**Primary Care Conference**

**Order of presentation**

**Kerry Baker IBCLC**

**Introduction**

Kerry Baker, IBCLC, BSc NMC Registered Midwife, with a background BSC Psychology

Sponsored by Munchkin.

‘Insufficient Milk Supply –

An empowering discussion to improve breastfeeding outcomes for women and children in the primary care setting in a time restricted service’.

**SLIDE 1**

**Diversity and Inclusivity**

‘I speak on behalf of Munchkin and I through sharing that we respect the diversity and inclusivity of all women, birthing, breastfeeding, and chest feeding people, and the pronouns in which people would like to be referred to as an individual.

During today’s discussion I will use the terms women and breastfeeding to refer to an individual that has birthed, has an infant or child and wishes to breastfeed.

Munchkin and I also advocate the freedom of choice of infant feeding.

We believe that an informed choice is the optimal way to feed any child and respect any person’s choice not to breastfeed.’

**SLIDE 2**

**Validation & Recognition**

When we are unable to support women to breastfeed it does not come from a place of not wanting to, but a consequence of insufficient staffing, resources and therefore,

a lack of time.

This discussion is set to empower us to re-discover efficient ways to deliver more breastfeeding support in these less desirable working environments and to advocate for women & children.

Ultimately, It is about working in a way that acknowledges these barriers and the challenges to provide this care, through finding effective ways to provide the best standards of care in these settings whilst they are this way. Calling for change and wanting more for women is vital for better outcomes.

**Lactation education** also needs to move with the current issues women are experiencing and what skills healthcare providers need to support women appropriately*.*

Most educational institutes unless they are specific lactation courses, focus solely and minimally on the normal parameters of breastfeeding, such latch and attachment, post physiological labour, with minimal analgesia and no maternal/infant health complexities.

We can in most instances breastfeed successfully around these obstacles, but we need the skills to manage this timely and effectively.

We are letting our population down by not ensuring the appropriate breastfeeding education for people working with lactating women to ensure they have sufficient knowledge to minimise breastfeeding cessation that isn’t from maternal choice.

With 42.4% in 2023/24 being the rate of emergency and elective caesarean section combined and 11.2% of deliveries being instrumental (RCOG), the statistics highlight the importance of working around non-physiological births and the challenges women can experience in these settings when trying to breastfeed.

More so, the reality of the lack of funding in infant feeding services is vast. Small feeding teams that need be available for the quantity of those women needing support is a system set up to fail those needing the service. We can’t preserve and protect the supply of women of those that need the support if they do not have access to the feeding specialists and after waiting so long without support, women’s supply has diminished. Women need continuity and consistency with feeding support if we really want to move some mountains and improve breastfeeding outcomes.

**SLIDE 3**

**BF statistics**

World Health organisation recommend exclusively breastfeeding for 6 months followed by a minimum 2 years of breastfeeding thereafter alongside other nutritional intake.

The UK Infant feeding survey started in 1975 and was conducted every 5 years aiming to assess prevalence, incidence, and duration of breastfeeding. This survey ceased in 2010. At the time breastfeeding initiation was 81% at day one, 24% in England, 17% in Wales, and 13% in Northern Ireland at 6 weeks and just 1% at 6 months. This data was only conducted for 10,768 women between August and October collectively.

The WHO and UNICEF conducted the Global Breastfeeding Collective to also address breastfeeding incidence and duration. The latest statistics are from 2023 suggesting a global increase in breastfeeding rates to 48% collectively.

There is no data on breastfeeding in England since 2010 and therefore no distinctive measure of the current prevalence of breastfeeding in England. This is concerning particularly after the pandemic and the challenges women experienced during this time alongside the difficulty in returning the nations feeding support services since.

Also, data from the British Science Association shares that the UK have the lowest breastfeeding rates in the world at 1 year at just 0.5%.

It is very clear that we need to gain a better understanding of breastfeeding rates in a way that is robust and consistent in England so identify where we are and if rates are improving.

**The cost of not breastfeeding**

It is approximated that the NHS could save £40 million annually if breastfeeding rates were to increase, primarily due to reduced costs associated with hospitalisations, GP visits, and treatments for illnesses related to formula feeding.

Some of the risks associated with not breastfeeding for women are:

**Women’s health**:

Increase in reproductive cancers

Osteoporosis in later life.

Mental health issues.

Cardiovascular disease
Obesity

Type 2 Diabetes
metabolic syndromes

**Children:**

Short term – Acute respiratory disease, ear infections, and viruses.

Long term - Auto immune disease, obesity, decreased IQ.

**SLIDE 4**

**History of insufficient milk supply**

- Gabriella Palmer.

**1925 – 2025**

**1867**
Grain and fertilizer merchant Henri Nestle launched the first artificial infant milk that was created with a mixture of wheat flour and condensed milk. He announced that his product had saved the life of a premature baby who had rejected his mother’s milk and all other food. By 15 days, the little boy had convulsions and his hope for life was fading. Then Henri Nestle came to the rescue with his product. By seven months, the little boy fed exclusively on Nestle’s product had never been ill and could sit up alone in his cradle. Within five years, Nestle was selling half a million boxes a year in Europe, The USA and Latin America, Australia and the Dutch East Indies. The force of marketing was very clear.

**1940**

The infant formula was advocated and available by Drs. Its superior culture influenced women in thinking that it was better than what they made.

Wealthy women that used wet nurses used the artificial milk as it was a sign of wealth. Breastfeeding was being undermined by women.

**1950**

Women were routinely separated from their babies at birth and put into nurseries and given lactation suppressants. Women were given their baby’s when they were hungry, but many midwives fed the supplements to allow women to rest and were convinced until women’s milk supply ‘came in’ the mother and baby dyad had no influence on supply.

New parenting advice that did not preserve breastfeeding.

Set feed times, not responding to the baby’s signs of distress so that babies were not attached to mothers or spoilt, thus hindering women's supply.

Free samples were given to hospitals to distribute to women, hindering supply production from the outset and forming a dependency on the artificial product for women when they went home.

The industrial revolution encouraging women to work outside the home interfering with breastfeeding success and duration.

Post WW2 improvements in sanitation, hygiene, toilets and the beginning of vaccinations, antibiotics, and generalized improved clinical medicine meant a lower incidence of morbidity and mortality masking the detrimental effects of not breastfeeding in England.

**1970**

Increase in mortality and morbidity in children in Africa, with regional Drs

understanding the link between artificial milk and disease. Drs raised concerns to artificial companies, but these were dismissed.

Today – Lack of skilled breastfeeding support, poor funding to improve breastfeeding services, deskilled staff due to low prevalence. Culturally normal to not breastfeed. Undervalued in our today’s society.

Gabriella Palmer (2025).

**SLIDE 5**

**The Grief of Breastfeeding**

Professor Amy Brown (2023) coined the term ‘breastfeeding grief’ to highlight how many women experience depression associated with the trauma of a negative breastfeeding experience or early cessation of breastfeeding before they wished to stop.

*‘A genuine loss for me that I felt physically through out every part of my body. I mourned it like I mourned somebody dying’*

The circumstances that have bought women here are all different. Over 2000 stories of how it went wrong for each woman within Professor Brown’s research. But the fundamental issue is the same. They lost their supply. The anatomy that they developed during pregnancy that in almost every case that would have been sufficient, but due their journey of poor support, lack of information, and inadequate stimulation meant that this was a system their body could no longer initiate and sustain. But the building blocks for the supply, the real reason why women physiology can’t breastfeed, was never the issue. They developed the appropriate tissue and system to do it. We let them and that process down.

The statistics of how women may experience depression after negative breastfeeding experiences isn’t known but it increasingly understands as an important part of postnatal well-being in women. As a service we have a role in minimising this experience for women is closely linked to the input and impact our knowledge and service has on the women we serve to help facilitate better breastfeeding outcomes. (Amy Brown, 2025).

Moreover, we have done a wonderful job in allowing women to believe that they are responsible for not being able to breastfeed. We need to empower women to understand what their body supplied all along and be more accountable in that the systems in place that support them in initiating and sustain this system was not provided at the time or the right skills.

**SLIDE 6**

**Breastmilk is Bioactive agent that modify the immune, gastrointestinal, and brain.**

**BREASTMILK COMPOSITION**

* Vitamin A C D K E B12 B6
* Probiotic/prebiotic bacteria
* Nonprotein Nitrogen’s
* Nucleotides
* Lactose
* Whey and Casein protein \*
* Lipids – polyunsaturated fatty acids \*
* DHA and AA – vital for brain and eye development.\*
* Minerals sodium, zinc, Iron, Calcium, Magnesium,\*
* Stem cells \*
* Lactoferrin \*
* Oligosaccharides \*
* Glycoconjugates \*
* Enzymes \*
* ***\* Melatonin \****
* *\* Hormones \**
* *\* Oxytocin\**
* *\* Immunoglobins & antibodies e.g. SIgA, igM, igG \**
* *\* Alpha – Lactalbumin \**

Let’s remind ourselves of the amazing composition of breastmilk. With its wonderful new benefits coming to light all the time through research. It’s easy to forget about all the amazing components of breastmilk in our everyday clinical setting when working with women and children. So, it’s always great to re affirm why it’s so incredible and sophisticated. Natures medicine as I call it.

**Oligosaccharides**

There are over 200 complex sugars found in breastmilk that are unique from one mother to another. These are known to support the infant’s immune system. They are the third largest component in breastmilk after lactose and fat. More information is coming to light about these amazing sugars of which some are entirely unique to human milk. The microbiome feed on these areas of the body to maintain the right cultures in these parts of the infant such and urinary tract.

 BM composition changes feed by feed, day by day, based on gender (protein),

 and the time (melatonin).

Melatonin – With this melatonin the hormone involved in sleep is released in higher quantities in the evening and night in maternal milk. To the point where if women expressed id suggest making a note on her breastmilk storage bag for example what time the expressed milk was removed in case she wanted to time that feed in keeping with the melatonin effects of night time.

Kissing baby – immune response – salivary feedback.

We now know that there is a feedback mechanism, whereby the saliva of the baby is absorbed through the breast for the maternal immune system to feed off of this information and make the necessary components in the upcoming feeds to help combat any pathogenetic cultures that the baby is sharing with the mother.

Breastfeeding Top Trumps theory

Aloe Vera – burns, acne, digestion, ulcers, GERD/acid reflux, antibacterial, antifungal properties,

Lions Main – improving cognition, anxiety and depression, cancer research, neuro protective, neurotrophic, recommended a gram a day.

**Social Trend**

Breastmilk can never be a consummative product. Based on its sophistication for the mother’s unique child it would be impossible. Wouldn’t it be great if there was a social wave of popularity in this amazing process. Even if women wanted there to be, with the way our support system is constructed and the sophisticated skills needed due the increased complexities in their intrapartum experiences, without our help, they couldn’t if they wanted to. Can we work together to let women be their own greatest product and let them and their child reap the fortune of it.

**SLIDE 7 Lactogenisis**

**Normal Physiology of Lactation.**

‘*The Issue it not at the source –*

*the biology of the woman.*

*It’s society interfering with the process’*

*Kerry Baker IBCLC.*

**Lactogenesis 1**.

Starts mid-pregnancy – end of pregnancy

Mammary gland production starts with prolactin and oestrogen levels.

Vascularised breasts for increased blood supply – increased vein appearance.

Increased size and weight of the breast.

Breastmilk secretion established around 27-week gestation.

Good signs to look out for signs of sufficient glandular tissue. Asking a mother, did you notice breast. changes during your pregnancy?

Nipples, areola become darker in response to hormonal changes.

**Lactogenesis 2 Post - Partum – Endocrine process – day 5 approx**

Drops in oestrogen and progesterone post-delivery as well as decrease in the hormone placental lactogen after the delivery of the placenta. Known as an **endocrine** response to lactation

This process will occur whether the mother wishes to breastfeed or not.

Prolactin has 7 – 20 spikes across the 24-hour period through initiating lactation and is released from the anterior pituitary gland in the hypothalamus.

The gaps between the alveoli closing are what initiates the copious onset of milk in L2. This is triggered by the rise in prolactin, which is the early stimulation is important for this.

The level of infant /maternal contact initiates the levels of prolactin that set up the levels of prolactin for the entire lactating duration. It is a time sensitive mechanism which then slowly declines over the course of lactation.

Prolactin pre pregnancy are in the tens, post pregnancy is in the hundredths. If we do not stimulate our supply, then by day 10 women’s prolactin levels are back to their pre pregnancy levels.

Fairy light analogy.

**Galactopoeisis– Autocrine process Day 5 approx - Involution**

Relies on supply and demand through stimulation and milk removal and is no longer driven by a hormonal response.

If feeding isn’t effective and good milk transfer adopted, the milk yield will suffer.

The interstitial spacing between the alveoli in the lactiferous ducts close and it is this mechanism that initiates a more water rich copious milk. Prolactin is the key chemical that stimulates the driving force to close these. Which is why stimulation and milk removal is crucial in the lead up to this to not delay it and not hormones acting alone at the levels needed. The wider intestinal spacing in the alveoli in the first few days is also way certain medications get into breastmilk that later wouldn’t or by the same volume.

It is through the act of nipple stimulation that initiates oxytocin that contracts the lactiferous cells known as the milk ejection reflex helping to traject the milk towards the nipple opening. This is more apparent in this stage and some women can feel this. One women described it as ‘ I feel like my boobs are going to sneeze’.

The consistent removal of milk signifies the body to produce more across the 24-hour period. The is a cycle that needs to be continuous, frequent, and efficient to continue for as long as the mother wishes to breastfeed.

**SLIDE 8**

**Positive feedback loop**

Lactation works on a positive feedback loop.

The infant attaches and stimulates the nipple, signals are sent to the posterior pituitary gland to release oxytocin that initiates the milk ejection reflex.

The removal of milk sends signals to the anterior pituitary gland that releases prolactin, for further milk synthesis. In doing so it is ‘putting in the order for the next meal’ to meet the demand of the infant.

Oxytocin releases approximately one minute into the feed and ceases around 6 minutes after the feed ends. During this process the milk ejection reflex causes the milk ducts to contact, moving the milk towards the nipple opening. Women typically have multiple waves of this throughout the feed.

Each breast is its own unique mammary organ. It’s vital that women stimulate each side to build an established supply on each side.

**Milk intake newborn – 6 months**

Milk yield increases dramatically. Looking at the 5-10ml every feed in the first 24 hours to approximately 500mls by day 5. The quantity of milk demand increases very quickly which is why this positive feedback loop needs to be at play form the outset and consistently for the mother’s body to meet the demands. By 4 weeks the 24 hours-milk intake is between 800ml-1200ml unique to that infant.

**SLIDE 9**

**Negative Feedback Loop**

Milk stasis initiates the Feedback Inhibitor of Lactation which is initiated when milk is not removed as a protective factor to minimise engorgement of the breasts. Involution will eventually occur If milk is not removed from the breast over time.

Mastitis is there a milk removal / supply issue?

Lymphatic massage is now the recommendation for women that are experience engorgement /mastitis. This overrides the previous guidance of over stimulating the breasts as this is now understood to irritate the glandular lumen further, increasing inflammation.

New guidance for mastitis

Don’t increase inflammation by expressing between feeds, meet your baby’s demand through usual on demand feeding.

Avoid firm pressure to massage the breast as this can increase inflammation also.

Symptoms of septic mastitis Nausea, diarrhoea, and slurred speech.

Flucloxacillin 500mg 4 x per day

Erythromycin 250-500 4 x per day / cefalexin 250-500 mg if penicillin allergy.

Stopping breastfeeding is not recommended and may make inflammation worse.

In Summary, nature has thought of everything! How to make milk, how to stop it! So many of us here will know these processes well. But I am guilty of questioning our bodies capabilities when I am surrounded in Maternity with the statistics of women not breastfeeding. But we must remain firm in our knowledge of what women’s bodies are doing and are capable of so that we don’t get lost in the ideology that it just can’t be done. We need to remember what happens effortlessly, and how our role is to advocate and support this process when women receive care from us.

**SLIDE 10**

**Normal baby behaviours to initiate lactation.**

**A reminder of the normal process of lactation to get things off to a promising start:**

* Undisturbed, skin to skin contact between mother and baby post-delivery.
* Feeding on demand. Initiated by the infant’s feeding cues, subtle and calmness the best time to initiate feeding rather than waiting too long and both learning under distress, less metabolic effort for baby also.
* 8 – 12 feeds in 24 hours.
* Cluster feeding
* Frequent bowl moves 3 x 50p size stools per 24 hours day 3- 4-6 weeks then less regularly is normal.
* 6 heavy, wet nappies from day 6. Creeping from 1 on day 0, to 2, 3, 4, 5 on days 0-5.
* Birth weight by 14 days old then typically 30g per day for the first month of life followed by 10g per day thereafter.
* Settled between feeds, coming off the breast at their own accord.

**SLIDE 11**

**Biological indicators indicative of insufficient milk supply in the mother**

* Diabetes type 1
* Thyroid/endocrine conditions.
* Prolonged second stage
* caesarean section.
* Breast augmentation
* Any incision involving the 4th intercostal nerve
* (8 o’clock on the right breast, 4’o clock on the left breast).
* Retained placental products post delivery
* Severe blood loss post-delivery > 500mls
* Obesity
* IV Fluids in labour
* Analgesia in labour
* Premature delivery < 37 weeks
* Poor psychological health in mother/ birth trauma
* Signs of insufficient glandular tissue, larger areolar for breast tissue – large spacing between breasts and tubular in appearance.

(IGT Picture on slide)

* Smoking

Based on the previous statistics regarding instrumental deliveries, and elective, emergency caesarean rates by the RCOG Over 50% of the current birthing population fit into these alone, let alone with combined factors or other factors.

Making it more likely than not you are supporting a mother that fits into one of these factors.

Delay does not mean fail. It means more support and education.

Identify women postnatally that fall into these categories and ensure that they have the right support in place in readiness to tackle the challenges that come with these factors. They are manageable in time sensitive well supported environment, and it is up to us to create that.

**SLIDE 12**

**Biological indicators of insufficient milk in the infant**

Prematurity – weak suck

Tongue Tie

Atonic oral muscles

Instrumental delivery nerve damage

Analgesia in labour

Hypoglycaemia

Jaundice

Metabolic conditions

Enzyme deficiencies

Cardiac abnormalities – signs in cardio/respiratory compromise when feeding

Oral Thrush

Supplementing with AF and missing feeds directly from the breast, slowing down milk synthesis

Prematurity

Certain medications, such as birth control, decongestants, certain antihistamines.

Escalating these baby’s early to the right people.

**SLIDE 12 B**

**Perceived insufficient milk supply**

Signs that come from a lack of trust and confidence in the mother. If feeding is otherwise showing promising signs in the infant and mother, weight gain, feeding frequency, quality of L&A and milk transfer, nappy output as expected and mother displays these symptoms, perceived milk supply is worth exploring.

* Breasts not feeling full – engorgement is not a sign of adequate supply and slows the process down – negative feedback loop.
* Baby cluster feeding – Otherwise a very normal adaptation or extrauterine life is bay is otherwise if baby is otherwise doing well.
* Unhelpful comments from HCP friends or family about the frequency of breastfeeds.

‘Are you sure he’s getting enough?’

‘They’re hungry again?’

* Misleading information in Artificial formula advertisements.
* Mother is expressing as well as direct feeding because she is worried feeding directly isn’t enough

It’s important that a thorough assessment is done to be able to confidently suggest the issues are a perceived milk supply of course! Through the process of elimination, it’s important to assume it is a supply issue before assessing thoroughly.

**SLIDE 13**

**It is insufficient supply – What next?!**

The three Keeps:

* Keep baby close – lots of skins to skin, relaxed exposure to the breast. Not waiting for feeding cues for the process, a baby moon, stop the visitors/days out for a few days and really focus on that uninterrupted time together.
* Keep milk flowing – Through lots of opportunities to breastfeed, expressing every 2-3 hours using a hospital grade electric double pump also during the night/after every feed.
* Keep baby’s intake – Ensure that baby is meeting the volume of milk they need in a 24-hour period based on their age through breastfeeding, expressed breastmilk, or artificial formula, or a combination of the three.

**SLIDE 14**

**Hand expressing and pumping**

* Privacy
* Relaxation techniques/visualisations
* Encouraging MER / breast massage
* LLLGB website – Stanford medicine video/ women need to a see a skill they are learning
* Hand placement / exploration
* No sliding fingers
* Expectations of milk volume and what’s normal
* Ideal for first 3 days.
* Recoil relaxing the breast.
* Chest, compress, release.

**Double pump expressing technique and availability**

Power pumping ways to maximise mothers expressing:

* Smelling their baby, photo videos, their babies for that oxytocin effect.
* Hiding the milk outlet so women don’t focus on these obtains more milk.
* Relaxing and feeling safe to release oxytocin and inhibit too much stress hormones.
* Doing a cognitive activity to relax but nothing too distracting.
* Power pumping sessions that replicate breastfeeding – 10 minutes on, 10 minutes off, 5 minutes on 5 minutes pause as examples.
* Ensuring pumping through the night when prolactin levels are highest.
* Hand expression in combination of expressing.
* Record expressing to see trends and progress
* Keep an eye on intake as well as output.
* Cut up sports bra for freedom – make the unsustainable more sustainable.
* Cluster/ power pumping mimicking baby’s behaviour.
* Expressing for 3-5 minutes after milk flow has eased – to put in the next order.
* Using a combination of all three methods for optimal output.
* Shield size.
* Ideally pumping after feeding giving baby the first opportunity whilst the milk flow is higher.

NIPPLE FLANGE gift on seats

Once you have measured your nipple, add approximately 0 - 3mm. For instance, 18mm + 3mm = 21mm breast shield size

**SLIDE 15**

**Pharmacological methods/galactagogues**

Where possible we really want to be working towards protecting women’s supply without the need for pharmacological input. In very rare cases based on perhaps some of the maternal biological criteria described above, certain galactagogues may be helpful. I do not have the qualification to address dosage, but these are used as an off-license drug for this purpose.

Metoclopramide – dopamine antagonist = increases serum prolactin. The doses and duration vary and longer use has shown better effects and abrupt cessation causing milk supply issues once more. It hasn’t been proven as more effective for those with premature infants.

Domperidone - Dopamine antagonist. Should be avoided if the infant or mother has cardiac conditions or arrythmia. On other contraindicative medicines (See BNF) hepatic impairment, mother and baby have high potassium or low magnesium levels.

‘Domperidone is preferred to metoclopramide because it poorly penetrates the blood-brain barrier and does not produce parkinsonian-like adverse effects or increase the risk of depression’ ‘The Breastfeeding Network’ (2024)

Both can have unpleasant side effects and should only be considered as a last resort for improving supply. We want to make sure that we have the time for women to improve breastfeeding outcomes naturally and not turning to pharmacology because it’s requiring less time. The underlining issues will still be present if the drug is being used and therefore close supervision from both the prescriber and feeding specialist.

**More natural galactogens:**

Fenugreek - Dosage varies and there are multiple contraindicators such as, those on anticoagulants or insulin, history of vaginal bleeding, those taking NSAIDs. There are multiple unpleasant side effects with fenugreek and there is no sound evidence of its effectiveness but has been used for centuries and women who use it have found improved milk supply in 24-72 hours. (The Breastfeeding Network, 2019).

**SLIDE 16**

**Fast access to specialist support.**

The sooner a specialist can identify the root cause of the milk supply concern, the sooner a plan can be put in place to rectify it. Based on how supply and demand works, this is time sensitive and if a mother wishes to maximise the use of her supply to reach her full capacity to exclusively supply milk for her infant. By day 7, if breasts are not stimulated and milk removed adequately prolactin levels fall back to pre-pregnancy levels, or not as high as a mother that has consistent stimulation and milk removal, and this will affect the long-term supply of the mother. Our bodies are amazing and despite these factors many women that have issues to begin with, with support go on to a fully established supply that meet the needs of their infant. There are two key messages here. Firstly, not to get complacent that if feeding isn’t going well ting will work out so don’t worry, as this is never a guarantee. But also, the amazing ability baby’s and mothers have in their ability to succeed in breastfeeding despite adversity.

I had a mother contact me at 8 weeks post-partum exclusively pumping. Her Baby was never on the breast from birth due to their feeding obstacles and lack of support. The mother reached out in a plea because she just wasn’t ready to accept that their direct breastfeeding journey was over. We spoke about realistic expectations but how as the supply is objectively enough based on pumping, we knew flow and supply would not be a barrier. Baby’s feeding cues were still wonderful heightened on skin-to-skin exposure together and with a slow progressive plan in place that preserved and protected the mother’s supply and baby’s milk intake, within 10 days, the mother was exclusively directly breastfeeding her infant and no longer expressing. The tears of joy that the mother shared are ones that will never leave me, for those wishing to breastfeed the sense of desperation is real and we should rise to the challenge as urgently.

It’s realistic that those in practise don’t have time to offer women this level of feeding support and continuity of care. This is where we need to be honest about the troubleshooting tools that we can suggest to women based on the three keeps that bridge the gap between our role and getting women to the experts in breastfeeding. We need to be advocates for change in making the access to these support networks quicker for women which I will go into in more detail.

The skill set of improving supply is a wonderful one to have and I would encourage anyone to come to the Munchkin stall so that we can more talk about these factors in more depth, to equip you with the knowledge of feeling more confident about milk intake volumes based on age, expressing, storing breastmilk, supplementation devices, and more.

**Ensuring help is facilitated:**

* Understanding what your Trust or community health currently offer for breastfeeding services
* Making sure these conversations begin in pregnancy. Encouraging breastfeeding education In pregnancy for women wanting to explore this feeding method. Sign posting women and following up with women on this when your providing care.
* National breastfeeding helpline: http://www.nationalbreastfeedinghelpline.org.uk/
* National Childcare Trust NCT: https://www.nct.org.uk/
* Association of Breastfeeding Women ABM: https://abm.me.uk/
* La Leche League Great Britain: https://laleche.org.uk/
* Private Lactation Consultants of Great Britain: <https://lcgb.org/>

**SLIDE 17**

**Counselling and language**

We can collectively say that most women that do not achieve their goals is a systemic flaw of ours. From a political, lack of resource and funding standpoint. It’s important that we are celebrating every achievement with women and having honest discussions with women about what is realistic and not making them feel bad for in some instances, doing the impossible. Checking in with their mental health is vital as I always share that this take precedence After relaying the evidence about what would be best practise to initiate and troubleshoot supply honest conversations about what is achievable and being creative with this is important.

**SLIDE 18**

**Latch and Attachment fundamentals**

A recap on the fundamentals of good latch and attachment for feeding. As well as the three keeps for troubleshooting supply it is vital that we understand the mechanisms of breastfeeding to be able to support lactating women that we are providing care for.

* Is mum comfortable?
* Breast weight distribution/natural placement.
* Supporting bay sustainably
* Making use of furniture
* CHIN
* Being opportunistic
* Look at the active feeding
* How does it feel for mum even if it looks okay
* Active feeding process
* Watch the baby not the clock
* SSB coordination

(Picture of active feeding cycle)

Video of audible sucks/swallows good drinking

Please bring your latch and attachment questions over to us at the stand. We’d love to unpick this further with you. Every question holds value, and we’d really love to hear them.

**SLIDE 19**

**How can we support women better in a time sensitive working environment:**

* Improve our breastfeeding skill set so we can identify good feeding or concerns more rapidly.
* Be okay with our limitations but not complacent with them. Be swift in reaching out for help to ensure that the mother has the support she needs. Where possible learn from it too. For example, if a colleague has an enhanced knowledge, if you can watch and learn from what they share with the women to acquire your own wisdom
* Fight for breastfeeding advocacy in your workplace. You don’t need to be an expert to know enough to expect more for the women that you are serving. In house specialist, funding to enhance the skill set of the team. Outside the box thinking feeding support or education in your team to provide this service to women.
* Learning the troubleshooting skill sets. It’s okay to not know the solutions it is the issues the women or baby are experiencing. The richness is in knowing where to signpost them, and what advise can be giving to preserve the situation. The breastfeeding situation can be beyond repair if left too long

* Ensuring practise areas are in keeping with THE CODE of Breastmilk substitutes. This allows evidence-based information and conversations to occur with out subliminal or less subliminal marketing of artificial products that may influence decision in absence of informed consent.

* Give women good visual resources and time to reflect and privacy.
* THE 3 KEEPS!
* Come to the stall and we can discuss specifically for your role the unique ways to support women based on how you provide care for them.

Questions

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