



Breastfeeding position and attachment practices among lactating mothers: An urban community-based cross-sectional study from Vadodara city in western India

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ABSTRACT

Problem considered: Incorrect breastfeeding technique is a common cause of breastfeeding problems and subsequent discontinuation. Representative community-based data on practice of correct breastfeeding technique is not easily available. This study assessed the breastfeeding techniques as practiced by mothers having child under 6 months of age residing in urban slum areas of a city in western India.

Methods: This community-based cross-sectional study was conducted after ethics committee approval. We selected 210 mothers through population proportionate to size cluster sampling with 30 slum areas as clusters and 7 mothers from each cluster. Breastfeeding technique was observed by a trained female investigator through a checklist based on Integrated Management of Neonatal and Childhood Illness guidelines. Outcome variables were percentage of mothers with good position, good attachment and effective suckling. EpiData analysis and MedCalc were used for data analysis.

Results: The proportion (95% confidence interval) of mothers having correct breastfeeding position was 45.2% (35.2–55.3%), good attachment 73.8% (67.2–80.4%) and effective suckling 73.3% (67.8–78.8%). 128 (61%) mothers reported having been taught the technique of breastfeeding by someone, the most common source being nurse at health facility. Nuclear family, low parity and previous training in breastfeeding technique were positively associated with correct breastfeeding technique.

Conclusion: The proportion of mothers with correct breastfeeding technique was low in light of the robust presence of maternal and child health programs.

1. Introduction

Successful breastfeeding is an art with a scientific base. Mothers need skilled help for successful breastfeeding. Support and counselling should be available right from antenatal period to prepare the mothers for initiating breastfeeding and continued in postnatal period to ensure correct and consistent practice.¹ Correct breastfeeding technique involves good position of holding the baby and correct attachment of baby to breast. Poor position often results in poor attachment. Poor position has been reported to cause discomfort, nipple pain and feeding problems.^{2,3} Integrated Management of Neonatal and Childhood Illness (IMNCI) strategy used in India provides practical guidance for correct technique in form of a checklist.⁴

In India, data on health behaviors are available through large scale surveys such as National Family Health Survey. Unfortunately, it does not cover data on correct position and attachment practices. Earlier studies from India on breastfeeding technique are hospital based.^{5–8} Earlier published community based studies are small scale in nature and only two from urban area.^{3,9–12} Slums are the underserved segment of the population in urban areas. Thus, we conducted this representative study assessing the breastfeeding technique among lactating mothers with children under 6 months of age in urban slums of Vadodara city in western India. We preferred infants under 6 months of age to correct faulty practice, if any, at early-stage.

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2. Methods

2.1. Study design

This was a community-based cross-sectional study conducted in urban slum areas of Vadodara city in western India from July 2016 to December 2016.

2.2. Study setting

The city metropolitan area has a population of around 2 million. Around 25% of the population lives in slum or slum-like areas. The city has a network of 34 urban primary health centers run by local civic administration. They make use of a network of close to 400 anganwadi centers for their out-reach activities. The women residing in slums use both the public and private health facilities for ante-natal care, mainly private facility for intra-natal care and depend upon home visits through public health facilities for post-natal care.

2.3. Study population

Our criteria for inclusion in study was mother with a living child under 6 months of age residing in slum area of city. Exclusion criteria included mothers not willing to participate, mothers not breastfeeding the child and mother or child being sick at the time of assessment.

2.4. Sample size

We calculated sample size for determining the proportion of mothers breastfeeding their babies with correct position and correct attachment using the software nMaster assuming the community proportion to be 50% (previous studies reporting this proportion in range of 25–70%).¹³ Keeping expected proportion as 0.5, absolute precision as 10% on either side of expected proportion, confidence level at 95%, finite population size 33000, the required sample size came to be 96. With design effect 2, the required sample size was 192. Taking 10% rate of non-availability of participants we came to a final sample size of 210.

2.5. Sampling

The study sample was selected using 2 stage sampling. At first stage the unit of sampling was a slum area and at second stage the unit was a mother-child unit within the slum area.

Selection of slum areas was carried out using population proportionate to size cluster sampling. One slum area was taken as a cluster. We obtained a list of 632 slum areas of Vadodara city covering population of 526963 from Office of Medical Officer of Health. For selecting the clusters, total cumulative population (526963) was divided by 30 to obtain the class interval of 17565. A single random number (04516), lying between 1 and 17565, was obtained using first five digits of a hundred rupee note. The cluster, whose cumulative frequency interval had this number, was picked up as the first cluster. The class interval of 17565 was added to identify subsequent 29 clusters. Thus, 30 such clusters were selected by population proportionate to size cluster sampling method.

To select mother-child units from each slum, mothers enrolled at anganwadis centers who had delivered within 6 months preceding the date of survey was used as sampling frame. Since, we needed to cross check this list at the time of visit for determining the accuracy, the actual sampling frame was available at the time of visit only. The size of the population for clusters varied from 300 to 2500. If the anganwadis had 14 or more eligible infants, we selected every second child. If the anganwadis had less than 14 infants, we selected every alternate infant from this anganwadi and selected the remaining infants from immediate nearby anganwadi on the list using a fresh systematic random sampling for this additional anganwadis. Thus, corresponding to each cluster, 7

mothers were selected in sample.

2.6. Study instrument and variables

The study instrument had two parts. Part 1 containing socio-demographic, health related and breastfeeding related information was administered by interviewer. Part 2 was an observation checklist for breastfeeding technique based on IMNCI guideline.⁴ The study instrument was translated to vernacular language. The translated version was pilot tested on a small sample of mothers at the urban field practice unit of the department where this study was conducted. A paper-based final version of instrument was used for data collection in the field.

2.7. Operational definitions

Good position, good attachment and effective suckling were the outcome variable of interest. Their operational definitions used in this study are mentioned in [Table 1](#).

2.8. Data collection

One trained female investigator conducted the assessments at anganwadi center of respective slum area for all clusters. Informed written consent was taken from mother before the data collection. Part 1 of instrument was administered in vernacular language.

Privacy was maintained while observing feeding of the child using part 2 of instrument. The breastfeeding process was observed for 5 min to assess the mother and infant's position, attachment to the breast and effective suckling. If the infant had not received feed during previous 1 h, assessment was done at that time. If the infant was fed during the last 1 h, then the assessment was deferred and it was conducted after waiting for appropriate time for the infant to have next feed. Next mother-infant unit on the list was selected from the same anganwadi, if selected mother or child was sick or mother refused to participate in the study. At the end of the assessment, correct breastfeeding technique was explained to the mother with the help of the photographs by the investigator.

2.9. Data management

A data documentation sheet was prepared for the final version of the questionnaire. The collected data were entered into EpiData software version 3.1 (EpiData Association, Odense, Denmark) and validated through double entry. The data were analyzed using EpiData Analysis V 2.2.3.187 (EpiData Association, Odense, Denmark) and MedCalc version 20.006 (MedCalc Software Ltd, Ostend, Belgium). The outcome variables are presented as percentage of mother-child units practicing techniques of good position, good attachment and effective suckling.

Table 1

Operational definitions of the variables of interest used in this study.

Variable	Criteria	Classification
Position	1. Infant's head and body straight. 2. Infant facing the mother's breast with nose opposite the nipple. 3. Infants body close to the mother's body. 4. Mother supporting infant's whole body	Good position - if 3 or 4 criteria are met Not well positioned - if 1 or 2 criteria met No proper position at all - if no criteria met
Attachment	1. Chin touching breast 2. Mouth wide open 3. Lower lip turned outward 4. More areola visible above than below the mouth	Good attachment - 3 or 4 criteria met Not well attached - if 1 or 2 criteria met No attachment at all - if no criteria met -
Suckling	infant taking slow deep sucks, sometimes pausing infant having rapid shallow sucks	Effective suckling Not suckling effectively

The 95% confidence limit of the proportions are calculated using formula for PPS cluster sampling where sampling units are same as elementary units.¹⁴ Chi-square and Cochran-Armitage test for trend is used for statistical significance testing in this paper. A p value of less than 0.05 was considered significant.

2.10. Ethical considerations

The research project was processed through Institutional Human Ethics Committee. The work described here adhered to the ethical standards.

3. Results

We could obtain the data from 210 mother-child units for this study. Table 2 presents socio-demographic profile of the mothers. The mean (±SD) age of the mothers was 24.9 (±3.8) years. Majority of mothers were Hindu, educated at least till primary school, housewives and belonging to joint families.

128 (61%) mothers reported having been taught the technique of breastfeeding by someone. Among those who were taught, 38 (29.7%) were taught by doctor, 63 (49.2%) by nurse, 21 (16.4%) by anganwadi worker and 6 (4.7%) were taught by a family member.

Table 3 shows findings of breastfeeding observation. 95 (45.2%) mothers had good position (satisfying 3 or 4 criteria) with 95% confidence interval ranging from 35.2% to 55.3%. Further elaborating, correct technique of infant's head and body straight and baby facing breast with infant's nose opposite her nipple was seen in 76.7% and 91.9% babies while infants body close to mother's body and whole body supported was seen in 47.1% and 41.9% babies only.

155 (73.8%) infants had good attachment (satisfying 3 or 4 criteria) with 95% confidence interval ranging from 67.2% to 80.4%. 154 (73.3%) infants were classified as suckling effectively with 95% confidence interval ranging from 67.8% to 78.8%. Correct technique of lower lip turned outwards was seen in 94.8% of babies while chin touching breast, mouth wide open and more areola visible above than below was seen in 70.5%, 72.4% and 71.4% babies respectively.

Table 4 presents mother related factors affecting the position and attachment of infant. Significantly high proportion of good position was observed among mothers belonging to nuclear family and having low parity. Though increasing trend of good position was seen with increasing education level of mother, it was not statistically significant. More proportion had good position among mothers reporting having

Table 2
Socio-demographic characteristics of mothers assessed for breastfeeding (N = 210).

Variables	No. (%)
Age of mother (years)	
≤20	25 (11.9)
21–29	148 (70.48)
≥30	37 (17.62)
Religion	
Hindu	165 (78.6)
Muslim	44 (21)
Sikh	1 (0.5)
Education	
Illiterate	51 (24.3)
Primary	70 (33.3)
Secondary	57 (27.1)
Higher secondary	24 (11.4)
Graduate	8 (3.8)
Occupation	
Housewife	195 (92.9)
Working	15 (7.1)
Type of family	
Nuclear	70 (33.3)
Joint	140 (66.7)

Table 3

Assessment of breastfeeding technique as per integrated management of neonatal and childhood illness guideline (N = 210).

Variables	No. (%)
Assessment for position	
Infant's head & body is straight	161 (76.7)
Baby is facing breast with infant's nose opposite her nipple	193 (91.9)
Infant's body is close to her body	99 (47.1)
Infant's whole body is supported	88 (41.9)
Position classification	
Good position ^a	95 (45.2)
Not well positioned †	104 (49.5)
No proper position at all ‡	11 (5.2)
Assessment for attachment	
Chin touching breast	148 (70.5)
Lower lip turned outwards	199 (94.8)
Mouth wide open	152 (72.4)
More areola visible above than below	150 (71.4)
Attachment classification	
Good attachment ^a	155 (73.8)
Not well attached †	55 (26.2)
No attachment at all ‡	0 (0)
Assessment of effective suckling	
Suckling effectively	154 (73.3)
Not suckling effectively	56 (26.7)
Not suckling at all	0 (0)

^a 3 or 4 criteria met, † 1 or 2 criteria met, ‡ no criteria met.

Table 4

Factors related to mother affecting position and attachment (N = 210).

Category	n	Good Position		Good attachment	
		n (%)	p value ^a	n (%)	p value ^a
Mother's age in years					
≤20	25	10 (40)	p = 0.26†	20 (80)	p = 0.69†
21–30	168	75 (44.6)		122 (72.6)	
>31	17	10 (58.8)		13 (76.5)	
Education					
Illiterate	51	20 (39.2)	p = 0.06†	33 (64.7)	p = 0.35†
Primary	70	32 (45.7)		57 (81.4)	
Secondary	57	23 (40.4)		39 (68.4)	
Higher secondary	24	13 (54.2)		20 (83.3)	
Graduate & above	8	7 (87.5)		6 (75)	
Occupation					
Housewife	195	86 (44.1)	p = 0.23	143 (73.3)	p = 0.82‡
Employed	15	9 (60)		12 (80)	
Family type					
Nuclear	70	39 (55.7)	p = 0.03	57 (81.4)	p = 0.07
Joint	140	56 (40)		98 (70)	
Parity					
1	73	40 (54.8)	p = 0.006†	60 (82.2)	p = 0.04†
2	88	40 (45.5)		60 (68.2)	
3	32	11 (34.4)		27 (84.4)	
4 and more	17	4 (23.5)		8 (47.1)	
Delivery place (n = 204) §					
Public hospital	108	44 (40.7)	p = 0.14	75 (69.4)	p = 0.22
Private hospital	96	49 (51.0)		74 (77.1)	
Taught BF technique					
Yes	128	64 (50)	p = 0.08	107 (83.6)	p < 0.001
No	82	31 (37.8)		48 (58.5)	

^a Chi-square test unless specific otherwise, † Cochran Armitage test for trend, ‡ Fisher exact test § excludes home delivered children.

been taught the technique previously, but this was not statistically significant.

Significantly high proportion of correct attachment was observed among mothers having low parity and who were previously taught breastfeeding technique. A higher (statistically non-significant) proportion of good attachment was seen among mothers belonging to nuclear families.

Table 5 presents the infant related factors affecting attachment and effective suckling. Though good attachment and effective suckling was higher among the full term and normal birth weight babies, this was not

Table 5
Factors related to infant affecting attachment and effective suckling (N = 210).

Category	N	Good attachment		Effective suckling	
		n (%)	p value ^a	n (%)	p value ^a
Gestation					
Pre-term birth	16	11 (68.8)	p = 0.8 [†]	11 (68.8)	p = 0.07
Full term birth	194	144 (74.2)		143 (73.7)	
Birth weight					
<2500	44	30 (68.2)	p = 0.3	29 (65.9)	p = 0.2
≥2500	166	125 (75.3)		125 (75.3)	

^a Chi-square test † Fisher exact test.

statistically significant.

4. Discussion

This is a first representative urban community-based study from India documenting the practice of breastfeeding technique among mothers.

This study found that only 45.2% mothers were practicing breastfeeding with good position, 73.8% with good attachment and 73.3% could achieve effective suckling. Nearly two third reported having been taught the breastfeeding technique.

The practice of breastfeeding in nearly universal in India whether or not the mother knows the advantages of breast-feeding. Yet, the practice of correct technique of breastfeeding was not found to be universal in this study.

Earlier studies have reported the breastfeeding technique assessment at hospital or community settings from India and other places. Most Indian studies have used IMNCI guidelines as reference while studies from outside India have used either WHO breastfeeding assessment guideline or self-created checklist.

Indian hospital-based studies have reported proportion of mothers with good position in a wide varying range from 25 to 67%.^{5–8} Among the community-based studies from rural India this proportion ranges from 60 to 74%.^{3,9,12} while for urban areas it ranges from 10 to 27%.^{10,11} Our study from urban area reports this at 45%.

Indian hospital-based studies have reported proportion of mothers with correct attachment in range from 26 to 74%.^{5–8} Among the community-based studies from rural India this proportion ranges from 42 to 77%.^{3,9,12} while for urban areas it ranges from 15 to 84%.^{10,11} Our study from urban area reports this at 74%.

Limited studies reporting the proportion of the observed babies with effective suckling have reported this in range of 46–90% compared to our study reporting 73%.^{6,7,12}

When individual study findings are looked at, for most studies, the proportion of mothers with good attachment is higher than that with good positioning. This points that incorrect position often but not always leads to inappropriate attachment. Further, the variation in the proportion across studies can be because of difference in interpretation of the checklist items through variation introduced by qualification and training of observers. The reasons for poor position and attachment could be not very comfortable clothing (clothing has to be held by the mother with one hand hence only one hand is used for support) or inadequate physical support (use of pillow).

This study reports that only two third mothers were ever taught the technique of breastfeeding. Among those who were taught, maximum were taught by the nurses in health facilities. We expect that with public health programs on maternal and child health running since long, a larger proportion of mothers should have been taught by the community level health staff such as ASHA and Anganwadi workers.

Our analysis indicates that the factors associated with good position and attachment are nuclear family, low parity and higher educational status of mother. In such case, mother is more confident, independent and has less household work burden which may be a factor in better

breast-feeding technique amongst these mothers. Based on our experience we can postulate that this is a reflection of the direct or indirect effect of educational status on breastfeeding technique. Few earlier studies have also reported higher proportion of correct breastfeeding technique among primiparous mothers.^{8,15} Our analysis also indicates that prior teaching of the technique was associated with good position and attachment. Previous research has also documented that the teaching of technique is a predictor of practice of correct technique of breastfeeding.^{16,17}

Among the infant related factors, higher proportion of babies with birth at full term gestation and normal birth weight had good position and attachment, though this was not statistically significant. It can be postulated that pre-term babies were probably late preterm and low birth weight babies were more of full term IUGR. Since, details on perinatal events were not included in the study and this cannot be elaborated.

The strength of this study is its representative sampling, use of standard checklist with a qualified and trained observer, robust data management and appropriate analysis. The mother may not be her natural self because of effect of being observed during the breastfeeding assessment. This was an inherent limitation of the study. Another limitation was that the assessment was done at anganwadis and not at home, which would have been technically more appropriate. Another limitation was that the information on gestational age at birth and history of perinatal events was not included in this study.

5. Implications

Focusing on female education appears to be a long-term promising solution. In short- and medium-term, efforts should be placed at teaching correct technique to the mothers. Thus, there is need for translating knowledge into practice. Ideally such training and support should continue from ante-natal to post-natal period. In ante-natal period this should be ensured during the mothers visit to clinics during the health and nutrition day through public health facilities and during their visits to the private obstetricians' clinics. The Mother and Child Health Card given to mothers contains information on breastfeeding technique. Such resource should be utilized by the attending health workers during ante-natal visits to educate the mother on correct technique. Mother needs to be supported for correct technique during immediate post-partum period. Earlier studies have shown effectiveness of such teaching.^{5,18} In scenario of large proportion of deliveries happening in private sector in this city, reinforcing the nursing staff's existing capacity in counselling the mother for correct technique could be one possible way of going forward. This support can be continued during the post-natal period through post-natal home visits by the Accredited Social Health Activists and during mothers' visits for the vaccination of baby. Future research in this area can focus more on the factors affecting the breastfeeding technique and comparison of effectiveness of different instructional interventions.

6. Conclusion

The proportion (95% CI) of mothers with child under 6 months of age from urban slum areas of the city having good breastfeeding position was 45.2% (35.2–55.3%), good attachment was 73.8% (67.2–80.4%) and effective suckling was 73.3% (67.8–78.8%). The proportion of mothers with correct breastfeeding technique was low in light of the robust presence of maternal and child health programs.

Author roles

KD: Methodology, Investigation, Data curation, Formal Analysis, Writing original draft and reviewing and editing; PC: Conceptualization, Methodology, Data curation, Formal Analysis, Writing original draft and reviewing and editing; CP: Methodology, Formal analysis, Writing -

reviewing and editing; DD: Formal analysis, Writing – Reviewing & Editing; KM: Formal analysis, Writing – Reviewing & Editing.

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Ethics statement

The study was conducted after taking approval of the institutional human ethics committee. Informed written consent was taken from the study participants.

Declaration of competing interest

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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