bathe the newborn, weigh, measure and administer Vitamin K injection along with attaching labels to the baby. The baby was then dressed and handed fully swaddled to the mother.

No rooming In - Postnatal Wards, ran efficiently, or so it seemed, by a system of care based on routine. Babies did not yet 'room in' with their mothers but were nursed in the ward nursery.

Fear of hypoglycaemia and no respect for colostrum - All babies were routinely given dextrose (sugar and water) within an hour of birth, and by day 2, were given a mix of 50% National Dried Formula milk and 50% water, those babies who were to continue to formula feed would be offered full formula milk by day 3. Breastfeeding mothers were advised to top up with formula after every breastfeed.

National Dried infant milk food – was based on unmodified cow's milk, parents were advised to add sugar to the formula. My colleagues & I each spent one full 8 hour shift per week, making up this formula for the entire postnatal unit.

3 – 4 hourly routine for bottle feeding babies influenced the timing of breastfeeds.

Restricted access to the breast.

Day 1 - Advised to offer the breast for just 3 minutes each side

Day 2 - 5 minutes each side

Day 3 - 10 minutes each side

Babies were soothed in between feeding by a member of staff in the nursery or offered dextrose feeds by bottle. The possibility of 'nipple-confusion' was never mentioned.

Any mother who had stated a desire to breastfeed would have her baby brought to her bedside when the 3- 4 hourly feeding schedule of the bottle-feeding babies was established. Some breast feeding mothers accepted that their baby had to go into the ward nursery overnight but would state their desire to be woken up when their babies woke for a feed. In many instances this request was ignored as the staff on duty thought

that mum needed her sleep, and it wasn't uncommon for the night duty staff to offer some formula to the baby. This was not the era of informed consent.

Drugs - Each evening, the ward drug round offered a menu of painkillers, sleeping tablets and bowel medication to each mother. There appeared to be a culture of trying to give the postnatal mother as much rest as possible. Babies were nursed overnight in the postnatal ward nursery. This most certainly had an impact on the breastfeeding rates.

Cultural differences

In **1984** I left the UK to take up a midwifery role in a small private hospital in the Middle East. The mothers in the hospital were a mix of European expats and local Arabic women.

From memory, many of the local Arabic women slept immediately following giving birth; they often shared their room with a female relative sleeping on the floor. This relative would care for the newborn and in some cases, colostrum was not offered.

In some instances, formula milk was accepted until day 3 of the mother's postnatal stay.

Family support - Assistance in latching the baby was given by whoever was accompanying the mother in her room. It may have been her mother, a sister or sister in law, guiding the new mother in latching the baby to her breast. Certainly, it appeared that despite not offering colostrum the babies and mothers accomplished breastfeeding with fewer issues than most of the European mothers.

My own personal experience of trying to establish breastfeeding: 1987

In **1987** I gave birth to my first child, whilst working in this small private hospital. In my situation as a first time mother, I had a strong desire to try breast feeding. My family history included a range of medical problems that I hoped to avoid by offering my baby breast milk from the start. It was a feeling born from instinct rather than research based evidence. I ensured that, during my 5 day postnatal stay, my baby never left my bedside. Fortunately, he was an eager feeder; he latched well from birth, and he requested to be fed very frequently.

Medical staff – no understanding of breastfeeding - I noticed on the early morning of day 4 that he was producing a 'changing stool' but when I pointed this out to our resident paediatrician, my excitement at my breastfeeding progress was dismissed. My colleagues were kind and caring but their demonstration of caring for me was to try to persuade me that I needed more rest and sleep than I was getting and to allow my son to be nursed overnight in the postnatal ward nursery. Despite their reassurances that they would bring him back for breastfeeding I am afraid I wasn't confident that this

would happen. It would have been perceived as an act of kindness to allow me to sleep and to offer my baby a few ounces of formula just to help me recover from numerous nights of little sleep.

Determination

I remained strong in my determination to keep him by my side and fed him whenever he was awake and alert. I fed him in bed and attempted several different breastfeeding positions in an attempt to get a comfortable latch. He drank eagerly and frequently, I soon developed sore, bleeding nipples. Having very little experience of diagnosing a tongue tie, I observed his heart shaped tongue with a tight frenulum. I showed this to the hospital paediatrician who informed me that this was inconsequential. I had no idea that this pronounced tongue tie was contributing to my extremely painful nipples. I continued feeding my baby and gritted my teeth for each feed. Fortunately, he was gaining weight and was very alert and both my husband and I were besotted.

On day 5 we were discharged and returned to our home over the road from the hospital. It was July in the desert, temperatures hovered around 40°C. My husband has always been an amazing support in my breast feeding journeys. With no postnatal aftercare, he provided nourishing meals and drinks in order for me to focus on feeding our baby. By day 13, I was still struggling with bleeding and very painful nipples, and becoming increasingly puzzled as to why our baby rarely slept for more than 90 minutes during the day and if we were lucky one or two episodes of 3 hours within the 24 hour cycle. He was cute, alert, gaining weight and very demanding.

Influence of friends and finding the right support

My only visitors were colleagues who wanted to help by suggesting dummies or supplementing with formula milk. One weekend, I was feeling extremely tired and frustrated about the intense frequency of our baby requesting to be fed. I walked in the dry, desert heat to the house of a colleague who had given birth 6 weeks earlier. This good friend had breastfed for 6 weeks and then elected to formula feed. I trusted her advice and asked her if I could borrow some formula milk to give to my baby. I needed a break from the intensity of frequent breastfeeding and the cracked nipples. My amazing friend pointed out that I had a thriving baby, he was healthy and gaining weight. She said that she had regretted her decision to stop breast feeding. In place of formula, she gave me encouragement, support and the will to keep going. It had never occurred to me that our baby was demonstrating normal newborn behaviour.

Understanding normal baby behaviour.

My expectations as a new parent were for him to feed, sleep in between feeds for around 3 – 4 hours and for him to be able to go down in his crib. I had a vision that by 6 weeks of age he would be sleeping through the night! All my assumptions were based

on observing formula fed babies in a regimented hospital setting or from years of helping family members who all bottle-fed their babies with formula.

As I persevered with breastfeeding, somehow my nipples healed, and my son and I adapted to life together. He continued to feed frequently and rarely slept for more than 3 hours, but he was growing and developing in a normal pattern. At this time, all growth charts followed the patterns of feeding babies with formula milk. We never did get the tongue tie snipped, fortunately he does not have any speech problems but as an adult he still demonstrates his heart shaped tongue when I request it!

It was this turning point in my own breastfeeding journey that led me to have an increased interest in breastfeeding rates and to try to increase my knowledge of assisting new mothers in their desire to breast feed.

In **1989** we relocated to the UK and I gave birth to my second son eighteen months later. I am pleased to report we had very few feeding issues and he did not have tongue tie.

In **1995**, when I returned to work as a midwife several years after becoming a parent, I requested to be allocated to the postnatal ward. I used my personal experience of breast feeding as a guide to support the women in my care.

Changes in hospital practice

The practice of rooming-in had been established in my absence from the UK and from midwifery. Formula supplements were no longer routine. Study days were not sponsored by formula feeding companies. In fact, we no longer displayed a feeding trolley on the postnatal ward with free samples of 3 different types of formula.

In **1999** I became a member of La Leche League GB and was interested in training to be a birth educator when we were posted to Belgium with my husband's company. At this time, I continued improving my own knowledge of breastfeeding through any medium I could. I continued my subscription to the La Leche League and travelled to the UK to attend breastfeeding study days in various universities whenever possible. I became known in our expat circle as a woman who might be able to support breastfeeding women. On a personal level, I was aware that although my empathetic and patient approach to supporting women was to some degree useful, I lacked any formal training and, on several occasions, despite my best efforts there were instances of mum and baby not enjoying their breastfeeding experience. I had a desire to be able to offer the best support with up to date knowledge.

In **2011** I reluctantly left our life in Brussels and accompanied my husband to live in Beijing.

I had no knowledge of Chinese culture and was part of a very small expat culture associated with my husband's employment.

La Leche League International

I attended the monthly meeting that was held in an International Hospital. I met an enthusiastic American lady who led the group. As I travelled back to my high-rise sophisticated apartment, I reflected on the need for breastfeeding support and how touched I was by listening to the stories of the mothers who had attended the La Leche meeting. A common theme ran through their stories of seeking breastfeeding knowledge. They were isolated; even more so as expats. They wanted to gain an understanding of their babies' behaviour patterns. In reality they had based a lot of their assumptions about how babies behaved on knowledge gained from other family members, or from reading baby books that often described strict routines in parenting.

At this time, I was not aware of the 2008 formula milk scandal. As my own thoughts led to establishing a weekly breastfeeding support group, I approached the UK National Childbirth Trust (NCT) to discuss establishing a Baby Café in Beijing. The NCT had successfully merged with Baby Café in the UK in 2010. The idea was to provide breastfeeding information in a relaxed environment where mothers could learn about breastfeeding from both qualified practitioners and from each other. Within a very short time, I had attracted up to eighteen mums and babies to my weekly support group which I held in my Beijing apartment.

From this starting point, I met expat women from all over the globe. Their determination to breastfeed was enhanced by the fear of the previously referenced 2008 formula milk scandal, whereby a major formula company was found to have adulterated milk formula with the chemical melamine. As a result, 300,000 children were affected with kidney damage. 54,000 babies were hospitalised and very sadly 6 babies died.

Week after week my breastfeeding group gained popularity. Whilst I was happily engaged in trying to offer support, I was acutely aware that I wanted to ensure my own knowledge of breastfeeding and milk production was solid. I explored the possibility of training to become an International Board Certified Lactation Consultant (IBCLC).

My mainly expat group of women gradually became a wider group of women which included a percentage of Chinese mothers. My understanding of Chinese culture at this time was that the unofficial class system in China resulted in varying levels of breastfeeding and child raising. The Chinese women appearing in my weekly support group had experienced university education and owned a small property. They would invariably have their mother-in-law living with them. In addition, they would follow the Zuo Yue Zi or 'sitting the month' a Chinese tradition to rest and recover from birth. It was common to hire a Yue Sao, or a night nanny. This woman was traditionally hired to support the postpartum mum in recovery from birth, ensuring her adequate rest. She often prepared traditional nourishing meals and cared for the baby in between breastfeeds. I had the privilege as a Westerner of being invited into several Chinese

homes in Beijing and witnessed the 'Yue Sao' in her postnatal carer role. In several instances, she slept with the new mother and massaged the mother's breasts to encourage milk production but also to alleviate early-days engorgement and discomfort. The downside of this was that the baby was held a lot more by the 'Yue Sao' than by the new mother. I noticed regulated and timed breast feeding, which gave me clues as to the mother's reason for inviting me into the home in the first place; to resolve breastfeeding complications.

A contrasting situation

In contrast, I would often engage the server in our local restaurant in conversation to ask after her family. These women would be in the category of poor Chinese. They may have returned to the countryside to give birth to their baby. Within less than a week following the birth, they will have returned to the city and returned to full time work. They had no opportunity to breastfeed. Their baby would be raised primarily by the grandmother. and a wet nurse may have provided some breast milk. Formula milk was not only expensive, but the fear of tainted milk powder following the 2008 milk scandal persisted amongst Chinese families. The disparity between the different classes and income of the women whom I encountered was huge.

As a mother myself I couldn't imagine the pain of leaving such a young baby in the care of anyone. The economic inequality between the women was huge. Both groups of women were hardworking, but the educated women had a career, a home and could afford childcare, while the uneducated woman lived an isolated life, working very long hours and in many cases only returning to the countryside home once every year or two.

In **2013**, after 2 short years in China, we were relocated to Paris. Once again, without a job and having plenty of time on my hands, I established a breastfeeding support group. We met in branches of the cafe Pret a Manger that were scattered around central Paris. In many cases, the French postnatal care in 2013 mirrored the 1970s approach to infant feeding in the UK. Encouraging mothers to get some rest, babies were often cared for overnight in a postnatal ward nursery.

In **2014** we returned to live in the UK. It took me a while to feel established in my local community. With the support of one empathetic mother of five, I established my own breastfeeding support group, holding meetings in various church halls in our market town.

In a short time, the drop-in breast feeding group attracted up to twelve mums and babies each week. I chose to run the group on Monday mornings as many parents are isolated over the weekend when breastfeeding support is generally not accessible. Monday became a popular day to seek support from me and to gain mum-to-mum support, make friends and enjoy time out of the house.

In **2018** I qualified as an IBCLC and finally felt that my informal breast feeding support group was offering research based, up to date breastfeeding support. Each mother and baby relationship is unique and I enjoy my role as a breast feeding supporter. My own knowledge and experience has taken me a lifetime to acquire and I am still learning. My journey started in 1978, led me to several different countries and I never stopped learning.

In **2025** my weekly drop-in breastfeeding support group attracts an ever-changing cohort of mums and babies. I want it to be a haven in which to share the highs and lows of breast feeding and to gain confidence in one's own unique breast feeding journey as a parent.

Positive changes observed over several decades, include:

- babies being put to the breast within the first hour following birth
- mother and baby being kept together whenever possible
- feeding without restricted regimes/baby-led feeding
- formula milk no longer visible or promoted within the hospital/clinic setting
- IBCLCs often employed within a hospital/community setting
- hospital and children's centres acquiring BFI status
- breast feeding peer supporters offering their time within the postnatal hospital stay and in the community.

¹ <https://laleche.org.uk/rolling-back-years-seventies/>

² Yanzhong Huang (2014) The 2008 Milk Scandal Revisited. Council on Foreign Relations
<https://www.cfr.org/blog/2008-milk-scandal-revisited>

³ Start Your IBCLC Journey: <https://ibclc-commission.org/how-to-become-an-ibclc/>

Biological Nurturing: Closing the gaps in midwifery to support breastfeeding *by Joelle Colson and Suzanne Colson*



Author Bio: Suzanne Colson PhD, MSc is a retired midwife and the creator of Biological Nurturing – laid-back breastfeeding.

Joelle Colson BSc, BA is a public health nurse and the director of The Nurturing Project, created to disseminate biological nurturing research. For more information see www.biologicalnurturing.com

Biological nurturing (BN), a neurodevelopmental approach to breastfeeding, was created in 1995. Radically different from the mainstream approach, mothers practising BN lean back instead of sitting upright or lying on their sides. During the day, sleeping babies lie cheek to breast on top of their mothers' bodies in continuous ventral contact. Gravity pins the baby's body to the mother's. This means mothers have both hands free; they become active agents. When the baby moves, mothers place them spontaneously mouth to nipple, helping their babies find the breast and latch. When these prerequisites are met, mothers are as competent as their babies.

In 1998, BN was first evaluated with vulnerable, at-risk newborn babies during metabolic research projects^{1, 2}. Notably, 11 late preterm babies and one small for gestational age baby were breastfed exclusively and directly from the breast at hospital discharge (around 5 postnatal days). Seven babies (57%) required no supplementation/complementation during the hospital stay. Colson encouraged mothers to BN their babies during the day with as much skin-to-skin contact as they wanted, and as often as they wanted. At that time, skin-to-skin contact was emerging as best practice. However, in this study, all mothers and babies remained lightly dressed. All mothers recorded BN non-nutritive cuddling time and intermittent BN active sucking and swallowing times in a diary. During the first 24 hours, mothers held their babies in BN for an average of 7 hours and 40 minutes (range 4 to 16 hours) during which time, babies actively transferred colostrum directly from the breast for a mean total of 2½ hours. All babies maintained a warm stable temperature in BN. At four months, 11 of

the 12 mothers were continuing to breastfeed, 8 exclusively. The complete study is reported elsewhere.^{1,2}

More recent research continues to reveal exciting results. In 2021, a meta-analysis examining 1936 mothers and babies, showed that just using the laid-back maternal posture reduced sore nipples by 42%.³ Another RCT⁴ published in 2020 compared BN to the teaching protocol in a baby friendly (BFI) hospital.⁵ For that study, the researchers included five of the [six basic BN components](#). Practising BN reduced the number of mothers experiencing sore or cracked nipples by half and more mothers in the BN group were breastfeeding exclusively at 5 months than in the BFI group. An historic study, undertaken in a paediatric Baby Friendly Initiative (BFI) community practice, implemented BN as their go-to strategy. During the study, 252 newborn babies, born at or over 30 weeks' gestation, were registered. At 5 months 62% were breastfeeding exclusively with a further 24.5% having some breastmilk alongside other milk or solid foods.⁶ At 1 year, the prevalence of breastfeeding was 59%. At three years, 7% of mothers were still breastfeeding, a statistic comparable to the 6-month rates of exclusive breastfeeding in many countries today!

These studies are in open access, freely available on the internet, yet few midwives and healthcare professionals know about biological nurturing. Some choose to ignore these studies, but many midwives just don't feel comfortable talking about BN to mothers.⁷ The original BN concepts have been underreported and require clarification. This introductory article aims to increase understanding of BN. If BN is instinctual breastfeeding for mothers, it requires learning new observational skills for midwives and others supporting breastfeeding.

What is biological nurturing?

Health professionals use BN as a method to observe maternal and infant behaviours which are divided into three groups: mother/baby positions, behavioural state, and innate behaviours such as actions and reactions. BN theory is anchored in the continuity of behaviours from womb to world. In other words, midwives identify, at a glance, whether the baby is in a sleep or awake state and if mothers appear calm and relaxed or stressed and uncomfortable. Health professionals recognise immediately if gravity is helping or hindering. They know instantly if mothers have both hands free and can gaze comfortably at their babies. Importantly, all health care providers can observe sequences of universal spontaneous breastfeeding movements. Under certain preconditions, maternal breastfeeding actions are instinctual, genetically programmed. Everyone knows that babies are hard-wired to breastfeed but few are aware of the self-generated movements that precede and enhance baby's breastfeeding reflexes.

Reciprocity is the watchword: Colson's doctoral thesis ⁸ clearly demonstrated that the six BN components interrelate, releasing spontaneous mother-baby interactions in skin-to-skin contact or when both are lightly dressed.

The mechanisms of biological nurturing (2006)⁷

In Colson's doctoral research, forty mother-baby dyads were observed:

- 3 mothers spontaneously started breastfeeding in the BN position with no difficulty.
- 37 initiated breastfeeding in traditional positions (upright or on their sides).
- More than half the sample (55%) encountered difficulties that prevented effective milk transfer.
- 23% (9/40) sacrificed their own physical or psychological comfort when their baby latched on and suckled with effective milk transfer.
- 15% (6/40) of babies in traditional positions latched on and suckled effectively without maternal or neonatal problems.

Mothers experiencing problems were encouraged to make positional changes and to wait for the baby to fall asleep to continue the feed. Importantly, Importantly, mothers and babies remained lightly dressed during breastfeeding initiation, prioritising close body BN cuddling rather than skin-to-skin contact to overcome their difficulties.; instead, all practised BN and all continued to breastfeed beyond four months, 88% exclusively.⁷

People often ask: if it's not skin-to-skin contact what are the prerequisites?

In BN, mothers are proactive; they find their own comfortable position and place their sleeping babies cheek to breast or mouth on nipple. Comfort is a subjective concept. No two people are absolutely comfortable in the same positions. However, no mother is ever upright or flat-lying. Instead, the degree of recline works with gravity so the mother's hands spontaneously touch and caress her baby. Since gravity maintains the baby on mum's body, her arms often make a nest. Non-verbal cues are a crucial part of the Homo sapiens behavioural repertoire; essentially, our hands express our thoughts and emotions. With their hands free, mothers can self-adjust their position, ensuring their body is fully supported. They also unconsciously change their baby's orientation - helping their babies to achieve what we call "*the right address*".

What is the right address ?

The right address, illustrated in the photos below, concerns the place of the baby and is always defined in relation to the maternal laid-back position using 3 essential criteria.



© Photo by Laurel K. Tharrington, RN, IBCLC, RLC 2008



1- The baby's face is always in bare-breast contact, whether lightly dressed or in skin-to-skin contact. In-between feeds, mothers keep their *sleeping* babies, cheek on top of their naked breast. This face-on-bare-breast contact immediately increases breastfeeding opportunities: as soon as the baby makes the slightest movement, he or she is in the 'right place' to latch even during sleep, enabling and conditioning a reciprocal breastfeeding bodily learning. Keeping the sleeping baby at *the right address* during the day reduces intervals between feeds, promoting exclusive breastfeeding during the early postpartum period ^{7:9}. Frequent, early and prolonged BN cuddles enable mothers to cultivate their breastfeeding relationship beyond upright latching techniques. The results are enhanced maternal satisfaction¹⁰ and reduced midwifery workload.¹¹ Maintaining continuity of baby sleep rhythms (behavioural state) is underpinned by recent advances from neurodevelopmental physiology. We discuss these in the next article 'Breastfeeding? Babies can do it in their sleep!'.

2- Lightly dressed or in skin-to-skin contact the force of gravity pins the baby to the mother's abdomen. She doesn't have to apply pressure to the baby's back, neck or head. Instead, gravity does the job! Furthermore, when mothers lean back, they open their bodies enabling full ventral uninterrupted contact. Gravity blunts the force and amplitude of the baby's movements which become smooth and fluid. This helps mothers and babies get started with breastfeeding: in BN it is as though the baby is swimming the crawl, a series of auto-generated movements rapidly conditioning breastfeeding reflexes. These observations contrast markedly with the skin-to-skin contact breast crawl, where mothers do not help and the baby's movements are described as a fixed action pattern that occurs [in nine stages](#).¹²

3- Crucially, babies feet are in contact with the maternal body or part of the environment; this foot support enables babies to stabilise themselves during latch and milk transfer.

What about mothers? How far back is laid-back ?

The degree of maternal recline varies from mother-to-mother and depends on the environment. Mothers do not experience any tension in their backs, shoulders or necks; they don't expend energy lifting their heads against gravity to see their baby (as in a flat-lying position) or bend or crane their necks to look down at their baby (as in the traditional positions). Mothers often spend hours gazing, stroking and savouring the sweet scent of their newborn babies. This effortless visual dialogue primes breastfeeding, producing powerful oxytocin highs that are essential for instinctual breastfeeding. Notably, these innate maternal breastfeeding gestures are only triggered when oxytocin is released directly from the brain. We can't teach mothers to coo, count fingers and toes and groom their babies. That's why we say that BN is instinctual! The mother's laid-back, physiological body slope is also protective: it facilitates baby's breathing. Since the mother is never flat on her back, the baby is never flat on his or her stomach; the baby's lungs do not expand against gravity. This is an important safety point.

Furthermore, upright or dorsal postures close or fold the maternal body and force the baby to lie across mum's midriff. Whether in skin-to-skin contact or not, seated in an upright position, mothers must hold their babies at breast level, exerting pressure on the baby's back, neck or sometimes on the baby's head. At a glance the pictures below may appear the same, however the first picture illustrates the interrupted ventral contact often resulting from this dorsal position.¹³ You can see the breastfeeding pillow helping to keep the baby in place at the breast. In the third picture, the BN mother has slightly increased her angle of recline. The result: the baby lies on top closing the gap. As the force of gravity pins the baby to the mother's body, tummy on tummy, mum has both hands free. These subtle positional differences have a huge and positive impact. Finally, the central picture illustrates the gap almost always observed between the baby's body and the breast in the so-called 'rugby hold' position. This gap is often exaggerated by 'writhing movements', those same jerky movements observed in the awake baby 'fighting the breast', often termed 'breast refusal' or 'latch failure'. Using gravity as an ally as in picture 3 can change everything.



Conclusion

Biological Nurturing is much more than a laid-back maternal position that we can teach mothers. Rather BN is a structured method to observe universal mother-baby breastfeeding behaviours. BN can be implemented straight from birth for all healthy term newborn babies and all vulnerable babies eligible for skin-to-skin contact. BN can also be used as a rescue strategy for any mother experiencing difficulties such as latch refusal, sore nipples, engorgement and other breast problems. The maternal laid-back posture always makes use of gravity and never exhausts maternal physical capacities. Babies lie on top of mum's bare breast in continuous ventral contact.

Even though research findings show that BN reduces sore/cracked nipples and increases the duration of exclusive breastfeeding, maternity staff often remain sceptical or apprehensive using it. Changing practice is always uncomfortable! Mainstreaming BN requires the ability to step out of one's comfort zone, away from teaching, protocols and received ideas. In BN, midwives continue to advocate and protect mothers' privacy; they inform rather than teach. The universal positional interactions, regardless of dress state, explain how BN aids breastfeeding initiation and increases exclusivity. Further research is needed to examine how all of the BN variables interrelate and interact to release instinctual breastfeeding.

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- 13 Editor's note: 'ventral contact' means that the front of the baby is lying in close contact to the front of the mother. In this picture, that contact is interrupted or incomplete.

Induction and breastfeeding

by Emma Laurinaviciene-Connor



Author Bio: Emma is a mother relatively new to the birth world, whose own challenging start has inspired a journey to advocate for smoother parenthood transitions for all.

At every antenatal appointment I was asked “*How do you intend to feed your baby?*” to which I would reply “*I’d like to breastfeed, if I can. I’ve heard it can be difficult*” And each time, that was the end of that conversation. What I really didn’t expect, however, was the incredibly intense and primal *need* to breastfeed that would come over me once my baby had arrived.

After six days of latching issues, nipple trauma, running out of antenatally expressed colostrum, a readmission to hospital, and panic attacks (that I’d never experienced before), I could no longer take the highs and lows of it all. We stopped exclusively breastfeeding, pumping and offered formula top-ups instead. Whilst this decision brought me huge relief, there was also desperate disappointment and an all-encompassing sense of failure. I couldn’t feed my baby the way I wanted to and I was letting her down.

Yet, I wasn’t willing to give up, and herein lies the beginning of a much longer struggle. After offering the breast casually and managing a twenty minute breastfeed here or there, at six weeks we returned to a significant amount of breastfeeding. I am incredibly proud of my determination and I believe this is the most important achievement of my life thus far. But, it came at a great cost to my mental health. We got stuck in a gruelling and precarious cycle of breastfeeding, pumping to top-up expressed breast milk and additional formula top-ups.¹ This continued for six exhausting months until I could no longer sustain it. Thereafter, I clung on to morning and evening breastfeeds until my daughter lost interest at 10 months.

There are several pivotal factors that I believe contributed to our difficult feeding journey.

Antenatal breastfeeding education was alarmingly non-existent, and in hindsight, I didn't take enough personal responsibility for seeking out that knowledge.

Then, my labour and birth were induced, which I now believe to be medically unnecessary, and this led to my decision to have an epidural.

Finally, to compound these challenges, my experience of postnatal breastfeeding support was poor and ultimately detrimental.

In this article I will address the impacts of my induction and postnatal breastfeeding support.

Induction and use of Epidural Analgesia

I was induced at 38+3 weeks due to Gestational Diabetes managed by insulin. I remember asking the consultant at my induction booking appointment, "*Is this really necessary?*" The justifications given to me were that the placenta can stop working sooner in people with gestational diabetes and they have concerns about the baby's ability to regulate their own sugars upon arrival. Although something in my intuition was telling me that I was well enough to continue the pregnancy and so was my baby, I trusted that the medical system knew best.

In hindsight, I now interpret [the evidence](#) as saying there is no medical necessity for early birth. My baby's monthly growth tracked perfectly along the 25th percentile, there were no issues with placental Doppler² (or other concerns, and finally, my own sugars were well managed with the insulin, so arguably she was not experiencing sustained high levels of sugar. Additionally, I have since discovered that NICE guidelines³ generally recommend induction for gestational diabetes between 39+0 and 40+6 weeks, or even later if sugars are well-controlled and there are no other complications. My induction at 38+3, in the absence of other risk factors, appears to fall outside these general recommendations, further suggesting a lack of medical indication.

My induction experience itself was relatively positive, I felt I had realistic expectations of the process and it ended with the birth I had been hoping for, a vaginal birth. It took four days and several interventions - a 24-hour Propess (prostaglandin) pessary, four doses of prostin gel, and a particularly intense membrane sweep from a consultant - before my waters broke 'spontaneously'. From that point, contractions came thick, fast, and relentlessly intense. Initially, this was manageable with the ability to move freely, but with a 'need' for CTG monitoring⁴ I was ushered onto the bed, thereafter unable to get myself off.

From this point on I requested every pain relief option available to me, making it clear I would want an epidural as soon as possible. Once transferred to the labour ward, the epidural provided much-needed relief, allowing me to regain some presence and even appreciate moments of labour. I was able to manage my epidural dosage, letting it wear off sufficiently before I was ready to push. However, it is important to note that the epidural reduced the frequency of my contractions. So, I was started on the artificial oxytocin drip as the next stage of induction/augmentation of labour. After 11 or so hours hooked up to the epidural and drip, and 46 minutes of pushing, my daughter was born.

When the risks of induction and epidural use are communicated, the focus seems to be largely on immediate, physical impacts such as increased likelihood of caesarean-section, infection risk, spinal injury, and, at a stretch, a brief mention of newborn alertness. But what is not made clear, are the impacts that this may have on bonding and breastfeeding - the exact outcomes that had a significant and long-term psychological impact for me.

Comparing physiological and induced labour reveals key differences in the hormone cycles that drive labour, bonding and breastfeeding. The introduction of synthetic oxytocin during induction can disrupt the body's natural hormonal rhythms, interfering with the body's production of organic oxytocin.⁵ Oxytocin is one of the major hormones, crucial for bonding and successful establishment of breastfeeding. In addition to this, inducing labour with synthetic oxytocin can be associated with a reduction in oxytocin receptors, meaning that the body may have fewer sites for the oxytocin to bind on to and so less opportunity for the oxytocin to bring about the desired response.⁶ Therefore, with potentially fewer receptors to respond to an already disrupted supply of oxytocin, the effectiveness of said oxytocin for bonding and breastfeeding may be diminished in the initial period after induced labour and birth, but more research is needed in this area.⁷

When it comes to epidural use, a 2019 survey carried out by the CQC ([Care Quality Commission](#)) found that 47% of induced labours included this type of pain relief, compared to 19% in spontaneous labours.⁸ Thus adding another layer of potential consequences for early breastfeeding. In newborns, exposure to epidural analgesia can be associated with reduced alertness⁹ and an altered behavioural state.¹⁰ What this means is that these newborns may be less likely to spontaneously wake to feed, less able to sustain the effort required for effective transfer of milk and less able to display consistent hunger cues.

But why does this matter for breastfeeding? The effective establishment of breastfeeding largely hinges on the principle of supply and demand.¹¹ The more

effectively and frequently milk is removed from the breast, the more milk the body is signaled to produce. When a newborn exhibits behaviours such as infrequent waking to feed, subtle or absent hunger cues, difficulty rousing, inability to effectively remove milk, or insufficient stamina for substantial feeds, this crucial supply and demand system for establishing a sufficient milk supply and a responsive dyadic¹² feeding relationship simply cannot get off to an optimal start.

When these challenges are compounded by the disruptions to oxytocin seen in induced labour, there are additional hurdles to overcome. Oxytocin causes the muscles around the milk-producing cells (alveoli) in the breast to contract, pushing milk down through the ducts in the milk ejection reflex or 'let-down'.¹³ Without an effective let-down, milk remains in the breast, leading to inefficient milk transfer and a signal that less milk needs to be produced next time. Oxytocin also has great influence over maternal bonding and calming, promoting feelings of love, calmness, and connection between mother and baby, facilitating the relaxed state conducive to milk flow and positive feeding experiences. With oxytocin's reduced effectiveness, breastfeeding which is often described as a beautiful, natural and lovely experience can instead become fraught with stress and difficulty.

Postnatal Breastfeeding support

My memories of the immediate postnatal period are blurry and fragmented, but as far as I remember, my daughter was able to breastfeed within the first two hours of birth. However, it was the student midwife who latched her for me after several unsuccessful attempts myself, and she even held my daughter for the entire first feed of apparently 45 minutes. I recall repeatedly asking to hold her myself, but she wouldn't allow it. I now understand that movement might have affected the latch or interrupted the feed (ironically important for establishing breastfeeding) and I'm sure the midwife felt proud of her decision to help in this way, but I now feel a profound sense of sadness at my lost experience.

Once transferred to the postnatal ward, my daughter was incredibly sleepy. She did not seem to wake herself up to feed, so I began setting my alarm to ensure I was feeding her every two-three hours. I tried every trick to rouse her: stripping her down to just a nappy, changing her nappy before a feed, stroking her face to encourage suckling, constant skin-to-skin contact, and using breast compressions. Despite these efforts, she rarely stayed awake long at the breast. Whether due to her epidural-related sleepiness or other factors, we consistently struggled with latching. This led to significant distress for both my daughter and, eventually, myself, which I now attribute, in part at least, to the induced labour.

When called to help at every feed, midwives and midwifery care assistants asked if they could try expressing milk from my breast to help my daughter to latch on. I watched

helplessly. Sometimes, the distress of these attempts became unbearable. I requested syringe feeding with expressed colostrum; we weren't permitted to be taught this ourselves. The importance of expressing frequently during this was not communicated to me either, and these difficulties resulted in us being kept on the ward for an additional day.

Slowly, however, I felt that I was getting the hang of it. I attempted a feed without calling for help and I believed it went well. I was proud that I had not needed support and eagerly told the next midwife who came to check on me. Her response, unfortunately, was that they needed to see themselves. Determined to begin feeding well enough to leave, I resolved to then show them that I could do this. I called them at each feed and every time they told me that they were happy that the latch looked good, and yet each time it was painful. I left the hospital dangerously misinformed, thinking "*when the latch is painful in this way, I am doing it right*", I was never asked how it felt.

At home it continued; sometimes we would get a 'good' latch, but this became increasingly painful and my nipples became progressively damaged. A 'successful' feed brought huge relief, the fleeting belief that we would finally be ok, until the next time we couldn't latch when both my daughter and I became very distressed. I found that I didn't want to pick my daughter up in between the two-three hour feeding schedule and, at some points, I couldn't bring myself to look at her. I wasn't eating, I wasn't sleeping well if at all, and I was suffering panic attacks. We were bridging the feeding gaps with my antenatally expressed colostrum and any transitional milk I could collect with a passive suction pump on my other breast during the successful feeds. Then we ran out and I simply couldn't face another feed.

My community midwives, concerned by my fragile mental health and witnessing my persistent feeding difficulties, suggested readmission to a ward specifically for postnatal feeding issues run by my NHS trust. I'd previously rejected this suggestion, I had this deep sense that it would mean I had failed. But with no expressed milk left, and no longer able to face feeding without constant professional support, I was fortunately readmitted.

At the ward, confronted with my daughter's signs of dehydration, I finally agreed to formula. She guzzled 70mls, and I initiated a pumping regime with the hospital-grade electric pump. Our feeding routine of breast, then expressed milk, then formula, was an exhausting endeavour, but at last I was sure my daughter was adequately fed. By her five-day weigh-in, her weight loss was just shy of the 10% threshold.¹⁴ The mystery of our latching difficulties persisted, though. No midwife or change of position provided a

solution, latching remained inconsistent. I could no longer endure the attempts to latch at each feed. Severe panic attacks, now triggered by topics unrelated to feeding, began. I confided in my husband that I could no longer manage to look after our daughter alone through the night, especially as he was not allowed to stay. The difficult decision to stop offering the breast was made.

We left the hospital with one piece of advice that truly stuck: after offering expressed milk and then formula, there must always be some formula left in the bottle, that is how we would know she had enough milk. But I don't recall being given any robust information on my pumping regime, or how to transition away from formula (the ultimate goal). In hindsight, I would expect anyone in my shoes to be sent away with further appointments and ongoing support to this end.

Although relieved and experiencing far less anxiety around feeding, I still wasn't satisfied. It was important to me that my daughter received the benefits of breastmilk, and I still desperately wanted to breastfeed her. In the comfort of my own home, and without the immense pressure to exclusively breastfeed, I continued to casually offer the breast. Eventually this led to a significant proportion of breastfeeding by six weeks.

I found immense support from my local [La Leche League](#) group meetings. The validation and understanding I received there were invaluable. When my daughter was eleven weeks old we were able to afford a private appointment with the group leader, an IBCLC (International Board Certified Lactation Consultant), but we simply couldn't afford the kind of ongoing support that would have truly helped. I just couldn't access the consistent, personalised guidance I needed to increase my milk supply and safely transition away from formula.

Consequently, triple feeding remained my only option, a regime typically recommended for just a few days. I persisted until my daughter was six months old, pumping twice in the night (despite my daughter sleeping through from five weeks) to get enough milk for one out of her daily three bottles to be solely expressed milk. Sometimes I power-pumped twice a day (on and off for an hour to mimic cluster feeding), petrified in case my supply diminished and compromised our precious time breastfeeding, but inevitably, I couldn't keep up. From six months to ten months I clung on and we continued with a substantial morning and evening breastfeed, with little comfort feeds few and far between, until, one unassuming day my daughter lost interest in feeding from the breast and we stopped.

Looking back, my breastfeeding journey really highlighted the missed opportunities and limitations of the support I received. From a well-meaning but disempowering start with a student midwife holding my baby, to being on the postnatal ward where my pain was overlooked and vital information about expressing or feeding techniques wasn't clearly shared, I often felt like I was navigating incredibly complex challenges alone. The

"support" sometimes felt more focused on checking boxes and only on my daughter receiving enough milk, rather than on truly helping me with my feeding goals and the psychology around this. Even after getting some fantastic validation from my local La Leche League group, the sheer lack of accessible, ongoing professional support meant we couldn't afford the consistent, personalised guidance I really needed. This often pushed me into unsustainable routines like "triple feeding," which took a huge toll on my mental and physical health. My experience really shines a light on a significant gap in how new mothers are supported through such a vulnerable and important time.

To conclude

My breastfeeding journey was defined by a powerful, almost primal need to nourish my baby, yet it was fraught with unforeseen challenges. I received little practical guidance before the birth and this left me unprepared. I believe my induced labour and the epidural, both likely to have been medically unnecessary, negatively impacted the beginning of our breastfeeding experience by affecting my daughter's alertness and disrupting crucial bonding hormones. A lack of good postnatal support compounded these issues. I believe my story highlights the critical need for comprehensive, ongoing and empathetic support that addresses both the physical and emotional complexities of this journey.

Further reading:

Smith S. (2024) Induction of Labour and successful Breastfeeding.
<https://realbirthcompany.com/induction-of-labour-and-successful-breastfeeding/>

1 Author's note: Something I now know should only be recommended for a few days with a strict plan of how to move away from this approach.

2 Editor's note: Doppler ultrasound measures blood flow through the blood vessels (including those in the cord and placenta) by bouncing high-frequency sound waves off the circulating red blood cells.

3 NICE (2020) Diabetes in pregnancy: management from preconception to the postnatal period. <https://www.nice.org.uk/guidance/ng3/chapter/Recommendations#antenatal-care-for-women-with-diabetes>

4 Editor's note: Cardiotocography or 'CTG' is used to monitor a baby's heart rate and a mother's contractions during labour.

5 Uvnäs-Moberg, K Et AL. (2019), 'Maternal plasma levels of oxytocin during physiological childbirth – a systematic review with implications for uterine contractions and central actions of oxytocin', *BMC Pregnancy and Childbirth*, (2019) 19:285. doi: <https://doi.org/10.1186/s12884-019-2365-9>

6 Phaneuf, S Et AL. (2000), 'Loss of myometrial oxytocin receptors during oxytocin-induced and oxytocin-augmented labour.' *Journal of Reproductive Fertility*. 120(1):91-7. doi: 10.1530/jrf.0.1200091.

7 Bell, AF Et AL. (2014), 'Beyond labor: the role of natural and synthetic oxytocin in the transition to motherhood.' *Journal of Midwifery & Women's Health*. 59(1):35-42. doi: 10.1111/jmwh.12101.

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9 Radzyminski, S Et AL. (2005), 'Neurobehavioral Functioning and Breastfeeding Behavior in the Newborn', *J Obstet Gynecol Neonatal Nurs* 34(3): 335–341.

10 Riordan, J Et AL. (2000), 'The Effect of Labor Pain Relief Medication on Neonatal Suckling and Breastfeeding Duration', *J Hum Lact*, 16(1): 7–12.

11 Kent J. C, Et AL. (2007). The volume of milk produced by mothers of preterm infants. *Pediatrics*, 120(4), e934-e939.

12 Editor's note: Dyadic refers to the interactive relationship between two people or entities.

13 Uvnäs Moberg, K., & Prime, D. K. (2013). Oxytocin effects in mothers and infants during breastfeeding. *Infant*, 9(6), 201-206.

14 Editor's note: Up to a 10% drop from their weight at birth is considered normal. I do not know how this threshold was decided but this article may be of interest:

DiTomasso D., Cloud M. (2019) Systematic Review of Expected Weight Changes After Birth for Full-Term, Breastfed Newborns. <https://www.sciencedirect.com/science/article/abs/pii/S0884217519304381>

Breastfeeding trauma

By Nicola De Sousa



Author Bio: Nicola is an Infant feeding coach in Jersey.

Breastfeeding trauma is something I never thought about or knew about. I never even thought about breastfeeding until I was pregnant and then thought - it helps you lose the baby weight so I'll give it a go. That was until I reconnected with my old uni friend Lizzie and she sent me some books on birth and breastfeeding. She was a huge advocate for breastfeeding after facing feeding trauma with her daughter and she opened my eyes to so much about birth and breastfeeding that I had no clue about.

I came from a family with little to no breastfeeding experience. Two generations on my side and also on my husband's side had formula fed. So that knowledge and expertise handed down from woman to woman had long been lost.

When I went into preterm labour at 35 weeks, I hadn't expressed any colostrum yet as it was still too early. I had written a birth plan, but not a feeding plan of any description. Something that could have saved me a lot of trauma and grief, in hindsight.

That day, I was up early to walk the dogs before work as usual and I remember getting absolutely drenched in very unexpected rain and having to come home and get completely changed and blow dry my hair. I remember going to the toilet, and when I stood up, I noticed 2 drips, one down each leg. I thought I'd just mis-wiped or put it down to some sort of pregnancy discharge.

I'm a secondary school teacher and we were in the middle of an inspection. It was day 3/3 and I hadn't been observed yet, so I knew one of my two A-Level lessons that day was going to be seen.

I was in the staffroom talking to a colleague about a bit of lower back ache I was having, when she said she could see my stomach contracting through my dress and she

thought I was in labour. I just laughed and told her I couldn't feel anything and it was too soon anyway. The next thing was, she'd called the school first aider who took one look at me and told me if I didn't get in her car to go to hospital, then she would call an ambulance and that would cause a scene in front of all the students.

I was adamant I was staying to do my lessons and contribute to the inspection, but in the end I was coerced into the car and took my laptop and a massive bag of marking with me as I was so convinced this was a complete waste of time.

Turns out I was indeed in active labour and had premature rupture of membranes (PROM). My cervix was fully effaced and already dilated to 4cm without me having any signs at all, and because I was only 35 weeks and 1 day, I was asked to stay in hospital to be monitored and to be given steroids and antibiotics to protect the baby. I was told I would be induced the following day if my labour stalled, which it did. Pretty much as soon as they told me I was in labour, my labour stopped.

To cut a long story short, I was induced the following afternoon. Our daughter was positioned back to back and I was forced to stay on my back on the bed, even when I was in agony. I only had gas and air - the labour was so fast there wouldn't have been time for anything else even if I'd wanted it! When our daughter was born, I remember seeing these big, brown eyes looking at me, reaching down and touching her little body, telling her I was there and hearing her cry...then she was gone. They whisked her away to be checked - no delayed chord clamping, no skin-to-skin, no golden hour. No time to bond. I was left in the bed shaking and I screamed at my husband to go with her when they took her out of the room.

He came back to get me as soon as she was deemed stable (she didn't need any breathing support) and was in an incubator. He wheeled me into the Neonatal Intensive Care Unit (NICU). I will never forget the realisation that I didn't know which baby was mine. I am haunted by that. I didn't get long enough to look at her to recognise her.

Even writing this makes me cry. She was lying there crying in the incubator. She was born, snatched from her mummy and put in a box. I wasn't even 'allowed' to try and breastfeed her. Now I just can't imagine how I accepted that - surely it would have been an overwhelming instinct? It wasn't. And I still feel guilty about that. I was only 'allowed' to hold her for a minute and then I was sent back to the ward. She was tube fed formula

because the nurse said, “She’s an early baby and she won’t even have the sucking reflex”.

I sobbed on the ward amongst all these mums with their babies. My husband was unceremoniously ejected at 5am even though he’d be allowed back at 7am to visit.

I’m sure now you can already see why I joined [Make Birth Better](#).

Here is where the real trauma started though.

The following day I was ‘allowed’ to try and breastfeed my own daughter. She latched perfectly the very first time. I had no idea what I was doing but I was incredibly lucky it was so natural and easy for us. The nurses were amazed and said, “Are you sure you got your gestation correct?” The bond between us then was suddenly activated - the love just took me over and seeing her feeding and getting so much comfort in my arms just overwhelmed me. From then on I didn’t miss a single feed or nappy change. I lived on the ward for 12 days and was woken by the nurses through the night and sat with her skin to skin next to the incubator all day every day.

The only thing that was going ‘to plan’ and that I felt some control over, was breastfeeding. I’d even stocked a mini milk bank in the freezer as I’d been pumping to build up my supply. Everything else was beyond my control, but the feeding - that was my job and I was doing it really well. ‘Good Girl Syndrome’ strikes again.

One day, my daughter pulled her feeding tube out and the nurses decided that they wouldn’t put it back in as we had now established breastfeeding and I wasn’t leaving the hospital. She instantly looked like a more ‘well’ baby and psychologically, I felt like we were one step closer to going home. A couple of days later, I’d just put her back in her incubator after a feed and lots of skin-to-skin and went back to the ward for a shower. I was probably gone for 15 minutes.

When I walked back in, everyone on the desk in NICU looked very sheepish.

I asked if she’d woken up and one of the nurses said, “Not exactly”

Why were they sheepish? Well, one nurse had come back from annual leave and hadn’t read our notes. She’d just seen my daughter with no feeding tube in and taken it upon herself to put a feeding tube back in - no consent from parents, no questions asked about why there wasn’t a feeding tube and with nobody there to hold her while they did it.

Not only that. She had given her formula through the tube despite the 30 plus bottles of my breastmilk that were in the fridge and freezer.

When I was told this, I had what can only be described as a mental 'break'. I literally felt myself 'snap' in my brain. I started sobbing, hyperventilating, screaming, pacing. I think writing this is actually the first time I've acknowledged just how horrific this was and the level of trauma they inflicted on us. How was this allowed to happen? I now know this was an assault on my baby.

I was so distressed that they had to get my husband to come immediately to try and calm me down.

The final blow when I look back, was being gaslighted by the nurse responsible who told me, "I was only doing what was best for the baby" - completely invalidating my reaction.

My mental health went downhill from there and I don't think I've ever been the same since, actually.

I developed severe anxiety and what I now know to be PTSD. I did not have my trauma understood or validated by people around me and I didn't really even validate it myself because 'we were both ok'. I tried to keep it all under control but anxiety about my daughter's health, about germs, about people holding her for extended periods of time and about the prospect of going back to work and leaving her with strangers - it eventually took its toll. And after one particular visit when someone wouldn't give her back to me when I asked, I felt another mental break. I felt like nobody could hear what I was saying and nobody understood how I was feeling and like I was screaming but nothing was coming out. Everyone just thought I was overreacting, and told me so. I felt sheer panic and an overwhelming loneliness. And the next morning when I woke up, the whole left side of my face had gone into spasm.

I had what's called a hemifacial spasm, brought on by acute stress and anxiety. The stress was so great that it had caused the blood vessels to my brain to contract and they had put pressure on my facial nerves.

The whole left side of my face was pulled up into a tight grimace, which made the other side look droopy and paralyzed. If I got stressed it would pull tighter and tighter. I thought initially, when I saw myself in the mirror, that I'd had a stroke. Three different doctors told me what it was but I didn't believe them.

I didn't get better over time. And I don't believe I would have recovered on my own. I asked for help from my GP who said waiting lists were so long that there was no point referring me for counselling.

I got some free talking therapy, but talking about it all wasn't helping. It was just like reliving it every time. It wasn't curing my extreme responses to things and my inability to remember what happened without having a traumatic episode.

One day my husband bumped into a friend whose wife was a psychotherapist. He must have told him I wasn't well and that he was struggling, because his friend suggested I go and see her. He said she would understand. Eventually I paid to go and see her. Thankfully I could just about afford to while on maternity leave, because she cured me as much as I'm likely to be cured, I think. In only 2 sessions. And she also released a vast backlog of other traumas from my past.

I've shared this story to offer validation to any other women who may have experienced something feeding-related that has caused a similar impact on their mental health. I want to make it clear that this is a biologically normal response for us. And this is not restricted to breastfeeding. I have met several women who have experienced trauma when they made the decision to formula feed, but didn't expect to feel utter grief and distress when other family members then started giving bottles. That was incredibly traumatic for them and again, was a response that was unexpected and totally invalidated by others around them.

My experiences led me to train as a Breastfeeding Counsellor and Infant Feeding Coach. Intensive training that I completed in the evenings online for 2 hours a week, submitted several pieces of coursework and then sat a formal exam. All while being back at work. But doing this training was part of my recovery when I look back, and the work I'm doing now, to support women in their feeding journeys, literally lights up my soul and continues to heal me.

What I'm realising is how much feeding trauma is out there. I've even spoken to men who have feeding trauma because they thought they were 'helping' their partners by supplementing with bottles. But for the women, it felt that their partner didn't believe in their ability to breastfeed and this breach of trust has affected their relationship negatively - for decades.

Having had my second baby, my son, just 6 weeks ago (he was born with a tongue tie), I have also realised why there is so much feeding trauma and why so many women have what they see as unsuccessful feeding journeys, or end up stopping earlier than they want to. We do not have sufficient antenatal education about breastfeeding and we do not have the continuity of care after birth with regards to breastfeeding support. This means that small niggles or problems are missed and go on to become bigger problems very quickly.

Women don't know how to protect their supply in the early days if there are issues and then end up with a narrative such as, "I didn't make enough milk so we had to put the

baby on formula”. It seems to always end up with mothers believing they have failed in some way.

We also aren’t educated or properly informed about how our choices around the birth of our babies can have a huge impact on breastfeeding. For example, many drugs we are offered in labour cross the placenta and can mean a very sleepy baby - one who doesn’t really want to feed much or who gets tired quickly. They therefore don’t kick start the ‘supply and demand’ needed for a robust milk supply. They may not put on weight like they need to and, because the breast isn’t being adequately emptied, mum may end up with mastitis. Despite all this not having anything to do with mum, it seems it’s always mum who is ‘blamed’. And breastfeeding not going the way they wanted can be absolutely devastating for those women who feel a deep NEED to feed their baby.

I would love for all women to be fully educated in all forms of feeding before having their babies, and also be aware that their birth plan should reflect their feeding plan (and yes, they should most definitely have both birth and feeding plans). I would also love to see feeding trauma being recognised and treated in its own right, as birth trauma now is.

If you have been upset or traumatised by how your baby was or wasn’t fed, this is normal and you deserve to be validated and supported. It is not ‘just’ how you feed your baby. For a mother it is much deeper and much more emotive than that. It is grounded in hormones and in instincts, and we as a society need to be much more sensitive to that.

Poor breastfeeding education for UK healthcare professionals: a huge gap in the provision of early breastfeeding support for new mothers.

by Lucy Moggridge



Author Bio: Lucy is a mother of four, an experienced Midwife of 10+ years and now working independently. She is also an International Board Certified Lactation Consultant (IBCLC). Her vocation is rooted in informed, compassionate midwifery and breastfeeding support—bringing together her life experiences and professional knowledge to empower families and challenge the gaps in

Despite widespread recognition of the benefits of breastfeeding and the acknowledgement of its significant health benefits for both mothers and infants, the UK continues to report some of the lowest breastfeeding rates in the world.

According to the World Health Organisation (WHO), breastfeeding for at least the first 6 months of life is essential for optimal infant development, nutrition & maternal health.¹ However only 1% of UK infants are exclusively breastfed for that recommended period (Infant Feeding Survey, NHS Digital, 2012; ^{2, 3} This points to a significant gap between science, knowledge, policy and ultimately actual practice.

In truth many mothers enter into parenthood with full intentions to breastfeed but quickly encounter barriers that undermine their confidence and success even when they are motivated to do so. A qualitative study by Brown, referred to in her book, *Why Breastfeeding Grief and Trauma Matter*⁴ revealed that many mothers felt disappointed by the care they received, with some citing a “tick box approach” to breastfeeding support. This approach to feeding only leads to early cessation, even when the mothers are highly motivated to continue.

It appears that one issue here is the insufficient knowledge and skills of many midwives who are the first line of support for breastfeeding mothers. Consequently, good

antenatal education about breastfeeding is lacking and, even more importantly, so is good support postnatally.

Health Professional Education : A Critical Shortfall

Health professionals often receive limited, inconsistent or outdated training on breastfeeding, many only using a little of what the mainstream services provide within a hospital setting and the rest built upon years of handed down methods and opinions. The UNICEF Baby Friendly Initiative has made strides, but gaps remain. A review by UNICEF UK (2017) found that breastfeeding features minimally in midwifery curricula. Without robust education, professionals may provide inconsistent and sometimes outdated, substandard breastfeeding support and advice, contributing to misinformation and reduced breastfeeding success.^{5, 6}

Institutions need to work towards an integrated, compassionate, individualised approach and this requires coordinated and compassionate responses including but not restricted to:

- Mandatory, evidence based training for ALL healthcare professionals (midwives, obstetricians, maternity support workers, maternity assistants, paediatricians, neonatal nurses etc).⁷
- Expansion and employment of IBCLC (International Board Certified Lactation Consultant) roles. This enables plans to be put in place for each family that is tailored to their needs.⁸
- Inclusion of peer support networks (peer support significantly increases likelihood of continued breastfeeding outcomes).⁹
- Reframing public health messages and reducing formula company marketing.^{10, 2}
- Embedding breastfeeding support into digital healthcare platforms

So why is breastfeeding/breast milk so important?

Essentially, in terms of human development, breast milk provides a vital role. Breast milk not only provides nutrition, it is a living, bloodborne, immunologically active substance that is specifically tailored for human infants. It contains necessary antibodies, hormones, enzymes and stem cells that contribute to infant immune system development and provides all important protection against infections, chronic illnesses and even some childhood cancers.¹¹ Furthermore, breastfeeding supports maternal health, reducing the risk of breast and ovarian cancer, type 2 diabetes and postpartum depression.^{2, 12} Given these unparalleled benefits, every effort should be made to ensure that breastfeeding is protected and supported as the human norm.

Benefits for mothers include:

- Reduced risk of breast cancer - for each additional 12 months of breastfeeding the overall risk is reduced by 4.3%. Breastfeeding reduces the risk of Triple-Negative Breast Cancer¹³ by 20%, and in carriers of BRCA1 mutations¹⁴, by 22–55%.¹⁵
- Reduced ovarian and endometrial cancer risk - long term feeding reduces risk further.¹⁶
- Lower risk of type 2 diabetes - by 32%.¹⁷

Benefits for babies include:

- Increased cognitive development and improved neurodevelopment (better working memory/nonverbal skills at ages 4-6).¹⁸
- The above was especially true in pre term babies receiving any breastmilk and they had lower neurodevelopmental impairment.¹⁹
- Fewer infections and increased immunity, particularly respiratory, gastrointestinal, and ear infections,²⁰ and better gut colonisation by bifidobacterium and lactobacillus, which enhance immune defences.²¹
- Lowered diabetes and obesity risks.²²
- Lowered rates of SIDS (sudden infant death syndrome) - breastfeeding duration of at least 2 months is associated with half the risk of SIDS.²³
- Longer duration of breastfeeding, at all or exclusively, is associated with better educational achievement at age 5. ²⁴

Initiation rates of Breastfeeding in the UK are relatively high at 81%, but only 34% of infants are still receiving any breast milk at 6 months of age.¹⁵ The early cessation of breastfeeding is often linked not only to maternal choice, but also to the lack of aforementioned support and knowledge of those healthcare providers, particularly in those early days and weeks. In my dual role as an Independent Midwife and an IBCLC I see the fallout of this in practice.

An **International Board Certified Lactation Consultant (IBCLC)** in the UK is a healthcare professional with specialist training in breastfeeding and lactation. Recognised for their advanced clinical skills, IBCLCs support families, healthcare providers, and public health efforts to improve infant feeding outcomes.²⁵

Our primary role is to assess and manage breastfeeding challenges, such as poor latch, pain, low milk supply, or tongue-tie. We develop personalised care plans to help

mothers and babies establish effective and comfortable feeding. IBCLCs also monitor infant growth and ensure breastfeeding is meeting nutritional needs.

Education and emotional support are key aspects of our work. IBCLCs provide antenatal and postnatal breastfeeding education, helping families feel informed and confident. We also support those facing complex situations, such as re-lactation,²⁶ induced lactation, premature birth, or health conditions affecting feeding.

In the UK, IBCLCs work in various settings including some NHS hospitals, community services, private practice, and voluntary organisations such as La Leche League or NCT. We often collaborate with midwives, health visitors, GPs and paediatricians, offering expert input on feeding in both routine and high-risk scenarios.

IBCLCs also play an advocacy role, supporting the Baby Friendly Initiative (BFI) led by UNICEF UK and promoting breastfeeding-friendly policies. Their work contributes to public health goals, such as reducing infant illness and improving maternal wellbeing. Yet rarely will you find an IBCLC in a hospital setting leading an infant feeding team.

Certification is granted by the International Board of Lactation Consultant Examiners (IBLCE) and requires a thorough exam, clinical experience and continuing education. IBCLCs adhere to a professional code of ethics and must recertify every five years (IBLCE, 2023)

In summary, IBCLCs provide expert, evidence-based support to promote and protect breastfeeding, making a vital contribution to maternal and infant health across the UK.

Breastfeeding Physiology: gaps in antenatal education

A fundamental challenge is that many women enter parenthood with minimal understanding of how breastfeeding actually works from a physiological perspective. Commonly during antenatal care, education surrounding breastfeeding is often rushed, basic and minimal - we have lost the trust that women can take on new knowledge through pregnancy, so it is simplified or omitted completely to “not overwhelm the woman with information”. Antenatal classes may prioritise labour and birth, treating breastfeeding as an afterthought. Many women don't know about how breastmilk is produced, where or how hormone involvement occurs to allow let down, about feedback mechanisms that allow milk to flow, or why latch is so important for milk transfer to assist this process. Some would say that a knowledge of breastfeeding anatomy and physiology is not necessary for successful feeding, that simply knowing some of the practicalities, how to get a good latch and where to find support is sufficient. For others though, especially when they have not grown up seeing breastfeeding in their daily lives, understanding how the body works helps them to manage expectations and make sense of everything.²⁷

Upon reflection this is most likely why I get so many women who are a week, two weeks, four weeks into their feeding journey, still struggling with basics such as latch, positions, and using incorrect flange sizes on pumps etc. Women are often contacting me for support when their breastfeeding journeys are already on the brink of failure, or have derailed entirely. However they are not failing, they are being failed by a lack of readily available practical support from an early stage.

Take, for example, a family I supported who were discharged home on a triple feeding plan (to breastfeed, pump and supplement with expressed Breast Milk (EBM) or formula). They were not told how to manage this plan or how to reduce it to get to the transition of exclusive breastfeeding. These intense regimes can be medically necessary, but can be overwhelming and unsustainable without clear guidance.

In another case, a family with twins had received no information about feeding when they were discharged home; the mother had not been referred to the appropriate Mental Health team, and had trauma from birth and a pre-existing mental health condition. When I got there I was then unpicking all the things that were missed, as well as supporting a traumatised first-time parent with twins, who was suffering with mastitis because they had only seen one person since going home, despite promises of Infant Feeding Team input that did not materialise until 10 days later.

Crucially, it seems many women have only been shown about nurturing positions such as laid back, [koala](#) positions to help with deep latch (therefore highly increasing the chance of eliminating sore nipples) if it is “trending” on social media. Nor have they been shown how to recognise [effective milk transfer](#) or how to manage engorgement, a key factor that can significantly affect latch and milk transfer in those early days.

Postnatal support: A system under pressure

Support in the postnatal period is patchy and in some cases almost non-existent (especially for subsequent mothers who already have children), and this absence occurs when help is needed the most. A 2024 survey by the Care Quality Commission (CQC)²⁸ stated that only 54% of mothers felt they always received the support they needed after birth, meaning almost half were left flailing (CQC, 2024). Many mothers also described feeling abandoned once they left the hospital, with no integral plans in place. They were expected to manage breastfeeding on their own, often with minimal follow up or guidance, even when there were issues such as faltering weight gains.

Midwives are central to postnatal care, but their capacity to provide skilled lactation breastfeeding support, in ever changing and deteriorating mainstream services, is often compromised by staffing shortages, time constraints, and a lack of in-depth current education. Furber and Thomson (2008)²⁹ observed that Midwives often feel conflicted between institutional demands and the time-intensive nature of breastfeeding support.

Organisational barriers, such as underfunding and a lack of highly skilled IBCLCs as Infant Feeding Leads, further limit consistent, non-conflicting care. Without sorting these staffing issues, all the education in the world is not going to help.

The root of the problem appears to lie in training. While the Nursing & Midwifery Council (NMC) mandates proficiency in breastfeeding knowledge (NMC, 2019), many Midwives report that their education fails to prepare them for real world breastfeeding support. Advice is often handed down midwife to midwife. A scoping review by Ingram et al. (2019) found that Midwives and student Midwives often lacked confidence in their breastfeeding knowledge, and frequently relied on their own experiences and experiences taught by seasoned Midwives, rather than evidence based techniques.

Experiential learning and mentorship emerged as vital components for developing confidence (not dissimilar to IBCLCs who are required to deliver 1000 hours of breastfeeding support during their training). These opportunities are rarely available. Midwives themselves have expressed a desire for more hands-on training and post qualification refreshers, not just the same 7 hour year-on-year study day, but interactive, deep-dive learning with case studies. This is particularly poignant in complex cases like under/over supply, perceived or otherwise' positioning and why each position works as it does the physiology of breast milk high palates; oral restrictions.

I could go on forever about how important this is and how passionate I am,, as are most IBCLCs I come into contact with.

In conclusion, breastfeeding investment is not just about feeding, it is about equity, sustainability and optimising the Nation's health for now and the future. It needs to be viewed as essential care, not merely an optional portion of care. Breastfeeding is not a lifestyle choice, it is a biological public health imperative. The amount we put into breastfeeding will show in the future and translate directly into reduced strains on NHS mainstream services. This will mean fewer hospital admissions , reduced prescriptions rates, and lower long-term health care costs. Currently though, the United Kingdom continues to face critical challenges in promoting, protecting and supporting breastfeeding women and families.

Further reading:

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Breastfeeding? Babies can do it in their sleep!

By Joelle Colson and Suzanne Colson



Author Bio: Suzanne Colson PhD, MSc is a retired midwife and the creator of Biological Nurturing – laid-back breastfeeding.

Joelle Colson BSc, BA is a public health nurse and the director of The Nurturing Project, created to disseminate biological nurturing research. She is currently undertaking her MSc in Developmental and Educational Psychology.

For more information see www.biologicalnurturing.com

Throughout recent history, infant feeding practices have evolved based on cultural beliefs, medical advice, and scientific understanding of newborn needs. One of the most significant debates in this evolution has been the contrast between **demand** or **baby-led feeding**—allowing a baby to breast or bottle-feed whenever they show signs of hunger—and **scheduled feeding**, which often follows a strict three-hourly timetable. To follow a baby-led approach, mothers are taught to breastfeed their babies when they cue or move in ways that indicate that they are ‘awake, alert, hungry and ready’ for a feed... a calm, neonatal awake state is believed to be “the window of optimal arousal when babies are ready to learn”.¹

Today mothers are very often taught to initiate breastfeeding when the baby is in a calm alert state of readiness. In this article, first we show the need to challenge this received idea and highlight its deleterious effect on exclusive breastfeeding rates. Then, using research evidence, we explain links between the sleeping foetus who develops sucking and swallowing competencies and the sleeping neonate who builds upon them to learn

breastfeeding skills. We introduce the concept of the ‘wombling’, a foetus who is now outside the womb, but fundamentally the same. We have chosen the term ‘wombling’ to suggest a baby still very much in the rhythm of the womb world. We conclude that the ‘window of optimal arousal’ for nurturing and breastfeeding occurs during light/REM sleep and drowsy sleep. Don’t wake the baby! The watchword is ‘continuity’ of sleep states from womb to world.

The Baby Friendly Initiative (BFI)² created in 1992, proposed 10 steps to successful breastfeeding. These became crucial to implement the revised 2001 WHO recommendations: exclusive breastfeeding (EBF) for the first six months, continuing for up to two years and beyond. Today the BFI 10 steps guide breastfeeding initiation in many European countries but few mothers continue to breastfeed exclusively beyond two months and around one third of European mothers supplement with formula milk whilst in the maternity hospital. For example, let’s focus upon data for Norway, Germany and Sweden. These countries are often cited as models for the success of the BFI support protocols because they have high rates of EBF at birth (98%, 97% and 94% respectively). However, a shocking number of these babies (30%, 11% and 14% respectively) are topped up with artificial milk in hospital. As could be expected, this downward trend continues and at two months, there is a sharp decline in exclusive breastfeeding (with only 73%, 68%, 64% respectively still exclusively breastfeeding). Far from achieving the WHO recommendations, Norway’s 17% exclusive breastfeeding rate at 6 months is the highest in Europe. ^{4,5}

The situation in England is another case in point. The BFI 10 steps have controlled breastfeeding support since the early 1990s. Today, even though 73% of mothers initiate breastfeeding at birth, only 37% are breastfeeding exclusively at two months. Notably, one third of these UK mothers feel compelled to top up their babies with artificial milk during the first week.³ The UK national [infant feeding survey](#) (2010) reported that mothers who breastfeed exclusively during the first week are 30% more likely to continue breastfeeding exclusively into the second week. These statistics suggest an urgent need to challenge current BFI best practice and revise our breastfeeding support strategies.

Since 2014, baby-led or demand feeding is often called responsive feeding.^{6,7} However, the age-old question remains unchanged: most mothers ask: “When and how often should I feed my baby?” A [popular poster](#)⁸ illustrates the typical feeding guidance, using photos of babies lying on their backs. The first line portrays ‘hungry’ babies who stir, bring a hand to their mouths, turn their heads from side to side, and open their mouths. In the second line, we see ‘really hungry’ babies who open their mouths even wider, stretch, make isolated arm, leg or finger movements and grimace. Health professionals suggest that these movements are ‘feeding cues’. As soon as babies make these movements, mothers are taught that they are ‘ready’ to feed.

In this article, we argue that the newborn baby breastfeeds optimally in sleep states and that the term 'ready' is inaccurate. Expecting the newborn to be in an early awake state limits breastfeeding opportunities and prevents babies from ingesting their full amount of colostrum. Responsive feeding often delays breastfeeding initiation: most babies transition quickly to an agitated awake state (fussy) and then cry. These behaviours are often labelled 'breast fighting', or 'breast refusal' and account for 33% of unplanned breastfeeding cessation during the first postnatal week.⁹ The following scenario illustrates a common failed breastfeeding experience.

Postpartum scenario: the baby too sleepy to breastfeed

A healthy term baby boy, born at 4 AM, held in skin-to-skin contact for an hour, does not suckle.⁹ At 8 AM, he's sleeping in the cot next to his mother's bed. The mother intermittently observes for hunger cues, but the baby continues to sleep soundly. At 2 PM he has not yet woken for a feed. Mum's worried; she calls the midwife who suggests gentle waking strategies, like a nappy change. This works: the baby arouses and cries. However, when placed at the breast, the baby again falls sound asleep. At 3 PM, the mother is urgently shown how to hand express her colostrum; a few drops to a teaspoon (0.05 mls)¹⁰ are given to the baby via a syringe. 'Just to be sure', the baby is cup-fed 30 mls of artificial milk. The next day, the baby has still not latched or sucked adequately, directly from the breast; maternal confidence is low: the more she worries, the less milk she is able to hand express. Her baby has lost weight and routine top-ups of her colostrum mixed with artificial milk are given after each attempt to breastfeed. On day 3, her milk volume has increased, and she is demand-feeding on cue but each time she puts her baby back to sleep in the cot, within 10 minutes, the baby stirs and cues for another feed. Because she's been told that these movements mean he's hungry, she immediately thinks that she doesn't have enough milk. During the first week, she continues to express, mixing her dwindling milk supply with regular top-ups of artificial milk. This mother represents one of the 28% who stop breastfeeding at two weeks due to perceived milk insufficiency and exhaustion.³

If not hunger cues indicating readiness to feed, what are the movements on [the poster](#)?

The movements on the poster are taken directly from Brazelton's Neonatal Behavioural Assessment Scale (NBAS), first published in the 1960s. Brazelton uses body, facial and eye movements, to evaluate the infant's **level of arousal, neurological maturity, and ability to respond to the environment.**¹ Together with breathing and heart rate, these movements identify six baby states: 2 sleep states, 3 awake states and drowsy, a transitional state towards sleep or wakefulness. The criteria for the definition of each behavioural state concern duration - the movements remain stable for at least 3

minutes - and transition. When the baby changes state, the differentiating movements all change at the same time.

Look at the movements described in Table 1 for REM (rapid eye movement) and drowsy sleep states. Do you see that these are the same as the ones described on the poster showing “hunger cues”? In other words, the movements on the poster have been *misinterpreted* as hunger and readiness cues. In the early days and weeks, in REM and drowsy sleep, these movements are **un-planned, involuntary neonatal actions or reactions** that occur regularly together indicating sleep states.

Table 1 Continuity of Behavioural State from Foetus to Neonate

Foetal Behavioural State Semela et al. 2022	F1 Quiet sleep similar to neonatal behavioural state Deep sleep	F2 Active sleep/REM sleep similar to neonatal behavioural state Light sleep	The equivalent to a drowsy state is not identified in the fetus	F3 Quiet wakefulness rarely observed and recently removed from fetal state classification, similar to neonatal behavioural state Quiet Alert	F4 Agitated awake similar to neonatal behavioural state Fussy	The equivalent to a crying state is not observed in the fetus
Neonatal Behavioural State Brazelton & Nugent 2013	Deep sleep	Light sleep	Drowsy	Quiet Alert	Fussy	Crying
Body Movements	Occasional Still, Startles, Occasional head turning	Finger movements Isolated arm leg, torso movements Torso stretches	Mostly still	Still, head turning Reactive to auditory / visual stimulants	Arm, leg thrusts Increase in amplitude & intensity	Uncontrolled high motor activity Head shaking
Facial Movements	Absent	Occasional grimace or smile	Frequent grimaces & smiles	Focused attention	Grimaces	Grimaces Contortions
Mouth Movements	Vacuum sucking*	Vacuum sucking bursts Tongue & Jaw	May purse lips	Relaxed or open May coo	Mouth open Brief fussy vocalisations	Open, tense lips Intense crying
Eye Movements	Absent	Closed REM under closed lids Occasionally slightly open	May be open but dull or closed or flutter Heavy lidded	Open Glazed look alternates with Bright look	Open or closed	Often tightly closed
Breathing Rate	Slow, regular	More rapid	Slow, regular	Slow, regular	Rapid	Apnea possible

**Vacuum movements are those movements that occur without any apparent sensorial stimulation*

A surprising continuity from foetus to neonate

The introduction of 2D, 3D and 4-dimensional ultrasound, foetal magnetocardiography and magnetoencephalography has enabled direct, prolonged and repeated foetal

observations. Starting in the 1970s, these new techniques enabled real breakthroughs in the field of developmental neurology. In 1993, Prechtl, an Austrian neurologist, suggested striking similarities between the brain of the mature foetus and that of the newborn baby.¹¹ In other words, there is an age-specific resemblance in brain structure and function from foetus to neonate. The term ‘wombling’ would perhaps be better suited to describe newborn competency during the first 8 postnatal weeks.

In 1982, Nijhuis et al. studied foetal movements to discover if neonatal behavioural states developed in the womb. At 38-40 gestational weeks, they identified eye, body and facial movements representing foetal behavioural states. These pave the way to competent neonatal motor and sensorial response.¹² Likewise, Prechtl observed a repertoire of 16 foetal movements from 7½ gestational weeks. Unexpectedly, he reported that these same movements were also seen after birth, without exception. Each movement has an adaptive function from foetus to newborn. For example, sucking and swallowing occur from 12½ weeks. One week later, the young foetus swallows amniotic fluid intermittently both day and night, in rhythmic sucking bursts. At 14 weeks, the rate of these bursts resembles that of a full-term baby swallowing breastmilk.¹¹ Importantly until around 28-32 weeks, the foetus is sound asleep, a state known as quiescence.¹² The only awake state, what Brazelton terms ‘fussy’ in the newborn, is observed around 34 gestational weeks.¹³

What about the calm, alert state of readiness?

Recent research suggests that a calm, alert state of readiness is only observed after birth.^{13,14,15,16,17} In other words, the newborn experiences this awake state for the first time, at birth. Widstrom et al (2011) suggest that some newborn babies have bouts of focused attention on the mother’s breast and face during the first 30 minutes after birth. However, the duration is unspecified. After about an hour, babies, reportedly, ‘feel sleepy’.⁹ Taken together, these observations suggest that if a baby has not suckled during the ‘golden hour’, s/he won’t breastfeed. Thereafter, periods of a calm, alert state of readiness, are usually of short duration. For example, on day 3, Brazelton counts state changes every 15 seconds. Some babies transition from one state to another up to 24 times during a 30-minute evaluation.¹ In any case, neonatal awake states are only observed 10% to 15% of the time in 24 hours.^{18, 19} However, most new mothers say that their awake babies are either agitated (‘fussy’) or crying.

Building upon these new understandings, we argue that sleep states, which predominate 85% to 90% of the time,¹⁸ are optimal for the newborn ‘wombling’ to coordinate his foetal sucking and swallowing competencies with breathing. The mature foetus makes 2 to 6 sucking movements before wide-mouth opening and swallowing.¹⁸ During this time, he swallows from 500 to 1000 mls of amniotic fluid per 24 hours.²⁰ We could guess-estimate that if every swallow equates to 0.5 ml, ideally, the

‘wombling’ would swallow between 250 and 500 mls during the first 24 hours. In other words, the ‘wombling’ would transfer a full complement of colostrum. This can only happen if new mothers are encouraged to be proactive: not only keeping their newborn babies sleeping on their breast **during the day**, but also helping the ‘wombling’ latch, when appropriate. During the first 24-48 hours, when the newborn is only allowed to breastfeed in a calm, alert state of readiness, transferring a full complement of colostrum becomes nearly impossible. Short, alert and awake periods lasting 3% to 5% of the time are insufficient to enable continuity of suck-swallow movements from foetus to newborn. Continuity is central to the theoretical framework that underpins biological nurturing (BN).



Biological Nurturing enables the wombling to transfer a full complement of colostrum.

What is Biological Nurturing - Laid-back breastfeeding (BN)?

Biological nurturing describes the instinctual breastfeeding behaviours mothers and babies exhibit when they are in close, constant abdominal contact. Importantly, in BN, the angle at which the mother reclines changes from mother to mother and always optimises baby gazing and eye-to-eye contact when the baby is awake.

Biological nurturing research, observing 52 mother-baby dyads (12 healthy late preterm and 40 healthy term babies), demonstrates that babies breastfeed optimally during the first postnatal month in REM and drowsy sleep.^{21,22} If they do not, mothers express colostrum directly into their babies’ mouths. A mouthful of colostrum triggers the familiar suck-swallow feeding patterns released during foetal life.²²

During doctoral research, twenty-two spontaneous breastfeeding movements and reflexes were identified and correlated with state, demonstrating that the same number of movements were observed in awake and asleep states.²³ Importantly, the movements observed in sleep states were smoother: the baby’s responses to sensorial stimulation were slower and calmer. Mothers practising biological nurturing had both hands free; they were able to help their babies, when necessary, to ensure pain-free, effective latch and milk transfer. Breastfeeding the sleeping baby during the day

enabled 85% of the sample to overcome those problems associated with early supplementation. Significantly, all 12 healthy late preterm babies were breastfed exclusively, at hospital discharge. Additionally, all 40 healthy term babies were breastfeeding at 6 postnatal weeks (87.5% exclusively).

Biological nurturing consists of six behavioural components. A behaviour is an action or a reaction. Here, we talk about ‘movements’, those gestures and reflexes that you see and can describe objectively, whilst mothers and babies are breastfeeding.²⁴ In BN, the baby’s position is as important as the mother’s. When practising BN, innate breastfeeding behaviours are reciprocal. Every time the sleeping baby moves on mum’s body, she responds. These interactions are involuntary; in other words they cannot be taught. In BN, the mother is proactive: she places her SLEEPING baby ‘tummy **on** mummy’ during the day. Ironically, the baby feeds asleep but the mother is always awake. Importantly, the baby is not held under the breast but lies on top, even when the mother is sitting semi-upright. This usually means that the baby lies obliquely or up and down on the maternal body rather than across her midriff. Mothers do not apply pressure to their babies’ backs, shoulders or necks to hold them in place. Instead, the weight of gravity does the job!

In these positions, babies move freely on mum’s body: their fingers grasp mothers’ clothes and massage their breasts preparing the let-down of early colostrum pearls; babies’ feet find support on maternal thighs. With every turn of their heads, their faces brush against the mother’s breast; at latch, babies’ noses and mouths are in contact with the nipple and the mother watches over her baby, protectively. Sleeping cheek to breast, tummy on mummy, these babies are at “the right address” to condition foetal movements to breast stimuli. Spontaneous movements are rewarded with sensorial stimulation just as they were in the womb. Read more in our [companion article](#).

Conclusion

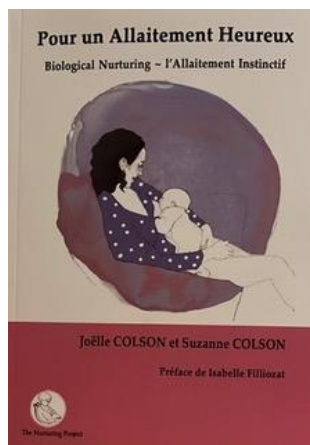
Maintaining continuity of behavioural state from womb to world is a newly developed research-based concept. To ingest the full complement of colostrum, the ‘wombling’ newborn latches and transfers colostrum optimally, in the same familiar sleep states in which they transfer amniotic fluid. Following birth and during the early weeks, newborn babies spend 85-90% of their time asleep. Although there is great variation, breastfeeding newborns when they are awake, alert and ‘ready’ often exceeds neonatal competence. ‘Readiness’ is an adult interpretation. For many years, this received idea has misguided infant feeding instructions, delaying breastfeeding initiation. The only behavioural state where the wombling/newborn could be termed ‘ready’ is in the active alert state. Research findings suggest that, during the first postpartum days, few newborns can modulate or maintain this state for longer than three to five minutes.

There is a strong physiological argument that early breastfeeding competencies develop through body learning, not through mental acuity, concentration and attention.

Finally, suggesting that the movements identifying REM and drowsy behavioural states are hunger cues is erroneous. This interpretation often leads to perceived milk insufficiency and routine supplementation with artificial milk. It's a vicious cycle leading to early unintended breastfeeding cessation.

Static and low European EBF rates in hospitals suggest that we need a rethink. During the first two months, major neurological transformations impact the amount of time a newborn can maintain focused attention in a quiet, alert state. Responsive feeding does not suit the 'wombling'; it corresponds better to the needs of an older baby, who experiences longer periods of wakefulness and cues for hunger.

It would be easy to replace reactive feeding guidelines, during the first weeks, with age-appropriate proactive recommendations based on neurological continuity from foetus to neonate. Is it now time for healthcare professionals and breastfeeding supporters to recognise that the newborn baby feeds optimally whilst asleep. Don't wake the baby!



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Disrupting breastfeeding confidence a drip at a time

by Alex Smith



Author Bio: As a childbirth educator, Alex was alerted to this issue having listened to a growing number of mothers reporting that their baby had lost too much weight in the first three days after birth.

An increasing number of new mothers begin breastfeeding following a long drawn-out process of induction of labour. Currently about one third of UK mothers are induced, a figure that is set to rise and a cause of [great concern](#) to many.

Over and above the repercussions of induction itself, a newly emerging worry is about the effect on women of having been on an IV drip for some length of time before the birth. This is likely to have been the case for anyone being induced with syntocinon. Author and childbirth activist Henci Goer, explains some of the unintended effects of IV fluids in this [short video](#).

The particular issue that I want to flag up here is the way in which IV fluids given to the mother can ‘waterlog’ the baby, overinflating the baby’s natural birthweight. This excess water is ‘peed away’ by the baby over the first 24-48 hours.¹

Most babies tend to lose a few ounces in the first few days after the birth and when this totals an amount equal to or less than 10% of their birth weight, no one is worried. However, the extra ounces of water can bring the apparent total weight-loss to over the 10% allowance and this is when the problem begins. Very few health practitioners are aware of the effect of IV fluids in this respect. When the weight loss is over 10% the mother will gain the impression that her breastmilk is insufficient. She will be encouraged to continue breastfeeding but may be advised to ‘[triple feed](#)’ her baby - breastfeed, pump and give expressed milk, and top up with formula. [NICE guidance](#) and many [hospital guidelines](#) recognise that topping up (or supplementing) with formula

increases the chance of early cessation of breastfeeding, but individual practitioners are often more focused on the weight gain.

Health practitioners may have no idea of the anxiety and torment caused when breastfeeding support fails in this way. The mother is already feeling wrung out and possibly very disappointed by the birth experience, and this is now compounded by breastfeeding grief.

Of course it is important to know that a baby is feeding well, so what to do?

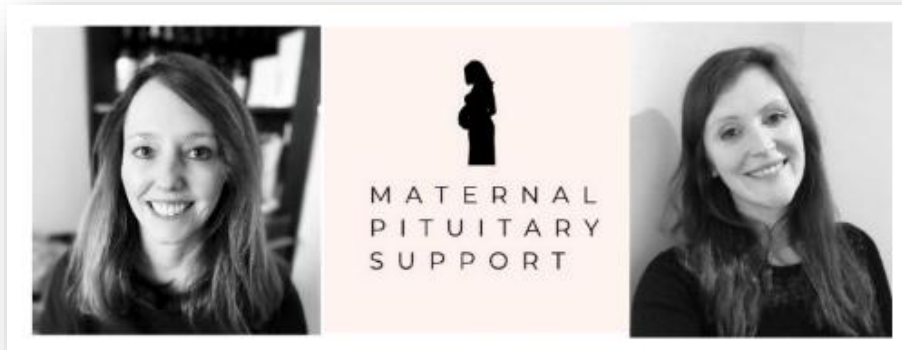
EASY - If the mother has received IV fluids during labour, weigh the newborn after the first 24 hours. This will give a much more accurate measurement on which to base the baby's weight gain.



¹ Giudicelli M, Hassler M, Blanc J, Zakarian C, Tosello B. Influence of intrapartum maternal fluids on weight loss in breastfed newborns. *J Matern Fetal Neonatal Med.* 2022 Feb;35(4):692-698. doi: 10.1080/14767058.2020.1731453. Epub 2020 Feb 20. PMID: 32079436.

Maternal Pituitary Support

By founders Claire Barlow and Jenn Kenworthy



Author Bio: Thank you very much to AIMS for inviting us to share a little about our organisation in this journal. We are delighted to be working alongside AIMS to advocate and raise awareness. Maternal Pituitary Support was launched in 2022 for those around the world with pituitary conditions arising in pregnancy and childbirth, such as Sheehan's Syndrome and Lymphocytic Hypophysitis. It was founded by Claire Barlow and Jenn Kenworthy, both mothers in the UK with Sheehan's Syndrome.

Maternal Pituitary Support was established in February 2022. It is a not-for-profit organisation, founded by us, Claire and Jenn, two mothers with pituitary conditions that arose in pregnancy and childbirth.

Becoming a parent is a unique experience and we recognise that coming to terms with a life changing diagnosis during this time requires specific understanding and support. We have both experienced first-hand the lack of information and support, and the isolation that comes with a diagnosis of a rare and often overlooked condition. In addition, we understand the incredible challenges of caring for a baby and recovering from a birth, especially if it has been a traumatic experience, whilst seeking a diagnosis or learning to manage a complex condition.

We have a wonderful, supportive online community where we provide a safe and supportive space for those living with maternal pituitary conditions around the world. We also support mothers with other pituitary conditions, such as pituitary tumours and

cysts. We hold online socials and events, with endocrinologists and experts to help us become expert patients ourselves. We are passionate about making a difference and speaking up for these lesser-known conditions. Unfortunately, these rare pituitary conditions are under researched; we hope to change this by campaigning for greater awareness amongst healthcare professionals so as to reduce time to diagnosis and improve treatment and care.

Maternal pituitary conditions:

The pituitary is a pea-sized gland found inside the sella turcica, which is a bony hollow within the base of the skull, level with the bridge of the nose. The pituitary is known as the ‘master gland’ due to its vital role controlling hormones essential for life and bodily function. You can find more information about pituitary hormones here:

<https://maternalpituitarysupport.org/your-hormones-1>

The pituitary gland becomes enlarged during pregnancy to respond to increased hormonal demands, making it vulnerable to damage. In addition, the anterior pituitary (front) relies on oxygenated blood from both the hypothalamus and the posterior (back) pituitary, making it further vulnerable to damage if it does not receive enough blood.

Sheehan’s Syndrome: is a condition where blood loss and low blood pressure during and after childbirth cause pituitary tissue to be damaged. Typically, for a clinical presentation, 75% of tissue needs to be damaged. There is no link between the amount of blood lost and the degree of damage. Hormone deficiencies vary and may include both the anterior and posterior pituitary. There are thought to be other factors involved, including autoimmune responses and small size of the *cella* (the bony hollow the pituitary sits within).

Lymphocytic Hypophysitis: is an autoimmune inflammation of the pituitary, causing it to significantly enlarge. This may be accompanied by severe headaches, visual disturbance, or hormone excesses. If there is tissue damage, there may also be hormone deficiencies. Lymphocytic Hypophysitis can affect anyone but is most common in pregnancy.

Post-Partum Hypopituitarism: is the term given for hypopituitarism that arises following pregnancy and childbirth, where the pituitary does not release enough hormones, due to damage. Treatment is usually life-long hormone replacement medication for each of those hormones that are deficient.



Jenn's Story – Acute Post-Partum Hypopituitarism

Jenn had her son in 2014 and had an acute onset of symptoms, resulting in adrenal crisis 13 days later. This is Jenn's story.

My pituitary was damaged following a 3rd degree tear when delivering my son, resulting in a haemorrhage and sustained very low blood pressure. I had emergency surgery and was given two blood transfusions.

I was advised by an obstetrician that my milk would be delayed coming in because I lost a lot of blood. They couldn't tell me when to expect my milk, but advised me to keep trying to breastfeed.

I was encouraged by many staff on the maternity ward to keep trying to breastfeed, even though I had no milk. I was advised that if I gave my son too much formula he wouldn't want to try to breastfeed and was repeatedly told that breast was best. This lack of milk should have been identified as an early warning sign of pituitary damage, due to a lack of the hormone prolactin. But it was missed. I wasn't referred to an endocrinologist and wasn't advised to start bottle feeding as soon as possible.

My son was very hungry, and we started to cup feed him with formula. We were told to use a cup so that he could still learn to breastfeed. We kept being advised to try to breastfeed and not to stop in case he would lose the ability to do so.

Each day I would desperately hope I'd see milk, but nothing ever came. I was even advised to start trying to express with a pump, just to see if it would stimulate any milk. It didn't work of course. All that happened was that I became incredibly sore and frustrated.

When it became clear that nothing was happening, my husband went to buy bottles and a big pack of formula. Despite recognising this was the right thing to do, I cried. I had been told over and over that breast feeding was the best thing for my son. I felt my body had failed and I didn't understand why. None of the health professionals around me could explain either. It seemed a complete surprise to everyone.

I gradually became more and more unwell. I was unsteady, unable to think clearly and had a terrible headache. I couldn't eat a thing, or sleep. I went to my GP after experiencing peripheral blurred vision, vomiting and diarrhoea in addition to not producing any milk. My pituitary damage was still missed and nobody realised the

danger I was in. When my son was 13 days old, I woke up in a life-threatening adrenal crisis and was rushed to hospital. I had a seizure and was sedated in critical care. It was only then that my pituitary damage was detected.

Looking back years later, I still feel sad about this. There were multiple opportunities for my symptoms to be identified as those of pituitary damage, and I could have had simple blood tests taken to identify my hormone deficiencies. I could then have been urgently referred to endocrinology, to be prescribed the hormone replacements I most urgently needed. These would have prevented my life threatening and traumatic experience of the adrenal crisis, along with weeks in hospital without my son.

What I actually needed on the maternity ward was to be supported to bottle feed formula milk as early as possible, because quite simply, there was nothing else that could give my son fluid and nutrients.

It felt at the time that there was this obsession with breastfeeding in society. This pressure came from all angles as a pregnant and then new mother. The maternity staff seemed equally insistent on breastfeeding as well.

My son is now a big, bouncy, healthy boy. He did really well on formula milk and has a huge appetite even now! I've been able to forgive my body; after all it was injured and crying for help.

I think there needs to be a shift in attitudes around breast and bottle feeding. There needs to be more empathy, kindness and understanding. There needs to be less judgement of what makes a good mother, and more support for the right choice for each individual.

Claire's Story – Chronic Sheehan's Syndrome

Claire had her daughter in 2019 and had a chronic onset of symptoms. This is Claire's story.

I had a long and difficult 40-hour labour after being induced. It ended in an emergency c-section. Because I had pushed for so long my daughter was quite far down the birth canal. A consultant came in and decided I needed an emergency c-section and during this they made a cut so they could remove her. Thankfully she was absolutely fine. I was stitched back up (although it turned out, not completely) and once on the ward I showed signs of a bleed. I held my baby once, before I was taken into theatre again. 3.5 hours later I was back on the ward, but not before losing 3.2 litres of blood.

My milk didn't come in, so I was unable to breastfeed. The medical staff all said it was due to the blood loss and that my milk would be delayed.

My milk never arrived. As well as the hospital consultants, midwives and community health visitors, I saw two lactation consultants and went to the GP to get some [prolactin](#)

[tablets](#) to encourage milk production. Not one professional spotted this major early warning sign. Not one of them mentioned that Sheehan's Syndrome could be a possibility.

It's utterly heartbreaking when you don't have milk to breastfeed.

At the time I wept daily. I grieved the loss of the chance to experience feeding my daughter. I cried so much I was flagged for postnatal depression. I explained I was just sad I couldn't feed my baby and people seemed to understand and accept this. In fact my pituitary gland had been damaged by the blood loss. The hormone prolactin wasn't being produced and my body was no longer functioning properly.

Nine months after giving birth, in 2020, I noticed I started to feel quite unwell. My hair was coming out in clumps. I had lost my sex drive, my skin was dry, nails breaking, I was gaining weight and generally felt dreadful. And when I stopped and took a breath, I noticed that my NCT gang were full of the energy that I didn't have - they were running up hills together with running prams, whilst I was having trouble walking up the hill - I was shattered. I also realised my period still had not returned and began to feel concerned.

At the beginning of 2021, after repeatedly going to my GP, I googled my symptoms and found a match: Sheehan's Syndrome. I couldn't believe it. I literally had every symptom listed, even the wrinkles on my face that I noticed had been coming on more and more over the past year. Dr Google said that Sheehan's Syndrome is a damaged pituitary gland caused by severe blood loss during labour. It says it is rare in the UK. Some further research led me to a private endocrinologist, and I was in a lucky position to book an appointment for the following day. One MRI scan, some blood tests and lots of sleepless nights later, I had a confirmed diagnosis of Sheehan's Syndrome. It was a relief in some ways to have a diagnosis, and in other ways incredibly frustrating and upsetting as I felt it could have been prevented. I wished I had fought for a planned c-section.

As my daughter grew into a toddler, she loved milk. When she was poorly or teething she asked for it over and over. One of her favourite things was milk, from a bottle with me. We cuddled quietly together. We built something together, instead of breastfeeding, and she doesn't know any other way. To her, this was perfect.

I can really empathise with the pain of not being able to feed your baby if that is what you desperately want. I can also say that from experience it's okay not to breastfeed. Perhaps a different experience from the one you had imagined, but it still has the potential to be equally as special for you both.

I was put in touch with Jenn by a kind lady at the Pituitary Foundation. I went there looking for answers and was given a fact sheet. I asked if they had a specialist in Sheehan's Syndrome and the answer was no.

When Jenn and I first spoke, I was so relieved to have found someone like me. Someone who understood. I remember sobbing all the way through our phone call, it was spring 2021 and I was in the garden.

We vowed then that no woman should face this alone. After huge amounts of work and energy, Maternal Pituitary Support was born in 2022. The aim is to support women around the globe, to campaign and raise awareness to reduce the time to diagnosis, and to secure funding to research this little known condition.

Acute and early symptoms

- *Visual disturbance / peripheral blurring / changes in vision*
- *Lack of breast milk / reduced supply*
- *Low blood pressure*
- *Dizziness*
- *Muscle weakness*
- *Difficulty sleeping*
- *High urine output*
- *Headache*
- *Fatigue / exhaustion*
- *Thirst*
- *Brain fog / unable to think clearly*
- *Unsteadiness / clumsiness / feeling drunk or drugged*
- *Diarrhoea / vomiting*
- *Racing heart*
- *Irritability*
- *Anxiety*
- *Feeling shaky*
- *Joint and muscle aches*
- *Mid / low back pain*
- *Hot flushes / night sweats*

Chronic and longer term symptoms

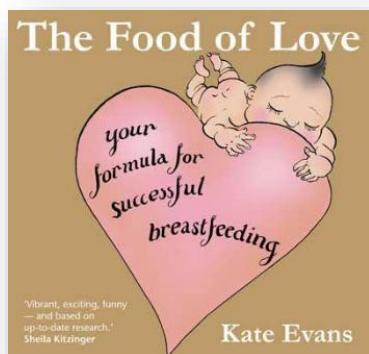
- *Fatigue*
- *Brain fog*
- *Short term memory loss*
- *Anxiety / depression*
- *No menstruation / irregular periods*
- *Hot flushes / night sweats*
- *Infertility*
- *Difficulty sleeping*
- *Weight gain around middle*

- *Loss of muscle bulk*
- *Loss of bone density*
- *Low libido*
- *Hair loss / thinning / losing hair at ends of eyebrows*
- *Unexpected weight loss*
- *Vaginal dryness*
- *Muscle and joint aches*
- *Constipation*
- *Diarrhoea*
- *Brittle nails*
- *Thinning of skin*
- *Wrinkles around eyes and mouth*
- *Irritability*
- *Generally feeling unwell*
- *Heart racing / fluttering*
- *Shaking hands*
- *Poor tolerance to cold / heat*
- *Difficulty sustaining exercise*

¹ Editor's note: The hypothalamus is an almond-sized part of the brain. It secretes hormones that stimulate or suppress the release of hormones in the pituitary gland, in addition to controlling water balance, sleep, temperature, appetite, blood pressure and even some parental behaviours.

A Conversation with Kate Evans, author of *The Food of Love*

Interview by Catharine Hart



Thank you for agreeing to be interviewed by AIMS, Kate. I love that this book doesn't try to sound authoritative, as a lot of baby books do. You start off at the very beginning before even the contents page saying:

"Now this book doesn't have all the answers. This is your baby, who isn't the same as the one in the books. You will arrive naturally at your own style of parenting, and feel free to take any advice about baby care, including all of this, with a pinch of salt."

The Independent newspaper described it as a “refreshingly different approach”- your style is so original, very honest and not at all preachy.

Aw, thank you! Yes, what I'm really proud of are the bits where I encapsulate ideas that are not able to be said in words. I can get them across using pictures. These are the things that really stand the test of time, the universality of birthing and breastfeeding experiences. I try my hardest not to be too prescriptive, because there isn't one experience that women are going to have of feeding and breastfeeding.



There are also some really great personal experiences you have captured here, in a graphic novel format, for example your Mum's experience, when she was trying to breastfeed and the student nurses came into her room to observe her because "they had never seen breastfeeding before".

Yes - they said to my Mum "We've brought all the student nurses to watch breastfeeding because they won't have another chance" (!!) - although I've drawn them clustered in a circle around her, I haven't drawn this accurately - apparently they were actually lined up in a row across the room!

Our theme for this AIMS journal is breastfeeding within the UK maternity services. Here in the UK we still have one of the lowest breastfeeding rates in Europe as well as globally.^{1,2} You touch on many aspects of our culture in the UK and how it can affect breastfeeding.

Yes, I don't know if any other country in Europe reserves the kind of vitriol which the popular press can direct at breastfeeding supporters. You don't see this in any other area of public health. You don't see the press calling dentists "Nazis", when they advise limiting sweets for children, or say how dare they talk about tooth decay and enamel, it will just make people feel guilty! Because there isn't any one way to "do it right" and there are conflicting schools of thought about how you should raise your baby, you're always going to be "doing it wrong" according to someone. This is a really culturally destabilising scenario. Because babies and the way that we raise babies are a really ingrained part of our culture, and the way that our culture sustains itself. Human culture is meant to evolve within groups of people who have all shared baby-raising practices. It seems fundamentally and biologically wrong for you to be unsupported and at odds with the people around you when you are raising a baby. So, nowadays, when you have both isolation and choice around which practices you adopt when you have a new baby, it's not surprising that women often feel sensitive and that they're being judged.



UNICEF reports that in the UK, around 80% of women give up breastfeeding before they would have liked to,³ which suggests our maternity services are not offering adequate breastfeeding support at all.

Formula feeding adverts aren't exactly helping either. I mean I am targeted with adverts for formula milk on the internet, and I'm 52 years old and a breastfeeding advocate!

Yes, you make the point very well - breastfeeding makes both “mothers healthier and their bank balances healthier”, especially now in a cost of living crisis with the cost of formula milk being £12-15 a tin, which can come to around £700 a year.

Yes, I don't call it a “cost of living” crisis – let's be clear – it's a “cost of billionaires” crisis! I don't actually think formula milk should be a commercial product to be sold for profit at all either, if we really believe “fed is best” it should be free, but women must also have informed breastfeeding support.



You're not saying you know there's only one way to do this - when I trained as a midwife, some of the advice was quite prescriptive.

It can be a really rocky road getting breastfeeding established, I had that with my second child. It was hilarious because I say in my book "your baby is unlikely to have read any of these books" – when I wrote this, I was mainly thinking about baby care manuals which talk about how your baby is ‘meant’ to behave – but after I had my second child, she probably had a lip tie and reflux - she was totally not on board with breastfeeding on demand! So she hadn't read my book either!

We have a cultural idea that babies are ‘meant’ to cry. If you ask children to do an impression of a baby, they will usually reply with “WAA WAAA”. There are babies who thrive on a routine of course, but what I object to is the idea that if you respond to your baby ‘too quickly’, your baby will be ‘undisciplined’ and that will make you a ‘bad’ parent.

You mention attitudes towards breastfeeding in other cultures, including ones where women may cover other areas of their bodies, yet generally public breastfeeding is common and accepted widely in these cultures.

Yes, because I am currently writing a book about Jane Austen, I have recently been researching dress in 18th century Britain. In those days women would be feeding, perhaps with a shawl to cover them, *everywhere*. In public spaces where there would have been babies, you would have seen babies fed, it would have been common. Historically, new mums would also have probably had more immediate community. There is also the tradition of ‘confinement’. It can sound medieval, but during your

confinement, until about 6 weeks after the baby is born, the expectation was that other people would come in to help look after your household.

Is there anything you would change or amend if you were to republish *The Food of Love* today?

I would definitely change the advice on not drinking alcohol at all when breastfeeding. There is more research now into this topic, discussed by Jack Newman for example.⁴ It's important to be aware of your alcohol intake in pregnancy or breastfeeding, but it's probably not true that you shouldn't breastfeed at all after drinking small amounts of alcohol, although awareness would still be needed around safe co-sleeping for example.^{5, 6}

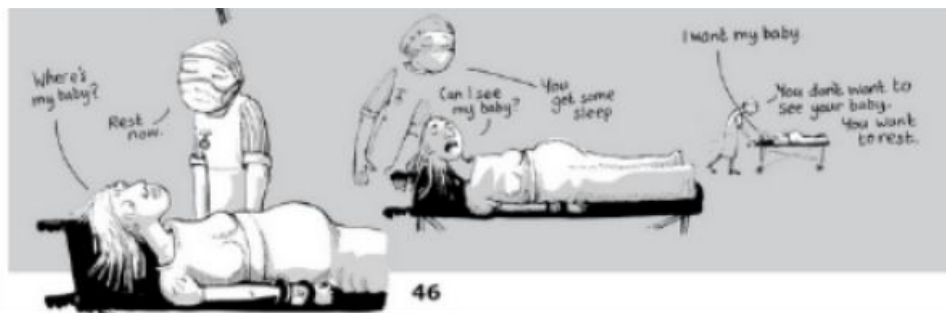


Your amazing illustrations – WOW – as you write "if you're feeling too brain-dead for reading, there are loads of pictures to look at instead". There is so much humour in the illustrations and they are so accessible, I found it really a joy to read, even if you're a bit sleep deprived! I love the "Mama Sutra" – covering different breastfeeding positions and your quote "breastmilk always comes in cuddles".

Yes, I designed the hard copy of the book purposely so it will stay open at the same page for you because of the spine – so you can read it with your hands full! I think I was influenced by also being around babies from a young age - my mum had a baby when I was 13, although apparently my sister and I weren't actually much help to her at the time!

When I wrote *The Food of Love*, as well as *Bump: How To Make, Grow and Birth A Baby* I wanted to be quite completist and provide some kind of 'manual'. If I was to reissue the books I think I would use mainly the artwork instead, creating something a bit more impressionistic. What is timeless in the book, as well as the comedy, is the general attitude. A political and philosophical idea of *meeting your child where they're at*, and this can be also thought about in terms of relations with other humans. This is very much the antithesis of trying to *control* other people.

I was looking to address specific problems by putting so much information into both books. But nowadays so many people will look online for answers for specific scenarios. So if I reissued my books maybe I wouldn't need to get so many words in there, but what needs to be celebrated is a *space* where you find out what your child's needs are and you meet them, at the same time as recognising that you yourself have needs and have other people around you, who can meet your needs. There aren't hard and fast rules about how your baby's needs are best going to be met. I'd like to create books that give indicators, but there will always be a baby or baby/mother dyad that confounds any hard and fast rules, where they will have their own way of making it work.



The Food of Love and Kate's subsequent book *Bump: How To Make, Grow and Birth A Baby* are published by Myriad editions and are both available to buy directly from Kate via her website (click [here](#)) – you can also order personalised signed copies (dedicated to a mum or baby of your choice!) directly from her.

For Jane Austen fans, Kate is also currently writing a book on Jane Austen, to be published later this year.

¹The Lancet (2016) 'Breastfeeding: achieving the new

normal': www.thelancet.com/action/showPdf?pii=S0140-6736%2816%2900210-5

² Nuffield Trust (2024) 'Breastfeeding': <https://www.nuffieldtrust.org.uk/resource/breastfeeding>

³ UNICEF (2025) 'Breastfeeding in the UK': <https://www.unicef.org.uk/babyfriendly/about/breastfeeding-in-the-uk/>

⁴ Newman, J. and Pitman, T. (2014) 'Dr. Jack Newman's Guide to Breastfeeding', p.383, 2nd edition, Toronto, HarperCollins Publishers. For advice about alcohol and breastfeeding see also La Leche league GB <https://laleche.org.uk/alcohol-and-breastfeeding/>

⁵ Drugs and Lactation Database (LactMed®) [Internet]. Bethesda (MD): National Institute of Child Health and Human Development; 2006-. Alcohol. [Updated 2025 Jun 15]. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK501469/>

⁶ The Breastfeeding Network 2021 - last updated 2025) Alcohol and Breastfeeding. <https://www.breastfeedingnetwork.org.uk/wp-content/dibm/2019-09/Alcohol%20and%20Breastfeeding.pdf>

The Fabric of Birth: Part two

By Nicole Schlögel



Author Bio: Nicole is a former midwife and author of the blog My Journey of Conscious Uncoupling from NHS Midwifery. She practices as a fascia therapist at Essentially Birth, her pregnancy massage clinic in Belfast. Nicole is passionate about the role of the soft tissues in birth and she is the co-creator of the Born Through Yoga Movement for Birth and Nurturing Newborns Programme.

Part one of this article was in [AIMS journal vol.37 no2](https://www.aims.org.uk/journal/item/anatomy-birth-massage) <https://www.aims.org.uk/journal/item/anatomy-birth-massage>

It's mushroom curry for dinner. I have put the first load of sheets from today's clinic in the washing machine and start with slicing the mushrooms.

*Some of the mushrooms still have bits of soil and mycelium attached. As I cut it away, I acknowledge that, until fairly recently, I thought those thread-like filaments were the mushroom's roots—after all, they anchor the mushroom into the soil. But then I watched the documentary *Fantastic Fungi*, and I was informed that they are not roots at all. I was immediately fascinated and inspired to investigate further.*

Now I understand that mycelium, though it looks like a root, is actually the main body of fungi. The mushroom is merely its fruit—emerging from its hidden underground network only to release spores to seed the next generation of its species.

For the second time today I am struck by the similarities between mycelium and fascia. These unassuming strands of fibre are part of a living network that forms the body of the fungus. They live below the ground like fascia lives beneath our skin.

We now know, beyond doubt, that individual mycelia communicate—not just for their own survival, but to strengthen the entire ecosystem. They even extend their support to other species by connecting with their roots.

I smile thinking how much we can learn from this intelligent organism. What if we embraced that the ecosystem of birth is strongest when all species of birth workers collaborate for optimal thriving?



There's another list of words to add to the student midwives' litany—another verse to the anatomy of childbirth.

“Engagement, descent, flexion, internal rotation, extension, restitution, expulsion”.

The cardinal movements.

Our lecturer today explains to us that the baby engages, then descends, flexes its head, then rotates in the pelvic cavity, then extends its head - *this* movement leads to the birth of the head.

The baby then rotates again to release the shoulders, a mechanism known as restitution or external rotation. This can be observed by watching the baby's head turn towards one of the mother's thighs. Finally, the body is born by expulsion.

It's not Sharon teaching this time but another of our lectures. She's nice but nobody quite matches Sharon's sharpness and clarity. By now, Sharon has secured her place as my favorite tutor. I admire her commitment to holding us to account in a way none of the others do and I admire her confidence in her area of expertise.



My hand cups yet another sacrum, that of a mother in labour. It feels as though the baby is right there, on the other side of this sacral bone and with every surge the bone seems to yield into my palm a little more.

“That soon?” I doubt the obvious, despite the bulging sacrum in my palm.

She deepens her breath intuitively. I massage her back and I watch as the surges continue to shift and intensify. Now they are definitely birthing contractions. Her belly heaves with each one.

She gets up from the bed to move into her birth space and I follow her.

On the drive home from witnessing this miracle I find myself in deep reflection. Birth after giving up my registration messes with my mind more than I expected.

I always felt that as a midwife I was pretty hands off. I saw many women through labour without ever performing a vaginal examination. I have seen many first time mothers give birth fast, and yet I find myself missing the structure offered by guidelines.

Even if a mother chooses to forego all routine observations there is a sense of control in operating from within a given framework. Now there's nothing other than what's unfolding before our eyes.



Sharon explains that a baby is not a mini adult and that this is important not only when a baby needs the kind of high-tech support available in a neonatal intensive care unit (Sharon's preferred habitat as a midwife), but also when it comes to understanding the adaptations that happen in the first minutes, hours and even days after birth.

Today we learn about fetal circulation. We each get a handout with a baby's heart, lungs, liver, major blood vessels and placenta drawn on it - or rather a fetal heart, lungs, etc.; the circulatory anatomy of a fetus is distinctly different to that of a baby and Sharon makes sure that we know that it would be wrong to refer to the fetus as a baby in the exam.

She goes on to explain the circulation of a human in utero. Firstly, given that the baby's lungs are not yet breathing but are instead two fluid filled bags of tissue waiting to be inflated for the first time, the placenta takes over the role of gas exchange for the baby through the umbilical cord (I know, I know it's a fetus! I can't help myself and thank goodness I am not currently sitting the exam). I realise that the placenta is the only external organ we will ever own and it belongs to the baby's anatomy. I vow to never call it 'your placenta' when talking to a pregnant mama. I will always refer to it as 'your baby's placenta'.

There are some unique structures that will change once the baby is outside. Two extra blood vessels and a little flap between the top two chambers of the heart ensure that the baby can grow and thrive inside its sea of amniotic fluid.

Birth changes everything.

I sit in awe as Sharon explains to us in great detail everything that has to occur for the new human to be able to sustain life on earth. As soon as the baby expands her lungs for the first time, the changes in pressure help the baby to now get their oxygen through the breath, the placenta is no longer needed.

There is no question in my mind that this *does* matter. It matters very much!

I watch Sharon in admiration - she has seen this occur over and over - and I know that I will never look at a newborn baby in the same way.



Another birth I miss entirely, also a first. The placenta is still inside when I arrive and has been for at least two hours now. I wait to be invited into the space. "Nicole, she would like to see you, she's getting out of the bath." I walk into their bedroom and I am greeted by the most sacred of scenes one can ever witness. A mother, her baby still tethered to her by the umbilical cord and the new father, all glowing in the candlelight. It's the middle of the night, there's a raging storm outside. I encourage him to support her to stand up and a little later the placenta plops out with the mother's gentle traction on the cord. The baby is still attached and happily nestled against his mother's chest. He has fed for most of this time, she tells me.

Wonderful! I catch a glimpse of the new baby and I share with the parents the miracle that I know is occurring right before our eyes beneath his skin.

While the parents get to severing the baby from his placenta, I help with some of the practical things like preparing some food and dismantling the pool. Once everything is tidy I leave the new family in their bubble.

On my way down the motorway, I ponder on the idea that witnessing birth is very different to observing birth. When you witness birth in the way that I just had, cardinal movements, pelvic diameters or the diameters of the fetal skull don't matter. Dilation of the cervix or the station of the presenting part (normally determined via a vaginal examination) don't matter either because nobody observes them.

I reflect back on the day I was introduced to the cardinal movements. I thought then that one followed the other. I don't think that this was specifically implied but they were presented as a list and to me this looked like they were in some sort of chronological order. It took me a few years of practicing as a midwife, to realise that it all occurs at the same time. Engagement, descent, rotation, and flexion occur by cause and effect.

With engagement comes descent, and with descent there's more engagement. As the baby moves deeper, flexion and rotation unfold together. Millimetre by millimeter the baby travels through. Diameters change fluidly through more flexion and rotation. The baby molds into the space as the mother yields around the baby.

It is a perfect design.

Over the last ten years or so, through my studies of the fascia and the spatial relationships within the pelvic cavity, I deepened my understanding of the role of our soft tissues in birth (I highly, highly recommend Tom Myers' course "Deeper Ground: Restoration and Vitality for the Female Pelvis." if you support women in any capacity at all).

The process of birth is guided by the innate asymmetries of the female body. The posterior pelvic floor tends to yield more easily on the left, while the uterus carries a natural rightward tilt. Together, these subtle imbalances create a spiral-like dynamic that is integral to birth, allowing the baby to rotate through the pelvis via the path of least resistance.

And yet, what I was taught makes up the anatomy of birth - both in the mainstream and holistic realms - is not at all part of the birthing mother's conscious experience nor does it exist for the baby.

The difference between witnessing birth, cognisant of the role of the fascia and soft tissues, and observing it, plotting 'progress' in regular intervals is that one is supportive of its unfolding - honoring the body in its orientation towards health and resolution - and the other is actively hindering the intricate hormonal orchestra.

Two different types of touch, one diagnostic, seeking to exclude a deviation from 'normal', the other nurturing - allowing the hormones of birth to flow more easily.

Birth within the medical system and birth outside of it are both part of the fabric of birth in society—like fascia, like mycelium. Each birth, in its unfolding, continues to weave this

fabric and shape our collective consciousness. Like the spores of a mushroom, it seeds the landscape of birth for future generations.



We sit the exam in neat rows in Whitla Hall. I sit behind a single desk and the students to my front and back and right and left are about five feet away. Consulting with each other would most definitely rouse attention (not that I would consider cheating). There's nothing unexpected on the paper and, although I don't ace the exam, I pass with a big enough margin to stay on track for the first honours degree I will collect two years down the line.

By the time I collect my degree I have learned about childbirth pathology. I know about 'delay in first stage' and the protocols that go with it for example - I already understand that the concept of 'too slow' is not at all useful in supporting birth physiology. I also now know how to respond to emergencies that can occur in birth and I pray that I will always respond in the correct way.

Sharon has taught us how to recognise a baby who might need help and, again, I hope that my eyes and ears will be vigilant enough to understand the sometimes subtle cues a newborn baby might give me to ask for help.

I am a fully fledged midwife ready to be released into the fascia of NHS maternity care and I am excited and nervous in equal measures.



My career as a midwife, in many ways, is everything I could have hoped for. In the eighteen years I spend in the NHS I see many examples of its strengths.

I can see that the very systems that are driving birth medicalisation - and many women away from institutionalised maternity care - are also offering a structure to look to when emergencies and tragedies do occur.

At the moment I can see a shake up in birth culture and I wonder how it will all evolve. I would love to see a birth ecosystem that appreciates the strengths of system based services and out of system services. Could we create an intelligent mycelium type matrix

to uphold a new maternity system, a fascia that allows for sensitive and supportive communication with pregnant women and their families?

Years ago I asked myself the question if the diameters I learned off by heart actually mattered. I think it's time for the institution to admit that they don't and stop focusing on attempting to measure. Those diameters are estimates and we know that they change with movement. They are not even definitive in a woman who is lying on her back - as most women in labour wards across the world still do.

On the other hand it is time to reaffirm the types of scenarios in which medical intervention will make a difference.

A father recently said something during a birth preparation session that stayed with me: "We don't know what we don't know."

He was struggling with the idea of his wife's right to decline interventions. Don't the experts know best? Wouldn't you just do what they say?

How insightful; we don't know what we don't know!

This is the dilemma that we all face all the time.

It's a shame that parents now find themselves in a position where, in order to protect themselves and their babies from the potential harm of unnecessary interventions, they may end up making decisions from a blind spot. This too, could potentially put them at a disadvantage.

There's no way to convey to parents all the ins and outs of the big picture. We cannot know which scenario will unfold. And the truth is, things are not as black and white as they are often portrayed—whether in birth activism or in medical maternity care.

Parents understand this—and they would love to be able to defer to the expertise of their midwives and doctors without facing a 40–50% chance of a caesarean section, or an additional 20% chance of an instrumental birth.

Could the incredible skill within maternity care—I would trust Sharon implicitly to nurse my baby— sit alongside a physiology-informed, functional approach to pregnancy and birth?

Will maternity systems make space for simple birth witnessing, reserving medical technology for when it's truly needed?

And more importantly, what would need to shift in our collective fascia—in our mycelium—for the extended ecosystem of birth—society itself, the legal system, and the press—to embrace such an approach?



AIMS Workshop: Technology in the perinatal period

By Kathryn Kelly



Author Bio: Kathryn Kelly has been a self-employed NCT Antenatal practitioner since 2009. She currently works for NCT reviewing evidence and informing parent content. Her particular interest is in learning and writing about perinatal informed decision-making, and she's developing a popular science book around birth.

Introduction

In April I was delighted to be joined by eight people from both birth-worker and non-birth-worker backgrounds, for a discussion into what we understand by 'technology' in the perinatal period. I'm enormously grateful to AIMS for providing this space so that I could invite discussion around a topic that I expect to form part of a popular science book I'm developing.

My writing comes from a position of emancipatory feminism and human rights, and my academic teaching credentials are underpinned by work with thousands of expectant parents through facilitating antenatal courses.

Why were we looking at technology?

Most people will have an instinctive reaction to the concept of technology in health and social care. So, this felt a good choice for our first of three discussion topics.

I wanted everyone to feel welcome, safe, and confident to share their thoughts within the room, and so it felt important to acknowledge that attendees were from different backgrounds. We needed to be respectful of everyone's lived experiences - for some technology may have been a vital and lifesaving tool. So, I made it clear that we weren't there to decide if technology was good or bad, or to demonise its use.

It's a natural human trait to see a problem and want to fix or solve it (maybe this is why I'm reading so many detective stories!). But the use of technology in health and social

care feels an important part of a larger cultural picture. Reasons for its use might include the elimination of risk – itself a muddy issue - or as a magic bullet to make life simpler or cheaper.

We'll have to save 'risk' for another time (though I did touch on it in my article on [Safety and place of birth](#)). For now, let's say that the muddiness comes from discomfort with risk (though we're largely happy to ignore it for our convenience) and responsibility. Our society is ill at ease with mortality and insufficiently developed to address the issues of social disability.

What technology are we talking about?

To aid our discussion I limited our definition to one year before and one year after birth. This would mean we could also touch on pre-conception technology.

I also explained that we could include technological concepts, for example, algorithms. This means the guidelines and protocols which inform so much of perinatal care, and extend to concepts such as time, risk, and safety.

To promote engagement, I invited everyone to contribute to a [Padlet Sandbox](#), where they could add 'Post-it' style notes to a prepared digital board. After a little time for everyone to add their thoughts, we worked through each page, sorting the notes into themes and discussing as we went.

Pregnancy

Throughout, I was surprised at the variety of parent-as-user tools suggested. Conception timing apps, personal health monitoring, and social media support forums were all mentioned for pregnancy.

The pregnancy test is now straightforward and self-administered, and we had no complaints about that.

We explored midwife tools; a combination of algorithms (e.g. when blood pressure is high or low, take a predetermined action) and older (pregnancy wheel, blood pressure cuff) or more modern technology (Doppler for fetal monitoring, ultrasound machines). Pregnancy tools also include scans and tests, digital notes and records.

These tools were introduced with the aim of making pregnancy and birth safer for women, birthing people, and their babies. And for the most part they appear unthreatening to the first-time parent. Contested areas include the BMI calculation, and carbon monoxide (CO) monitoring.

BMI is not a valid tool for many populations whose muscle mass differs from the norm, established from Belgian men in 1832¹. And CO monitoring can result in people feeling anxious that they will be judged for smoking or living in a smoking household. Some people decline genetic screening or testing as their values are incompatible with ending a pregnancy.

Labour and birth

When it came to labour and birth, we had to touch on the use of the calendar and clock – time as a technological concept – and how they affect the duration of pregnancy and what happens in labour.

We also noted the parental use of contraction apps. These might provide a sense of control and so feel reassuring for some parents. They might suggest a lack of trust in the body or the process of birth. They might create distance between the embodied experience and external, authoritative knowledge. Could this distancing lead parents to be more accepting of external authority throughout their labour, or do we think that deferral to authority is already embedded?

We know that an individual's values are central to decisions they make about their care. Some will opt for low-tech birthing stools, couches or active birth aids such as pulleys, balls, and pools. While others prefer the clinical and flexible modern hospital bed. Monitoring options in labour move from the lower tech – observation, Pinard or Doppler, the partogram – to higher tech – fetal scalp electrode, fetal blood sampling, and cardiotocograph (CTG).

Even the most technologically complicated – CTG – is still quite basic in modern terms. Research into [using AI to improve the value of CTG is under way at the University of Oxford](#). We wondered if layering more technology into an already contested technology would be helpful or distracting. Use of AI might strengthen the value of CTG, or it could demonstrate its lack of value – both of which could be positive outcomes.

We acknowledged that the development of medication – pain relief, hormones, antibiotics etc., - will have involved a level of technical innovation in their manufacture and storage. Delivery systems require varying degrees of technical complexity, for example, injection or catheter and drip. Similarly, induction of labour includes a range from the simple mechanical to the complex bio-chemical tools.

We know that the history of forceps was a marketing success story, creating work and reputation. And while some babies and women will have been helped, many were damaged, and midwifery was squeezed out of practice.

Other clinical tools - ventouse, scalpels, cauterisation, stitches and dressings - were developed with the laudable aim of minimising mortality and morbidity. It feels important that it would have been rare for women's voices to be heard in the development of any of this technology.

Postnatal

Given the higher maternal risk in the year after birth, I found the notable shift in our notes on this period fascinating.

We highlighted incubators, newborn tests, and vaccinations. Then the algorithms of nutrition guidelines and the guidance that informs the Health Visitor checks and care. The fact there is little to support the woman perhaps reflects that maternity services discharge her once the urination, feeding, and mental health questions are ticked. Care then moves to public health, in the form of the Health Visitor, within a couple of weeks. As a result, much of the technology we identified postnatally is that which is marketed to parents.

For parents, buggies or slings and car seats might be considered essentials. Cots, sleeping bags, and nappies too. Many parents use smart devices for self-monitoring, and social media for peer support.

While hand-expressed breastmilk has been collected since ancient times, the C19th brought the mechanical pump and the C20th the electric (at that time almost exclusively used within hospitals). Now there are a wealth of options to express and store breastmilk, as well as sterilising the pumps and bottles.

In addition to these fundamentals, we now have a raft of products of debatable value. Marketing positions these as increasing either 'safety' or 'ease'. Whatever the promise, they certainly part new parents from money.

Products positioned as taking the load off the mother or primary carer could be said to be emancipatory. However, many cater only to the privileged: auto rocking cradles, auto bottle prep, and remote-controlled reclining chairs come with hefty price-tags.

Some products are informed by, and certainly play on and feed, parental anxiety: apps to log feeding and sleeping, baby monitors and cot cams, home weighing scales, and room thermometers.

I'm conscious of the importance of listening to recent parents – neither our personal experience of parenting, nor our personal values, should cloud our perspective and lead us to judge new parents. But it can feel like most products benefit the marketeers, rather than the parents.

Some feel actively bonkers - heated baby wipe containers, pee teepees, anyone?

The future

I had intended to touch on ectogenesis in our discussion, but we didn't get round to it. Research into artificial wombs is inspired by the aim of keeping very premature infants alive. But there are those who would create and develop babies entirely outside a womb, which prompts serious ethical questions^{2,3}.

It's an interesting example of one kind of feminism – that sees childbearing as burdensome and the foundation of inequity between the sexes – being diametrically opposed to another kind of feminism – that sees pregnancy and birth as intrinsic to their femaleness⁴.

Discussion

For many of us in the discussion, our first exposure to what technology in childbirth might look like came from Monty Python's 1983 film 'The Meaning of Life'. (You can watch the clip [here](#).) We've come a long way from 'the machine that goes ping', and I think we can agree that the experiences of women and birthing people are now higher on the agenda.

Attendees summarised that tools are assessed on their clinical function, with historically little research into their side-effects or impacts. Therefore, most tools went into routine use without a good evidence-base or research into the long-term impact on the woman or baby.

This was particularly true if the side effects were not considered to be clinically relevant, such as the impact on mobility, gut flora, or the woman's experience or identity.

The algorithms embedded in NICE and local Trust guidance can be informed by custom and practice due to a lack of good quality evidence. Some feel that CNST⁶ pressure has led to ‘action bias’, where the clinician feels safer acting, rather than not acting, because it’s easier to defend ‘we did everything we could’ in the courts of either justice or public opinion.

For some birth-workers this might feel like a patriarchal ‘fixing’ of problems, rather than trusting the process and allowing situations to unfold, reminiscent of Monty Python’s sketch. And that’s true, but recent maternity investigations, and worldwide maternity care, illustrate that not intervening appropriately (or having the resources to do so) can also lead to dangerously poor care.

I was interested in my own response to exploring this topic. Preparing for the discussion made me think through my own biases. It revealed the breadth of application of technology – beyond physical artefacts - and helped me to see it in a wider context. Having said that, I’d like to see the ‘machines that go ping’ under dust covers until women are heard, the tech is proven necessary and helpful, and healthcare resources are more equitably distributed across the globe.

But broadly speaking, our discussion agreed that it’s not the technology that’s the issue, it’s the way it’s used. Thoughtful, intelligent use of well-grounded and continually reviewed technology (from guidelines to physical tools) is beneficial. Sadly, we know that the current maternity services are under extreme stress, which can lead to poor decision making and defensive practice.

Summary

Does it matter if members of the general public understand the role of technology in the perinatal period?

Part of my motivation for working on this book proposal was that educating parents in the third trimester can feel too little too late. At that point we have a lifetime’s social conditioning (not least by tv medical dramas) to overcome.

If our whole society was better educated on the perinatal period – the physiology, the impact of intervention, the enablers and disrupters of an optimum experience for all – then those with the power to bring about change would have a better understanding. And then, maybe, change would be more likely.

Our next discussion was about Power and Politics in the Perinatal period, and you can read more about that in the next AIMS Journal.

1 Pray R, Riskin S. (2023) The History and Faults of the Body Mass Index and Where to Look Next: A Literature Review. Cureus. Nov 3;15(11):e48230. <https://doi.org/10.7759/cureus.48230>

2 Kleeman, J (2020) Sex robots and vegan meat. London, Picador.

3 Wilkinson S, Williams NJ, Fovargue S (2023) Artificial wombs could someday be a reality – here's how they may change our notions of parenthood. <https://theconversation.com/artificial-wombs-could-someday-be-a-reality-heres-how-they-may-change-our-notions-of-parenthood-217490> [26 May 25]

4 Tong R, Botts RF (2017) Feminist Thought: a more comprehensive introduction. (Fifth). New York, Hachette.

5 Monty Python (1983) The Meaning of Life: Birth.

6 The Clinical Negligence Scheme for Trusts (CNST) provides insurance against clinical negligence claims for NHS Trusts. NHS Resolution (no date) Clinical Negligence Scheme for Trusts. <https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/> [26 May 25]

Why Fatherhood Solutions Matters - the first year

By Scott Mair, Founder and Director of *Fatherhood Solutions*



Author Bio: Scott Mair is a father who understands the complexities and rewards of fatherhood. He is passionate about promoting mental health for fathers and providing them with the tools they need to embrace their roles with love and understanding. It is his hope that this article will shed light on the importance of supporting fathers and celebrating the unique journey of fatherhood. Scott is proud to share this short film, produced by Coventry City Council, showcasing the work he has been doing to support dads across the City.

[Fathers Matter – YouTube](#)

Twelve months ago, we set out to make a bold, loud case for dads. Not as extras in the parenting journey, not as just "helpers" to mums, but as central, active parents with their own needs, strengths, and challenges.

Reflecting on the last year, I am proud to say we have made considerable progress, however there is still much more to do.

Why Fatherhood Solutions Exists

Too often, dads are left out of the conversation whether it is in antenatal care, birth trauma recovery, feeding, bonding, mental health, or early years education. When dads are ignored, children and families miss out with dads left navigating some of the hardest transitions of their lives in silence.

We help services become father-inclusive from the inside out, undertaking system audits, developing action plans and pathways, delivering training and workshops, facilitating support groups and embedding lived experience.

We work alongside health visitors, midwives, family hub teams, charities, universities, and local authorities, always asking the same question: *Where are the dads in this?*

We are working hard finding ways to include fathers, not just in areas where our “Step into Fatherhood” model is thriving, but across the country.

What We Have Done This Year

Here is a snapshot of what Fatherhood Solutions has delivered over the past 12 months.

Expanding local authority Dad Support Offer

We have continued our work with local authorities through the *Start for Life* programme, embedding support for dads into every stage of the first 1,001 days from pregnancy through to toddlerhood.

This has included:

Dad-only Baby Massage classes taught *by dads, for dads*, offering not only bonding time but practical knowledge on infant cues, touch, and regulation.

Weaning Workshops designed with dads in mind hands-on, no-fuss sessions helping build skills and confidence around feeding.

Pregnancy After Loss Support Groups run online in collaboration with charities, ensuring dads who have experienced loss are seen, supported, and never left out of the healing journey.

Storytelling sessions highlighting the importance of not just reading but storytelling in a way all dads are comfortable with.

Stay and play with dad a variety of activities designed to improve parenting confidence and socialising.

Supporting dads with neurodiverse children or neurodiversity.

Military Dads A programme supporting deployed dads.

Frontline Fathers Monthly support and webinars for fathers on the frontline.

Walking the Walk Connection is powerful and sometimes it starts with something as simple as a walk. Our monthly Dad Walks have brought together hundreds of dads and their children. These are not just strolls; they are spaces where dads talk openly about parenting, mental health, and everything in between, surrounded by other men who just *get it*.

Five-a-Side Football We also launched our first Dads’ Five-a-Side Football sessions. No pressure, no egos, just dads showing up, moving their bodies, and boosting their mental health in a space that is welcoming, fun, and judgement-free.

Birth Trauma Support

Too often, birth trauma is only associated with mums, however [dads experience it too](#). Whether they witnessed a traumatic birth, felt powerless during a medical emergency, or felt sidelined in the process, it *stays with them*.

This is why we have built a strong partnership with the **Birth Trauma Association**, running **Bimonthly Zoom support sessions for dads**, offering a safe, supportive environment to talk, reflect, and heal. This work was highlighted at the *Make Birth Better Summit* and *Theo Clarke MP's book launch*, where we proudly stood up for the inclusion of fathers in trauma-informed care.

Young Dads, Neurodivergent Dads, and Dads with Lived Experience

We have been intentional about reaching the dads who are *least likely* to be reached. Our **young dads' sessions** have included practical cooking workshops for weaning and 121 mentoring.

We have supported **neurodivergent dads** with tailored sessions, plain language resources, and sensory-aware environments that make it easier to engage.

We have also worked with dads **recently released from prison, those living in temporary housing, and those from the most deprived postcodes** ([SIMD](#) 1 & 2, and the [IMD](#)),¹ helping them reconnect with their children and build back trust with professionals.

When services meet dads where they are, everything changes. We have seen it firsthand: dads building confidence, bonding with their babies, and actively engaging in services they used to avoid.

"I never thought I'd be this involved — I didn't think it was for me. But these sessions have changed how I see myself as a dad." – Dad

Training the Workforce – Father-Inclusive Practice at the Heart

At the core of everything we do is workforce development. This year we have delivered training to a wide variety of health and social professionals including:

- Family hub teams.
- Midwifery and health visiting professionals.
- Speech and language therapists.
- Social service teams.
- University students (including midwifery, social work, and early years).

Our **Father-Inclusive Practice workshops** are built on real-life stories, evidence-based strategies, and a clear framework for change. We are not just ticking boxes, we are shifting cultures. From explaining how to spot signs of paternal mental health struggles to rethinking appointment access for working dads, we are helping services walk the talk when it comes to inclusion.

National Advocacy and Influencing Policy

Fatherhood Solutions has been working behind the scenes attending national roundtable talks, contributing to research, and amplifying dads' voices in places they have been missing for too long.

Highlights include:

- Attending the *Make Birth Better Summit* and receiving the **Impactful Organisation Award** for our commitment to supporting fathers during the perinatal period.
- Partnering with **Action Menopause Warwickshire** and **Healthwatch** to conduct focus groups with men on how to better support their partners through menopause.
- Contributing to discussions with the *Men and Boys Coalition*, *1001 Critical Days Foundation*, and other key bodies focused on improving early years outcomes.

We believe change happens both at the grassroots and at the top and we are proud to be doing both.

The Impact – Why It Matters

All this is not about just delivering events, it's about changing lives.

It is the neurodivergent dad who finally felt confident enough to take his baby out solo.

It is the grieving dad who joined our online session and said, *"This is the first time I've said it out loud."*

It's the young dad who cooked his baby's first solid meal and sent us a photo with a beaming smile.

It's the professional who told us, *"Your training made me rethink how I speak to dads – and it's already made a difference."*

This is what father-inclusive support looks like: practical, honest, tailored, and built on trust.

Looking Ahead – What's Next?

We are just getting started. In the next year, we are looking to:

- **Expand our "Step into Fatherhood" model** into more places across the UK.
- **Offer workplace consultancy** so employers better understand and support working dads, especially in the military, blue light services, and male-dominated industries.
- **Grow our lived experience team** and create more spaces where dads can lead the conversation.

Final Word

Fatherhood Solutions exists because we know that *when dads are supported, everyone benefits*. Stronger families, better outcomes for babies and healthier communities.

We are proud of what we have built this year, but we are even more excited about what is ahead. To every dad who's walked with us, shared their story, or taken that first step toward being the dad they want to be - thank you. We see you, we hear you, and we are here for you.

And to every service, local authority or employer wondering how to better support the dads in your world - let us talk.

Quote from a Dad of twins who engages with the step into fatherhood programme.

"I wholeheartedly recommend Scott and the Fatherhood Solutions Group to any father navigating the early years of parenthood. Whether you're looking for advice, support, or simply a space to connect with like-minded individuals, this group is an invaluable resource that will undoubtedly enrich your journey as a father."

Quote from a Mum, whose husband is supported by Fatherhood Solutions

"My husband engages with other support groups for dads and finds comfort in listening, supporting, and encouraging other dads. This is all down to Fatherhood Solutions, which I thank for your service. Not only for my husband, but for myself as he has offered me support and guidance. Thank you for being a network we can rely on at anytime, no question is too much for Scott."

Fatherhood matters - it is time we treated it that way.

¹ Editor's note: SIMD stands for the Scottish Index of Multiple Deprivation. Scott also works with dads from the most deprived areas of England too. IMD

Working together to influence the future of midwifery research

By Dr Jude Field and Jenny Cunningham



Author Bio: Jenny Cunningham - I am one of the part time Research Advisors at the RCM. Prior to this I was a clinical midwife, a research midwife, and a midwife researcher in the southwest of England. I was also the RCM Learning Rep at my local hospital Trust. Since working for the RCM, I have led on the development of the RCM's Research and Development strategy and am now with my Research Team colleagues delivering projects to help and support midwives with their involvement in research. I am also undertaking a part time PhD on the topic of weight stigma in pregnancy.

Dr Jude Field - I job-share with Jenny as one of the two part-time RCM Research Advisors. Alongside this roles I am a side-by-side maternity trainer with The Flying Child. Prior to working for the RCM I was a clinical midwife and midwifery lecturer in North Wales, and have also worked as a qualitative research assistant on a perinatal mental health RCT running across England. I completed my PhD in 2018, and my focus was on improving how home birth is offered to women and birthing people. My current research interests also include maternity care provision for victims and survivors of abuse.

The UK's top 10 midwifery practice and maternity care research priorities are here! We first wrote about this project two years ago when we were in the planning stage. AIMS was a founding member of the project, with Nadia Higson on the Steering Group and AIMS as a Project Partner. We have been delighted with the involvement of AIMS

and thank Nadia very much for her commitment and engagement throughout the life of the project.

The Royal College of Midwives (RCM) led the project and worked with the James Lind Alliance (JLA) to make sure we used a clear and trusted process. We invited AIMS and other service user organisations to become Project Partners to make this a collaborative project which reflected the priorities of women and birthing people, as well as midwives, midwifery students, maternity support workers (MSWs) and maternity care assistants. Perhaps you responded to one of our surveys which led to the top 10. You can see more about the project including details of the research team, steering group and project partners [here](#). As a reminder, we circulated two electronic surveys, one in January 2024 and one in January 2025. The first survey gathered people's thoughts and ideas about what was important to them and where the gaps in evidence were. The second survey listed 67 priorities for research – created from the information given in the first survey - and asked respondents to identify up to 10 of their choices.

EDI considerations

We used an Equalities, Diversity and Inclusion (EDI) lens throughout as we wanted to ensure the top 10 reflected the UK's diverse population. We know that research is so often drawn predominantly from white, middle-class participants who are typically overrepresented in research. We used strategies throughout the life of the project to seek to change this bias, including reaching out to service user organisations who represent or work for minoritised groups, extending the surveys to respondents from the global ethnic majority, and considering the priorities which were considered most important by those from the global majority, members of the LGBTQ+ community and respondents who had identified as disabled (both physical and psychological). This was to ensure that EDI was central to the priorities discussed by the workshop.

The workshop

The top 10 were decided at a workshop of 24 people - women, birthing people and representatives of service user organisations (including AIMS) as well as midwives, midwifery students and MSWs. This group chose from a list of 26 priorities which were the most important options of those who completed our 2nd survey. The list of the 26 priorities can be viewed on the [JLA website](#).

We were observers to a carefully developed and gently led day, with plenary as well as important breakout sessions. We were struck by the respect each person showed to others when discussing sensitive and often personal topics, which included baby loss

and racism within maternity services. The outcome – the top 10 – was announced at the end of the day and everyone had at least one of their top 10s in the final list.

We are excited to share with you the final top 10.

1. What is required to create and implement culturally safe maternity care in the UK for women and birthing parents, and their babies, and staff from the global ethnic majority? What role does decolonisation of the midwifery curriculum and ongoing learning in clinical settings play in improving cultural competence and safety?
2. What are the appropriate reasons for induction of labour? What are the short and long term maternal and baby outcomes associated with it? How should this be communicated to women and birthing parents and their informed consent gained?
3. What are the important components of personalised maternity care to ensure informed choice and decision making and how should this care be provided?
4. How does the culture within the maternity services, including racism, incivility and other negative behaviours amongst staff impact on midwives, maternity support workers and maternity care assistants, and what can be done to address this?
5. What factors mean that birth is becoming increasingly medicalised, and what are the long and short term outcomes resulting from interventions? How does medicalisation impact on the choices that women and birthing parents can make and the clinical care that they receive?
6. How can the causes and consequences of pre-existing psychological trauma during the perinatal period be better understood and prevented or the impact reduced? What role does trauma-informed care play in addressing it?
7. How can postnatal care be prioritised and improved so that mothers and birthing parents and their babies receive high quality care that meets their individual needs?
8. How can the maternity services improve bereavement care? How should the best available information be used by maternity services to improve the bereavement care experience for parents who suffer a loss in their current or previous pregnancies? What support and care provision should be available for families following a maternal death?
9. How can midwifery continue to be an attractive career for potential applicants? How can midwifery students and qualified midwives be helped to stay in the profession in a way that provides a positive work environment and supports the provision of safe and compassionate care?

10. What are the specific needs of neurodivergent individuals (including those undiagnosed) throughout their maternity care, and what knowledge, understanding and communication skills should maternity care professionals possess to provide safe and compassionate care?

What happens next?

We need to make sure that these top 10 priorities become funded research projects. The RCM will champion the Top 10 research priorities and seek to ensure their take-up by individuals and organisations across the UK. We will highlight and promote funding opportunities with grant makers and charities, such as the NIHR (National Institute for Health and Care Research) and the Wellbeing of Women. As a JLA project, they are automatically eligible to be used by midwives and other researchers in the [NIHR James Lind Alliance Priority Setting Partnerships rolling call](#).

While it is acknowledged that this project was undertaken in the UK the RCM will highlight its relevance to the international midwifery community. We will also evaluate the success of the top 10 on a regular basis.

The RCM will embed the Top Ten research priorities within its organisational-wide practices. It is a central plank in the [RCM Research and Development Strategy 2025-27](#), as is the commitment to amplifying the voices of women, birthing people and their families within midwifery and perinatal research.

We would be delighted to hear from any of AIMS members who wish to get involved in research into one of the top 10.

Jenny Cunningham and Dr Jude Field, RCM research advisors researchpriorities@rcm.org.uk

Margaret Jowitt 1955 - 2025

It was with great sadness that we heard the news of Margaret Jowitt's death earlier this year. Margaret had been a great friend to AIMS working as our honorary treasurer for a while and writing for the AIMS journal. I was never fortunate enough to meet her in person, but we enjoyed occasional exchanges on the UK Midwifery Yahoo group where she kept us firmly grounded with reminders about human birth physiology, her area of expertise. As a childbirth educator, both of Margaret's books, 'Childbirth Unmasked' and 'Dynamic Positions in Birth' take pride of place in my book collection. I am grateful for her strong clear voice in [lobbying](#) for caution in the use of induction and continuous electronic monitoring, and for furniture in the birth room that supports the woman's freedom of movement. Margaret was a long-time runner in the relay race towards physiology-informed maternity care. I only hope there are people as passionate as her to take up the baton.

Alex Smith (Editor)

Margaret worked with the Association of Radical Midwives (ARM) for many years and it is with their kind permission that we republish their own tribute to her.



At the beginning of May we heard with great sadness of the death of our much loved friend and colleague Margaret.

Margaret has been a member of ARM since the early 1990s. She was not a midwife but a woman who was deeply committed to the wellbeing of women and babies, and was motivated by the desire to explain and promote physiological birth and its benefits. She became interested in childbirth in the process of bearing her own three children and always related how she obtained a home birth for her third baby through contacting ARM and being put in touch with an independent midwife. She undertook to edit our quarterly magazine Midwifery Matters from 1996 until 2013, making it a respected journal and fascinating read; a unique compilation of academic articles, news, and personal stories.

She was the main writer and editor of our New Vision for Maternity Care published in 2013 which was foundational in providing the themes for the UK National Maternity Review Document Better Births (2016). Margaret was a highly intelligent woman who published several books; Childbirth Unmasked (1993), Dynamic Positions for Birth: a fresh look at how women's bodies work in labour (2014) and The Natural Science of Childbirth (2019).

She corresponded with physiologists around the world and disseminated her very original ideas relating to the way in which the bodies of both women and babies operate with a beautiful synchronicity during labour and birth. Her insights met with interest and respect, and she spoke about and demonstrated them online and in-person. Her commitment led her to develop and market a birthing chair to facilitate positional change in labour and active birth.

She was particularly troubled by the negative impacts of interference with normal processes, in particular induction of labour and had developed a wide knowledge of understanding of the effects, particularly on the fetus.

Margaret was a talented musician, played the fiddle and was a devoted mother and grandmother, the birth of her three grandchildren over the last few years was a great joy. She had lived on the Isle of Wight for many years, sometimes having mixed feelings about the challenges of her geographical situation but that didn't stop her making enormous efforts to attend ARM gatherings and conferences, missing very few until she suffered from periods of poor health during the last few years.

Margaret was a vital, inspirational part of ARM, and was much too inclined to repeat that she was "not a midwife,". Many of us would tell her that she was in fact the best of us all, and of the Association of Radical Midwives, having more knowledge and understanding of birth than many midwives and obstetricians. I shall miss her very much, as will all of her friends in ARM and we send our deepest condolences to her family and friends.

Katherine Hales, National Co-ordinator

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Jean Robinson 1930 - 2025

By the AIMS management team



(Jean speaking at AIMS 50th Anniversary Luncheon 2010)

We were deeply saddened to hear of the death of our former President, Jean Robinson at the age of 95.

As the funeral celebrant Kirsten Baker commented in her eulogy:

“Jean was immensely and rightly proud of her involvement – always in a voluntary capacity - with the Association for the Improvement in Maternity Services. Her AIMS President badge was visible from her bed just very recently throughout her decline, signifying the huge significance this had for her.”



(Jean and the AIMS committee modelling the "Don't mess with me! I am an AIMS Member" T shirts 2007)

Jean was a hugely influential and inspiring figure within AIMS and beyond. As Debbie Chippington Derrick said in a personal tribute:

"She set AIMS moral and ethical compass which has continued to underpin our work today."

Jean joined AIMS in 1973, after her work dealing with complaints as chair of the Patients' Association led her to realise how many women were being traumatised by the widespread use of oxytocin drips to induce labour. Using her self-taught research skills she identified the lack of evidence to support this practice, which she highlighted in a letter to The Lancet.

In 1975 she took on the role of AIMS research officer. She was a frequent contributor to the AIMS Journal, with articles including hard-hitting reviews highlighting the evidence around key issues in maternity, and regular 'Research Round-ups' to explain the latest findings in clear, non-technical language. In this she set the standard for AIMS to provide evidence-based information in an accessible format. You can see some of Jean's Research Round-ups [here](#).



(Jean at the AIMS 50th Anniversary luncheon 2010)

She also worked tirelessly on the AIMS Helpline, supporting women and listening to their stories. It was this combination of drawing on the voices of women and using her rigorous research skills that made Jean such an effective campaigner. As her daughter Lucy said at the funeral:

"Jean talked a lot about 'a women's way of working', listening to and believing women, she read piles of letters and spent hours on the phone listening to women's experiences."

She wove these individual stories together, connecting the dots between individual experiences, and used her careful research to hold structures to account...”

Having heard from many women who were feeling suicidal after giving birth, Jean successfully lobbied for suicide to be recognised in the Confidential Enquiries process as a leading cause of maternal deaths. Also drawing on her experiences on the Helpline, and together with our late Chair, Beverley Lawrence Beech, she wrote a letter to the British Journal of Psychiatry that is credited as the first published identification of post-natal PTSD. She followed this up with a presentation at the Royal College of Obstetricians and Gynaecologists’ symposium Maternal Morbidity and Mortality in 2002, pointing out that “most postnatal PTSD is avoidable - it is iatrogenic (an illness caused by medical care), mainly due to the way women are treated.”{ref [Post-traumatic stress disorder: AIMS' voice at the RCOG](#)}. AIMS is still campaigning for the recognition of [Obstetric Violence](#) and its potential impact on the mental and emotional wellbeing of mothers.

Jean was also influential in proposing the need for a [Charter for Ethical Research](#) in maternity. This was subsequently drawn up in a collaboration between AIMS, the NCT and the Maternity Alliance and published in 1997 [A Charter for Ethical Research in Maternity Care](#). This, and in particular the principle that “Research should be undertaken with women, not on women” is now widely recognised as the appropriate basis for maternity research.



(Jean at the AIMS Trustees Retreat 2015)

In an [interview with Emma Ashworth](#), published in the AIMS Journal in June 2018, following her retirement as President, Jean expressed the wish for AIMS to:

“Go on listening to women and representing their different voices. We will continue to succeed by perpetually challenging obstetricians for their evidence.”

In similar vein, Lucy encouraged those at the funeral:

“So work like Jean. Do the research, ask the difficult questions and ask them as loudly and publicly as you can, preferably with the press watching.”

We hope that we in AIMS are honouring Jean’s legacy by continuing to do this.

AIMS thanks Kirsten Baker and Lucy Robinson for permission to quote from their words at Jean’s funeral.

What has the AIMS Campaigns Team been up to this quarter?

By the AIMS Campaigns Team

Published written outputs:

- Critique of the 'Big Baby' trial
- June 25th: [Open letter to Wes Streeting](#) about the [National Maternity review](#).

Conferences and group meetings attended:

- 13th May: [Make Birth Better's](#) 10th Annual Birth Trauma summit
- 27th May: [APG](#) on Women's Health Meeting & AGM Belfast
- 29th May: [Plan-A](#) team meeting
- 26th June: Maternity Voices Partnership Stakeholder council meeting
- 2nd July: [Make Birth Better](#) Working Group on National Maternity Inquiry
- 22nd July: Launch of FiveXMore's [Black Maternity Experiences Report](#)

Who we have been liaising with:

- Applied for AIMS to join [National Voices](#), a national coalition for health charities committed to tackling inequalities in health and social care
- Liaison meeting with [Birthrights](#) about homebirth restriction

What we have been reading/listening to/watching:

- Kayode G. et al '[Disparities in Stillbirths in England: Analysis of A Population-Based Study of 1.3 Million Births](#)' BJOG 132:8 July 2025
- [Change NHS: 10 year plan](#)
- UK Preconception Partnership's [Preconception care toolkit](#)
- De Backer, K et al '[Characteristics, outcomes, and maternity care experiences of women with children's social care involvement who subsequently died: national cohort study and confidential enquiry](#)' BJM Medicine 4:1 July 2025

Thanks to all the AIMS Campaigns Volunteers who have made this work possible. We are very keen to expand our campaigns team work, so please do get in touch with campaigns@aims.org.uk if you'd like to help!