

# Mothers' experiences of sharing breastfeeding or breastmilk: co-feeding in Australia 1978–2008

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## ABSTRACT

While the concept of breastfeeding in contemporary Western culture is of a mother breastfeeding her own baby or babies, others have replaced the mother as provider of breastmilk, for a variety of reasons, through most periods of human existence. Existing policies for the sharing of this bodily fluid, milk, appear to have been written without the benefit of a detailed examination of the actual experiences of the mothers and babies involved. This study attempts to fill this information gap by investigating the sharing of breastfeeding or expressed breastmilk by Australian women in a recent thirty-year period, 1978–2008. The objective of this study was to explore the mothers' experiences of sharing breastfeeding or human milk including: the circumstances in which this bodily fluid was freely shared; what screening process, if any, was used before the milk of another mother was accepted; the mothers' feelings about the experience; the reported attitudes of others; and the children's behaviour when put to the breast of someone other than the mother. The underpinning reason for the sharing of breastfeeding or breastmilk was the desire of mothers to provide human milk to their babies, exclusively, including while they were absent or temporarily unable to breastfeed. Most mothers were selective about those with whom they would share breastfeeding or breastmilk.

Keywords: Australia, breastfeeding, cross-nursing, expressed breastmilk  
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## INTRODUCTION

### Definitions

The term 'wet nursing' was previously used to loosely describe any breastfeeding by someone other than the baby's own mother. More recently, the term 'cross-feeding' (or 'cross-nursing' in North America) has been used to describe the sharing of breastfeeding or breastmilk between peers and to differentiate this practice from wet nursing as an occupation (Krantz & Kupper 1981; Long 2003; Minami 1995; Shaw 2004; Thorley 2008a, 2008b). In this article, the term 'wet nursing' will be used for the employment of a woman to breastfeed a baby or babies. Others have discussed the practice of wet nursing as an occupation in the Australian context in the late-19th and early-20th centuries (Featherstone 2002; Swain 2005; Thorley 2008a, 2008b). As a form of employment, paid or unpaid, wet nursing is almost never a reciprocal arrangement, whereas the informal sharing of breastfeeding among sisters or friends may sometimes involve reciprocity. Hence, the replacement of the terms 'cross-feeding' or 'cross-nursing' with 'co-feeding' is proposed, as it more clearly expresses the idea of the sharing of breastfeeding or expressed breastmilk (EBM). In this article, 'milk' will refer to human milk. The term 'milk siblingship', which is the bond between children breastfed by the same woman, will be used in both a religious and non-religious context.

### Background

Personal accounts of mothers' experiences of co-feeding during the 1970s were reported in the popular press (Irving 1972), in the Nursing Mothers' Association Newsletter (Goldfinch 1980; Herman 1974; Hooper 1978; Reid 1978) and elsewhere (Goldfinch 2006). In another instance, a baby who was rejecting the breast was enticed back by being put to another mother's breast, just the once (Hubner 1994). After Lindy Chamberlain was gaoled, in what was known as the 'dingo baby case' and gave birth to her daughter Kahlia in 1982, Kahlia was breastfed by her first foster mother by mutual agreement (Chamberlain 1990, 2004). The closeness of Kahlia and her milk sibling, the daughter of her foster mother, was mentioned in a report of Kahlia's wedding in 2007 (Australian 19 Nov 2007). Giles reported a case of a woman who had shared breastfeeding informally with friends in Darwin in the 1980s and who later advertised in a Perth newspaper for a wet nurse to breastfeed her child while she attended classes (Giles 2003). Also during the 1980s, in a widely reported case of surrogate pregnancy involving two sisters, the sister who did not give birth induced lactation and the shortfall was initially made up by EBM from the birth mother and a generous acquaintance (Kirkham & Kirkham 1988). Numerous human-interest articles or interviews on co-feeding have appeared in the Western media in recent years (Thorley 2008a).

The informal sharing of breastfeeding among mothers in the mid- and late-20th century has been discussed in the academic and professional literature (Giles 2003; Long 2003; Shaw 2005; Thorley 2008a, 2008b). Shaw (2004, 2005) discusses attitudes towards mother's milk as a bodily fluid and the feelings, commonly expressed in Australia and New Zealand, that the act of breastfeeding someone else's baby violates the mother-infant bond. In her ethnographic study in an urban Australian setting, Long (2003) reported community repugnance to breastfeeding the child of another woman, but observed that respondents were more accepting of the idea of feeding EBM by bottle.

### Features of period

The 1970s were chosen as the starting point for this study for several reasons. Firstly, this period marked the proliferation of mother-support groups for breastfeeding women in local areas throughout Australia (Reiger 2001) after the reversal of an earlier decline in breastfeeding. Mothers experiencing a peer group of like-minded breastfeeders, in what was generally a bottle-feeding culture, were committed to providing breastmilk for their babies and often formed strong friendships in these peer groups. Secondly, mothers from this period were available for interview and in some cases were also the mothers of women who co-fed. Additionally, access to banked human milk was increasingly limited for women during the postnatal period and even more unlikely after discharge from hospital.

### Limited alternatives

Hospital-based milk banks, though they existed (Allison 1975; Connelly 1975; Harmer 1974; Lohse 1978), were mostly informally organised (Lording 2006) and were declining in favour of milk rooms set up for dispensing of artificial baby milks (ABM), instead of EBM from maternity in-patients (Thorley 2008b). Even the unique human milk bank at the Townsville General Hospital in North Queensland, run by volunteers from the Nursing Mothers' Association of Australia and housed in the paediatric ward, was established for sick babies, rather than for the general community (Beal, Ashdown & Mackay 1978; Nursing Mothers' Association of Australia 1977). Later, an overreaction to the HIV scare from the 1980s led to the closure of many human milk banks (Boyes 1987). Formal milk banking in Australia did not resume until 2006, when two milk banks were established in Perth, Western Australia, and on the Gold Coast, Queensland (Brophy 2006; Mothers' Milk Bank 2007). These milk banks have initially provided a limited service within their local areas; however the Queensland milk bank closed in 2008 through lack of funding (Stolz 2008).

Some hospitals during the 1970s and 1980s continued to pool human milk expressed by new mothers, usually to feed premature babies. From time to time other hospitals drew upon local NMAA groups for supplies of EBM (Harmer 1974).

In the 1970s, attitudes towards sharing breastfeeding in the Australian community were mixed. After all, this was a time when the rate of breastfeeding by the baby's own mother had only recently reached its nadir, followed by the first increase in

a Western country recorded in Victoria in 1971 (Smibert 1978). Breastfeeding had not yet reached the acceptability it achieved in the early-21st century. However, mothers who had met through organisations such as NMAA formed close friendships. Caring for a friend's baby when she was absent sometimes led to offering the breast when the baby was hungry and distressed before the mother returned. Consent was either specifically discussed beforehand, or implied.

Another situation during the 1970s and 1980s in which NMAA members informally shared EBM or breastfeeding was when the mother of an adopted baby was establishing lactation. A 1971 guide to inducing lactation for adopted babies, or to reverse early weaning, suggested swapping babies with another mother to stimulate the adoptive mother's supply and to provide her baby with the experience of suckling from a full breast (Phillips & Hapke 1971). Similar advice was provided in a subsequent NMAA booklet in 1984 and 1989, though it was omitted from the 1992 revision (NMAA 1984, 1989; Thorley 2008b). Several case histories of mothers who received informally donated EBM after adopting their babies or while re-establishing breastfeeding appeared in the Association's Newsletter in the 1970s and 1980s, without editorial comment (Herman 1974; Goldfinch 1980). The lack of editorial comment suggests that the practice was considered appropriate. Similar reports also appeared in other publications (Irving 1971; Goldfinch 2006; Kirkman & Kirkman 1988). Co-feeding experiences were also discussed in a feature article in the NMAA Newsletter in 1994 (NMAA Newsletter in 1994). This material reflects the evidence from some of the interviews conducted for the research described here, that the informal sharing of breastfeeding or EBM by members of NMAA groups in the 1970s and 1980s was, for a time, sanctioned. A further article will explore this issue in depth.

### Health concerns and screening

Ideas about what constitutes a healthy diet for the breastfeeding woman and what she should or should not eat and drink have been inconsistent, particularly on the matter of alcohol use (Thorley 2007). In the community, especially early in this period, advice still circulated that drinking a glass of alcohol would improve milk production or assist the milk-ejection reflex (MER). It is now understood that alcohol in breastmilk can reduce the amount that babies drink and inhibit the MER, and mothers are usually advised to abstain (Thorley 2007). Some of the mothers in this study specifically mentioned avoidance of alcohol. These women became mothers after the thalidomide tragedy had led to greater caution in taking medications during pregnancy and lactation. Mothers who ate healthy food and who avoided ingesting alcohol, recreational drugs and pharmaceutical drugs, for fear they would pass into the milk, had similar requirements when accepting the milk of another mother.

Concerns about the transmission of infection through co-feeding have centred on the infections considered transmissible in the particular era. In ancient times, these concerns included

diarrhoeal disease, according to the fourth-century writer, Oribasius, who drew on earlier traditions (Lascaratos & Poulakou-Rebelakou 2003). Later, transmission of syphilis and pulmonary tuberculosis (TB) were the main health issues mentioned in advice on the selection of a wet nurse (Collins 1939; Queensland Baby Clinics 1930), with both diseases common among the urban poor in Australia in the late-19th century (Swain 2005). It should be noted that other forms of tuberculosis could be contracted by humans from the milk of cows infected with *t. bovis* (Armstrong 1905; Great Britain Royal Commission 1907). The Wasserman test for syphilis was available from 1906. During the period of the study reported here, screening for syphilis was a standard part of pregnancy blood tests in Australia, and remains so today, even if mothers are unaware of it. Syphilis was only infrequently seen in the community during the period (Campbell J 2008, pers comm 9 January). A national compulsory chest x-ray program to screen Australian residents for TB had been running from the 1950s (Boag 1971; Tyler 2006), but the prevalence was so low that federal funding for the screening program was discontinued in 1977 (Tyler 2006). So these two diseases had ceased to be a legitimate concern by the 1970s, the period at the start of the study reported here.

Lawrence and Lawrence (1999 p564) state when a mother has an infection, breastfeeding is generally not contraindicated for her own baby, with few exceptions. It was one matter for a *Staphylococcus aureus* carrier to breastfeed her own baby, but donated milk was intended for sick or premature infants. This point is why hospital milk banks tested for this pathogen (Beal, Ashdown & Mackay 1978; Law et al 1989) or boiled the milk (Thorley 2000).

The arrival of HIV in the 1980s and the possible transmission of the virus through breastmilk became a concern in the sharing of breastmilk with others (Boyes 1987). Human milk banks today are concerned about other viruses as well, which the public are less aware of, and their protocols usually require the milk to be pasteurised (Lawrence & Lawrence 1999). Where raw donor milk is required in health care facilities, careful screening is done, including for lifestyle factors (Lawrence & Lawrence 1999). This study has identified the informal screening that existed among Australian co-feeders outside any formal system of milk donation.

It should be remembered that anything substituted for the mother's own milk has a margin of risk, with donor human milk from a safe source the next best choice. Lawrence and Lawrence (1990) suggested co-feeding as an acceptable option, provided the source is healthy and has no signs of infection, is well-nourished and a non-smoker, and avoids medications. The community perception of artificial baby milk as normal and completely without risk is misplaced, even today (Ball & Wright 1999).

### **Milk siblingship**

Milk siblingship is the situation where breastfeeding by someone other than the mother creates a relationship that is treated similarly to a blood relationship. In Islam, it falls under the consanguinity laws, so that children who have received the same

milk are forbidden to marry (Al-Naqeeb et al 2000; Gatrad 1994; Kocturk 2003). The custom of milk siblingship has traditionally been practiced in a number of other cultures, particularly around the eastern Mediterranean and the Caucasus (MacClancy 2003). This custom is also found among Jewish families elsewhere (Kazatchkov H 2008, pers comm 21 January). In Christian Greece, milk siblings could not marry each other and it was considered desirable for both the wet nurse's baby and the other baby to be the same sex (Pechlivani, Matalas & Bakoula 2008). MacClancy (2003) has described a range of interpretations of milk siblingship, from a simple one involving only the children breastfed by the same woman, to a complex constellation of other kin who become milk siblings. This relationship, or milk tie, has had many purposes besides the obvious one of nourishment of a child, both because of the alliances it creates and its strategic use to prevent the undesirable later marriage of two children (Altorki 1980; MacClancy 2003). In traditional Islamic societies, the inadvertent marriage of milk siblings, if discovered later, leads to annulment of the marriage, both in historic reports (MacClancy 2003) and today (Altorki 1980; Arab News 18 Jan 2008). The question of how many breastfeeds or sips of expressed breastmilk are required to create the milk relationship has been debated by jurisprudentialists within the cultures (MacClancy 2003). While the gender of the children is not necessarily a barrier to co-feeding, occasionally there is a cultural requirement that the children be of the same gender (MacClancy 2003). The term 'milk sibling' is also used in a broader, informal sense by Anglo-Celtic Australian women who have shared breastfeeding within a friendship, even where the family has no religious or cultural tradition of milk siblingship.

### **Objectives**

The objective of this study was to explore the experience, from the point of view of the mothers involved, of sharing breastfeeding or EBM. The article focuses on: the circumstances in which this bodily fluid was freely shared; what screening, if any, was done before the milk of another mother was accepted; how the mothers felt about the experience; the reported attitudes of others; and whether the children noticed and, if so, how they behaved.

### **METHOD**

During October 2007 to March 2008, mothers were recruited through personal contacts and several email lists or websites, using a 'snowballing' method, a useful strategy for recruiting populations which use hidden practices. That is, mothers were encouraged to pass on information about the study and the author's contact details via their personal contacts and various online lists. The online discussion or distribution lists included: JoyousBirth online forum; the discussion list for email counsellors of the ABA; research announcements posted on the ABA website; and the email announcements lists for Queensland and South Australian ABA counsellors. The respondents were given a choice of interview methods, that is, whether by telephone or email, or both. Similar questions were asked, and expanded where the information led to other issues.

## RESULTS

### Demographics

Forty-six women were recruited; two did not respond when contacted for interview and a third was ineligible. Thus information was collected from 43 women. The method of recruitment inevitably resulted in a well-educated study population from backgrounds in which breastfeeding was encouraged. Co-feeding by the respondents occurred in all six Australian states and the Australian Capital Territory, irrespective of the current state of residence, with Queensland predominating (Table 1).

**Table 1. Relationships between the mothers, by occupation and State.<sup>a</sup>**

	Sisters/ Sisters- in-law	Other related	Friends	Acquaintances	Partners
<i>Occupation</i>					
Medical/ nursing/ health	7	-	5	-	1
Other professional/ academic	5	1	2	1	1
Home duties	10	5	9	2	-
Other	2	-	2	-	-
<i>State of residence</i>					
New South Wales	5	-	2	1	-
Queensland	15	2	5	-	1
South Australia	2	-	4	-	-
Tasmania	1	-	-	-	-
Victoria	2	1	1	-	-
Western Australia	-	3	4	-	-
Australian Capital Territory	-	1	1	-	-

<sup>a</sup>Some respondents are in more than one category.

The majority of respondents were middle-class, Anglo-Celtic, married, heterosexual women. Two respondents were in same-sex relationships in which both partners had infants. Respondents included two grandmothers, one of them a cultural grandmother (a great-aunt to a baby with an Indigenous heritage), and the other a biological grandmother. Attempts to include Australian women from Islamic backgrounds, for whom religious law accords a special 'milk siblings' relationship between the children concerned, were unsuccessful.

Of the two respondents whose relationship to the baby was as a grandmother, one had milk as she was still breastfeeding, but the other was 'dry' and used the breast as a soother for a disconsolate grandchild whose mother was late returning. The baby of another respondent was put to the breast by her mother, who was not interviewed, but the baby would not attach as there was no milk. This grandmother had not asked permission and the baby's mother said she 'was a bit weirded out by it'. One respondent, who had co-fed the babies of other friends, on one occasion, latched a baby to her breast and drip fed the mother's own EBM, as that was the only way she could persuade the baby to take the milk from a bottle.

A majority of respondents participated in co-feeding in the 2000–2008 period. Some mothers co-fed more than one baby at different times. Respondents sharing breastfeeding were included if a baby had latched and suckled at least once, even at a dry breast. Sisters, in particular, shared breastfeeding reciprocally. While some sharing of EBM was of limited duration, some milk donors continued to express for weeks or months. Table 2 gives a breakdown of the period. Limited numbers did not permit a breakdown of how frequently mothers shared breastfeeding or EBM, that is, whether co-feeding was frequent, sporadic or a single occasion.

**Table 2. Breakdown of respondent categories across study period.**

<i>Category</i>	1978–79	1980–89	1990–99	2000–08
Respondent breastfed (BF) another mother's baby	2	3	4	10
EBM donor	-	-	-	5
Both BF and EBM donor	-	-	-	3
Reciprocal co- feeder	1	1	2	11
Respondent's baby BF by another woman	-	1	-	2
Respondent's baby a recipient of donated EBM	-	-	-	4

### Mothers' reasons for co-feeding

The overwhelming reason for women to share breastfeeding or EBM was to meet the mother's desire for her baby to have human milk, rather than milk deriving from an animal. These women were conscious that alternative foods were less healthy than breastmilk. For some mothers, short- or long-term receipt of EBM from others tided their babies over until maternal health or infant difficulties improved.

*If you are desperate you would take any means that were necessary for your child. I don't like formula milk. I had a prem, at 26 weeks. When I brought him home at over four months, another mother expressed for me. [My] baby had reflux and didn't know how to suck strongly. I thought it was great. (CF.21, 1979)*

*[My sister] was having trouble, but determined to feed. Baby – small mouth, [mother] engorged. After discharge I'd feed while she expressed. (CF.33, 1994)*

*[My baby] had serious breast attachment issues for the first six months of her life. In this period we were fortunate to meet a beautiful woman who provided breast milk for us. My daughter was fed this EBM through a supply line ... for 4 months. At six months my daughter's attachment improved to the point that we did not need the EBM or supply line. The fact that I was able to give my daughter donated EBM was the foremost reason that we were able to develop and continue our breastfeeding relationship. We are still feeding [at 15 months]. I am forever grateful to our milk donor's amazing generosity. (CF.31, 2006–07)*

Women who provided breastfeeding or EBM were conscious of helping their friends avoid the use of ABM.

*[I was] very proud to be able to help this mother and father achieve their goal of not having to give baby any*

*milk other than human milk before her repair surgery. (CF.5, 2000)*

*It was really fantastic feeding a friends [sic] baby. She needed to work, and hated to leave her son, but we were all happy to take care of him, anything to see that he didn't end up given formula. (CF.22, 2007)*

*It's something you'd want someone to do for you if you were put in the same situation. (CF.17, who breastfed a friend's baby while providing care, 2007)*

Within this overall reason were other reasons (Table 3), including convenience.

*Most of the time [my sister] fed mine when I was helping with kindy and she was babysitting him. It was good, because I knew she could feed and I could feed hers. (CF.43, 2000–2007)*

*One other occasion I wanted to go for a swim, and while I was in the middle of the dam my son started to cry for a feed, so [cultural Nana] fed him. (CF.43, 2000–2007)*

*Amongst my group of friends, if there is a child/baby that needs feeding and his/her mother is in another room or occupied with an older sibling, then we usually just check that it [sic] ok, then go ahead. (CF.22)*

**Table 3. Category and reasons for co-feeding.<sup>a</sup>**

Category	Mother unwell	Maternal low supply (chronic) or chronic latch problems	Maternal low supply (temporary)	Baby stressed, hungry, or needed comforting	Convenience (co-feeder providing childcare; to maintain supply in absence of child)	Female bonding <sup>b</sup>	Other
Respondent was a co-feeder	2	2	2	4	22	1	2
Respondent's baby was breastfed by another mother	—	—	2	1	15	—	—
Respondent donated EBM	2	3	1	—	—	—	—
Respondent's baby received donated EBM	—	4	—	—	1	—	—

<sup>a</sup>Some women gave more than one reason.

<sup>b</sup>Mentioned by others as an outcome, rather than a reason.

## Screening

When co-feeding involved close relations, such as sisters, or close friends there was personal knowledge of each other's family health and lifestyle. Thus the mothers involved were aware of many, if not all, of the health and lifestyle issues currently screened for in the Red Cross Blood Bank questionnaire for blood donors (Australian Red Cross 2006). Some respondents who had breastfed sisters' babies would not allow friends to do the same if they were unsure of health status, or preferred to keep it in the family. In the case of women in same-sex relationships, who sometimes shared breastfeeding with the partner, screening before sharing breastfeeding was not necessary. Most mothers in this study believed they did not consciously screen the women with whom they shared this bodily fluid. However, further questioning elicited the fact that screening usually was done, even where the mothers were unaware they were doing so. Even in the few cases where donors of EBM were acquaintances and not well known to the recipient mothers, they came from similar backgrounds. Questioning of women who believed that they did not screen friends revealed that they would allow a particular friend or relation to breastfeed or provide EBM, but not another. They articulated clear reasons for this. Women whose milk was acceptable shared a healthy lifestyle and were not users of pharmaceutical or illegal drugs. Avoidance of alcohol during the breastfeeding period was also mentioned, as was smoking, and one mother stated that she would prefer a vegetarian, though in an emergency she would prefer her baby to have any woman's milk, rather than milk derived from a cow. One mother explained, when asked if there were any friends she would not allow to breastfeed her baby:

*Yes, only if they were on medication or had been drinking... I don't use medications on my child, and I don't drink. So I wouldn't want it passed thru breastmilk to him. (CF.22, 2007)*

*Basically, we all got together thru a homebirth website. We all practice attachment parenting which supports practices like homebirth, gentle discipline and sustained (long term) breastfeeding. We started a thread on the forum we frequent, basically a role call of who would be willing to feed each others [sic] babies, a few details on ourselves, and our availability. (CF.22)*

*I would firstly want close family/friends feed my baby... Following that, I would accept milk from a reliable source, i.e. known not to be using drugs or to be infected etc. So long as my child was receiving EBM from a reliable source, but not necessarily screened, I would be happy that they were receiving BM [breastmilk] over ABM. (CF.39, 2004)*

A respondent who breastfed several children of friends when caring for them had also been breastfed by a friend of her mother's. Her mother had consented to this. However, her mother's attitude had been different when another, unsuitable woman breastfed another of her children.

*My sister was cross-fed without my mother's permission, and she wasn't happy about it. Mainly because of the other person [using] drugs. (CF.18)*

This same respondent wrote of her own experience, a generation later, of breastfeeding the babies of friends:

*I was honest and open with my friends. I'd had HIV and STD testing and so they didn't need to worry. They didn't actually ask me, though. (CF.18, 2005–07)*

Other mothers also commented on the need for consent and mentioned their informal screening process.

*As long as we have a consensual agreement – if some kind of crisis. I would prefer to know beforehand and have some kind of arrangement. [I wouldn't] if they are not in my friendship circle, a drug-taker, imbibing something. (CF.19)*

Consent was sometimes tacit. Lack of prior consent in a case of childhood friends caused reflection, but a generally positive feeling.

*I did not [give] consent to my friend feeding my baby.... However upon reflection on it I didn't have a problem with it and thought it was rather a kind and instinctual response to feed a hungry baby, it was special. (CF.30, 1988)*

Although the respected international breastfeeding organisation, La Leche League International, discourages co-feeding (La Leche League International c.2007), two of their reasons were not identified amongst this study of Australian mothers. These reasons are that sharing breastfeeding could damage the mother-baby bond and that it would also make babies refuse the biological mother's breast. While some older babies were aware that the breast being offered was someone else's, only two babies refused the breast of the other mother. Not one baby refused the breast of the biological mother after co-feeding. These points suggest that some existing policies on the informal sharing of breastfeeding or EBM may be theoretically based, rather than evidence-based.

## Mothers' attitudes to the experience

Mothers who had provided the co-feeding, either directly at breast or as EBM, were generally comfortable with the experience.

*It was just what we did. It just made sense. We knew we were flying against the cultural norm. (CF.1, 2000–2007)*

*When my sister has breastfed my baby I just feel so nurtured and so blessed – something really very special, very powerful to me... Giving is important.*

*What a handy asset having not one, but two women in the family possessing this golden ability to instantly produce*

*the finest food possible for our babies! I felt quite proud of us actually. It felt that we were working together as a family in a unique way. (CF.35, 2006)*

Some were uneasy at first, but became open to the experience.

*The first time I [breastfeed sister's son] I remember feeling that I had crossed some invisible line into deviant behaviour, or had broken some taboo.... At the same time I also felt somewhat liberated as I intellectually knew that what I was doing was better than giving my nephew ABM, even if my emotional response was different. (CF.23, 2005)*

*When my sister ... first suggested that we could feed each other's baby if necessary, I was a bit taken aback.... My initial reaction was irrational and, I think, based on cultural conditioning. I thought, 'EWWW?' ... Anyway, I decided to open my mind to the idea – she was my own sister after all. (CF.35, 2006)*

Where there was a considerable difference in age between the babies of the mothers concerned, the respondents were conscious of this in the baby's feeding quality.

*I guess it's kind of weird feeling another child suck, especially when there's an age differential. A child near in age seems more normal. It's something you'd want someone to do for you if you were put in the same situation. (CF.17, 2007)*

*[Niece] was very different to [son] to feed, but gentle enough and willing. I felt a great sense of satisfaction when I could get her to sleep peacefully and blissfully in my arms when all else had failed. I loved being able to nurture her in this way. (CF.35, 2006)*

Sometimes, the first time evoked feelings of emotional discomfort or regret, which quickly passed. This response was especially so if the respondent was a recipient of EBM because of chronic low supply, as was this mother.

*First time, when it was actually offered, almost like a jealousy, that someone else could give what I wanted to do. But I knew it was best. The second time I had qualms, the third time, positive. I would have been fearful if someone else had fed her on the breast, in case she rejected me (from) less flow. (CF.7, 2007)*

Respondents who informally donated EBM to others were positive about the opportunity to help. Usually, they had an excess supply when they heard of a friend or other mother who was struggling to maintain her supply.

*I was honoured that she would use that from me as obviously it was bodily fluid. I was [pleased] it wouldn't go to waste. (CF.9, 2007)*

*Very positive and extremely happy to help a friend, but would also have done the same for anyone willing to use my freezer-full of milk which my daughter would not need, nor would take. (CF.10, 2007)*

### Attitudes of others

The attitudes of friends and family were mixed. Within a breastfeeding culture, whether it was a family or a network of friends that met in a childbirth or breastfeeding group, the response was mostly positive. Because co-feeding is not generally acceptable in the community, responses from outside these circles could be negative. For instance, one respondent stated that sharing breastfeeding was accepted in her ABA group, where 'they think it is fabulous', but that her other friends do not know. (CF.38, 2006–07)

*Most of my friends have said they thought it was nice but some have said not for them. Most in theory think it would be ok [but] some were concerned about catching diseases. (CF.30, 1988)*

*Some thought we were lucky to have such a good resource available, and others were shocked and appalled. (CF.36, who shared breastfeeding with her sisters, 1990s)*

*I have told some members and former members of the Australian Breastfeeding Association, and all their reactions have been positive. I have been selective about who else I have told. (CF.45, 2000s)*

*Our mother (who breastfed all her children) was completely supportive and in agreement about the sharing of breastfeeding between sisters. She encouraged and helped us. Our other sister who hasn't had children yet thought it a bit strange and wondered if it was the right thing to do. My husband was a bit 'iffy' about it at first, thinking I wouldn't have enough milk for [son] if I fed [niece] so often. But we sorted these issues out with those who were concerned and the family was happy about it. My Dad thought it fine. We all thought it very convenient really. (CF.35, 2006)*

Another respondent described other people's opinions as, 'Various reactions from very accepting through to repulsed' (CF.37, 1990s). A few respondents specifically stated that some family members would not have approved and so were not told.

*My husband knows I have fed my niece. He seemed less happy with the idea of someone else feeding his son. So it was not discussed, so he couldn't say 'no'. I think my parents would just freak. (CF.38, 2006–07)*

Attitudes could be affected by regional factors and the period, too. A mother from northern New South Wales, whose baby received EBM donated by a friend in 1979, commented, 'We live

in an area where people think its all joy and happiness' (CF.21). A few respondents, who had co-fed a generation ago, considered that sharing breastfeeding was done more openly in the 1970s, at least in their own friendship circles. According to one, it was 'commonplace' to breastfeed each others' babies in her NMAA group, and sharing of EBM was also common (CF.2). Others stated:

*We were very relaxed in those days. Nobody cared at the time. It was normal. Now, everybody goes, 'It's terrible.' ... People pretty much laughed, as a sign of the times, [which] would be the normal reaction. Today, 'Weren't you worried about infection?'* (CF.6, 1970s)

*I did bring it up [co-feeding] at my Australian Breastfeeding Association meeting. They were fine. They were pretty open-minded. A few had first- or second-hand knowledge of it - some of them, their Mums had cross-fed.* (CF.44, 2001-02)

Another respondent with a new baby, who had previously reciprocally shared breastfeeding with her sister, donated EBM in 2007 after an appeal on an ABA email list for breastmilk for newborn twins (CF.23).

The attitudes of medical doctors, as reported by the respondents, were generally positive. Several of the respondents were medical doctors or had shared breastfeeding or EBM with someone who was. One mother, a health professional herself, had a positive reaction from her baby's neonatologist, about her use of informally donated EBM. She wrote:

*'He was extremely positive about it. Said it was a fantastic thing and more women should be doing it'* (CF.7, 2007).

Mothers who had co-fed, but whose babies had not to their knowledge been breastfed by someone else, were asked how they would feel if their babies had been the recipients, to ascertain if there were differences in perception. Some were uncomfortable with the idea, and some were surprised at their reaction to the question.

### **The child's behaviour**

The mothers' recall of the ages of the babies during the time when they were sharing breastfeeding was unreliable, especially where it was ongoing, and so the data does not permit the children's reactions to be associated with specific ages. In general, however, the babies took little notice of the different source of milk if they were very young, though some of the older ones noticed.

*Not with a very young child. An older child, if for comfort they sort of know it's not their Mum.* (CF.17, 2007)

*Was hungry so had booby, I think too young to know the difference.* (CF.30, 1988)

*At the time [son] was young enough to accept it (or not notice it) and not feel jealous of me feeding another baby. There were some days when I would spend almost the whole afternoon going from one room to the other settling and feeding the two babies. I felt like a real wet nurse!* (CF.35, 2006)

*My baby doesn't bat an eyelid. [Friend's] baby will feed from me, but he seems aware of it. He'll feed from me, [but] he watches me all the time.* (CF. 16, 2007)

Some mothers mentioned that they or a sister breastfed the two babies at the same time, concurrently, like twins.

*Both babies accepted feeding from their aunts. They were even tandem fed by my sister once or twice when I was out working. I was told my son thought it hilarious, but it worked. They both fell asleep, [my son] laughing into the eyes of his cousin opposite on his aunty's chest.* (CF.35, 2006)

Differences in age accentuated differences in behaviour towards a different breast,

*[Sister's babies] looked up and went, 'Oh, that's the wrong person.' But then they'd go back to feeding.* (CF.6, 1980s)

*[Nephew] initiated cross-feeding. Any passing boob will do. My daughter, not very willing. More boobs specific than he.* (CF.19, 2006)

*It's quite funny, sometimes they pull faces as if to say 'that's not my boob!' especially the older babies, but then most of them go 'oh well', and drink anyway.* (CF.22, 2007)

and sometimes the weaning of one child would create new issues.

*They are like twins. We were living in the same house at the time, and therefore had to wean at the same time! [Nephew] at five months would have a look, but would decide it was food. I had to eat a similar diet [to my sister's] while breastfeeding.* (CF.33, 1994)

*My own son wasn't impressed that I fed another child. He was a little jealous and three and about to give up the breast. This possibly encouraged him to feed a little longer.* (CF.34, 2000s)

An occasional baby or toddler breastfed from an aunt while the baby's own mother was in the room.

*My nephew would sit up, look at his Mum, and then go back to feeding - as if to say, 'Hey, look, it comes from two places.'* (CF.19, 2006)



*[My baby] thought it was quite a novelty. [My sister's] girl was very glad as she was upset as her mother wasn't there. She [also] asked for [my breast] when her mother was there but then didn't want it. (CF:32, 2006–07)*

Only two babies refused to accept a breast that was not the mother's and objected strongly. One respondent, who a generation ago breastfed the baby of a friend who was working, recalled: 'I had to have a towel over my face so he wouldn't recognise me and would latch on' (CF:2). In the other case, the other baby objected vocally, but was able to be persuaded.

## DISCUSSION

The respondents self-referred to enter the study and were found largely through email lists or by word of mouth through networks such as ABA and JoyousBirth, groups which attract middle-class mothers with a strong interest in breastfeeding. Because of their focus on breastfeeding as a natural part of life, some mothers in these groups are likely to have a greater interest in less usual breastfeeding practices, such as co-feeding, than the general population. Consequently, a weakness of this study is that it is not representative of the population as a whole. However, after recruitment for this study was completed, personal communication with a number of women from various other contexts revealed that they, too, had encountered the sharing of breastfeeding or EBM among their own close associates. The reluctance of Australian and New Zealand women to disclose their co-feeding, as reported by Long (2003) and Shaw (2004, 2005), suggests recruitment of co-feeders from the general population would have been more difficult. Even amongst mothers recruited from ABA networks, a few needed to overcome their initial embarrassment before providing information.

This study provides insights into what mothers actually do. The author makes no recommendations, but hopes this material will inform future policies and revisions of existing policies of non-government organisations and public health authorities.

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**Editor's note:** The Australian Breastfeeding Association has no specific ABA policy on co-feeding but *The Policy Statement on Breastfeeding* (Counsellor Manual 2006) states, when discussing human milk banking,

*In circumstances where a mother is not able to provide milk for her child, ... human milk from another woman is the next best alternative. Therefore, ABA supports and encourages the establishment of human milk banks ...*

The Australian Breastfeeding Association also acknowledges that sister/cross-nursing is a traditional practice in some cultures and societies, and is also practiced occasionally within Western society, where the mothers give full consent.

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