The first time you ever breastfeed.

Let's imagine baby is due imminently. You've probably talked quite a lot about your birth. You have a birth plan. You have some ideas of what you are aiming for.

Now let's take a few moments to imagine the very first breastfeed.

Perhaps you've already had a breastfeeding class. Perhaps you already know about things like skinto-skin and feeding in the first hour. I hope so. Maybe you've even written a birth plan or spend time visualising your first breastfeed. When you've finished reading this, close your eyes and so some imagining. Can you really know what it will feel like? Not really. The same is true of birth. Doesn't stop us talking about preparing about our birth for hours and hours though! I think we're entitled to some hypno-breastfeeding or talking through the first breastfeeding with our partner.

After you've given birth, the ideal is that baby is placed on your tummy (or higher if the umbilical cord lets them get that far). The baby isn't washed or separated from you unless absolutely necessary. Sometimes we then let the baby perform a 'breast crawl'. The newborn has an incredible ability to find the breast and latch on all by themselves. They literally scoot up the mother's body and are guided by smell and primitive vision and find what they need. These instincts might be affected if they had had any intervention or were dealing with medication in their system. Spend some time on YouTube watching breast crawl videos and I defy you not the utter the occasional 'Whoah!' http://www.youtube.com/results?search_query=breast%20crawl&sm=3

Send some breast crawl videos to your partner at work and I guarantee the chances of a 'Whoah!' or 'That's coooool!' text are high.

Whether we let baby do their thing, or whether we give them a helping hand, we would aim to have some skin-to-skin as early as possible and plan to try to do the first feed within the first hour after birth. After that babies seem less alert and may want to sleep for a block of time. It's a good chance for us to sleep too. That first feed can happen in a hospital bed, in a birthing pool, in the recovery room after a C-section, on a sofa after a home birth.

What should that first feed look like? There are lots of ways to position a baby at the breast and there isn't one correction position. You certainly don't have to sit up straight to allow the milk to flow and in fact some early breastfeeding is best done lying down or reclining. Have a look at www.biological nurturing.com for some ideas.

There are some key principles though. Your baby will need to open their mouth wide –'the gape'. They need to take a big mouthful of breast and not just to perch on the nipple with pursed lips. The big mouthful of breast gives their tongue a chance to scoop a big chunk of you towards the back of their mouth and get your nipple past their hard palate.

Feel the roof of your own mouth with your tongue. If breastfeeding is going right, the end of your nipple will sit in the soft palate on the roof of the mouth and just beyond the junction of the hard and soft palate. If it's going wrong, your nipple will rub against the hard palate and will get sore. If a nipple comes out looking compressed/ squashed/ with a white line across it/ tapered at the end like an old lipstick – that's a clue it's been pressed against the hard palate and something is going wrong.

Your baby needs a big mouthful and ideally more of a mouthful below the nipple than above. We ideally don't want the nipple to enter the mouth centrally but asymmetrically – nearer the roof of the mouth. Picture that nipple heading where we want it to go – towards the junction of the hard and soft palate. You might think, but if I put the nipple nearer the top half of the mouth how will it go back far enough? Won't it get jammed on the roof of the baby's mouth. Nope. The key thing is giving the tongue as much space on the breast as possible. Then it can scoop as much breast as possible. The nipple will actually be stretched to two-and-a-half to three times its natural length when feeding. It will be extended by that tongue scoop and negative pressure created by the suck.

So we need the big gape. But there's no point in having a big gape if other things aren't right too. The baby's chin needs to be making contact with the breast and even more than that – usually pressed into the breast a little. This means that the baby's head will probably be slightly tilted. When you are taking a big bite out of an apple or a burger, you'll usually lead with the chin. Usually the chin makes contact first with the breast. The nose will probably only rest very lightly on the breast or may not even touch at all. Some women with very large soft breasts find that the baby's nose is slightly buried in too – don't panic. Baby nostrils are very clever. They are designed to leave little air gaps around the corners even when the nose is making complete contact. You do not need to push your fingers into the breast to move the breast away so they can breathe. That's a great way to get blocked milk ducts. Many of our ducts are quite close to the surface of the skin and pushing into the breast with a finger is enough to prevent flow. Try first encouraging your baby's chin to tilt more into the breast. If the baby's nose is still buried, it might just be about the consistency of your breast. The baby will prioritise breathing and come off if there's a problem. That's one reason we don't hold the baby on the back of their head or put pressure on the back of their head – we need to give them the freedom to be able to come off. Holding the back of the baby's head firmly to push them onto the breast can repress the sucking instinct and cause a baby to become quite distressed.

The baby's bottom lip with ideally be a bit flanged out. A bit like a fish lip. This gives the tongue more chance of being where it needs to be – over the gum ridge and scooping breast tissue. If the lip is tucked back, the tongue is probably not far out enough. The top lip doesn't need to be flanged out. In fact if the top lip is, that can be an indication the gape isn't wide enough. However here's a thing – once the baby is on the breast and feeding we can't check lips and latch anymore. If a baby is positioned properly we probably can't even SEE the lips and the cheeks are hiding them by making close contact with the breast. If you can see lips or see breast tissue moving in and out of lips, your baby probably doesn't enough breast in their mouth. Be a bit wary if someone wants to check your latch by pulling at your breast or pulling baby's cheeks. Best to check latch by watching as the baby goes onto the breast, watching how they naturally feed and looking at the shape of the nipple once it comes out of the baby's mouth.

So we've got the big gape.

The more-of-a-mouthful-below-the-nipple.

The chin contact and chin driving into the breast with a head tilt.

The baby's body should also be in a line. That's to say ear, shoulder, hip all facing the same way. Try drinking a glass of water with your neck twisted to one side.

Baby will also be close and tight to your body if we've got a hope of getting that chin close enough.

What's happening with their hands? In the early days, hands can seem a little inconvenient. However they are an important part of a baby's sensory tools so we try and avoid swaddling when breastfeeding and soon the hands will be your friends. Ideally a baby won't be wearing any clothing at all or be wrapped in anything when they have that first feed. You might have a sheet or blanket lightly around both of you. In the early days, if a baby can't get their face to the breast, they'll try and get there with their hands. We don't want the hands to end up on the baby's chest or tucked at their neck as this will push their upper chest away from you which pushes the chin away which means a shallower latch. Baby's hands shouldn't be between your bodies. We also don't want bulky clothing between you or bras containing breast pads squashed between you. One of the reasons skin-to-skin is so great for breastfeeding is you don't have to deal with all the unhelpful fabric in the way!

What about holding your breast? Hmmm. Be careful about this. A leading cause of nipple soreness and damage is a mum holding her breast and 'offering' it towards the baby or 'putting it in'. Nooooo. The breast is then going to slip subsequently and probably end up on the hard palate again. And holding breasts is a great way to end up with those blocked ducts again. Not to mention the fact that you'll be doing this breastfeeding lark for a lot of hours and you're going to appreciate having a hand free. Be wary of anything who tries to 'help you out' by holding your breast or touching your baby. None of that should be needed.

There's a phrase we use a lot: "baby to breast". That means that the baby moves TO YOU. You don't move to the baby. Find yourself a comfortable position with good back support and the baby moves to you. If you lean forward, push the breast about, lift the breast up, you are risking problems. If you don't feel you can move the baby towards the breast, check how you are holding them. Perhaps you're holding them just around the head and it feels a bit like your yanking them from the ears? Look at placing more of their body on your arm if you're using the cross-cradle or cradle hold. If you feel the need to lift the breast, are you using a breastfeeding cushion/ pillow that's too high? We all have a different amount of space between our lap and our breasts. Breastfeeding cushions perpetuate a myth that we're all roughly the same shape. For some women, a commercial breastfeeding pillow will be far too high. Their breasts hang such that the baby need only rest on their lap. For some people, it's far too low. If we lean back slightly, the baby's weight will be resting on our torso and we should not need a cushion at all. Also look at the angle of our nipples. Some of us have nipples that come out at right angles from our body. So baby will come onto our body at a right angle. A lot of us have nipples that point down slightly, so baby will need to come slightly up from under the breast to make sure both cheeks are making contact with their breast. They will be looking slightly up towards our shoulder, rather than towards the middle of our backs. If we put that baby to the slightly drooping breast at a right angle, their bottom cheek wouldn't be making contact and some breast tissue on the lower side wouldn't be far back enough in the baby's mouth. Try and breastfeed with your breasts in their natural shape and things will be a lot easier.

So:

Big wide gape with bottom lip out like a fish lip.

The more-of-a-mouthful-below-the-nipple.

The chin contacts on the breast and chin driving into the breast with a head tilt.

Baby's body close and tight to yours.

The baby's body should be in a line. : Ear/ shoulder/ hip

Baby to breast, not you leaning forward and 'offering'

Breast in its natural shape wherever possible

Both cheeks touching breast. Lips not even visible.

Mum comfortable.

That's too many things to make a clever mnemonic out of. BMCLBNCC?

What will it feel like?

It feels like a teeny being sucking your nipple to about 3 times its natural length and then massaging your breast with its tongue while creating a vacuum and wiggling its chin up and down.

However that doesn't quite capture the magic.

It feels exciting and important. It feels like this tiny person is connected to you in ways you couldn't quite imagine. Oxytocin hormone is flying everywhere and you feel quite blissful. Some people say powerful. Perhaps a bit tired too. Exhilarated and peaceful – you can be both of those things at once. The beginning of a really important journey. Perhaps the most valuable journey of your life.

Article written by IBCLC and ABM BFC Emma Pickett