

Breastfeeding, chest feeding
and human milk feeding:

Supporting LGBTQIA+ Families



Australian
Breastfeeding
Association



rainbow families
connecting • supporting • empowering

This book provides information and support to the LGBTQIA+ (lesbian, gay, bisexual, transgender, queer, intersex, asexual and more) community.

It covers breastfeeding, chest feeding and human milk feeding, aiming to be inclusive of all LGBTQIA+ families.

This book is a collaboration between Rainbow Families NSW and the Australian Breastfeeding Association (ABA) and has been put together by members of ABA and the LGBTQIA+ community for the community. The Australian Breastfeeding Association is Australia's peak breastfeeding information and support service. Rainbow Families is the peak NSW organisation supporting LGBTQIA+ parents and children.

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Stories and photographs have been sourced from the LGBTQIA+ community of Australia and the Australian Breastfeeding Association.

For more information on the Australian Breastfeeding Association and Rainbow Families See [*Chapter 15. Support services and resources*](#)

We acknowledge the Aboriginal and Torres Strait Islander peoples of the lands on which we live, work, and raise our families. We pay our respects to Elders past, present, and emerging. We pay tribute to and honour the lives of all Aboriginal and Torres Strait Islander lesbian, gay, bisexual, queer, trans, intersex, sistergirl and brotherboy people, past and present.
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CHAPTER

1

Introduction

Lactation is very flexible and can work in many different situations. A person can make milk even if they have never been pregnant or given birth. Two people can make milk for the same baby. A person may make milk and feed a baby after surgery or hormone replacement therapy. How you feed your baby is your decision. Every family is different and the decisions each family makes will be different.



The information and support each family needs will also be different. In this book we endeavour to cover as many of these situations as possible.

One section of this book may meet most of your family's needs, or you may draw on several different sections. The early sections about the importance of human milk and the way bodies make milk are likely to be useful to most families, however they choose to feed their baby.

You will find the following terms in this book:

- ABA — Australian Breastfeeding Association
- Birthing parent — the person who birthed the child.
- Breast/Chest — the body part immediately surrounding the nipple and areola.
- Feeding from the body — when a child is being fed directly from a person by suckling at their breast/chest.
- IBCLC — International Board Certified Lactation Consultant.
- Lactating parent — a parent whose body is making milk for a child.
- Lactation — the process by which milk is made in the mammary glands.
- Milk — human milk.
- Milk-making tissue — the glandular tissue involved in the production and delivery of milk.
- Support person/people — anyone who is supporting someone who is lactating and feeding.

We understand every person uses language differently and identifies as a parent in a way that is meaningful to them. This book aims to provide information based on current research and in consultation with Rainbow Families NSW and Intersex Human Rights Australia. Throughout this book you will find references to other ABA resources available to you. The information they provide may apply to many different families but they are not specifically designed for the LGBTQIA+ community. In this book we have avoided using sexed language as much as possible. If you would prefer to access resources that use sexed language then we recommend ABA resources.

‘Breastfeeding is for the baby, not the baby for breastfeeding’,
ABA Code of Ethics.



CHAPTER

2

How feeding works

Many parents can feed their baby or babies with human milk. Whatever your situation, the special loving bond between you and your baby can grow stronger through the cuddles and smiles you share during feeding. As you watch your baby grow and develop, you can be proud of your body's ability to nourish and nurture them.

While you are feeding your baby from the body, they can feel the warmth and softness of your skin and hear the soothing sound of your heartbeat. As



they get older, they will respond by gazing into your eyes, smiling at you and reaching up to your face or stroking your skin. The memory of this precious bond between you will remain as they grow.

Importance for babies

- Human milk contains all the food and drink your baby needs for the first 6 months of their life and continues to be the most important part of their diet throughout the first year.^{1,2}
- The colostrum your baby receives in the first few days and the milk that follows contain anti-infective factors that protect against infection.³
- The unique blend of fatty acids and other factors in human milk help ensure normal brain development. The lack of these in formula may result in lower IQ in babies fed that way.^{1,4}
- Babies who are not fed human milk have a lower resistance to infection (such as gastrointestinal, respiratory and ear). Overall, these babies have more doctors' visits and spend more time in hospital with illness.¹
- Lack of feeding human milk is linked with a higher risk of Sudden Infant Death Syndrome (SIDS).^{1,5}
- Babies who are not fed human milk have an increased risk of becoming overweight or obese.¹

Importance for parents

- Feeding from the body can help the birthing parent's body return to their pre-pregnant state more quickly.
- Birthing parents who have not fed from the body are more likely to get breast^{1,7} or ovarian cancer.^{1,8,9}
- Menstruation is likely to return sooner in birthing parents who are not feeding from the body.⁹
- Lactation's contraceptive effect can delay the return of fertility in parents who have ovaries and a uterus. This works best if the baby is under 6 months, is exclusively feeding and periods have not returned. This is known as the Lactational Amenorrhea Method (LAM) of contraception and provides about 98% protection from a new pregnancy.¹¹



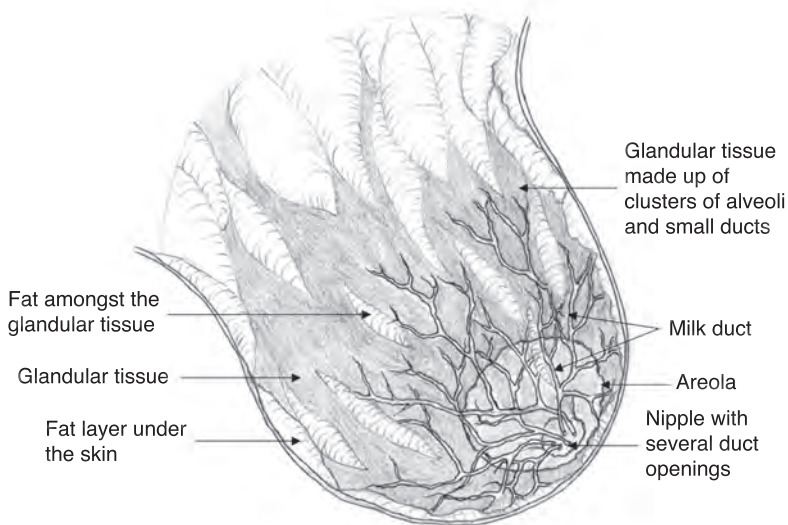
Importance to our environment

Making and feeding formula has a far greater and more harmful impact on our environment and world resources than feeding human milk. Formula-feeding impacts on the use of food resources, fuel and energy.¹²

Structure of milk-making tissue

Milk-making tissue is made up of lobes of glands. These contain clusters of alveoli — little hollow sacs with milk-making cells around the outside and the milk in the centre. Tubes, called ducts, run from the alveoli and carry the milk towards the nipple. Some of these ducts are quite large beneath the areola. It is from these ducts that the milk flows out, through tiny openings in the nipple.

The amount of milk-making tissue is not always related to how well it can make milk. Much of the tissue in the breast/chest is made up of fatty and support tissue rather than milk-making glands. Different lactating parents can store different amounts of milk in their milk-making tissue (not necessarily related to overall breast/chest size) in between feeds.



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For some, this may affect how often they need to feed their babies. For example, a parent with a smaller storage volume may need to feed their baby more often than a parent with a larger storage volume. However, those with small or large storage volumes can all make plenty of milk for their baby. It is also common for a parent to have a different amount of storage in one side compared to the other. Therefore, they may find their baby spends longer feeding on one side than the other. This is also perfectly normal. We also know that babies born to the same birth parent sometimes have very different feeding patterns. Milk-making tissue storage volume is only one factor in how often a baby feeds.

How the body makes and gives milk

During pregnancy, hormones including oestrogen, progesterone and prolactin prepare the birthing parent's body to make milk. Without pregnancy, prolactin by itself can cause milk-making structures to grow and start making milk.¹³ This means that lactation can happen even if you have not been pregnant. Some parents can relactate or induce lactation to feed from the body, even if they are not the birthing parent (See [Chapter 5. Relactation and induced lactation](#)).

In pregnant people, milk-making tissue begins to make milk from week 16 of pregnancy. This milk is called colostrum. It is very concentrated and is made in small volumes. After birth, the removal of the placenta triggers the making of larger volumes of milk, often much more than the baby needs. Over the next 6 to 8 weeks, your supply will gradually settle down to make only what your baby needs. It is the milk being taken out that causes more milk to be made. This is often called the principle of supply and demand. A baby who is well attached and removing milk well, drinking as much as they need as often as they want and for as long as they want, will be stimulating the milk-making response.

Your baby's suckling causes the release of hormones (prolactin and oxytocin). Prolactin acts on the milk-making tissue to make milk and is released when the nipples are stimulated, for example by a suckling child, hand expression or a breast pump. Oxytocin is released when a child suckles or a pump is used. It allows the milk already in the breast /chest to flow. This

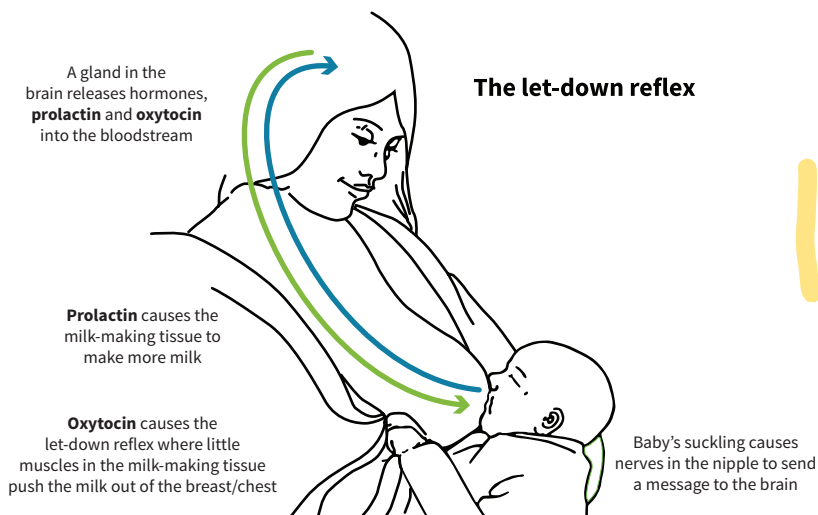


release of milk is known as the let-down reflex (sometimes called the milk ejection reflex).

About the let-down reflex

The let-down reflex makes your stored milk available to your baby. A baby feeding from the nipple and areola stimulates the release of a hormone called oxytocin. Oxytocin causes cells around the alveoli to contract and squeeze out the milk, pushing milk down the ducts towards the nipple. The hormone also makes the milk ducts widen, making it easier for the milk to flow down them. Some lactating parents feel the let-down as a tingling feeling that can be quite strong or a feeling of sudden fullness or they notice milk dripping from the other nipple. In the early days, birthing parents may feel their uterus contract when they let down, especially if this is not their first baby. Some lactating parents don't feel anything, but notice a change in the baby's sucking pattern from a quick suck-suck to a rhythmic suck-swallow pattern as the milk begins to flow.

The let-down reflex is a response to your baby's suckling. It may also happen if you see or hear your baby or even just think about your baby. It can also be triggered by touching your breast/chest and nipple area with your fingers or by using a pump. On the other hand, tension, anxiety, pain and fatigue can slow the let-down.



Let-downs usually occur more than once during a feed, but many people only notice the first. The let-downs that follow occur in response to changes in a baby's suckling. Some lactating people feel the let-down in the early days or weeks, but later find that this feeling goes away. In most cases, the let-down happens by itself when you feed your baby, but there may be times when you feel it is a little slow.

You can encourage a let-down by:

- Making an effort to relax, using any method that suits you. If possible, try to feed somewhere quiet and calming, away from distractions. While feeding, breathe slowly and deeply. If you drop your shoulders and relax them at the same time, your chest will also relax. Some lactating parents have a drink of water before feeding or listen to soft, soothing music.
- Gently massaging your breast/chest before a feed. Stroke down towards the nipple and gently roll the nipples between your fingers. While you cannot actually push the milk out by massage, you can help trigger the let-down by touching the area surrounding the nipple.

Milk changes throughout the feed. Early in the feed, the milk has a lower fat content. This helps to quench the baby's thirst. As the feed goes on, the fat content of the milk rises and your baby's hunger is satisfied. A baby who is allowed to finish the first side, so that they feed until they come off by themselves before being offered the second side, takes as much milk as they need to satisfy their appetite. At times your baby may be satisfied with just one side. At others they may also want the second side. By switching the side you feed from first, you will ensure each side keeps making a good amount of milk.

How your baby removes the milk

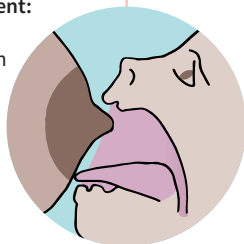
When a baby attaches, the nipple and areola are drawn into their mouth and are held there by suction. The baby removes the milk by lowering their



tongue to create a vacuum.¹⁴ A baby cannot bite while feeding correctly because their tongue lies over the bottom gum (and teeth).

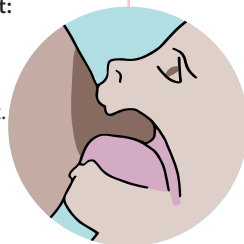
Approaching attachment:

Baby has wide gape with tongue down and forward. Nipple is aimed at the roof of baby's mouth, with first point of contact being baby's lower jaw or chin on the areola, well away from nipple.



Optimal attachment:

Tongue is forward over gums, lower lip rolled out, chin against breast/chest. The tongue lowers to create vacuum to remove milk.



Building and supporting milk supply

Building up and supporting milk supply means frequent milk removal. The more often your baby feeds and removes milk well, the more milk you will make. Some people believe it is not good for a baby to feed often and that you should wait for your body to make another full feed. This is not true. It is the frequent removal of milk that ensures a good milk supply.

There are some things that can impact milk supply such as birth control pills containing oestrogen (the 'combined pill') used in the first 6 weeks after birth, excessive alcohol, some over-the-counter medications and possibly large amounts of some herbs (such as sage)¹⁵. Try to avoid these if you can.

Testosterone interferes with prolactin, and can cause a decrease in milk supply and impact upon let-down.¹⁶ People on hormone therapy should discuss with their health professional how to manage this before pregnancy or lactation.

Considerations for intersex people

Some intersex variations can impact lactation.



Female people with congenital adrenal hyperplasia (CAH) can have high levels of androgens that affect the action of oestrogen and reduce milk-making tissue development during adolescence.^{17,18,19} If you have undergone steroid treatment to manage your CAH during puberty, this may have had the effect of promoting milk-making tissue development.^{20,21} Where milk-making tissue development is reduced, people may have *breast hypoplasia* (which literally means underdevelopment of the milk-making tissue). There is no research on CAH and lactation but sometimes *breast hypoplasia* can make it difficult to make a full milk supply.²²

People with Turner Syndrome may produce low levels of the hormone oestrogen which can reduce milk-making tissue development during adolescence and may also result in *breast hypoplasia*. If you have been given oestrogen therapy this may have assisted milk-making tissue development. How easily someone with Turner Syndrome will make milk will likely vary but there are published cases of people with Turner Syndrome successfully making milk to fully feed their babies with support from their health providers.^{23,24}

Where reduced milk-making tissue is shown to be the cause of low milk supply this is sometimes called having ‘insufficient glandular tissue’. If you have a diagnosis of CAH or Turner Syndrome, speaking with an ABA counsellor or seeing an IBCLC can help you work out a plan. Getting lactation off to the best start possible will help you avoid problems that could reduce your milk supply. ABA counsellors and lactation consultants may not have helped someone with CAH or Turner Syndrome before, but many will have helped others who have *breast hypoplasia* for other reasons. Having *breast hypoplasia* does not mean that you will not be able to make enough milk for your baby.

Little is published or known about the impact of many intersex variations on milk-making potential, or needs. If you find that you have difficulty with making milk it is good to know that there are ways to feed a baby from the body even without a full milk supply. These include partially feeding from the body and also giving donor milk or formula. Donor milk or formula can be given by bottle, or using a supply line. See [Chapter 9. Donor milk](#) and the section on [‘Supply line feeding’](#) on page 59, for more information. Your baby can also suck for comfort no matter how much milk you make.



Some people with intersex variations may have fertility challenges. If you have not been pregnant and given birth to your child, you may still be able to produce milk and feed your child. See [Chapter 5. Relactation and induced lactation](#) for more information and the ABA booklet [Breastfeeding: relactation and induced lactation](#).

Before baby arrives

Get to know support services that meet you where you are. The Australian Breastfeeding Association and Rainbow Families organisations are fantastic sources of support. Please find more information in [Chapter 15. Support services and resources](#).

It is a good idea to learn as much about options for milk feeding your baby and baby care as you can while you are waiting for your baby to arrive.

How you can prepare before the birth

The first weeks at home are a big learning time for parents as well as the baby. You may find things that were easy before, like making and eating dinner, will be harder. However, some planning before your baby arrives can really help. You could plan for easy meals, perhaps freezing some before your baby is born; arrange for someone to help you at home, either family, friends or a home help service and have your groceries home delivered.

It can help to think about your clothes if you are planning to feed from your body. Front-opening nightwear and tops are good for feeding, as are T-shirts, singlets and pull-on pants, skirts and shorts.

For birthing parents, the clothes that you wore before you were pregnant may be too tight for a while after the birth of your baby. You may need to wear a larger size or loose-fitting clothes. Special feeding tops are available. Patterned fabrics can hide milky marks from leaking nipples. Over-shirts, lightweight wraps and scarves can provide extra cover for yourself and your baby when you are out and about. Well fitted bras, if you wear them, may give greater support and comfort during pregnancy and feeding. Some



parents prefer using a singlet or crop top instead of a bra under a loose button-up shirt. Single-use or reusable pads may protect clothes from leaking milk.

If your baby is to be born in hospital, ask the staff about feeding policies.


All hospitals support lactation and feeding and most expect parents to have their baby in a cot beside the bed. Many health services in Australia are accredited through the Baby Friendly Health Initiative, which follows 'The Ten Steps to Successful Breastfeeding' (see <https://www.breastfeeding.asn.au/bf-info/your-baby-arrives/your-hospital-baby-friendly>). Being close to your baby means you will be able to cuddle your baby skin-to-skin often, which makes it easier to get feeding started well. A [feeding plan](#) can be downloaded from the ABA website and taken with you to hospital.

For the birthing parent, there are simple things you can do during pregnancy to prepare to feed your baby from the body. They include:

- If you wear a bra, check that it still fits well as your breasts/chest grow during pregnancy.
- Do not use anything drying on your nipples.
- There is no need to do anything special to prepare your nipples.
- Gently pat breasts/chest and nipples dry after showering or bathing.
- If the skin on your nipples is very dry, talk to your doctor about the use of a suitable cream.
- If you bind your chest, there is further information in [Chapter 8. Lactating as a transgender or gender diverse person](#).

If you are the birthing parent, you may notice that your nipples and areolae change during pregnancy. The paler 'pimples' around the areola (the coloured area that surrounds the nipple) are called Montgomery's glands. These secrete oil and sweat and help to keep the nipples and areolae soft and supple and prevent harmful germs growing. Many birthing parents find the colour of their nipples and areolae becomes darker during pregnancy.





This is noticed more in birthing parents with darker hair and skin colour. Birthing parents with pale skin may notice little or no change.

Sometimes people have flat or inverted nipples. For birthing parents, these often become less so during pregnancy. Research has shown that special antenatal nipple preparation (for example, using breast shells) does little to help.¹ The normal changes during pregnancy and the early days after the birth cause most nipples to become larger, more erect and supple. If your nipples remain flat or inverted, you may need some extra skilled help with the first feeds. You may find the Australian Breastfeeding Association booklet [*Breastfeeding: breast and nipple care*](#) helpful. It can be also helpful to speak to an ABA counsellor if you have any questions.

After baby is born

When babies are born, they know by instinct how to make their own way to the nipples, attach and start suckling.²⁵

As long as you are both well, your baby can be placed skin-to-skin on your chest straight after birth. Most babies are in a quiet, alert state at this time and this helps your baby to follow their instincts. Your baby will move across your chest towards your nipple and areola, attach to your nipple and areola and begin to feed.

For some babies, this happens quite soon after birth, in the first hour or so. Others may be affected by the medications used during the birthing process or they may just be content to take their time. Your baby may be happy just to lick or nuzzle the breast/chest, nipple and areola for some time before being ready to feed. This is also normal. It is part of the series of inborn actions that lead your baby to suckle.

Let your baby take their time and they will soon show when they are ready to feed. For birthing parents, early sucking is important because it causes the release of a hormone (oxytocin) that makes the uterus contract. This helps to control blood loss after birth. If frequent feeding follows, the uterus will return to its normal size quickly. Babies also find it easier to learn how to





feed if they are allowed skin-to-skin contact straight after birth and are less likely to have problems feeding.

If you have a caesarean birth, either planned or emergency, you can still feed your baby soon after the birth. After they are born, babies can be placed onto the birthing parent's chest. They are then cared for together in recovery. Sometimes the birthing parent and baby cannot be together until they return to the ward. Even then, the baby can still have skin-to-skin contact with a support person until the birthing parent is able to hold the baby. Babies often retain their inborn feeding response for months.²⁶ Even if there is a gap of some hours or days before you can spend close skin-to-skin time with your baby, their inborn feeding responses can still be stimulated. Once you are able to feed your baby from your body as often as they want, you will be well on the way to establishing your feeding relationship. For further information, see the ABA booklet [*Breastfeeding: caesarean births and epidurals*](#).

If you have a premature birth, your preterm milk is vital for your baby. Even if your baby cannot suckle at first, you can still give them your milk. Many birthing parents of premature babies start to build up their supply of milk by expressing until the baby is able to feed from the body. This is usually done by using a hospital-grade double electric pump. The expressed milk

may be fed to your baby or frozen to use later. Skin-to-skin contact time between parent and baby is even more important for a premature baby. If the birthing parent is not available, another parent can provide this contact, also called 'kangaroo care'. This helps to keep the baby's heart rate, breathing rate and temperature steady.²⁷ This skin-to-skin contact helps to release the feeding hormones in your body and will help build your milk supply.²⁸

For further information, see the ABA booklets [Breastfeeding: your premature baby](#) and [Breastfeeding: expressing and storing breastmilk](#) as well as the website article [Expressing and storing breastmilk](#).

It is best for the birthing parent to provide the early feeding from the body to the baby. Only the birthing parent will produce the colostrum that provides concentrated immune support to the baby after birth. Also, frequent feeding from the body (with no skipped feeds) is an important part of a birthing parent building a milk supply. Once the birthing parent has a good supply, shared feeding could work well. For more information on shared feeding, see [Chapter 7. Co-feeding](#).

Emotions

You may be surprised at how strong your feelings are once your baby is born. Be ready for the ups and downs that almost every birthing parent seems to have after childbirth. That great joy and those ready tears are very normal. After the excitement of giving birth, you may have days when you feel low, or you may feel on top of the world. At this time, the most important things for you to do are to sleep, rest and get used to feeding. Please find more information in [Chapter 15. Support services and resources](#).



CHAPTER

3

The early days



This is a learning time for both you and your baby. It is normal to feel upset if everything is not how you hoped it would be. Whether your baby is born in hospital, at home, or in a birth centre, try to have someone to help you with these first feeds. Gather what you need before you start, perhaps a drink of water, tissues and extra pillows. In hospital, you may like to draw the curtains for privacy.

Babies need frequent feeds for comfort and to feel safe, as well as for food and drink. Feed your baby whenever they seem interested. It is common for newborns to feed 8 to 12 times in 24 hours, or even more. If, for some reason, you cannot have your baby beside you, ask the staff to bring your baby to you each time they wake, or take you to your baby in the nursery. A sign could be placed on your baby's cot saying 'HUMAN MILK/BREASTMILK ONLY, PLEASE'.

Baby-led attachment

Baby-led attachment is the term given to the process where your baby follows their instincts to get to your breast/chest. It can be helpful when you and your baby are learning how to feed.



The process can be described as follows:

- 1 **Sit comfortably**, whether in bed with pillows behind you and one under your knees, or on a chair with your feet on a low stool or cushion. Leaning back is easier for this than sitting upright. Make sure you are well supported and comfortable, as you may be in that position for a while. Speak to your doctor if pain is making it hard for you to relax.
- 2 **Start while you and your baby are both calm.** We all learn best when we are calm. Your baby's instincts will lead them to move to your nipple area and start to suckle. However, it is the milk they then receive that teaches them that this is where milk comes from. If your baby is stressed, crying or upset, or too sleepy, they may not be able to follow their instincts. If your baby is upset, calm them by gentle rocking and cuddling, talking to them, making eye contact and holding them skin-to-skin. If this is not enough, let your baby suck on your finger for a few moments. It works best if the baby is hungry but not frantic for a feed. Otherwise, your baby may be too impatient to follow their instincts. In these early days, keep your baby skin-to-skin on your breasts/chest as much as possible, so they can start to feed whenever they are ready.
- 3 **Skin-to-skin contact** is an important part of this whole process. While you are both learning, you may find it useful to remove your shirt, singlet or bra. Remove your baby's clothes too, leaving them in just a nappy. Make sure the room is warm enough to be comfortable. If either of you are cold, you can place a soft blanket over you both. The warmth of your breasts/chest will keep your baby warm.
- 4 **Hold your baby against your body in a way that feels right for you.** Many parents find that leaning back with their baby on their chest works best for them.
- 5 As your baby starts to follow their instincts, they may at first 'bob' their head against your chest. **Support your baby's body but allow them to move freely.** They will start to slide, crawl, fall or even throw themselves towards your nipple. Your baby will be using the feel of your skin on their cheek and chin to find the nipple.



- 6 **Support your baby.** As your baby moves towards your nipple, you may find it helpful to move your baby's bottom across your body towards the other side. You may also need to move your hand and wrist to support your baby's back and shoulders. This support to your baby's upper body makes them stable enough to be able to control their head movements as they attach. If you lean back with your baby on top of you, gravity will also support your baby so they can move where they need to.
- 7 **Attaching to the nipple and areola.** Now that your baby's head is near your nipple, they may nuzzle you for a little while. They may even suck their own fist. That is fine. Resist the temptation to move their hand out of the way. As long as your baby is still calm, when they are ready, they will dig their chin into your breast/chest, reach up with an open mouth and attach to the nipple and areola. If you are not leaning back, you may find it helps to pull your baby's bottom closer to your body, or to give even more firm support to their back and shoulders at this time. This will help your baby to dig their chin in, keep their nose free and get a good mouthful. The whole process may stop if your baby loses contact with your skin. They may continue once in contact again, but if they do not, you may need to move them back to a more upright position on your chest and start again.
- 8 **When your baby is well attached it should not hurt you.** Their mouth will be right over the nipple and well onto the larger darker area (areola), with their tongue underneath the nipple. Your baby should have more of the 'chin-side' of your areola in their mouth than the side next to their nose. Their bottom lip will be turned out (flanged) over the breast/chest while the upper lip is neither tucked in nor turned out. Your baby's chin will be pressed against the breast/chest and their nose will be free. A correctly attached baby will be able to breathe while feeding without you holding your breast/chest away from the baby's nose. Doing so may pull the nipple from the baby's mouth or block milk ducts. If the baby's nose is pushing into you, try moving their body and legs closer to you. This will bring their chin further in towards your breast/chest and free the nose. You can tell your baby is drinking milk well when you see their jaw pause for a moment in the open position during sucking, as a mouthful of milk is being swallowed. You may also hear a soft ticking noise as your baby swallows.

Your baby's body will be held so that their head, neck and spine are in a straight line, with their head tipped back over your hand or arm. Their body should be facing yours. Your baby may be across your body below the breast/chest or nipples, lying across your body at an angle, in line with your body, or even into your lap. As long as your baby's back is straight, their whole body close to yours and you are both comfortable, that is all that matters. Take the time to try different positions to find what best suits you both.

It's common to feel pain with the first stretching of your nipple in the early days. However, if it continues, your baby may not have taken a big enough mouthful of nipple and areola. They may come off again on their own. If not, you can break the suction by putting a clean finger in the corner of their mouth, between their gums. Your baby may be happy to attach again without changing position, or you may need to bring them up your chest and start the process again. If your baby becomes upset during the 'baby-led attachment' process, calm them first and then start again. This is a learning process for both of you and it is okay to take your time.

As you and your baby start to feel comfortable with feeding, you will soon be able to put your baby straight into the feeding position you have both come to enjoy. This may be sitting up or lying down — any position in which you are both comfortable.

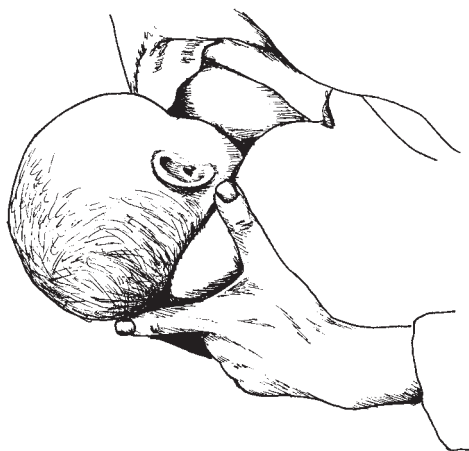


Another attachment method

You may like to try a more structured approach to positioning and attaching a baby. These techniques are useful to know and are listed below. A baby who has already made a good start with baby-led attachment should transfer smoothly to this method when you are ready. Once your baby is attached, you can lie back in a comfortable position, making sure your baby moves with you.

With this more structured technique for attaching your baby, you also start off sitting comfortably, with your shirt, singlet or bra either taken off, or well open so as not to get in the way.

- 1 Unwrap your baby and hold them close.** You can hold your baby with their head and shoulders supported on your forearm or hold them with your opposite arm, with your outstretched hand supporting their shoulders and your forearm holding the baby close (drawing below). Your baby's body will be turned towards you so that their hips, tummy and chest are against you. Your baby's lower arm can be tucked around your waist. Your baby needs to be at the same level as your breast/chest, with their mouth and nose about level with the nipple. You may wish to support your breast/chest as your baby attaches. It is important to ensure your fingers are behind the areola, so as not to get in the way of your baby feeding.



You may find it helpful to support your baby behind their shoulders as you bring them in close to feed.



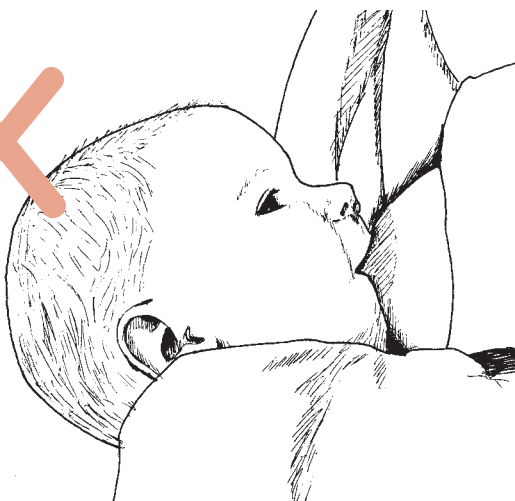
Pushing your baby's head onto the breast/chest may mean their nose makes contact before their chin.

2

Encourage your baby to open their mouth wide. Gently brush your nipple and underside of your areola against your baby's mouth. Their chin against your breast/chest will help them open their mouth wide. Avoid moving your breast/chest or chasing their mouth with your nipple. Try to keep the nipple in its natural position (where it would be if you were not holding it with your hand). Your baby's inborn reflexes will help them find the nipple.

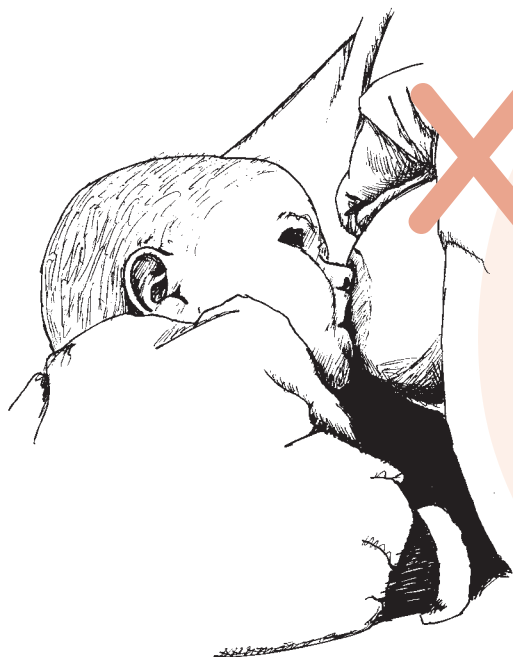


This baby's lower lip is not opened out over the breast/chest. They do not have a good mouthful of breast/chest.



3

Bring your baby to the breast/chest, not the breast/chest to your baby. Wait until their mouth is open wide and their tongue comes forward. Then move your baby's body gently, but quickly, towards yours. Aim the nipple towards the roof of their mouth. Try to make the first point of contact their lower jaw or chin, well down on your areola. This will mean your baby takes a large mouthful of breast/chest.



This baby is not close enough to the breast/chest. Their chin is not touching the breast/chest, their nose is buried into the breast/chest. Putting firm pressure between their shoulder blades, and tucking their hips and feet firmly against the feeding parent's body, may be enough to fix this attachment.

When your baby is attached well:

- Their mouth covers the nipple and a large amount of areola, more on the lower than the upper side.
- Their chin is touching the breast/chest.
- Their nose is clear of, or just touching the breast/chest.
- Their bottom lip will be turned out (flanged).
- It is normal for the upper lip to rest in a neutral position (ie not tucked in or turned out).



Some parents find that this more structured method of positioning and attachment does not work well for them. Some babies may seem to fight, seem tense or upset, have hands and arms in the way or arch their back. Others may seem sleepy or not interested, not open their mouth, or seem not to know what to do to attach. If your baby is like this, you may find that baby-led attachment works better for you. Spend lots of time skin-to-skin with your baby, talking to them, making eye contact and just getting to know them. Every parent and baby is different and together you will work out what is best for you.

During the first days, your baby will suckle for varying lengths of time.

Remember, feeding from your body is a learned skill and it is normal to feel awkward at first. The midwives, lactation consultants or ABA counsellors can be a big help at this time. Ask for help if you need it. During these early days, your body needs your baby to feed often to build your milk supply. If you have your baby with you in hospital, or you are at home, you can feed your baby whenever they fuss or when you feel full and want your baby to take some milk from you. If your baby has to be in the hospital nursery, ask that your baby be brought to you for a feed whenever they wake, or at least 3-hourly. Feeding whenever your baby wakes is ideal, but hospital routines sometimes get in the way. If this turns out to be the case, try to relax and not worry. Once you get home, you can feed your baby as often as you and your baby want.





Colostrum

For the first few days, until your milk ‘comes in’, your body will produce colostrum, your baby’s first food. Colostrum is of great value to your baby, as it is very rich in ingredients that protect them against many infections. This colostrum, or ‘first milk’, is all your baby needs in the way of food but they need it often. Small amounts suit a newborn’s tiny stomach. Most babies lose weight in the first couple of days. This is normal and does not mean that they need formula. Over the early days, the creamy-yellow colostrum changes into mature milk, usually bluish-white in colour and increases in volume.

Formula top-up feeds

A healthy newborn baby who has free access to feed from the body needs no fluid or food other than your colostrum or milk. If your baby is being kept to a feeding schedule or is unsettled for some other reason, formula feeds may be suggested.

Formula feeds can disrupt feeding from the body because they fill up your baby and reduce the amount of time spent sucking. Giving formula to babies can also make them more likely to get infections. Research has shown that babies who are fed both from the body and given formula lose the same amount of weight as babies exclusively fed from the body in the early days.²⁹ Your body is making more milk all the time and your milk-making tissue is never completely empty. If your baby does not settle after a feed, you could try feeding from your body again. The extra milk they get may be all that is needed to settle them. The extra suckling will help increase your milk supply too.

If you are told that your baby needs extra fluids for any reason, this can be your expressed milk or that of someone else. See [Chapter 9. Donor milk](#) for more information. Formula should only be given when medically necessary. You may wish to print out the Academy of Breastfeeding Medicine’s ‘Supplementation’ protocol (bfmed.org/protocols) and share and discuss it with your doctor. You can ask that any extra fluids be given by cup or spoon, as the different sucking action needed for a bottle teat can make it

harder for them to learn to suckle at your breast/chest. As your milk supply increases, it is likely that the amount of expressed milk, donor milk or formula can be slowly reduced and finally stopped.

Night feeds

It is normal for babies to wake and need feeding at night. Frequent feeding during the day and at night in the early days will help prevent engorgement when your milk comes in (see section below on 'Engorgement'). It is also important to help increase your milk supply.

It may be tempting to have someone else feed your baby while you sleep for the first night or two. Most birthing parents find that, while this sounds good in theory, they often still wake for their baby during the night. It is nature's way of making sure that babies get the feeds they need and that your milk supply is maintained.

Burping baby, or bringing up wind

Not all babies burp easily. Many parents prefer to feed without trying to burp their babies. In many cultures, burping babies is unknown. A short rest period between offering the first side and the second, or an upright cuddle at the end of a feed will often be enough to ensure comfort for your baby. Spending a long time trying to burp a baby can be very tiring for both parent and baby. The baby may not even have any wind to bring up. Babies fed with a bottle often swallow large amounts of air during a feed, which tends to cause more wind than feeding a baby from the body. However, when lactating parents have a fast flow of milk from the body, young babies may swallow air and need to burp afterwards.

One way of checking if a baby does have wind to bring up is to sit your baby on your lap. Put the heel of your hand just under their rib cage or under their chin. With your other hand supporting their head and back, gently lean your baby forward, or put your baby to your (cloth-covered) shoulder, gently rubbing their back.





Engorgement

Many birthing parents find that they become engorged when their mature milk comes in. Their breasts/chest become very full and tight. This is caused by both the increased milk volume and other fluids, including the increased blood supply needed for the body to make milk. Your breasts/chest may feel quite uncomfortable and your baby may find it hard to attach well. Frequent and effective feeds will help to prevent engorgement.

Cold compresses can help you feel more comfortable. Cold packs (or a frozen water-filled disposable nappy or frozen vegetable pack) or thoroughly washed and dried, crisp, cold cabbage leaves can be applied over the affected area. Take care not to leave cold packs on for more than about 15–20 minutes.

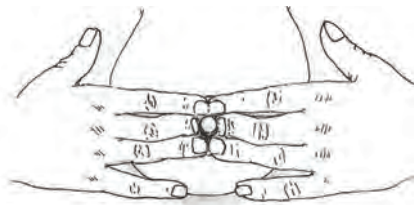
Research results are mixed about whether cabbage leaves have some special agent that helps to reduce swelling or just work because they are cold.^{30,31} However, many lactating parents find them soothing. Cabbage leaves should not be used if you have an allergy or are sensitive to cabbage.

The baby's frequent feeding is the best way to prevent engorgement and to relieve the fullness should it happen. Gentle downward massage towards your nipple may help milk flow. This can be done before and during feeds.

If your nipple does not stand out far enough because the breast/chest is too full and tight, you may be able to soften it by hand expressing a little milk before attaching your baby. You can also use a technique called 'reverse pressure softening'.³²

To do this, apply pressure with your fingers placed flat at the sides of and close to your nipple; or use all the fingertips on one hand to push the breast/chest in around the whole nipple. Maintain this pressure for 1 to 3 minutes or more until the area softens beneath them. This will soften the breast/chest around the nipple and areola. Your baby will then be able to draw your nipple well into their mouth so that they are less likely to damage it. It is also likely to trigger your let-down reflex.

‘Reverse pressure softening’ to soften overfull breasts/chest before feeding or expressing. (This works best when the feeding parent is lying on their back.)

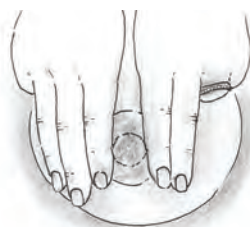


2-handed, 1-step method:

With fingernails short and fingertips curved, push in with each finger touching the side of the nipple. Hold for 1-3 minutes or more.

2-handed, 2-step method:

Use two or three straight fingers on each side, first knuckles touching the nipple. Push in and hold for 1-3 minutes or more. Repeat above and below the nipple.



1-handed, ‘flower hold’

With fingernails short and fingers curved, push in around the nipple in a circle. Hold for 1-3 minutes or more. A hand mirror may help you see your areola more easily.

In cases of very painful engorgement, you may be advised to empty the breast/chest as much as possible, either by hand expressing or with an electric pump. This sometimes eases the swelling within the breast/chest. If for any reason you need to express, talk to a midwife, an IBCLC or ABA counsellor. Detailed information can be found in the ABA booklet [*Breastfeeding: expressing and storing breastmilk*](#) and the ABA website article [*Engorgement*](#).



Please see '[Hand expressing](#)' on page 51.

A newborn's nappies in the early days after birth

Many parents are surprised how few wet and dirty nappies newborn babies have in the first few days. They may worry that their baby is not being fed enough milk. Babies have very small stomachs, so only hold a small volume at a time. On day 1, a baby drinks about a teaspoon per feed, and a few tablespoons on day 3.^{33,34}

In the first 4 days after birth, a baby who is getting enough human milk will have one wet nappy per day of life. This means only one on the first day, two on the second and so on. From day 5 onwards, a baby will have at least 5 heavy wet single-use nappies or 6 or more heavy wet cloth nappies in each 24-hour period. The urine should be very pale or clear.³⁵

The first bowel motions a baby has are black and sticky. This is the meconium present in the baby's digestive tract before birth. By day 2, the motion should be softer but still dark in colour. Over the next few days the motions change to a greenish-brown and then to mustard-yellow. As the colour changes, they become less sticky and larger in volume.³⁵

If your baby's nappies differ from this, speak to your midwife or medical adviser. It is better to check out any feeding problems sooner rather than later.

Preventing sore nipples

Many lactating parents feel some nipple pain in the early weeks when the baby first attaches.³⁶ If pain is severe or continues, or if there is nipple damage, it is usually a sign that that a baby is not attached well. Here are some things to help reduce the risk of damage to nipples and treat sore nipples:

- The most important thing is to make sure your baby is correctly positioned and attached for feeding.

- Start feeds on the less sore side first. Start the milk flowing by hand expressing a little before attaching your baby. If you feel very full and hard, use 'reverse pressure softening' before trying to feed your baby.
- You may be surprised at the strength of your baby's suction. If you need to stop the feed, protect your nipples by breaking the suction gently. To do this, place a clean finger between baby's gums, in the corner of their mouth and gently break the suction.
- After a feed, hand express a few drops of milk and spread it over your nipple.
- Keep your nipples dry between feeds. Change pads, bras and singlets often if they become damp with leaking milk. Avoid pads that hold moisture against the skin.
- If there is broken skin or scabbing, it may help to hand express some milk to soften the scab before feeding. There are also products that some lactating parents use to help heal the damaged skin. Speak with your midwife or lactation consultant about options that may suit you.
- For further information on sore or damaged nipples, talk to a midwife, an IBCLC or an ABA counsellor. Refer to the ABA booklet [Breastfeeding: breast and nipple care](#) and to the information on the Association's website about [sore nipples](#).

It is important to find your own way with your baby. Your baby is a person with their own needs. These may not be quite what you expected or what others tell you. They may be happy after a quick feed or may prefer to suckle for longer on each side. Your baby may need lots of cuddles and soothing or they may settle quickly and easily to sleep.

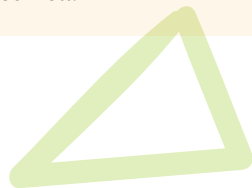
The key is to learn and respond to your baby's unique needs. If a baby is showing signs of getting enough milk (see [page 42](#)), this means they are feeding well. If feeds are long (eg more than 30 minutes each side) and the baby is not showing signs of getting enough milk, then they may not be feeding well and help should be sought from an IBCLC or an ABA counsellor.



It is best to ask for help early if you are worried, as it is usually easier to solve problems when they first start.

Remember:

- The more often your baby feeds from the body, starting at birth, the sooner you will bring in a full milk supply.
- Milk supply equals demand. Feed your baby whenever either you or your baby wants to. This will maintain your milk supply.
- Being relaxed can help your milk to let down more quickly.
- A baby who is well-attached is less likely to hurt your nipples and will be more likely to drain the breast/chest well.



CHAPTER 4

The early weeks





Looking after yourself

During the early weeks, as you begin to adjust to caring for your baby or babies 24 hours a day, you will be glad of any plans to make life easier at this time.

You may have arranged to have some help at home during the first few weeks. Caring for and learning about your new baby is a full-time job. So, accept offers of help from your support network. Some parents find a 'to do' list on the fridge useful. That way, if anyone asks what they can do to help, you don't have to think of something on the spot, just refer to the list.

It is normal for parents to feel tired in the early weeks. Birthing parents are recovering from the birth. The new responsibility of a baby means busy days and disturbed nights for most parents.

Try not to worry if your home is not as tidy as usual. Focus on doing those few things that are most important to you. Visitors may be happy to make you a cup of tea or bring in the washing and will understand if you excuse yourself to go to bed in the evening. Many parents hang a note on the front door when they want to sleep or feed without being disturbed during the day. You may prefer to put your phone on silent when sleeping or feeding, or while you bath or change your baby.

Eating well is good for you and your baby. Simple meals using fresh foods are best at this time. Eat any food in moderation and avoid foods that do not agree with you or that you do not like. Try not to skip meals because hunger can make you tired and grumpy. Snack on fresh or dried fruit, raw vegetables, nuts or crackers with cheese. Drink when you are thirsty. Water is fine. There is no need to drink large amounts of fluids.

Alcohol passes into your milk and will be at the same level as in your blood. The Australian Government advises lactating parents to avoid drinking any alcohol as the safest option and, definitely, for the first month of their baby's life. If you decide to consume alcohol, you can express some of your milk in advance. This can be fed to your baby while alcohol is being cleared from your body after drinking. More information about alcohol and feeding can be found in the [Alcohol and breastfeeding](#) article available on the ABA website.

It is important to have people around who can offer support and encouragement. We can be very unsure of ourselves when we have a new baby and may find it hard to deal with criticism. Advice from family, friends and others can make us question how we parent. A call to an ABA counsellor may help you decide what is important to you.

Most importantly, trust your instincts with your baby.

Keeping first things first

The first short months of your baby's first year are precious and they pass quickly. You may not feel like the same person you were before your baby was born. You may feel you must rush back to all that you did before. However, most parents find they need to take life at a slower pace for a while and resume outside interests slowly.

Feeding your baby means that you will have frequent rest periods during the day when your baby is a newborn. You can lie on your bed to feed or sit in a comfortable chair. These restful feeding times are important because they give you a chance to relax.

Use them to get to know and enjoy your baby. You can also listen to music, watch television, read or catch up on social media while feeding. For your baby, feeding is more than just eating. Your baby also has a need to suckle that can be met in the loving comfort and security of a parent's arms.

Although there will be changes in your social life, feeding from the body does not mean you have to stay at home. Once you are used to meeting your baby's needs, you will find it simple to go out with your baby and, if you wish, for short breaks without them. Some parents need to plan feeding outside the home, including finding safe spaces such as parent rooms, or having someone to help with feeding. It really depends on your feeding journey. It can be helpful to connect with others who may have had a similar experience.

Many parents return to the paid work force, study or other commitments while their babies are young and still feeding. If possible, delay your return to work until feeding is going well and, for birthing parents, you feel



recovered from the birth. Although not framed for the LGBTQIA+ community, the ABA booklet [*Breastfeeding: women and work*](#) may be helpful as you plan your return. ABA also has a Breastfeeding Friendly Workplace program that provides information and support to parents returning to work while feeding, and to their workplaces. Further information can be found at: breastfeeding.asn.au/workplace.

How often will baby need feeding?

You may be surprised at how often your baby needs a feed. Human milk is easily and quickly digested because this is the milk your baby's system is designed to have. After the first week, a baby's stomach is about the size of their clenched fist. Babies feed often. It is normal for a young baby to need 8 to 12 feeds or more in a 24-hour period. Some of these will be at night. Feeding your baby 'according to need' (demand feeding) helps you build and maintain your milk supply. Few babies younger than about 8 weeks sleep for long periods between feeds. If they do, they may balance this by a period of more frequent feeding, often in the late afternoon or evening.

Your supply adapts to meet your baby's needs if you feed them whenever they seem hungry or fussy. Sometimes they may only need to suckle for a few minutes, while at other times they may need to suckle for longer. Even though you may be told that babies need a routine, feeding mostly works better if you watch your baby and respond to their needs.

There may be times when you seem to spend the whole day feeding, but such times usually last for only a few days at most. If you can meet your baby's needs on these 'fussy' days, you will soon find you have a more contented and settled baby again.

You may already have children or other things you need to do that cannot be put aside while your baby is very young. If so, your only option may be to strike a balance between feeding according to need and some sort of routine. You will find it easier if you can be fairly flexible. Try to set aside a time each day when you and your baby can enjoy a long, restful cuddle during which they can feed as much as they like.

Some babies are sleepy and don't wake to feed as often as they may need.



If this happens, you may be advised to wake your baby for feeds, usually at least every 3 hours during the day. Unwrap your baby to try to wake them, or change their nappy. The ABA booklet [Breastfeeding: and your supply](#) covers sleepy babies in more detail.

Actual suckling time in these early weeks may vary from feed to feed. Let your baby feed as long as they want on one side. Then offer the other side if they want more, again for as long as they want. However, don't feel that you have to sit there for hours at each feed, with baby suckling and dozing. It is better to end a feed after about 40 to 50 minutes in total, at the most. If your baby doesn't settle, offer another short feed a little later or feed them again after an hour or two. If your baby falls asleep after a feed, there is no need to wake them to offer the second side. At the next feed, start on the other side to the one you started on last time. Some babies are quite content to feed from one side only per feed, especially in the early weeks.

Night feeding

It is easier to manage night feeds if you have your baby in bed with you or in a bassinet or cot beside your bed. Red Nose organisation recommends that babies sleep in their own safe sleeping place next to their parents' bed for the first 6 to 12 months, to reduce the risk of sudden infant death.³⁷ This also makes it easy to bring your baby into bed with you for a feed. If this does not suit you, you could have an easy chair or spare bed set up in another room. Just take care never to fall asleep in a chair with your baby, because sleeping with a baby on a chair or sofa is unsafe. You could drop your baby or smother them against the cushions or an armrest. For more information, search the ABA website for the leaflet [Bed-sharing and your baby: the facts](#).

Going to bed early and having a daytime nap can make up for time spent awake at night caring for your baby. As your milk supply settles down and your baby grows, they may go longer between feeds and you may need less rest. This is a slow process that takes longer for some babies than others.



Supply and demand

If at any time you feel that your baby wants more milk than usual, feed them more often for a few days. Your baby may need another short feed if they do not settle after feeding or wake again in less than an hour. Try not to rush the end of the feed, so that your baby has time to take all the milk they want. This will help give your baby more milk.

**Remember, the more often milk is removed,
the more milk you will make.**

A dummy may reduce the number of feeds a baby asks for and could affect your supply. If you want to use a dummy, wait until feeding is going well and your baby is gaining weight well. It is not a good idea to use a dummy to stop your baby crying or to make them ‘go longer’ between feeds.

For birthing parents, in the early weeks it is common to make more milk than a baby needs. As time passes, you may notice that your breasts/chest do not seem as full as soon after the birth. This does not mean that your milk supply is low. It means that your body is starting to make the right amount of milk for your baby. Many birthing parents notice their breasts/chest feel ‘softer’ at around 6 weeks.

Fussy days

From time to time you will notice that your baby has fussy days, when they seem to want to feed more often than usual. People used to say that the baby was having an ‘appetite increase’ or ‘growth spurt’ and needed more milk to meet their growing needs. We now know that a baby’s daily intake stays about the same from 1 to 6 months of age.³⁸ It is not clear why babies have these fussy periods, but it is common. If you follow your baby’s lead and feed more often for a few days, you will probably find that your baby soon settles down again. The comfort your baby receives from these extra feeds plays an important role in their development.

How do you know if you have enough milk?

Many lactating parents worry that they will not make enough milk for their baby. It is good to know that most birthing parents can make more milk than their baby needs. However, this depends on your situation as well. For parents with some medical conditions, or those who are inducing lactation or relactating, or who have had surgery or hormone treatment, there are factors that may impact milk production.

If your baby is only drinking milk from your body, you can know if they are getting enough milk by asking these questions:

- Does my baby have at least 5 heavily-wet single-use nappies or at least 6 pale, very wet cloth nappies in 24 hours?
- Are my baby's bowel motions soft? Does my baby have at least 3 soft or runny bowel motions every 24 hours? (Babies older than 6 weeks may have fewer bowel motions.)
- Is my baby generally content — even if sometimes unsettled or fussy?
- Are my baby's eyes bright? Does my baby have good skin tone? (If you gently 'pinch' their skin, does it spring back into place?)
- Has my baby been gaining weight? Has my baby grown in length? Keep in mind that weight gains can vary from week to week. It's usually best to look at them over a longer period such as 4 weeks.¹ Each time you weigh your baby, make sure it is without clothes (or in clothes that weigh the same) and on the same scales. Take note if your baby has just had a big feed or a bowel movement, as these can change weight results quite a lot.

If you answered 'yes' to the above questions, your baby is getting enough milk. If you are still concerned, speak to your child health nurse or doctor. If your milk supply is low, it may help to read the ABA booklet [Breastfeeding: and your supply](#). Many lactating parents feel as if their milk supply is low at times. If it truly is low, in most cases it can be increased. An ABA counsellor will be able to give you support and information at this time.



In summary:

- If your baby is fed only human milk, appears alert and reasonably content, has at least 5 heavy single-use nappies or 6 very wet cloth nappies in 24 hours, regular soft bowel motions and is gaining weight, then your milk supply is meeting their needs.
- If your milk supply is low, more frequent feeds will increase it. Supply equals demand.
- It is normal for babies to have fussy periods. It does not mean you are 'running out of milk' but is part of their growth and development. Meeting your baby's need for more frequent feeds during this time will keep your baby happy and well-fed until they return to a more settled pattern.

Contraception

If it is relevant to you, the combined oral birth control method ('the pill') is usually not recommended while feeding, at least in the first 6 weeks.³⁹ After this, or when the milk supply is established, the combined pill can be used but some lactating parents have found their milk supply reduced. The progesterone-only type (for example, the 'minipill', implants, etc) are the most common hormonal methods used by lactating parents. However, some have found that their milk supply seems to lessen, or their babies seem to be extra fussy even when they use a progesterone-only birth control method. This can often be fixed by giving more frequent feeds for 7 to 10 days. If not, you may need to discuss another form of birth control with your doctor.



Crying babies

All babies have times when they cry for an unknown reason. This can be stressful for the whole family. If you have fed your baby not long ago and they are dry and comfortable, it may be you that they want! Being close to a parent is a very real need for a baby. You won't spoil them by picking them up when they cry. Crying is your baby's only way of telling you that they need something. Your baby could be hungry, lonely, in pain, cold, hot, bored, in need of a clean nappy or overtired.

There may be one time of the day (often in the late afternoon and evening) when your baby needs extra attention. They may need more feeds, cuddles and play. A massage or warm bath may relax them. Taking your baby for a walk can be good for both of you. Many parents have found a well-fitted baby carrier really helps. Baby snuggles in next to your warmth and comforting heartbeat, while you have both hands free.

Some babies have trouble either burping or passing wind. This can cause some discomfort. If your baby seems to be in a lot of pain, it is often called 'colic'. There are many theories about the cause of colic. Sometimes it can be linked to a lactating parent who has lots of milk and/or a strong let-down reflex.

Other babies who seem to be in a lot of pain are said to have gastro-esophageal reflux.

If the lactating parent has too much milk and/or a strong let-down reflex, reducing these can often help both colic and reflux problems.

One cause of colicky symptoms is lactose overload. When this happens, the baby will be gaining weight very well. Lactose is the milk sugar present in human milk. The level of lactose is fairly constant and a major part of the milk. It has nothing to do with what the lactating parent eats. Their body makes the lactose as part of making milk. It does not come from their diet. Most of the lactose is broken down as the milk passes through the baby's digestive system. The rest reaches the lower bowel. Normal gut bacteria use this extra lactose to maintain a healthy bowel flora. However, if you have a large milk supply and your baby is taking in large amounts of milk, excess gases are formed that may cause the wind and pain, and many large loose bowel motions.



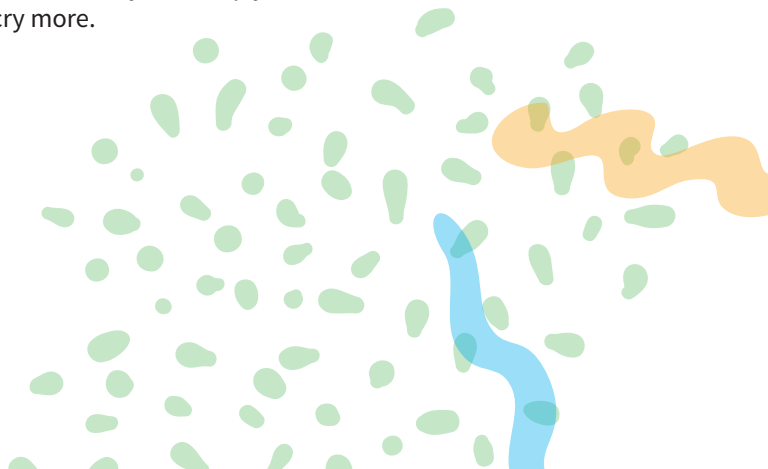
Letting your baby finish the first side first may be the key to solving this problem. Your baby should decide how long they spend feeding on one side. If you have a large supply of milk they may only need one side at each feed. This may mean that you need to express (just enough for comfort) from the other side. For more detail about this cause of crying babies, see the ABA website article [Lactose overload in babies](#)

Some parents feel that it helps their baby's colic or reflux if they keep baby upright for a feed, or lie back with baby on top of them, similar to baby-led attachment when the baby was young. This often helps a baby to cope better with the fast milk flow. There is more detail about this in the ABA booklet [Breastfeeding: and your supply.](#)

If you have lots of milk and your colicky baby falls asleep after only the first side but wakes soon after, you can return your baby to the same side. The milk that they get then is higher in fat than at the start of the feed. It satisfies their hunger and helps to settle their system down and reduce the wind in their bowel that causes colic pain.

Colic usually eases once your baby is a few months old. Letting your baby kick without a nappy or giving a gentle tummy massage in a clockwise direction can sometimes help to relieve tummy aches.

If your baby seems to be in a lot of pain with colic, have them checked by your doctor to rule out any other problems. The ABA booklet [Breastfeeding: and crying babies](#) contains many ideas for coping with colic and crying. A talk with an ABA counsellor may also help you work out if other factors are making your baby cry more.



Mixed feelings



For many new parents, the early months with a new baby are a time of mixed emotions. The thrill of seeing your baby achieve a new milestone or drift to sleep on your chest, full and content, can give way in an instant to a flood of tears.

Some parents also feel anxious and helpless at this time. Many find it hard to get used to having someone rely on them for every need. It can be very stressful if your baby cries for reasons you don't know or if your baby is hard to comfort.

Nothing can prepare you for the feeling of responsibility that comes with a new baby. However, as time passes, you will get to know your baby and can better predict what they will do. When that happens, things will improve. It is also common to feel grief at the loss of your 'before-baby' lifestyle.

However, if things don't improve and your worries mean that you can no longer find pleasure in life and in your baby, seek medical help. You

may also find reading the ABA website article [Postnatal Depression and Breastfeeding](#) worthwhile at this time.

Not every parent falls in love with their baby straight away. The delay is more common if parent and baby are kept apart after the birth or if the birth is traumatic for the parent. However, it can happen to anyone. It can be hard not to feel guilty. Just take each day as it comes, caring for your baby as well as you can. The love will come, but it may take some time. In the meantime, talk about your feelings with other parents. You will find that you are not unusual and it does get better.

Many parents find that skin-to-skin contact can improve their bond with their baby. Just place your baby, naked except for a nappy, upright on your bare chest. This contact causes a release of hormones that make you feel good about your baby.²⁸ When you do this, it is normal for your baby to act like they want to feed. Let your baby follow their instincts. If it is cool, just wrap a blanket around you and your baby, leaving your bare chests touching. Sharing a bath with your baby is another lovely calming way to spend time together.

Talking and sharing your joys and worries with other parents can reassure you. To find out that you are not the only one to have these feelings really helps. You can find more information in [Chapter 15. Support services and resources](#).

If you decide to wean

Sometimes, despite the best efforts of a parent and their support people, problems arise that cannot easily be solved. For some lactating parents, feeding from the body does not work out. You are not alone. Please see [Chapter 10. When feeding doesn't work out](#).

CHAPTER

5

Relactation and induced lactation

It is possible for a person who has never been pregnant or given birth to make milk. This makes it possible for non-birthing parents to feed their baby from their body whether they have a baby born to a partner, a baby born via surrogacy, or an adopted child.

There are two terms that may apply when bringing in a milk supply:

Relactation occurs when someone wants to re-start a milk supply at any time after having been pregnant.

Induced lactation is the process of building up a milk supply if you have never given birth or been pregnant.

In both situations, the milk-making tissue in the breasts/chest starts from a non-lactating state and needs to be stimulated to make milk. Those who have been pregnant (or have fed a baby before) may find it easier to make milk than those who haven't, because pregnancy changes milk-making tissue. However, this is not always the case.

People who have never been pregnant, who no longer have (or have never had) ovaries or are past menopause can often produce some milk to varying levels. This is unless there has been surgery that has removed all of the milk-making tissue or severed the ducts to the nipples. This is very individual.



People vary hugely in how easily they can build up a milk supply and this can make it seem very complex. However, there are really only four things needed for a person with milk-making tissue.^{38,40,41,42}

- a desire to feed from the body or make milk
- knowledge about lactation and feeding from the body
- a suckling baby or expressing by hand or with a pump
- support people to build confidence.

Here are some (but not all) situations where LGBTQIA+ people may be thinking about relactating or inducing lactation:

- You are in a same-sex relationship and are not the birthing parent.
- You are a transgender or gender diverse parent, but not the birthing parent.
- You are adopting a baby or toddler.
- Your baby is being born via surrogacy.



Getting started with relactation or inducing lactation

Relactation or inducing lactation both follow the same process. If this is what you would like, there are things you can do to prepare for feeding. Relactation or inducing lactation work through the action of the hormone prolactin. During pregnancy, the hormones oestrogen, progesterone and prolactin prepare the milk-making tissue to make milk, but prolactin can do this on its own. Prolactin is released when the nipples are stimulated through the suckling of a baby or through using a breast pump or hand expression. Once milk begins to be produced, removing that milk results in more milk being made. The ABA booklet [Breastfeeding: relactation and induced lactation](#) also provides helpful information.

Breast pumps

Pumps can be used to build a milk supply because they stimulate the milk-making tissue and remove milk. People vary greatly in how they respond to pumping.

- It is a good idea to pump at least 6 to 8 times a day, preferably including once during the night.
- It is best to use an electric pump with a double collection kit that stimulates both sides at once. It helps boost prolactin levels and this grows the milk-making structures within the breast/chest. It saves you time and removes more milk.^{13, 42}
- Frequent pumping for short periods works better than less often for longer sessions. Start out slowly, pumping only for 5 to 10 minutes on low suction to begin with. You may have some discomfort while your body gets used to pumping. You can be 'hands-free' if you have something else to hold the pump cups in place. A tight-fitting singlet top or sports bra cut over each nipple will allow you to push through the backs of the pump kit shields (or shells). You can also buy special products to hold the shields in place. This allows you to do other things while pumping, such as caring for another child, reading a book, eating or using your phone or computer.



Make sure that your pump is working well and is suited to long-term use. Some of the smaller pumps, like those with batteries or those that only allow you to pump one side at a time are not designed for very frequent and long-term use. They may lose their suction with time and/or not work as well. Double electric pumps can be hired from many local ABA groups.

Store your pumping kit, un-rinsed, in a clean, closed container or plastic bag in the fridge between uses; or you can rinse it in clean water and store in a closed container out of the fridge. It can help to warm the shields just before the next use, especially if they have been in the fridge. This helps the milk flow more quickly.⁴³ Once a day, take the kit apart, rinse it in cold water and then wash it thoroughly with hot water and detergent. Rinse well. Air dry the kit covered with new paper towel or dry using new paper towel.^{44, 45, 46, 47} See the ABA booklet [Breastfeeding: expressing and storing breastmilk](#) and the website article [Expressing and storing breastmilk](#) for more details.

Hand expressing

In relactation and induced lactation, the milk supply increases slowly. Hand expressing after pumping can remove milk that the pump has not and so help increase the milk supply.

- Try doing some hand expressing after pumping or between pumping times. This may help to push your body to increase the amount of milk it makes.
- The emptier the milk-making tissue, the stronger the message it gets to make more milk.
- Hand expressing is a very useful skill that takes practice to master.
- Before starting, wash your hands well with soap and water. Dry them on new paper towel or a clean unused towel. Place a clean towel on your knees to catch any drips and to dry your hands if they become wet.
- Express directly into a clean container. A bowl is ideal.

Being shown how to hand express is ideal, but if this is not possible, these photos show the basic technique step-by-step.



1

Place your thumb and forefinger on either side of your areola.



2

Gently press your thumb and forefinger back into your breast/chest.



3

Press your thumb and forefinger towards each other.



4

When the flow slows, move to another section of your breast/chest.

1. Place your thumb and forefinger on either side of your areola. Your fingers should be well back from the nipple with an imaginary line between them running through your nipple. A mirror may help if you cannot easily see the lower part of your breast/chest.
2. Gently press your thumb and forefinger back into your breast/chest. If your breast/chest is full of milk, it may feel hard, lumpy or even a little sore. Treat your breast/chest gently. Expressing should not hurt. When the let-down reflex happens and the milk flows, the breast/chest softens and expressing becomes easier.
3. Press your thumb and forefinger towards each other, using a slight rolling action. This will squeeze the ducts just behind the nipple and make the milk flow out of the nipple. Until the let-down reflex happens, the milk may drip from the nipple and you may need to hold your bowl close to catch it.
4. It may take several minutes for your milk to let down. Continue the pressing motion, in a rhythmic way, until it happens. The milk may spray from the nipple or come out in several jets with each squeeze. The let-down reflex is a learned response. This means it should happen more quickly as you get more used to expressing.
5. When the flow slows, move to another section of breast/chest, working your way around the areola. Always place your finger and thumb on either side of the nipple, as before. If your hand gets tired, swap to the other hand.
6. If the flow slows down, try expressing from the other side in the same way. Change hands and sides often if your fingers get tired. You will find they become stronger with practice. You can swap between sides until the milk no longer flows well.
7. If your supply is low, you may find that you get only a few dribbles each time you express. Don't give up! Lots of short sessions will gradually build up your supply.
8. When you are expressing for all your baby's needs, aim to have some longer and some shorter expressing sessions. During the longer sessions you may find you will get two or more let-downs and so get more milk.

9. Express for as long as it takes for the main milk flow to slow down after the let-down occurs. Switch sides a few times to make sure you get as much milk as you can. This may take as long as 20 to 30 minutes or as little as about 5 to 10 minutes. It varies from person to person. It will get quicker and less tiring with practice.
10. Some lactating parents use their right hand for their left side and vice versa. Others use their left hand for their left side and their right hand for their right. Still others use both at different times. With practice you will find what works for you. To avoid strain in your arms and shoulders, relax and change your position often.

For both pumping and hand expression, an ABA counsellor may be able to assist you as you learn. You can find videos of [hand expressing](#) on the ABA website.

I pumped at every meal while I ate and in between each meal for a total of six times a day. The first 2 weeks were hard because I saw no milk but when I started seeing drops, I could then hand express more milk after each pumping session. My milk supply increased slowly but steadily by a few mL each day until I was making all the milk my child needed.

Induced lactation and relactation with a suckling baby

If your baby has been born and is in your care, you can induce lactation or relactate by allowing them to suckle on your nipples. If they accept, let them feed as often as possible, day and night.

If you want to share feeding the baby from your body with another parent, there are some extra things to consider. See the section on co-feeding below.

Just like parents who have birthed their babies you may need assistance with attaching your baby. An IBCLC or ABA counsellor may be able to assist.



The more often a baby suckles, the stronger the message to the milk-making tissue to make more milk. Supply line feeding (sometimes called a breastfeeding supplementer) can help to keep your baby sucking as it gives them extra milk while they feed. See section below on [‘Supply line feeding’](#) on page 59.

How will I know that my efforts are working?

The first change you may notice once you start is that your body feels different. Your breasts/chest may feel hotter, tingle or get bigger or heavier. In anything from a few days to a few weeks after starting, you may be able to express some drops of milk. In some cases, hormonal changes may cause a brief slump in mood just before the first milk appears. So, feeling down may be a good sign, and a breakthrough may be just around the corner. As your supply builds, you may also start to feel regular let-downs. Your milk won’t ‘come in’ like it does for a parent who has just given birth. The change in hormone levels after birth means that a lot of milk is produced quickly. Instead, when you are relactating or inducing lactation, small amounts of milk are produced at first and then your milk supply increases gradually.

Encouraging the let-down reflex

If you are pumping, use the highest suction you are comfortable with. Having the suction higher than this won’t help you express more milk. In fact, it can slow the let-down and damage your nipples. The let-down reflex usually works fine while feeding your baby but may take longer to occur when using a pump. Relaxation exercises can often help.

Some ideas to help you relax:

- calm, deep breathing
- exercise
- massage (a partner or support person can assist)
- loving contact with your baby, cuddling or just thinking how beautiful they are
- having a drink or something to eat
- a short rest in a comfortable chair, or on your bed
- your favourite calming music
- thinking of pleasant scenes or experiences
- feeling confident you can succeed.

If your baby or child has already arrived, skin-to-skin contact with them just before feeding or expressing will help to release oxytocin. This will help your let-down and increase the amount of milk removed.⁴⁸ You could also try stimulating your nipples, by rolling them between your fingers, just before feeding or expressing. Habit plays a part in helping the let-down. Follow a routine when feeding or expressing. For example, have a drink, sit in the same chair, play some music. Breast/chest massage can help too.



No matter how hard I tried, I seemed not to be able to get any more than 120 mL per day by hand. So I changed the method of expressing. First I would express in the usual manner and after I had emptied my breasts, I would massage them and express all over again. The output nearly doubled.

When using a pump, some lactating parents have said that watching the milk expressed makes them worry about how much they are getting. This may affect the amount they can express. If this happens to you, it may help to distract yourself by doing something you enjoy while you express. Parents who are waiting for their baby to arrive sometimes find it helps to connect with them, by cuddling a teddy or blanket they have ready for their baby or looking at a photo (if they have one).

Being able to relax and have your milk let down when needed usually becomes easier over time. See the ABA booklet [Breastfeeding: expressing and storing breastmilk](#) and the ABA website article [Expressing and storing breastmilk](#) for more details.



Building up your milk supply

The key message is that building up your milk supply needs frequent feeding and/or expressing. When your baby is feeding or suckling, the more often they feed and remove milk, the more milk you will make.

You may read in books or on the internet that it is rare for a person who hasn't given birth to be able to make a full milk supply for a baby. This is not true for people who have been assigned female at birth. Current research shows that, if they persist, most will at some stage be able to supply all the milk their babies need.⁴¹ Research has also found that a baby's need for human milk doesn't change much between 4 weeks and 6 months of age.³⁸ It will then slowly decrease over the next months as the baby begins to eat solid food.

How much milk people assigned male at birth can make is still unknown, but in one case, a parent who had induced lactation reportedly produced 240 mL of milk per day.⁴⁹ This is about one third of what babies under 6 months drink on average in a day.

If you are the only person who is planning to produce milk for your baby, aim to feed them from your body every 1 to 2 hours and at least 8 to 12 times in each 24 hours. If you are sharing feeding with another lactating parent, you may need also to express by pump or hand in between feeding, see [Chapter 7. Co-feeding](#).

If your baby is not feeding from the other parent, they will need other milk while you are relactating or inducing lactation. For babies under 12 months and, especially under 6 months, it is important for the baby to get enough milk. For more information on extra milk feeds, or if you are unsure how much to give, contact your early childhood nurse or an IBCLC. They, or an ABA counsellor, will also be able to help if you want to know how to wean them off extra milk feeds. For more information, see the ABA website articles [Mixed feeding](#) and [How to wean off formula supplements](#).

It is important that your baby feeds well with good attachment. If your baby is not suckling well and removing milk, your milk supply will not increase. Problems with the way your baby suckles may make feeding painful and damage your nipples. If you have concerns about attachment or feel any discomfort or pain, an ABA counsellor or an IBCLC can help.



Medications and alternative therapies for increasing milk supply

Frequent feeding from the body or expressing milk is the most important thing you can do to build your milk supply. However, medications and other treatments can also be helpful. These should be discussed in detail with your doctor, as there is the chance of adverse side effects. It's important to understand that while medications and other treatments can be useful, they are simply 'extras'. They cannot take the place of frequent feeding or expressing and making sure that the baby is well attached.

Synthetic oestrogen and progesterone have been used to copy the changes that occur during pregnancy and some people use these to prepare their body for lactation. However, they can have serious side effects and close medical supervision is required. There is no evidence that hormones used in this way lead to a greater milk supply.

Many people have found prescription medications that boost the release of prolactin helpful. In some cases, they are needed for only short periods of time, but others may need them for many months. In either case, you need to wean off these medications slowly. Some information that may be helpful to your doctor can be found at: thewomens.org.au and search for 'Domperidone for increasing milk supply'.

Alternative methods include herbs, acupuncture, osteopathy and massage. There is little documented evidence for these. If you would like to learn more or try any of them, speak to a qualified health professional or an IBCLC for advice about them.

There is an article [Galactagogues \(substances claiming to increase supply\)](#) on the ABA website. This discusses the scientific evidence on medications and herbs often used by lactating parents to boost their milk supply.

Supply line feeding

While you build your milk supply you may wish to use a supply line (also called a breastfeeding supplementer). This is a device to provide extra milk to your baby while they feed from you.

It consists of a container that holds milk and fine tubing that carries milk from the container to your nipple. When your baby suckles, milk is drawn through the tubing into their mouth. At the same time your baby stimulates your nipple and removes what milk you have made. This rewards their suckling efforts and means they are more likely to be willing to feed from you and stay for longer periods, even when you are only producing small amounts of milk. Their suckling and removal of milk will also increase your milk supply.

A supply line can be used to provide expressed milk — yours, your baby's other parent, donor milk, formula; or (if the child is older than 1 year) other milk. A supply line can make it possible for you to fully feed your baby at the body, regardless of how much milk you are making.



Supply line feeding can work well and encourages feeding from the body. It can help stimulate supply and encourages skin-to-skin. It is important to be aware that a baby can get more milk than needed from the supply line. If this happens they may take less from your body. Some babies become so used to the flow from the supply line that they refuse to feed without it.

Suggestions for avoiding these issues:

- Close off the tube of the supply line when your baby first attaches, so that milk will not flow straight away. Your baby will learn that they need to suckle for a little before the let-down occurs and they get milk.
- Begin feeds without the supply line and then gradually extend the time spent feeding without it.
- Feed without the supply line for some feeds.
- Lower the bottle or bag of the supply line during the feed so your baby has to suck a bit harder to get the milk.
- Use a thinner tube in the supply line (if possible).

The idea of using a supply line can feel daunting. Setting up can be complicated and you may feel like you just don't have enough hands. However, lactating parents report that they quickly become used to it. The emotional and social rewards of feeding their baby can make it well worth the effort. The skin-to-skin contact through feeding from the body increases bonding and attachment between you and your baby.

Some tips when using a supply line:

- If you can, get a supply line before your baby or child arrives. Practise taking it apart and putting it back together.
- If you use tape to keep the tube in place and your skin reacts to the repeated use of the tape, try an adhesive bandage with padding in the middle. The tube can be slipped through the middle and the same bandage can be left on for many days. Some people find that they do not need to tape the tubing at all or that the tube can be kept in place by their clothing.
- If you have trouble getting your nipple and the tube in your baby's mouth at the same time, you may be able to attach your baby to your nipple first and then slip the tube in place. This may not work if the tubing is very soft or flexible.
- Try using the supply line for the first time when your baby is calm, rather than really hungry and/or upset.
- Connect with other parents who use supply line feeding. See [*Chapter 15. Support services and resources.*](#)



If a supply line doesn't work well for you, there are other ways to give extra milk and encourage your baby to feed directly from you.

- If you are not making much milk, use a spoon, medicine cup or dropper to place milk directly on your nipple or drip milk down the breast/chest and into your baby's mouth when they are feeding from your body. They may be happy to stay suckling for longer.
- You can also use a cup. Cup-feeding can be used with both young and older babies. An ABA counsellor can help you learn how to do this. There is more information on [cup-feeding](#) on the ABA website.
- Giving extra milk with a bottle is also an option. However, some babies have trouble switching between feeding from a bottle and feeding from the body because of the different types of suck needed. If you want to use a bottle, it is a good idea to 'pace' the feeds. Use a slow-flow teat so the milk does not flow too quickly. It can help to begin the feed in an upright position, so that gravity does not assist the flow. Then gradually lean your baby back as the bottle empties. Pause often, so your baby is able to more easily let you know when they have had enough. More details about paced bottle-feeding can be found in the ABA booklet [Breastfeeding: expressing and storing breastmilk](#) and in the leaflet on the ABA website, [Caregiver's guide to the breastfed baby](#). How a bottle is used is more important than what type is used.

There are a number of brands of supply lines on the market and an ABA counsellor or an IBCLC can teach you how to use them. More details can be found in the ABA booklet [Breastfeeding: using a breastfeeding supplementer](#) and the article on the ABA website [Using a breastfeeding supplementer](#).



Support

Good information and support is crucial to being able to relactate or induce lactation. As well as this book, you can find information in other books and on the internet. Information on the ABA website is backed by research. This may not be the case with other sources. Check the basis of the information you may read elsewhere. Surround yourself with people who believe in what you are doing and who will support you. It can also be helpful to connect with parents who have had a similar journey. Please find more information in [*Chapter 15. Support services and resources.*](#)

Health professionals vary widely in their knowledge of relactation and induced lactation. Some are willing to learn more on the subject and can become a great source of support. Unfortunately, this is not always the case. If you need medical or professional feeding assistance and the first person you see is not helpful, try someone else. Keep trying until you find someone who can help you.

Quite often, friends and family won't understand why you would want to relactate or induce lactation. Try to explain the positive impact you believe feeding will have for you and your baby and why you want to feed from your body. Even when you do this, some important people in your life may still not understand. In these cases, let your loved ones know how much it would mean to you if they could support you, just because it is important to you, even if they do not understand why. Many family members who see little value in feeding from the body are later glad to have been a support at the time.



CHAPTER

6

Surrogacy

This chapter discusses some of the options for parents preparing for their baby born via surrogacy. Your individual situation will influence the choices you can make. If you have specific questions it can be helpful to contact an ABA counsellor.

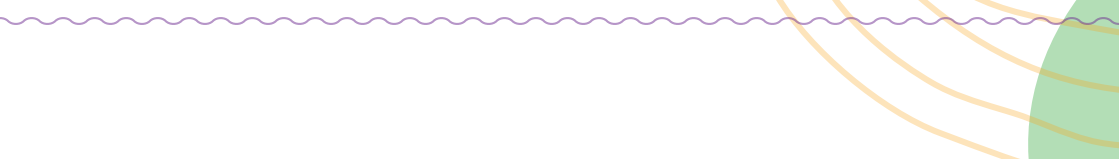
Before birth

Some parents may choose to build their own milk supply before their baby is due. In this way, you may already have a good supply of milk when your baby is born. However, it can be hard to maintain a milk supply if you need to travel overseas to meet your baby. Plan for this early on. You will need to learn how to hand express and be prepared to use a manual pump or hand express when you travel.

After birth

Some parents start the process of making milk after their baby is born or start feeding with a supply line from birth. Newborn babies are often very willing to suckle often and for a long time. This means that you can build up a milk supply just by your baby suckling and may not need to prepare before your baby is born. Starting relactation or induced lactation with a very young baby can be quite a simple and easy process.





Many surrogacies result in multiple births. You may be told that a parent will not be able to relactate or induce lactation to make enough milk for two or more babies. People may advise you not to try. However, it is possible for one lactating parent to make enough milk for more than one baby. One research paper from the 1970s described caregivers in an orphanage in Vietnam who relactated to feed two babies each.⁵⁰ Some lactating parents may not make enough milk to fully feed their babies in the early months. However, as the babies grow, other food will be added to their diet and their need for milk will decrease. It is very likely that, at some point, yours will be all the milk they need. Remember, feeding is more than just giving a baby food. Feeding from the body can be successful no matter how much milk the parent makes.

Some parents want their babies to have human milk, even though they choose not to establish their own milk supply. In these situations, there may be other ways to feed your baby human milk.

Some birthing parents are willing to express milk for some time for their babies. Discuss this prior to the birth of your baby. If you feel that it is important for your baby to receive colostrum in the day or two after birth, discuss how this could be managed. They may agree to express the colostrum, even if they are not willing to feed from their body. Some may be happy to lactate and provide milk for you to feed your baby. Others will not want to do it. Whatever their feelings, this is likely to be a highly emotive issue for all involved. If you want to talk to the birthing parent about this, your relationship may affect how easy or difficult this conversation is. Many people find it helps to mention the idea during the planning stages and continue talking about it through the pregnancy. Feelings can often change, particularly in such an emotive relationship as surrogacy. It is not uncommon for some people to change their minds once the baby is born and you should be prepared for this.

You may also choose to feed your baby donor milk. See [Chapter 9. Donor milk](#) for more on this.

It can be useful to seek out support and information about feeding and preparation before your baby is born. Peer-to-peer support from other LGBTQIA+ families can be helpful. Rainbow Families is a great starting point and can connect you. Please find more information in [Chapter 15. Support services and resources](#).



CHAPTER

7

Co-feeding



With co-feeding, more than one lactating parent feeds human milk to their baby or child. Co-feeding can vary a lot between families and the roles can change over time.

People who co-feed may include those who:

- are already feeding at least one baby or child and have a well-established milk supply
- are not currently feeding a baby or child and want to induce lactation or relactate
- are making milk after birthing a baby.

Some examples of co-feeding arrangements may include:

- the birthing parent feeds for the first 6 to 8 weeks and a second lactating parent shares the feeding after that time
- one lactating parent provides most of the feeds and a second lactating parent feeds overnight or one feed each day
- one lactating parent provides all feeds for the first few months and moves to a second lactating parent providing all feeds after that time, for example when the first parent returns to work.

Co-feeding young babies

When you give birth, the removal of the placenta triggers your milk production. Over the next 6 to 8 weeks, your supply gradually adapts to make only what your baby takes. A baby who attaches and removes milk well, drinks as much as they need as often as they want and for as long as they want, will stimulate and control the milk-making response.

If you have not given birth, expressing by hand or with a pump can build a milk supply before your baby is born. However, the easiest way to build a milk supply is often through a baby's suckling.

Many parents wait until after the baby is born to relactate or induce lactation knowing that in the early weeks after birth the infant will be feeding from the body of the birthing parent, receiving colostrum and helping them to establish their milk supply. Others choose to build a supply before the baby is born. If the birthing parent is apart from their baby or their own milk supply is slow to come in, having a second milk supply can be helpful as the second parent can provide supplementary milk. However, if the birthing parent is planning to feed from the body, it may be advisable to delay feeding from the body of the second parent until the milk supply of the birthing parent and feeding is established (after about 6 weeks).

If you are already lactating and feeding a child, feeding another baby will increase your milk supply. Your feeding routine may also change. You may choose to feed different children at different times or at the same time. If the young baby has trouble coping with your let-down reflex, the older child could be fed first. The young baby may find it easier after the first fast flow has eased. This may also help the younger baby get more of the high-fat milk. An ABA counsellor can discuss how to manage your supply and issues that often arise when feeding more than one child.

Ideally, with a young baby fed mainly by one lactating parent, the change to either partial or complete feeding by another lactating parent will take place slowly. Pay attention to the signs that a baby is getting enough milk. This will help you make sure that your baby continues to be well nourished, as the first lactating parent slowly reduces the number of feeds they give each day. The ABA booklet [Breastfeeding: weaning](#) has useful information about

reducing your milk supply, even if you need to do this quickly. Another ABA booklet [Breastfeeding: your supply](#) may help the parent who is taking over the feeding build their supply before and during this transition. This process will be different for each co-feeding family. An ABA counsellor can discuss your individual needs and give you information and support.

If you are a parent who is not already lactating, you can allow your baby to suckle for comfort. Many babies enjoy doing this, even if there is no milk. You can also build a milk supply through a process of induced lactation or relactation. [Chapter 5. Relactation and induced lactation](#) discusses how to build a milk supply without a pregnancy.

How to maintain and manage more than one milk supply

Over time, some co-feeding parents develop a feeding pattern which allows each one to feed at regular intervals. Each will maintain a partial milk supply and together they will meet their baby's needs.

When you need to manage more than one milk supply for a single baby, you need to know how to tell if the baby is getting enough milk. See [‘How do you know if you have enough milk?’](#) on page 42.

When co-feeding, it is important to watch for blocked ducts and signs of mastitis, especially if the frequency of feeds varies. When milk-making tissue becomes engorged, there is a risk that one or more of the ducts that carry milk to the nipple will become blocked. A lump forms and the breast/chest begins to feel sore. If the blockage is not cleared, milk can be forced out of the duct and into the surrounding tissue, which becomes inflamed. You may get the shivers and aches and feel like you are getting the ‘flu’. This is called mastitis and can come on very quickly.

The ABA website has information on how to treat [blocked ducts](#) and prevent [mastitis](#). See your doctor if you get the flu-like symptoms or if you cannot clear a blockage within a few days.



If things change and you feed less often, you may find you need to express regularly to maintain your milk supply. It may help to talk about what is happening with an ABA counsellor. In some cases it may be possible to continue your current feeding pattern. In other cases, you may need to make some changes to the shared feeding setup.

This may be a challenge, but it doesn't always need to be long term. You may feel frustrated or upset because you cannot feed the way you had hoped or planned. With the right support you may find it becomes possible again. Sometimes you may find a new normal that also works for you.

Co-feeding older babies and children

If you have been co-feeding since birth or the early months, the pattern is likely to change as your child gets older and feeds less. One lactating parent may offer fewer feeds or wean completely, or both may continue to feed the child. As time goes by, each lactating parent's milk supply will adapt to match the needs of the child according to how much they feed them. Feelings of engorgement if the frequency of feeding changes become less likely.

In some cases a lactating parent may become pregnant. They may continue to feed or choose to wean. Note that it is common for milk supply to drop during pregnancy due to hormones. The ABA booklet [Breastfeeding: as your family grows](#) may be a helpful resource.





Emotional highs and lows

For some, co-feeding brings emotional challenges for example the effort of keeping up more than one milk supply, sorting out roles and feelings of envy and jealousy. There can be mixed emotions if a lactating parent is weaning, as well as sadness and grief if the co-feeding didn't work out as planned. These emotions are common and normal. If you are struggling with emotions around co-feeding, reach out for help. See [Chapter 15. Support services and resources](#) for information.

Co-feeding can be a journey in many different ways. Plan, negotiate, be flexible and get good information and support. Many families find they are able to develop a feeding pattern that works for them.

CHAPTER

8

Lactating as a transgender or gender diverse person



Many transgender and gender diverse parents nurture and nourish their children from their body, in very similar ways to other parents. Feeding from the body is not only about the amount of milk produced, but also about the feeding relationship.

A diverse community

Not every transgender or gender diverse person has had surgery and not every transgender or gender diverse parent will use hormones. How lactation and feeding work for you will depend on your own situation and choices. This chapter covers topics that may be especially helpful to transgender and gender diverse people. Not all of this information may be relevant to you.

More the same than different

Healthy full-term babies are all born with a similar level of nipple, milk duct and milk-making tissue growth.⁵¹ Female sex hormones during puberty, pregnancy or where medically provided, trigger an increase in the milk-making capacity of this tissue.^{52,53,54}

Transgender and gender diverse people in a variety of circumstances can make milk and feed their babies.^{49,55,56,57,58}

How does gender identity impact lactation?

Becoming a lactating parent may bring about positive and negative emotions in relation to gender. For some people, the social and physical changes of lactation may affect feelings of gender dysphoria. Some people find planning to feed easy, some may find it hard to decide, and others may find it impossible. Making milk for a child is a life transition and brings changes to hormone levels that can affect mood and bonding. Your feelings around feeding may change in ways that surprise you.⁵⁵





There is no right or wrong way to feel.


Transgender and gender diverse parents report a similar amount of transphobia as those without children.⁵⁹ Stepping into the role of a lactating parent may change the types and settings of this discrimination and stigma.^{55,57,58} Body changes may also affect you in ways you don't expect. It may be helpful to think about some of the common situations that you may face and how they may make you feel:

- short-term engorgement and swelling in the chest area
- chest skin stretching if lactating after pregnancy
- nipples stretching
- further growth of milk-making tissue
- cramping while feeding or expressing if you have recently given birth
- lack of private places to feed
- problems wearing a binder
- possible increased need for contact with health care settings, including emergency medicine, allied health, pathology, child health, mental health and gendered 'women's' services
- the possible need for your chest and/or nipples to be examined.

Coping with feelings and situations

Your mental health as the result of discrimination, stigma and dysphoria may affect how you feel about lactation.^{55,57,58}

As a transgender or gender diverse person, it's likely that you've already thought about and planned for many life challenges and this can make you stronger.⁶⁰ The increased resilience that may come with being transgender or gender diverse can help you with these new changes.⁶¹



Facing challenges is a normal part of life and all lactating parents will have bad days. For many people, the benefits of feeding far outweigh any potential problems. Take time to think about the things you value about being able to lactate or feed your child, such as:^{55,57}

- feeling that your milk-making tissue is useful and has a purpose
- the value of human milk to your baby
- meeting your need to feed and nurture your child from your body
- a sense of achievement from overcoming roadblocks
- being a role model for others
- affirming your gender in the traditional social role
- the knowledge that your gender is defined only by you, not whether you lactate or not.

If you are feeling distressed, seek support from an appropriate health professional. You can find information about this in [Chapter 15. Support services and resources.](#)



Some transgender and gender diverse people find that lactation can worsen gender dysphoria.⁵⁷ You have a right to non-judgemental support if you need to or decide to stop feeding your child human milk. If you do not feed from your body, you may still choose to express your milk to feed to your baby in other ways. Seek out informed support to help you find a way that works for your whole family.

Lactation suppression

Some transgender and gender diverse parents may decide to suppress lactation. Sometimes medications are prescribed for this purpose. If this is advised, talk over the pros and cons of using them with your doctor, as there are some risks to their use.

Lactation suppression simply reverses the milk-making process. As less milk is removed from your body, less milk is made. The process will depend on how long you have been feeding or removing milk. The longer lactation has gone on, the longer it can take to reverse. People who have just given birth or are in the early days of lactation may find their chest becomes very full if they don't remove milk. You can use the ideas below for your comfort. If you have been feeding for some time, you will need to gradually reduce the amount of milk removed over a period of days, weeks or more. The length of time it takes differs for everyone. Your body's response and comfort levels will guide you.

Some ideas to assist in suppressing lactation:

- Wear clothing that provides firm but comfortable support to the chest.
- Relieve pain and swelling by putting cold/gel packs in your clothes or use cold compresses after a shower or bath.
- Handle your chest very gently as it can bruise easily.
- Avoid stimulating your nipples
- If your chest feels too full, express a little milk. Express only enough to make you comfortable.

- Mild painkiller medications may help relieve pain. Your doctor will be able to advise you about this.
- Drink when you are thirsty. Cutting down fluids will not help reduce your milk supply.
- You may be uncomfortable lying in bed if your chest feels full. Try lying on your back or on one side with an extra pillow supporting your chest. If you like to lie on your front, place a pillow under your hips and stomach to ease the pressure on your chest. You can use a soft towel across your chest if you are leaking milk.
- Cold cabbage leaves worn against the skin can be soothing, although there is no evidence that they reduce milk supply. Wash and dry the leaves before use and cut out any large, bumpy veins.

Monitor your chest during lactation suppression or weaning to avoid the risk of blocked ducts. The ABA website has information on [lactation suppression](#) and how to treat [blocked ducts](#) and prevent [mastitis](#). An ABA counsellor or IBCLC can help you work out how to wean quickly, if you need to, when you have an established milk supply.

Do I need to stop taking hormones?

This is a new area of study and so caution is advised.

There could be unknown risks involved with lactating during or after taking hormones.⁵⁸ There are known risks in stopping or delaying the hormones needed to treat gender dysphoria.^{57,62,63,64} Decisions concerning hormones and feeding a baby need to be considered carefully, with the support of a medical professional.



Finding professional support

Health professionals who specialise in transgender and gender diverse hormonal management may not know a lot about lactation, while lactation providers may not know much about transgender and gender diverse care. You may need to find someone who has knowledge in one area and is willing to learn more about the other.

There are free resources for health care professionals who wish to learn more about lactation or transgender and gender diverse health care:

- Monash Medicines Information Centre: 03 9594 2361 or <https://monashhealth.org/health-professionals/medicines-information-centre/>
- NPS MedicineWise: 1300 MEDICINE (1300 633 424) or <https://www.nps.org.au/>
- LactMed database, NCBI (US source): <https://www.ncbi.nlm.nih.gov/books/NBK501922/>
- North Western Melbourne Primary Health Network Trans GP Module: Primary Health Care for Trans, Gender Diverse & Non-binary People: <https://nwmphn.org.au/health-systems-capacity-building/trans-gp-module/>
- Position statement on the hormonal management of adult transgender and gender diverse individuals, *Medical Journal of Australia*: <https://www.mja.com.au/journal/2019/211/3/position-statement-hormonal-management-adult-transgender-and-gender-diverse>

Learning more about the hormones involved in different stages of lactation can help you to work with your health care provider. You can read more about the milk-making process in [Chapter 2. How feeding works](#).

What can I wear on my chest?

Garments worn on the chest may have different meanings for different people. Despite their common use, any garments worn on the chest during lactation can sometimes cause problems. Whatever you use or wear, hygiene is important to help prevent fungal and bacterial infections.⁶⁵

- Change absorbent pads or clothing often, particularly if they become damp.
- Clean nipples and areolas with water. Avoid non-prescribed ointments or creams.
- Frequently wash any garments worn on the chest in hot, soapy water and air dry outside where possible.

Bras

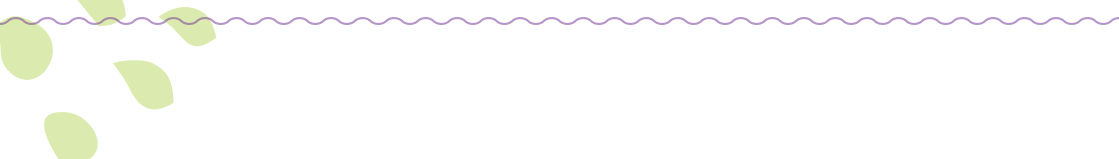
For people who wear bras, there are things to think about when choosing a bra to wear during lactation.

- They need to be comfortable, with a properly fitted, wide band.
- You may need extra cup room for your chest as it changes between being full and empty.
- Underwire bras are not advised due to the pressure they can cause as the chest fills with milk.
- Cotton and natural fabrics breathe the best.
- You will need cups that provide easy access to the nipple and do not press into the chest when open.

Binders

Binding can mean different things to different people and can involve a wide range of garments and compression levels.⁶⁶ Binding the non-lactating chest may cause harm to milk-making tissue. Binding the lactating chest will increase the risk of blocked ducts and mastitis. (see [page 68](#)). Some people have found occasional light binding once lactation is well-established has worked for them but caution is advised in any binding of the lactating chest.⁶⁷





There are some things you should know about the use of a binder during lactation.

- Compression has been used in the past to suppress lactation, particularly during the early days and weeks, so may affect your milk supply.
- The size of the chest will change as milk fills the milk-making tissue and is emptied.
- The tight fabrics may irritate nipples and chests that are already more sensitive.
- Feeding frequently may be more physically difficult.

If possible, don't use a binder. For lactating parents who continue to bind under the supervision of a health care professional, it is important to note that there will be times when they won't be able to bind so there is less compression. This includes the early weeks while building a milk supply.⁶⁶

As well, you will usually need to avoid restrictive clothing and synthetic materials across the chest if any of the common nipple and chest problems, like cracked nipples, arise during lactation.⁶⁵

Ways to minimise the appearance of the chest that may have less risk include using:⁶⁸

- soft wire-free crop tops
- singlets with built-in support
- baggy or structured layers of clothing over tighter singlets or T-shirts.

Many lactating parents who cannot bind find it helpful to focus on this as a short-term concern and some make plans for chest minimisation surgery or surgical revisions after weaning.⁵⁵ Some lactating parents find it helpful to focus on the way their chest is providing nutrition and comfort for their baby.⁵⁵ If not being able to bind during lactation is a concern for you, please seek an appropriate health care provider for individual support.

Surgery and how it can impact feeding

Any surgery on the chest, milk-making tissue, nipple, and/or areola could affect lactation. Because surgery techniques vary widely, even within the same procedure,⁶⁹ it is hard to predict how your individual surgery will affect your chances of making milk. Breast implants do not normally have a big impact on lactation.⁷⁰ Surgery to remove milk-making tissue will usually impact milk production. Removal of some milk-making tissue may not have much impact on making milk⁷¹ but even then it depends on how the surgery was done and how many milk ducts were removed or cut.⁷²

If most of the milk-making tissue is removed, as may occur in top surgery, then it is possible that some milk could be made but the chances of making a lot of milk are low. If the nipples are removed during surgery, and then placed back in new positions, lactation is not possible as there will not be intact milk ducts to carry milk from your milk-making tissue to your baby. This is also the case with nipples that are tattooed or reconstructed from non-nipple skin. In these situations, it may be possible to feed at the chest with a supply line, but it may also be too painful or difficult for your baby to attach to the chest. If you wanted to feed from the body, but were not able to, it is normal to feel grief or sadness. You might like to speak to an ABA counsellor about these feelings.

Scar tissue may increase the risk of blocked ducts and mastitis.⁶⁵ It is vital to tell your health care provider about any surgeries to your chest area if you are lactating or pregnant.

Supply line feeding

If your baby can comfortably attach, you can use a supply line, whether or not you are lactating. It can be a helpful tool for those who have a partial milk supply, while stimulating extra milk production. Other parents may use it if they are not making milk, but still wish to have a feeding relationship. People with tattooed or reconstructed nipples may have extra issues when using a supply line, and should contact a lactation professional for individual advice. You can read more about this in the section on '[Supply line feeding](#)' on page 59.



Skin-to-skin

Skin-to-skin means holding your baby while you are both bare-chested. Skin-to-skin supports bonding, can increase milk production and has many benefits for your baby. See 'After baby is born' in [Chapter 2. How feeding works](#) for more information.

Non-lactating parents can also bond with the baby and provide the many benefits of skin-to-skin contact. If you are in a health care setting and would like to try skin-to-skin, you have a right to ask for some privacy.



Donor milk

If you are unable to build a milk supply or choose not to lactate, or to suppress lactation, you may still choose to feed your baby human milk. See [Chapter 9. Donor milk](#).

Support

Tips and quotes from transgender and gender diverse parents

- There are many social media groups and online forums that can be helpful. Many transgender and gender diverse parents find a lot of support and solidarity in these groups.
- You can also find support by sharing and listening to personal stories.
- Having a child can change how you express your identity. Be aware of this and find support people you can talk to.
- There are many ways to feed your baby.
- Choose the affirming words and pronouns you want your baby and others to use for you before your baby is born. Talk about this with your support people and ask them to advocate on your behalf if needed.



For me, my kid uses 'zaza', but if my child doesn't feel safe they can use 'papa' (short for parent)

- It will be a hormonal rollercoaster. You are still good enough no matter how you feed.
- Get informed. Read blogs and watch videos.
- Your experience may be different from child to child.
- Don't listen to the horror stories. Listen to the good ones.
- Feeding in public. Think about how you could do this.



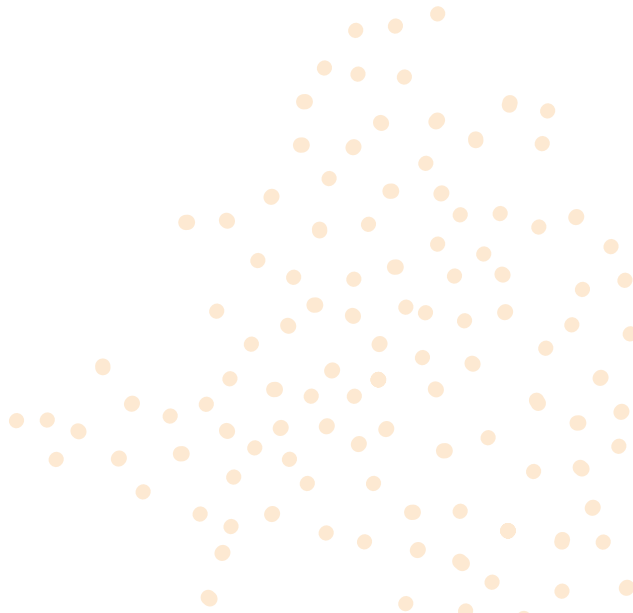


I have to plan out feeds and know of access to parent rooms etc. Always having to think ahead.

- The parent's heart is in the chest for a reason.
- Don't get sucked into the 'body back after baby' thing. Your body tells a story.

It is important to connect with others. See [*Chapter 15. Support services and resources*](#) for further information.

Rainbow Families NSW has resources for trans and gender diverse parents that can be downloaded from: <https://www.rainbowfamilies.com.au/>



CHAPTER

9

Donor milk

There may be times when it is not possible to feed from your body or express milk for your baby, but you still want them to have human milk. This may be long term, or for a short time, such as when:

- You are unable to build a full milk supply and your baby needs extra milk while you partially feed from your body.
- Your baby needs extra milk for a short time, until you return to full feeding from your body.
- You have chosen not to relactate or induce lactation.
- You have chosen to suppress lactation.
- Your feeding journey has not gone as planned and you have chosen to wean.

Feeding your baby milk from another person is known as donor-milk-feeding, or milk-sharing.

Some parents have a lactating friend or family member who is willing and able to provide expressed milk. Other parents and caregivers seek donors for private milk-sharing arrangements where a lactating person provides expressed milk. This may be a one-off relationship or an ongoing one. You may choose a bulk donation of frozen milk or receive donations on a regular basis. In some situations, perhaps most commonly for short-term donations from a friend or family member, you may agree that the donor feeds your baby directly from their body. This is sometimes known as wet-nursing.



There are risks involved in using privately-sourced donor milk.⁷³ ABA strongly encourages parents to make sure that they inform themselves about the risks and benefits of donated milk and the ways to minimise risks. They can then make decisions based on their own individual situation. Tips to minimise these risks are listed at the end of Roy's story on [page 107](#).



Some parents choose to access milk from human milk banks. Milk banks provide tested, donated milk for babies, from a range of donors not known to you. Some families consider milk banks a safer option than private donation, as there is thorough testing of the donors and milk. At the time of writing this book, only one milk bank in Australia provides donor milk to babies in the community. There are costs involved and the milk is in limited supply, with premature or sick babies given priority.

More information can be found in the following resources.

- www.eatsonfeets.org
- www.hm4hb.net

These websites are listed for information only and this does not represent an endorsement.

CHAPTER

10

When feeding from the body doesn't work out

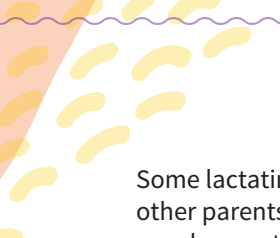
Sometimes, however hard you try, you and your support people meet challenges which you cannot overcome.

Birthing parents who have not had surgery or hormone treatment, and are wishing to lactate, are almost always able to produce enough milk for their baby. However, some people may have physical challenges as a result of surgery, medications or medical conditions. Those who are relactating or inducing lactation face extra challenges, especially if they were assigned male at birth. Other factors, such as a baby who does not suck well over a long period, tension, fatigue, depression or previous trauma can also make feeding from the body seem very hard.

If you cannot feed your baby from your body, you may decide to express your milk and feed this to your baby with a bottle or cup. Your baby will still be getting your milk. You may need to do this only for a short time, perhaps for a baby who is sick or very premature, or the problem may be long-term. There is more information in the ABA booklets [Breastfeeding: your premature baby](#) and [Breastfeeding: expressing and storing breastmilk](#) and on the ABA website.

Babies with special needs may need particular support, including those with Down Syndrome and cleft lips and palates. The ABA has booklets about feeding these babies from the body — [Breastfeeding: your baby with Down syndrome](#) and [Breastfeeding: babies with a cleft of lip and/or palate](#).





Some lactating parents may find feeding affects their mental health. For other parents the effort and challenges of inducing lactation or co-feeding may be greater than the benefits. They may choose other ways of building a relationship with their baby. Feeding from the body is one way to bond with and provide milk for your baby, but it is not the only way. Your baby needs you to be happy, healthy and able to form a loving, attached relationship with them.

Many parents are able to overcome problems with patience and support. Talking and sharing your joys and worries with people who have faced similar challenges can be helpful. Please find more information in [*Chapter 15. Support services and resources.*](#)

There may come a time when you decide to wean your baby onto donor milk or to express your milk for your baby. Or you may feel that you have no other choice but to feed formula. Usually, this does not mean you won't be able to feed another baby in the future. Accept that you have done your best. Even though you will not be feeding this baby from your body, you and your baby can still be close, with plenty of skin contact, rocking and cuddling.

There are many ways to measure success. Not every parent ends up feeding in the way they first hoped, but many still say their experience was a good one. Perhaps it will be easy for you to produce milk, but your child will not suckle and you may need to give milk in another way. Some describe this milk as 'liquid love'. Or it may be that you can't make a full milk supply and need extra milk for a long time. Whatever your journey, you can still celebrate your feeding relationship.

“My daughter would have nothing to do with breastfeeding but she loved her breastmilk! She would get very excited when she saw me hooking up the pump and she would even lie on her back with her mouth open for me to spray my milk into her mouth. I'm very glad that I induced lactation, that I gave my daughter my milk. It was worth the effort.

“

I started breastfeeding my son when he was 6 months old and he weaned at 3 years of age. Even though I wished to be able to breastfeed without supplementing, that never happened. By the time my milk supply increased to a level where breastfeeding without a supply line might be possible, my son was unwilling to do without it. However, it was still worth breastfeeding. I cried silently the day we started breastfeeding and thoroughly enjoyed the breastfeeding relationship. It has been a wonderfully fulfilling experience for both of us.



As you think about lactating or feeding, keep in mind that everyone is different. No two parents are the same. No two children are the same. No two situations are the same. There is no right or wrong way. The road to feeding is different for everyone (and you may decide that it is not for you). You will approach this in your own way with the resources you have and what suits you.

CHAPTER

11

For partners and support people: Relationships after baby arrives

It is easy for support people to feel left out in the excitement of the first few weeks after a baby's birth. The lactating parent and baby seem to be the centre of attention. At home they may appear to be too busy and too tired to do anything with you.

Many families find that the first few days at home are best spent alone with their new baby with all getting to know each other. You may like to ask others not to visit just yet and explain what you are doing. The love that you have for each other can strengthen and deepen over these early weeks.

For most lactating parents, the amount of time and energy needed to care for a baby means that there is little left for anything else. It can be very helpful for support people to take on some of the household tasks. Decide between you what tasks simply must be done and then try to live with the rest, at least for the time being.

Use these early days to get to know your baby. Although they may appear quite small and fragile, your gentle handling will not harm them. Changing nappies, bathing and dressing may all be new to you, but most parents soon become skilled in handling their new baby.





Sharing your feelings is important. Listen to each other, as you share the joys and perhaps the worries or fears of those early days. Your support is vital to the lactating parent, as they learn to feed and care for the new baby. Learning about feeding means you will be able to offer ideas and support if problems arise.

The time when you return to work can be hard for you both. Those living together will most likely be tired and the extra workload and changes to routine may mean you both need time to adjust. Easy evening meals, a quiet social life and some time-out for each of you can help you settle in to your new routine.

You can find more information in [*Chapter 15. Support services and resources.*](#)



CHAPTER 12

Societal expectations of parenting and feeding roles in a family

There are many ways to parent and feed in families. As LGBTQIA+ parents you may have to navigate societal ideas and assumptions about your parenting role.

Within society

Everyone's experience is different and unique. Attitudes and beliefs from their families of origin influence all new parents, sometimes in ways they do not expect. When we parent in a world that makes many assumptions around gender expression and binary genders, parenting can bring up many more conflicting emotions.

For example, in families with two mums, it may be assumed that the birthing mother will be the primary carer and feed the child. If she does not want to do this, she may feel confused, guilty, shamed and frustrated at not being heard and seen.

Similarly, a mum who is not the birthing mother may feel that she is not seen as a mother to the child. This can bring up feelings around her own role as a mother, and confusion around how the roles of both mothers fit together. She may feel frustrated, not needed, or not valued.






When some people think of feeding from the body and parenting, they think of femaleness, a womanly figure, and strong mothering identity. This is often not the case for transgender and gender diverse people. For example, a transgender or gender diverse parent may find others assume them to be the 'mum' or 'woman' if they are pregnant or feeding. Their identity may often be unseen or perceived not to exist. This can bring up feelings around their role as a parent, particularly in relation to their gender identity.

On the other hand, some transgender and gender diverse parents may find the feeding experience gender affirming and positive.

It may be helpful to remember that parenthood is not a set of rules or social standards. Every experience is individual and unique. It is important to take the time to understand, acknowledge and accept your own experience and feelings.





Some parents find the language used in parenting spaces, including support services and health care services, to be binary. These services operate on the assumption that parents identify as either men or women and that the birthing and feeding parent is a woman. Sometimes it is also assumed that the birthing parent has a partner, and that they are of the opposite gender. This can be a barrier to access for some LGBTQIA+ parents and caregivers and may have an impact on their sense of inclusion and mental wellbeing.

Some transgender and gender diverse parents may also face perceived or actual exclusion from ‘women-only’ spaces such as mothers’ groups or breastfeeding support groups if they do not pass as female, whether it is their aim to do so or not. For all new parents, feeling safe is an important part of seeking help and support.

The reality for many LGBTQIA+ people is that they have to come out each time they enter a new space. This can be even more common in parenting spaces. In some instances, you may be the first parent in the group to have a same sex partner, or to identify as non-binary or transgender, or to be feeding a baby birthed by someone else. You may find yourself educating the support people and health care professionals. This can at times frustrate or overwhelm you, or leave you feeling that there is a lack of support.

You may find it helpful to seek the support of your partner/s, family, and friends, or LGBTQIA+ parent networks throughout your pregnancy and parenting journey. For further information regarding the experiences of transgender and gender diverse individuals, please see [Chapter 15. Support services and resources](#) or contact your local LGBTQIA+ support network.

It may also be useful to take this book along to your health care professional, to let them know how they can support you and your family.

Your birthing and feeding choices, and your identity as a parent, are important and valuable. You are entitled to be seen and heard in the way you choose. Whatever choices you make for you and your family will be right for you.



Within a family

Some parents and support people find it helpful to explore ideas and beliefs about feeding human milk together, when making plans or working out parenting roles.

It can be helpful to think and talk with partners or support people about:

- How milk is made and the steps in building and maintaining a milk supply.
- How the dynamics of milk supply may impact on feeding roles and choices within the family, for example decisions about time spent in shared households or decisions about when co-feeding may be started.
- The importance of human milk, to help everyone involved to understand and support your parenting goals.
- What the feeding role looks like in the family and what supports may be needed to reach these feeding goals.
- What you would like to be called and how you would like to be referred to. This will ensure you have your labels established and can talk to health care providers and lactation supporters. Will you be called 'mum', or 'dad', or 'papa' or 'zaza', as examples? Or simply by your name?

CHAPTER 13

Parent stories



Here are some personal stories offered by LGBTQIA+ parents. Rainbow Families and ABA thank the community for sharing their personal stories.



Anonymous

My family is made up of three parents and two children. We identify as two mums and one dad. My partner gave birth and solely fed human milk to our first child and I gave birth and solely fed human milk to our second child.

We didn't know that co-feeding was an option when we had our first child and the breastfeeding journey was not an easy one in the early days for my partner. I quickly learnt that my role as a non-feeding parent was valid but different. I found myself surprised at the unexpected feelings that arose in not providing that feeding role. I found the role of support for my partner was essential for emotional and practical support.

The second time around we knew about the option of co-feeding but we decided that we were happy with the roles that worked the first time and that I would solely feed human milk to our younger child.

We co-parent together along with the donor dad of our two children. Our children spend time in both homes and we spend time in the homes of each other as a family. My partner and the dad of our children spent many hours baby-wearing, cuddling a sleeping baby or doing jobs like walking the dogs, cleaning the house, playing with our toddler or cooking, while I spent many hours sitting on the couch learning to breastfeed in those early months!

It worked for us to have open, ongoing parenting discussions and planning when considering starting overnight visits, length of day visits and practicalities around expressing and storing human milk. I finished feeding human milk to our younger child when she self-weaned at 4½ years. I found that having three parents was a great parenting support system for feeding human milk to our children because we could talk through and focus on the practicalities and needs of our children, and the importance of the feeding role, as well as drawing on each other for parenting help.





Ash

My first baby struggled to feed. He couldn't suck, but with support in those early days we both got there. He often fell asleep on the breast and he fed for hours. As a first-time parent you don't really know what's right and fear that they need more.

My second baby got on the boob as soon as he was born. He fed all the time too. I loved the intimacy and being able to nourish them. Those first years it felt like my boobs were out all the time. Sometimes the whole parenting thing can feel like you don't have personal space and your body isn't yours. My little one (now 6 years old) would still like to touch the boobies and still likes to talk about my breasts.

People can be really judgmental about feeding. They insist you breastfeed, but if it goes on for too long, they start criticising that too. You can't win. So do what's right for you and your baby.

You can always tell if a friend or stranger knows about breastfeeding, as they are the first to bring you a tall glass of water, offer a pillow, cut up your food into little pieces, and take the baby so you can eat. It's the simple things that support feeding.




Casey

I have three boys.

My first (now 6 years old), was exclusively breastfed until he was 18 months old. The only reason I stopped was to start IVF for our second child. As he was my first, it was a massive learning curve. The moment he was born, the doctor placed him on my belly for the extremely important skin-to-skin and he instinctively made his way to my breast. He had more of an idea of what to do than I did!





Breastfeeding was an odd thing for me. I have a supply so plentiful that I could outsource to dairy farmers but I've just always found it a little awkward, perhaps because of my size. I learnt how to feed and that it's possible to do so in different positions, thanks to my midwife. Having now had three kids, I realise how lucky I was to have that midwife. I am glad I listened to her. Lactation consultants can also be a wonderful help. Many people will give you their opinion. The best thing to do is to listen to everyone, then pull apart the bits that are right for you.

Our third son was born very early due to pregnancy complications and as a result, has spent several months in NICU. Being born so young meant he required oxygen to help him breathe and a feeding tube, as he didn't have the ability to suck-feed. I had to learn how to pump/express and bottle-feed expressed breastmilk (EBM), which was a whole new experience for me. It certainly takes up a lot of time in your day and I did miss just being able to breastfeed on demand. I expressed multiple times a day and fed him the EBM via bottle in the morning and at night, then fed directly from the breast during the day. Pumping is a balancing act that takes a couple of days to get right. Buying/renting the right pump is important too so you don't spend too much additional time pumping and cleaning the bottles (which is very time consuming anyway!)

I am now a very proud milk donor for the Red Cross, something I am honoured to be able to do. Breastfeeding has been an amazing journey. Who knew the body was so amazing?!





Leigh

When I became pregnant with my first baby I had mixed emotions. Having children was something I had always wanted and no doubt about it I was going to nurse, because I had been told that everyone can nurse their baby.


The time came and my baby was born. After the birth, my baby was whisked away for 'mandatory checks' before any skin-to-skin took place. After my baby had all their checks done, they were then placed on my chest, skin-to-skin. It might be a small thing but I believe this delay in skin-to-skin may have been the start of our most challenging journey.

At the first feed my baby latched on and suckled for a very short time and then unlatched. This happened every time they would feed. Over the next day or two I became very engorged and began leaking a lot of milk. My baby was not getting much milk from me, and the hospital believed my baby was at risk of jaundice. It was advised that they give my baby formula because 'baby needs something!' I didn't question this, as I thought this was probably all normal.

I had seen a lactation consultant at the hospital for some support and their advice was to latch baby on, then when they came off I would top them up with formula. In the meantime, I had to hand express, pump, drink all these herbal teas to keep my supply up and I was given a nipple shield to use as well. We were discharged with this feeding plan but no follow-up from the lactation consultant or the hospital. I didn't know about follow-up options so I just thought this was all normal.

After 2 months of attempting to nurse my baby I decided to stop nursing and use formula. I felt incredibly sad about this and I believed I had failed as a parent and my body had failed me. I had extreme guilt and felt resentment towards my baby as well. Over the first few years these feelings manifested, but I thought this was all normal. I thought that I was meant to feel this way.





Looking back, I know that it was not and I should have asked for help. But back then I had no idea who to turn to. No one told me about postnatal depression. No one told me that nursing can be a challenge. I felt so very angry for a long time at breastfeeding and lactation advocates because I believed they lied to me and were lying to everyone else.

When my child was 5 years old, I had my second baby. Despite my anger, grief and loss of 'giving up nursing' with my first, the drive to nurse my second baby rose inside me again.

Our second baby came and the birth was exactly like our firstborn. Prior to the birth, I asked my partner to speak up for me if need be and request our baby FIRST be placed on my chest skin-to-skin straight after birth. My baby lay there for ages. There was no rushing baby away. When my baby was ready for the first feed, I laid back and encouraged baby-led attachment. I helped support my baby crawl to my breast and attach. This continued feed after feed. My second child self-weaned by age 3.

My relationship with my breasts has always been a hard one. The act of nursing helped me recover from the PND. I realised I needed to be compassionate towards myself. I also understood that the challenges with my first baby were actually never my fault. Although I don't identify with my breasts as being feminine, for me, they were functional and actually had a purpose. In fact, I respect them a lot now.

“Andrea and Heather

We have had the good fortune and incredible challenge of both breastfeeding our second child. The plan to share breastfeeding didn't arise out of novelty or a shared desire to breastfeed. It came from necessity. Heather carried our first child and breastfed him up to 20 months. Heather loved breastfeeding and he was a healthy child who grew quickly.



Heather really wanted to carry our second child. However, we had the painful experience of losing two pregnancies and our fertility specialist confirmed that Heather's chances of carrying another pregnancy to term were limited. I was the best option for having a second child and I agreed to try. Knowing the value of breastfeeding, Heather asked that I breastfeed the baby for at least 6 months. I agreed and was soon pregnant with Piper.

Meanwhile Heather set about researching whether it would be possible for her to relactate so that she could continue feeding the baby past 6 months. There were stories of women initiating lactation without pregnancy, but there were not many and we found it hard to find definitive information. Eventually Heather saw a lactation team who specialise in assisting women to relactate or induce lactation.

The impression we got was that relactating without a pregnancy was difficult and the results would be uncertain. Heather's success in breastfeeding our first child was viewed optimistically but there was still very little to reassure us that it would be possible this time around.

I gave birth to our daughter Piper at full term. She was generally healthy but with a low birth weight. She also had to be treated for jaundice 3 times in the first fortnight. This meant an extended stay in hospital where I started my journey with breastfeeding.

Due to her low weight and the need to 'flush' the jaundice out with fluids, I was on a strict 3-hourly cycle of feeding, expressing, spooning precious drops of colostrum into her tiny mouth and starting again. It was intoxicating. I wasn't annoyed, I was in love.

Heather's lactation preparation must have been effective because after the amazing rush of being at Piper's birth, Heather discovered she had leaked milk. When Piper was 6 weeks old, Heather started expressing. This involved pumping both breasts simultaneously eight times a day for 15 minutes right through the day and night.

We were told we would need to hire a hospital grade pump but Heather got away with using two battery-operated pumps. She went from getting 50 mL in the first 2 days to getting over 500 mL per day within 2 weeks. Heather was really excited and relieved, given the initial doubt and uncertainty.

We intended to slowly transition to Heather being primary breastfeeder over the next 6 weeks. However, we found that shared breastfeeding had several challenges. Essentially we were both maintaining a full supply of milk. Whoever wasn't feeding the baby had to pump to prevent supply dropping and to avoid mastitis. So if I was up at 3 am breastfeeding, Heather was also up pumping and vice versa. With a newborn and an older child, this burden of pumping and feeding was utterly exhausting. The constant need to discuss who would take every feed tested our negotiation skills and we found ourselves without time for anything else.

So within 2 weeks we switched almost all feeds to Heather. I expressed decreasing quantities of milk, slowly reducing my supply over a few weeks. With Heather's supply looking good and Piper gaining weight, I decided to quit altogether.

But quitting too soon was a huge mistake, as Heather's supply dipped slightly.

There is also a huge emotional component to breastfeeding, the power of which took us by surprise. We have both found that breastfeeding an underweight baby is a direct path to high levels of anxiety. We also discovered that the primary breastfeeder feels this most intensely, while the other parent can more objectively see that the baby is fine. At times there was envy. Further, once we transitioned, I realised that I couldn't be alone with Piper for long periods of time. What was I supposed to do with my own crying baby - who still refused a bottle - at mothers' group? And later when Piper needed hip surgery, only one parent could stay overnight at the hospital. It was so strange not being the one to stay with her after having carried her for 9 months.



All told, I found stepping away from breastfeeding heartbreaking. So, at the last minute, just as my supply was running dry, I pumped back two feeds (6 am and 6 pm). I kept them until she was 6 months old and I returned to work.

Piper is now 21 months old and is growing consistently. She is a healthy toddler. She still feeds 2 to 5 times per day and I see how she loves breastfeeding with Heather.

When other women hear our story they often exclaim, 'How awesome! I would have given a lot to have my husband be able to breastfeed the child and give me a break!' We can both see that sharing the breastfeeding can take pressure off one parent and sharing the connection that comes with feeding your baby is incredibly valuable.

Briar's tips

Briar is a parent of two children

- Social media groups and online forums for transgender and gender diverse parents can be very helpful with many folks finding support and solidarity in these groups.
- Listening to others' parenting stories can be helpful.
- There is NO right way to be a transgender person or a parent. Only your way.
- Language in some spaces (online and offline) is very gendered eg 'hi mummies' and this makes you feel excluded, and makes you not want to get informed.
- Try to think of how animals parent and remember humans are animals too. Gender is personal and whatever identity you apply to the act of lactating, then that is what you do for you. It doesn't make you female or feminine unless you say it does.
- Having a kid can change how you express your identity.

- Think of what affirming words you want to use for yourself before your baby arrives, what would you like to be called, think about pronouns. If you have a partner or partners have a conversation about this.
- It will be a hormonal rollercoaster. You are still good enough no matter how you feed.
- Read blogs and watch videos and get informed
- ‘Where’s the mother?’ by Trevor MacDonald is an amazing book, Read it.
- I did a course through ‘Birthing beyond the binary’ and this was helpful.
- ‘A womb of their own’ is a great documentary to watch.
- Don’t underestimate donor milk. There are so many lactating parents out there who want to help families.
- Find a contact person who knows your boundaries. Find your people.
- Nursing in public. It helps to plan out feeds and know of access to parent rooms.
- The heart is near the breast for a reason.

Carolyn

Before my partner Emily got pregnant, I thought maybe I would like to also breastfeed any children we might have, but when she finally was pregnant, I wasn’t completely sure if I would want to. I was working full-time, commuting nearly 2 hours a day, very tired, and adding inducing lactation to that just wasn’t something I could take on emotionally.

But I did call the Australian Breastfeeding Association to ask about inducing lactation and we went to an ABA breastfeeding workshop while Emily was pregnant. This was where I first heard



about hand expressing. The first time I tried to hand express, I found there was a drop of milk there already! So I decided to just try feeding when the baby was born and see what happened.

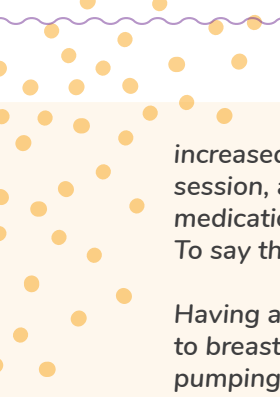
When our baby, Alex, arrived, I knew very soon that I had a strong desire to feed him myself. He was tiny and had trouble latching. The priority was to get him feeding from Emily, which we achieved with the help of a wonderful lactation consultant.

For the first 7 weeks, I took leave from work but I didn't worry about trying to get a milk supply going in that time because we needed to have Alex feeding well from Emily. However, I did put him to my breast each day and sometimes he would comfort-suck to sleep on me. I assumed since he was happy enough to suck at my breast, that I must be making milk, but when I tried to express some, there was practically nothing.

I went back to work after the 7 weeks. Luckily, my workplace had a provision for an hour of lactation breaks a day. This was the point when I decided that I needed to put in the hard work to make milk happen.

I bought a double electric pump and negotiated with my manager to take three short breaks of 20 minutes, so that if I also pumped at lunchtime as well, I was able to pump for 15 minutes 4 times a day at work. On a good day, I also managed to pump before work, when I got home, before bed, and in the night while Emily was breastfeeding Alex. Every tiny increase in milk production was exciting, but after 2 weeks of this ridiculous schedule, my milk was still only measured in drops, so we looked around for other ways to help.

I saw a GP who also does lactation consulting. She was sceptical that I would be able to get a milk supply at all, because she usually recommended a protocol of medications to trick your body into thinking it's pregnant, and then pumping a lot. However, she was willing to prescribe me medication to see if it made any difference. I also had herbal capsules 3 times a day, and kept up the pumping schedule. I think my breasts just needed that boost. By my second appointment 12 days later, my supply had



increased from tiny drops to around 5 mL of milk per pumping session, and a week after that, I suddenly had to decrease the medication dose because my breasts were exploding with milk. To say that the GP was surprised would be an understatement!

Having a milk supply is one thing, but convincing a 3-month-old to breastfeed from someone different is another. In my frenzy of pumping, I hadn't had time to encourage Alex to feed from me much, and he had established breastfeeding with Emily, whose breasts are very different to mine.

When Alex was 14 weeks old, Emily went back to work, and I went on paid parental leave. This was just at the point when my milk supply exploded, so I had milk to feed him, but he really wasn't sure about it, and would mostly end up crying when I tried to feed him. This stressful period lasted a few weeks and I felt like all the effort had been a waste of time.

Eventually Emily showed me how to breastfeed Alex lying down, and after a couple of tries, he decided that was ok. So we just did that for a week, then one evening while I was eating dinner on the couch with him on my knee, he wiggled down a bit until his mouth was level with my left breast. I lifted up my top and he just popped on! He was relaxed and fed happily. It was like it just had to be on his terms, in his time.

After that, Alex seemed quite happy to feed from me during the day and from Emily when she was at home. We both fed him overnight, which is the most brilliant arrangement ever! There was a slight milk oversupply at first, but after a couple of weeks, it settled down and we both made the right amount between us for Alex's needs.

Breastfeeding has become a really important part of my identity as a mother. One of the hardest times was around Alex's first birthday, when he had a 1-week breast strike from me (but kept feeding from Emily). It made me realise how important breastfeeding was to me. Fortunately, he did come back, and seemed quite content again.



Alex is 15 months old now, and we fully intend to breastfeed until 2 and beyond. I'm certainly not ready to stop any time soon. Breastfeeding Alex has made me into a fierce advocate and I'm able to pass on things I've learned to other mothers. People are constantly amazed when they hear you can induce lactation.

Roy

I am a FTM (female to male) transgender and have fed my son, Jack, exclusively on donated human milk for his first 2 months of life and we are still going.

I had chest reconstruction surgery 10 years earlier so it was believed I would not be able to breast/chest feed. I wanted to feed Jack on human milk because it is the most natural food source for babies, and perfect for their digestive systems and development. The Australian Breastfeeding Association lists many benefits to breast/chest feeding such as a lower risk of infection and SIDS <https://www.breastfeeding.asn.au/bfinfo/how-long-should-i-breastfeed-my-baby>.

I have been able to provide Jack with human milk because of an extraordinary online community of parents who share their excess milk or even express extra just so they can support parents without. Jack also has a few aunties (close friends of mine) who have wet-nursed him.

A few months prior to Jack's birth I joined a social media community. I posted that I was due to give birth soon and couldn't breastfeed, and asked for donations. Two people donated to me and over the next couple of months I stockpiled 9 L, including some precious colostrum. I thought this would last me the first 4 weeks. It only lasted 2. The next time I posted in the community, this time with a cute picture of Jack, I was overwhelmed by replies, finding another 15 donors, and then a few more by word of mouth. Some of these donors offered to donate on a regular basis, although I found that their situations



often changed. It was a massive job picking up all of the milk from as far north as Noosaville, as far south as the Gold Coast and as far west as Toowoomba. I was very grateful to a few friends who helped pick up milk, as it was a big job to do on my own with a newborn.

I have been blown away by the generosity of other parents and it had brought me to tears a few times. One thing I regretted was not telling people up front that I was transgender. In my post I said I had had a double mastectomy but didn't say why because I was worried it would be seen as a choice. I just felt that I had not been my authentic self. After all the generosity, I wanted to remedy that so I sent a thankyou note to all donors, telling them about my journey.

As I said earlier, a few friends wet-nursed Jack. One friend wet-nursed him when he was first born in the hospital while I touched his head. It was a truly beautiful moment for both of us. A couple of other friends feed him daily and weekly. This milk is always best, as it may have immune factors for any disease Jack's body is fighting or the wet nurse has come in contact with.

It will also have the appropriate hormones for the time of day and be the right concentration for hydration, say if it is a hot day. The wet nurses have developed a special bond with Jack as they see him so regularly. Some extra special moments have been when they have fed their own babies and Jack at the same time.

Tips and tricks:

- When you ask for milk from the group, tell them about your situation and put up a cute picture of bub.
- Ask donors about their health, medication and alcohol consumption.
- Provide donors with milk bags (you can get them from the chemist).
- Make a spreadsheet of donors and group them into areas so that you can pick up from several at once.
- Be reliable.
- Get informed about the risks of disease transmission via breastmilk and ways you can mitigate this risk, such as by pasteurisation.



CHAPTER

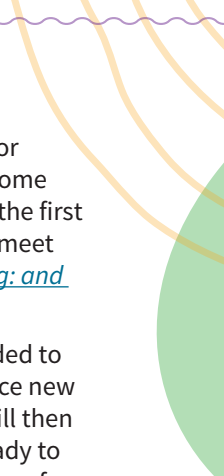

14

A final word



As you gain confidence in your parenting role, you can look forward to many months of pleasure in feeding your child. Some tips to help you at this time:

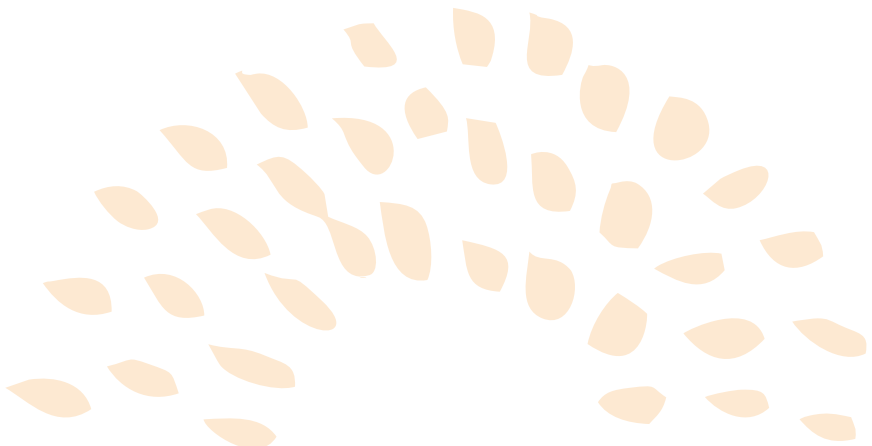
- Your baby's needs change from time to time. It is normal to have some days when they want to feed often.
- Illness, teething and developmental changes may upset a baby's normal feeding pattern.
- Milk alone is all the food and drink a healthy full-term baby needs for about the first 6 months of life. Giving other foods in the early months



can increase the risk of allergy. It also lessens the baby's appetite for milk (which is the proper food for your baby) and may affect how some nutrients in milk are absorbed. If your baby seems extra hungry in the first 6 months, more frequent feeding will increase your milk supply to meet your baby's needs. You may like to read ABA booklets [Breastfeeding: and your supply](#) and [Breastfeeding: and family foods](#) for more details.

- Weaning is a gradual process that begins when other foods are added to a baby's diet. At first the number of feeds will remain the same. Once new foods are begun, your baby will gradually take less milk and you will then produce less. Feeding can continue until you and your baby are ready to give up the special closeness of this relationship. Weaning takes time, for both your milk to decrease and for you and your baby to get used to new ways to relate to each other. The ABA booklet [Breastfeeding: weaning](#) can help you when you are at this stage.

Feeding from the body can be a truly satisfying and fulfilling experience for the whole family. During the time you are feeding, you will learn about yourself and your baby and sense the changing needs of your growing child.



CHAPTER

15

Support services and resources



This resource was developed by a partnership between the Australian Breastfeeding Association and Rainbow Families NSW. Support services and resources, including LGBTQIA+ specific, can be found in this chapter.

The Australian Breastfeeding Association

The Australian Breastfeeding Association (ABA) provides a range of information and support from pregnancy through to weaning, including face-to-face, online chat, over the phone 24/7, website articles and printed material.

[*Breastfeeding Education Classes*](#), online and face-to-face are held in many areas throughout Australia for parents planning to feed their babies.

Local support groups provide regular friendly get-togethers, both online and face-to-face, with information and support from trained volunteers. You can meet parents and caregivers with babies and toddlers of different ages and learn from their experiences. You may also be able borrow books on lactation and parenting from group libraries.

Trained volunteer breastfeeding counsellors are happy to answer any questions you have about lactation and feeding your baby human milk. They are trained to help parents where they are at, in a non-judgemental way, by listening, asking questions and offering ideas based on the latest knowledge and research. Breastfeeding counsellors are available to members and non-members alike on the National Breastfeeding Helpline (1800 686 268) 24 hours a day 7 days a week, or face-to-face at ABA events or, for members only, via email through breastfeeding.asn.au.

The ABA website breastfeeding.asn.au also provides a wealth of information on a range of topics. Trained volunteer community educators also run a LiveChat service at selected times.

When you join ABA, you will receive quarterly issues of the magazine *Essence* and monthly member eNewsletters. These have articles on lactation and parenting for today's families. These articles cover areas such as paid work and feeding, solids, weaning and other topics of interest to parents with babies and small children.

The ABA also has an app, *mum2mum*, that allows parents to search content grouped into a baby's age and stage, record their baby's feeds, sleeps and nappies, note milestones and keep a journal of information to help at health professional appointments. All members have access to premium content. The *mum2mum* app is available to download from Google Play or the App Store: breastfeeding.asn.au/mum2mum



Rainbow Families NSW

Rainbow Families NSW has a vision of a community of lesbian, gay, bisexual, transgender, intersex, queer and asexual (LGBTQIA+) families across the whole of NSW, where each family is included, respected and has value. Rainbow Families is the peak NSW organisation supporting LGBTQIA+ parents and children. As a community organisation run by LGBTQIA+ families, Rainbow Families NSW acts as a support network for parents and carers and their children, as well as future parents and carers. The mission of Rainbow Families is to build a community which fosters resilience by connecting, supporting and empowering LGBTQIA+ families.

Rainbow Families NSW defines a Rainbow family as any lesbian, gay, bisexual, transgender or intersex person who has a child or children; or is planning on having a child or children by way of donor insemination, surrogacy, foster care, fostering to adoption, adoption, opposite-sex relationship, co-parenting or other means.

Rainbow Families NSW provides support and resources to members of the LGBTQIA+ community so that they and their families can live their best and most colourful lives.

Rainbow Families NSW hosts events, including playgroups, story-times, discos, camps and general get-togethers, that connect LGBTQIA+ families, particularly those that are feeling isolated because of social pressures, financial difficulty or where they live.

Rainbow Families NSW advocates on behalf of the community and is a strong and consistent voice for NSW LGBTQIA+ families to address discrimination, raise awareness and promote acceptance, including collaborating with similar organisations from other states to push for change across the nation.

New South Wales Rainbow Families NSW

<https://www.rainbowfamilies.com.au/>

Queensland Rainbow Families QLD

<http://www.rainbowfamiliesqld.org>

There are many other Rainbow Families organisations in Australia (such as ACT and Victoria) that Rainbow Families NSW can put you in touch with.



Feeding resources - LGBTQIA+ specific

By Trevor MacDonald:

- Website: <http://www.milkjunkies.net>
- Book: 'Where's the mother? Stories from a transgender dad'
- Journal article (with other authors): 'Transmasculine individuals' experiences with lactation, chest feeding, and gender identity: a qualitative study' available at <https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-016-0907-y>
- Web article: 'Transgender parents and chest/breastfeeding' available at <https://kellymom.com/bf/got-milk/transgender-parents-chestbreastfeeding/>

Breastfeeding after breast and nipple surgeries: <https://www.bfar.org/index.shtml>

La Leche League International: 'Support for Transgender and Non Binary Parents' available at <https://www.llli.org/breastfeeding-info/transgender-non-binary-parents/>

Evan Joy 'My journey: Non-binary nursing' available at <https://www.lllusa.org/my-journey-non-binary-nursing/>

Additional LGBTQIA+ Resources

Intersex Human Rights Association: <https://ihra.org.au/>

Intersex Peer Support: <https://isupport.org.au/>

ACON: <https://www.acon.org.au/who-we-are-here-for/>

Gender Centre: <https://gendercentre.org.au/services>



Australian TGD Peer Support: <https://www.tgdsupport.info/>

Beyond Blue: <https://www.beyondblue.org.au>

Qlife: <https://qlife.org.au>

Reach Out: <https://au.reachout.com/articles/lgbtqi-support-services>

Non-LGBTQIA+ specific

(Please note some of these resources may contain cisheteronormative language.)

Australian Breastfeeding Association book

[*Breastfeeding ... naturally 3rd edition 2017*](#)

‘Relactation: review of experience and recommendations for practice’

— World Health Organization booklet on relactation enonline.net/relactationreview

‘Ask Lenore’ website — information about inducing lactation: asklenore.info/breastfeeding/induced_lactation/gn_protocols

Hands-on expressing technique: med.stanford.edu/newborns/professional-education/breastfeeding/maximizing-milk-production.html

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