How to breastfeed a baby step by step

1. Prepare for a calm, responsive feed

Begin by washing your hands if needed, settling into a supported position, and bringing water or another drink within reach. Choose a chair, bed, or sofa that allows your shoulders to remain relaxed. Pillows may support your arms or back, but they should not be used to prop the baby unattended. The goal is to bring the baby to the breast rather than leaning your torso forward toward the baby.

Watch for early feeding cues rather than waiting for intense crying. These cues may include stirring, hand-to-mouth movements, lip smacking, rooting, or turning the head toward contact. Crying is a late cue and can make coordination more difficult. Skin-to-skin contact may help a drowsy newborn become more organized and may support responsive feeding.

Before attempting the latch, position the baby close enough that the chest and abdomen face your body. The baby’s ear, shoulder, and hip should be broadly aligned, with the neck neither sharply flexed nor rotated. Keep the nose near the nipple and the body well supported. This preparation reduces the need for the baby to reach, twist, or pull at the breast.

2. Choose a position that supports alignment

There is no single correct breastfeeding position. Select the hold that gives you a stable view of the baby's mouth and keeps both of you comfortable. In the cradle hold, the baby rests along the forearm on the same side as the feeding breast. This can be comfortable once feeding is established, although some new parents find it harder to guide the first latch.

The cross-cradle hold uses the opposite arm to support the baby's neck and shoulders while the hand on the feeding side supports the breast. It often gives a beginner precise control of the baby's head and is useful when practicing a deep breastfeeding latch. Avoid pressing directly on the back of the baby's head; support the neck and upper back so the baby can extend slightly and approach the breast.

In the football or clutch hold, the baby is positioned alongside the parent, with the legs pointing toward the back of the chair or bed. This can be useful after abdominal surgery, with larger breasts, or when the parent wants a clear view of the latch. Side-lying may allow rest during a feed, but use it only in a safe environment and return the baby to a separate, safe sleep surface after feeding. MedlinePlus and the Mayo Clinic describe these positions and emphasize support of the baby's neck, back, and bottom.

3. Bring the baby to the breast for a deep latch

Hold the baby close with the nose level with the nipple. Lightly brush the nipple across the baby's upper lip or wait for the mouth to open in response to the breast. Wait for a wide gape rather than placing the nipple into a partially open mouth. When the mouth opens widely, bring the baby quickly and gently toward the breast, leading with the chin. The baby's chin should contact the breast first, while the nose remains free or only lightly touches.

A functional latch takes in more than the nipple. The baby should draw a substantial amount of breast tissue into the mouth, with more areola generally visible above the upper lip than below the lower lip. The lips should be flanged outward, the cheeks should remain rounded, and the baby's body should stay close. You may initially feel tugging or pulling, but sharp, pinching, or persistent nipple pain is a reason to break the suction and try again.

To release the latch, place a clean finger gently into the corner of the baby's mouth to interrupt the vacuum. Do not pull the baby directly away while suction is maintained. Reposition the baby and repeat the attachment sequence. Several attempts may be normal while you and your baby learn. A lactation consultant assessment can be especially helpful when the baby repeatedly slips off, the nipple appears compressed after feeding, or pain continues despite adjustments.

4. Assess milk transfer during the feed

Newborns often begin with a period of quicker sucking that stimulates the milk ejection reflex, followed by slower, deeper sucking as milk flows. Look and listen for a pattern of suck, swallow, and brief pauses. Audible swallowing may be subtle, particularly when milk flow is slower, but it can be heard as a soft "kuh" or a quiet breath-like sound. The jaw may move deeply rather than making only small movements at the lips.

During an effective feed, the baby's hands and facial muscles may gradually relax. The baby should remain attached without repeated clicking, coughing, or pulling away. A single feed does not provide a complete assessment of intake. Over time, clinicians evaluate feeding behavior alongside weight trajectory, hydration, stool and urine patterns, alertness, and physical examination.

Allow the baby to remain on the first breast while active sucking and swallowing continue. When the baby becomes less active, releases the breast, or appears satisfied, offer the second breast. Some babies take both breasts at every feed, while others take one breast and then request the other later. Avoid imposing a rigid time limit; active milk transfer is more informative than the number of minutes alone.

During the early days, colostrum is produced in small volumes but is concentrated and biologically active. Feeding frequency varies, and cluster feeding can occur. Follow the feeding plan provided by your maternity or pediatric team, particularly if the baby was premature, has medical risk factors, or requires monitoring of intake.

5. Finish the feed and protect comfort

When the baby stops swallowing, releases the breast, or becomes relaxed and

satisfied, gently break the suction if necessary. Keep the baby upright briefly if this is comfortable and recommended by your clinician. Burping is not required after every feed; some babies need it, while others do not. Observe the baby's breathing, color, and comfort, and place the baby on a separate, firm, flat sleep surface when it is time to sleep.

Inspect your nipple after the feed. It should not be persistently flattened, creased, or blanched. Temporary tenderness can occur during the first days, but ongoing pain, cracking, bleeding, or worsening nipple trauma warrants prompt feeding assessment. Avoid routinely washing the nipples with soap or applying products that have not been recommended for breastfeeding; gentle cleansing with water is usually sufficient.

Breast fullness may change as milk production adjusts. If the breast remains very uncomfortable, ask a healthcare professional about appropriate milk removal and comfort measures. Do not attempt to diagnose or treat a breast infection based only on an online article. Fever, a rapidly worsening localized breast problem, or feeling systemically unwell requires timely medical advice.

6. Troubleshoot common difficulties step by step

If the baby is too sleepy to feed, use gentle stimulation such as unwrapping, skin-to-skin contact, or changing the diaper, unless your clinical team has advised otherwise. If the baby becomes frantic, pause and calm the baby before trying again. A quieter room and a different position may improve coordination. For babies who repeatedly cough or pull off at the beginning of a feed, discuss the pattern with a lactation professional rather than assuming a single cause.

If nursing hurts, first check alignment and attachment. Bring the baby's whole body close, keep the nose level with the nipple, wait for a wide mouth, and make sure the chin reaches the breast first. If the nipple is pinched after the feed, the baby may need more breast tissue in the mouth. A painful latch assessment can identify positional problems, oral-motor concerns, or nipple trauma that requires individualized care.

Keep a short record when concerns arise: feeding times, which breast was offered, whether swallowing was heard, and diaper output. Newborn diaper output changes across the first days, so interpret the record according to the baby's

age and the advice of the pediatric or maternity team. Do not use diaper counts alone to decide whether supplementation or other treatment is needed.

Arrange professional help promptly if the baby is difficult to wake for feeds, repeatedly cannot latch, has signs of dehydration, or is not following the expected weight trajectory. A lactation consultant, midwife, pediatric clinician, or physician can observe a feed and create a plan appropriate to your circumstances. Seeking help is a normal part of learning and does not indicate failure.