

When to start breastfeeding and first latch



When should breastfeeding begin?

When a newborn is breathing effectively, maintaining an appropriate temperature, and does not require urgent medical intervention, breastfeeding should usually be initiated within the first hour after birth. The World Health Organization recommends early initiation and emphasizes immediate, uninterrupted skin-to-skin contact when possible. This period is sometimes called the first hour or the baby's first sensitive period, although the exact sequence and duration vary.

Early initiation is recommended because newborns commonly pass through predictable behavioral phases after birth. Following an initial period of alertness, many babies become more settled, then begin making small movements, bringing their hands toward the mouth, licking, rooting, and gradually moving toward the breast. Allowing this process to unfold with minimal interruption can support self-attachment and responsive feeding.

Observational research has found an association between breastfeeding initiation within the first hour and improved infant survival. This evidence supports the public-health recommendation, but it should not be interpreted as a rigid deadline or as proof that one delayed feed determines an infant's

outcome. Clinical safety takes priority. Resuscitation, respiratory support, maternal instability, operative care, or other urgent needs may appropriately postpone the first latch.

Parents can discuss this preference during prenatal care and include it in a birth plan, while understanding that the plan may need to change. The practical request is usually simple: place the stable newborn skin-to-skin with the parent, keep the airway visible, delay nonurgent interruptions when clinically appropriate, and offer skilled help when feeding cues appear.

Why skin-to-skin contact matters

Skin-to-skin contact means placing the diapered newborn directly against the bare chest of the birthing parent, then covering both with a warm blanket while keeping the face and airway visible. It supports thermoregulation and can help stabilize cardiorespiratory transition, glucose use, and behavioral state. It also gives the parent an opportunity to notice subtle feeding cues before the baby becomes distressed.

During skin-to-skin contact, a newborn may initially rest quietly. Later, the baby may flex the limbs, move the head, open the mouth, salivate, lick, nuzzle, or make small crawling movements. These are signs that the newborn may be preparing to feed. Crying is a late feeding cue, and a crying baby may have more difficulty coordinating rooting and attachment. Calming the baby with close contact before attempting the latch can be helpful.

Safety remains essential. The parent should be awake enough to observe the newborn, and a trained professional should assess both individuals according to local practice. The baby's nose and mouth must remain unobstructed; the head should be turned to one side, the neck positioned without excessive flexion, and the chest visible enough for ongoing observation. If the parent is sedated, medically unstable, or unable to monitor the newborn, another safe arrangement and continuous staff observation may be necessary.

Uninterrupted contact can continue through the first feed when the clinical situation permits. Routine procedures that are not urgent may sometimes be performed afterward, but hospital protocols differ. Parents can ask the care team which assessments can occur while the newborn remains skin-to-skin.

How to recognize a good first latch

A latch is the way the newborn takes the nipple and surrounding areola into the mouth. Effective attachment allows the infant to compress breast tissue behind the nipple, rather than drawing only on the nipple itself. The goal is a deep, stable latch that permits milk transfer and limits nipple trauma.

Before attachment, the newborn should generally be facing the breast with the ear, shoulder, and hip in a relatively straight line. The abdomen should be close to the parent's body. The nose can be level with the nipple, allowing the head to tilt slightly back. Brushing the nipple across the upper lip may encourage a wide gape. When the mouth opens widely, bring the baby toward the breast rather than leaning the breast toward the baby.

Signs of effective attachment include a wide-open mouth, more areola visible above the upper lip than below the lower lip, rounded cheeks, and the chin contacting or approaching the breast. The lips should be flanged outward. Early sucking may be brief or irregular, followed by deeper sucks and occasional audible swallowing as milk becomes available. Colostrum volumes are small, so swallowing may be subtle and the feed may not resemble a later, sustained milk feed.

Some pulling or stretching is expected, particularly at the beginning. Persistent pinching, sharp pain, cracking, bleeding, dimpling of the nipple after release, clicking, repeated slipping off, or a baby who cannot maintain attachment suggests that positioning or latch should be assessed. Ask a professional to observe a feed rather than trying to judge technique alone. A small adjustment in the baby's body alignment or the timing of bringing the baby to the breast can make a substantial difference.

Colostrum and the first hours of feeding

Colostrum is the thick, concentrated milk produced during the first days after birth. It contains immunoglobulins, including secretory IgA, leukocytes, growth factors, and other bioactive components. Its composition is suited to the newborn's early gastrointestinal and immunologic needs. Although the quantity expressed at one time may appear very small, that does not mean it lacks value

or that the parent is producing too little.

Newborn stomach capacity is limited, and early feeds may consist of drops or small volumes. Feeding frequency is variable, but responsive feeding is generally preferred over waiting for a strict schedule. Offer the breast when the baby shows early cues such as hand-to-mouth movements, rooting, lip movements, or increased alertness. The baby may feed from one or both breasts in a session; staff can help evaluate whether transfer appears adequate.

The transition to larger-volume milk, often associated with lactogenesis II, commonly occurs around the second to fifth postpartum day, although timing differs. Breast fullness, milk appearance, and the infant's behavior can change during this transition. Until then, frequent effective stimulation and removal of colostrum help establish the hormonal and local signals involved in ongoing milk production.

If the baby cannot latch, hand expression can collect colostrum for administration according to the care team's instructions. A nurse, midwife, or lactation consultant can demonstrate hand expression and discuss appropriate collection, labeling, storage, and alternative feeding methods. Supplementation may be medically indicated in some situations; it should be planned with the newborn's clinician while protecting parental milk production when possible.

Positioning after different types of birth

Positioning must protect comfort, incision or perineal healing, and the newborn's airway. After an uncomplicated vaginal birth, semi-reclined biological nurturing, cross-cradle, or football positioning may be comfortable. The best position is one that keeps the newborn close, supports the shoulders and neck without forcing the head, and allows the parent to see the mouth and breast.

After cesarean birth, the incision and abdominal tenderness may make direct pressure uncomfortable. Breastfeeding after cesarean birth can still begin during the first hour if the parent and newborn are stable, including in the operating or recovery environment when appropriate staff and equipment are available. A football hold, side-lying position with supervision, or a laid-back position may reduce pressure on the incision. The parent should

receive help moving or repositioning the baby, especially while numb, weak, dizzy, or receiving sedating medication.

After epidural or spinal anesthesia, the parent may have limited mobility or altered sensation. Pillows and an additional adult can help maintain a secure position, but pillows should never cover the newborn's face. Following a complicated birth, the first priority may be maternal stabilization or newborn assessment. In that situation, the team may help initiate expression of colostrum and support skin-to-skin contact as soon as safely possible.

Position changes should be gradual. Tell the care team about dizziness, increasing pain, heavy bleeding, shortness of breath, or weakness. Feeding support is part of postpartum care, not a separate task that the parent must manage alone.

If the first latch is delayed or difficult

A delayed latch is common after prematurity, difficult labor, maternal exhaustion, analgesia or anesthesia, respiratory transition problems, hypoglycemia risk, or temporary separation. It can also occur without an obvious reason. Avoid forcing the baby's head onto the breast or repeatedly attempting while the baby is crying. Return to skin-to-skin contact when safe, reduce stimulation, and watch for a calmer period of alertness.

Request a feeding assessment if the newborn cannot attach, repeatedly detaches, appears unusually sleepy, has weak or uncoordinated sucking, or does not show expected feeding behavior. The clinician may assess respiratory status, tone, glucose risk, oral anatomy, and hydration, while a lactation professional evaluates positioning, breast anatomy, milk expression, and milk transfer. These assessments are complementary.

When direct breastfeeding is not immediately effective, expressing colostrum by hand or pump may provide stimulation and allow expressed milk to be given as advised. The frequency and method should be individualized by the care team, particularly for a preterm or medically fragile newborn. Parents should ask how expressed milk will be labeled and administered, and how often reassessment will occur.

Progress may be gradual. The first meaningful goal can be safe skin-to-skin contact, followed by rooting, a brief latch, or a few coordinated sucks. Later feeds may be more organized. Compassionate support matters because pain, anxiety, and exhaustion can interfere with learning, but needing help is not evidence of failure.

How to obtain support before leaving care

Before discharge, ask a qualified professional to observe at least one feed and review the newborn's output, alertness, weight trajectory, and feeding pattern. Parents should know how to recognize effective swallowing, how to hand-express colostrum, and whom to contact if feeding becomes painful or ineffective. Written discharge instructions should include local lactation services and the newborn's follow-up plan.

Contact the newborn's clinician promptly if the baby is difficult to awaken for feeds, has persistent breathing difficulty, shows signs of dehydration, develops worsening jaundice, or is feeding substantially less than advised. Seek urgent care for severe breathing problems, marked limpness, bluish coloration, or an inability to feed.

For the parent, urgent evaluation is warranted for heavy or rapidly increasing bleeding, fainting, chest pain, severe shortness of breath, or a sudden severe headache with neurologic symptoms. Breastfeeding support should continue alongside routine postpartum care. Pain control, recovery, mental health, and adequate hydration and nutrition all affect the ability to feed and recover.

The first latch is an important opportunity, but breastfeeding is established through many feeds rather than one moment. Early, responsive support can help protect both the newborn's intake and the parent's confidence while allowing clinical priorities to guide timing.