Sharing breastmilk: wet nursing, cross-feeding, and milk donations.

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ABSTRACT
Wet nursing and cross-feeding both involve the breastfeeding of a child by someone other than the mother. Wet nursing involves a woman who is not the social equal of the employer, is never reciprocal, and is normally for payment. Cross-feeding (also ‘cross-nursing’) is the informal sharing of breastfeeding between equals, and is usually unpaid and may be reciprocal. Community attitudes in the late-20th and early-21st centuries are distrustful of this practice, though satisfaction is reported by the women involved in sharing breastfeeding. Community unease has included feelings of revulsion, rationalized by concern about the transmission of infections. Yet recently there have been sporadic feature articles in the print media reporting instances of, and opinions, on these practices. This review article explores the sharing of breastfeeding, principally in Australia, and provides an historical context for concerns about transmission of infection. These issues will also be discussed in relation to human milk banking.

Keywords: breastfeeding, cross-nursing, human milk banking, wet nursing

INTRODUCTION
Recently there have been sporadic media reports in developed countries that suggest breastfeeding by someone other than the biological mother is becoming more ‘popular’ (Kwan 2007; Lee-St John 2007). In April 2007 the topic was also raised on television on The Today Show (USA) (NBC 2007) and the syndicated Dr Phil Show (USA) (McGraw 2007), in the latter case entirely negatively. Although the sharing of breastfeeding was practiced through the twentieth century (Groskop 2007; Thorley 2007) as it has been for millennia, it was generally done as a covert activity rather than openly. As such, there are no prevalence data for comparison to see if this practice is, indeed, growing in popularity. It is also doubtful if the recent reporting of it, particularly of individual celebrity cases, constitutes growing ‘popularity’. Indeed, as a human-interest article in the Guardian in 2007 noted, in Britain the practice had become socially unacceptable, except in some circles where friends baby-sat for each other and breastfed the babies, with maternal consent (Groskop 2007). An article published in Canada’s Toronto Star in 2005 on cross-feeding, as this practice is called, also reflected that these are very much minority activities, though a later article claimed the practice had ‘gone mainstream’ (Gordon 2007; Pratt 2005). The Washington Post also carried an in-depth report on the sharing of breastmilk and the issues involved (Henry 2007), issues also covered by Canada’s Globe and Mail (Pearce 2007). These media reports described mothers’ largely positive experiences, raised concerns about health screening and intrusion into the unique mother-infant relationship, and quoted opinions ranging from satisfaction to disgust. Due to such recent interest in the media, this article will provide an overview of the various modes of breastmilk sharing in modern Australia, placing them within a historical and international context.

DEFINITIONS
The sharing of breastmilk has taken many forms across time and continues to do so. Wet nursing is a historically familiar concept, where the wet nurse’s own baby may, or may not, be present and the arrangement is not reciprocal. Today in developed countries wet nursing is rare, though it is recommended by the World Health Organization (WHO) as preferable to artificial feeding if maternal breastfeeding is not possible (WHO 2003). However, cross-nursing or cross-feeding, the informal practice of sharing breastfeeding among equals, such as sisters or friends, continues today and is often reciprocal. Some personal accounts mistakenly call this informal practice ‘wet-nursing’ rather than the less widely known, but preferred term ‘cross-feeding’. A third form of milk...
sharing, the banking of donated human milk, to be fed to babies by bottle, has usually been based in an institution, even if the donor mothers live in the community.

The primary sources used in research for this article include: Australian advertisements for wet nurses; books of advice on household management; medical journal articles; and articles in the popular print media that either provided authoritative advice or reflected practices and attitudes. While the focus of this article is primarily Australian, this discussion is set within a broader context.

HISTORICAL PERSPECTIVE

Wet nursing

Since time immemorial families and institutions have hired wet nurses to breastfeed infants who have lost their mothers or whose mothers were not breastfeeding them for whatever reason. A fourth-century text by Oribasius repeated advice from earlier texts from the Hippocratic, Greek and Roman traditions, some of which are no longer extant, and synthesised this information with his own ideas (Lascaratos & Poulakou-Rebelakou 2003). The wet nurses of antiquity were usually women of a lower social class than the employer and the wet nurse was well paid or, in the case of a slave hired out as a wet nurse, her owner was paid (Fildes 1988). According to Fildes, lower-class freewomen were sometimes employed as wet-nurses for slave children, who were regarded as a valuable commodity for the slave master to rear.

The focus in wet nursing was primarily on the baby to be nourished, rather than on the wet nurse’s child, or even on the wet nurse herself, other than as a provider of a valued commodity (Featherstone 2002). Because of this focus on preserving the life and health of the baby to be breastfed by the nurse, regulations or laws were drawn up by a number of cultures to prevent women hiring themselves out as wet nurses if they had inadequate milk supplies, were unhealthy, or had become pregnant. Among the regulations that have survived are a number cited by Fildes from Hammurabi’s Babylon in c.1720–1686 BC and from Greece and Rome in the period 200 BC–200 AD (Fildes 1988). Recommendations for selecting a wet nurse have invariably included requirements that enable the employer or a physician to identify a woman with an inadequate milk supply or obvious signs of tuberculosis, syphilis or other health concerns (Anon 1916; Anon 1930; Cadogan 1748; James 1923; Kocturk 2003; Phaire 1545; WHO 1956).

In her research into the situation of poor mothers in Melbourne in the second half of the 19th century, Swain (2005) has described how the care of the babies of desperately poor single women involved a continuum that included wet nursing, baby-farming (sometimes a loosely-used term) and institutional care. Local midwives often acted as intermediaries to find a wet nurse or care-giver for a baby whose mother needed to work. Some women from poor streets themselves earned a living by breastfeeding the babies of others; other women boarded several babies for a low fee and artificially-fed them. Artificial feeding in these circumstances was unsafe and these babies were not expected to survive (Swain 2005). Although in other circumstances the focus was on the child, the authorities in Melbourne at this time seemed to regard the children of poor, desperate women as commodities, failing to remove them from nurses or care-givers who were neglectful (Swain 2005).

Wet nursing declined in developed countries in the last quarter of the 19th century, with the increasing use of bottle-feeding of either home-modified cow’s milk or commercial substitutes for breastfeeding (‘patent foods’). Indeed, Levin (1963) referred to the use of the feeding bottle during this period as the ‘pocket wet nurse’. After the first years of the early 20th century, in Australia as well as in other Western countries, obtaining a wet nurse became difficult (Anon. 1930; Thorley 2007; Turner 1926), although some household advice books continued to recommend them (Anon. 1916; James 1923).

The long-term effects of loss and grief felt by historically prominent persons after the departure of a wet-nurse or other non-parental care-giver in early childhood has been described (Díaz de Chumaceira 2006). It is reasonable to presume similar emotions were felt by ordinary individuals on separation from a long-term wet nurse; however, there is no evidence that wet nursing in early-20th century Australia extended beyond the early months.

Cross-feeding

The informal sharing of breastfeeding between women well-known to each other has probably always existed in Australia, including in indigenous cultures (Berndt C. c.1968, personal communication; Hitchcock 1990; Thorley 2000). Anecdotally, the sharing of breastfeeding also occurs within lesbian couples where both partners have babies. Even when only one has given birth, a sensitive health professional may ask whether both partners plan to breastfeed and provide support if this is their choice (Spidsberg 2007).

In Islamic cultures there is a religious requirement that, when a child receives the milk of someone other than the biological mother, the mothers concerned must be known to each other. This requirement is because the children who receive the milk of the same mother become milk siblings and are forbidden to marry each other (Gatrad 1994). Hence it is possible for women within the same family, or close friends, to breastfeed each other’s children and the practice has been common in the past (Al-Naqeeb et al 2000). There has to date been no study of cross-feeding in Muslim families within Australia. These religious requirements have made it difficult to conduct human milk banking in Islamic countries, and milk banking procedures that pool human milk cannot be adopted. However, milk banking was achieved for premature infants in a hospital in Kuwait, in the late-1990s, with the religious requirements acceptably met (Al-Naqeeb et al 2000). That is, the mothers were required to meet so that the donor and the mothers of the recipient infants knew each other, and the religious obligations were explained to them.
DISCUSSION

Cross-feeding
There is only sporadic written evidence of cross-feeding in 20th century Australia, most likely because this was usually an informal arrangement and partly because of unfavourable attitudes in the general community, at least late in the century (Shaw 2004). In the absence of professional wet nurses for hire, public health authorities sometimes recommended the use of an informal arrangement within the family (Anon. 1930; Turner 1926). Thorley (2000) reported two examples of cross-feeding in Queensland in the 1940–1960 period: in one consent had not been obtained from the baby’s mother, who still felt outrage decades later; the other was a consensual arrangement between two close friends. Shaw (2004, 2005) has also pointed out the importance of consent. There were only isolated mentions of cross-feeding in publications of the Australian Breastfeeding Association (formerly the Nursing Mothers’ Association of Australia, or NMAA) in the 1970s and 1980s, mainly in the context of borrowing a friend’s baby to stimulate the milk supply in an adoptive mother or when re-establishing lactation after weaning (Herman 1974; Phillips & Hapke 1971). Later, a collection of members’ experiences of the informal sharing of breastfeeding was published in the NMAA Newsletter (NMAA 1994). These and other reports of the sharing of breastfeeding among sisters or close friends, where consent was given, suggest that women felt satisfaction from sharing this very feminine activity with women in their close circle (Groskop 2007; Pratt 2005; Thorley 2000). However, La Leche League International (LLL) does not support the practice and encourages the mother to put her own baby’s needs first. If she wishes to donate her milk, LLL discourages informal sharing, instead recommending contact with a registered milk bank which carefully screens donors (LLL c.2007).

Wet-nursing
Sporadic accounts of wet nursing, as employment, have appeared in newspapers in Australia in the 1980s and the United States and China in 2006–2007, leading to the mistaken impression that it was becoming popular. In an Australian case in the 1980s, a Perth mother advertised for a wet nurse to nourish her baby on days when she was attending university classes; because such advertisements were unusual, it was reported in the news section of the paper (Giles 2003). There was debate in the Chinese English-language media on the ethics of selling milk when an agency for housekeeping services in Shenzhen in southern China established a wet nurse service (Kwan 2007). The well-paid wet nurses were provided with dormitory accommodation and uniforms. Reports in Time magazine in 2007, as well as in the electronic media, reacted to a renewed public interest in wet nursing the United States, where Certified Household Staffing, an agency that provides domestic workers to the affluent, also advertises that it can provide wet nurses (Certified Household Staffing nd; Lee-St John 2007). The Los-Angeles-based agency was mentioned in media reports because this nation-wide service was unusual. Users of the service have included affluent women who had undergone breast surgery or who had high-powered careers.

Health questions and community perceptions
Nineteenth century and early-20th century concerns about transmission of infection from the wet nurse to the baby were focused on syphilis and tuberculosis. From 1906, the Wasserman test for syphilis was available. Since most of the attention given to wet nursing was placed on the employer’s baby, there was little attention given to the possibility of the wet nurse being infected by the baby, except for a sporadic correspondence in the Lancet in the 1840s and early-1850s (Lancet 1835–1860). The medical men of the time disagreed on whether a baby with congenital syphilis could infect the wet nurse via facial chancres; in fact, this can happen (WHO 1956). Syphilis was not unusual among the poor and babies were dying of congenital syphilis in inner Melbourne in the late-nineteenth century (Swain 2005).

Advertisements seeking wet nurses in early-20th century Australia sometimes used words such as ‘healthy’ or used a doctor as an intermediary, although some families were so desperate for a wet nurse that they stressed urgency, rather than health. Some examples of classified advertisements from the ‘Situations Vacant’ columns of the Melbourne newspaper, the Age, follow. Similar advertisements could not be found under any employment heading in the Sydney Morning Herald or the Brisbane Courier of the same period, despite a careful search.

WETNURSE, young, healthy. Early, Overdale, Spring Vale. (Age, 26 Nov 1902, p 9)

WETNURSE, infant under 3 months. Between 9, 11 am, or 1.30, 2.30 pm, Dr Lillies, High-st, Armadale. (Age, 1 Dec 1902, p 9)

WETNURSE, experienced. Call Dr A Davenport High-st, St Kilda, between 2 and 3 this afternoon. (Age, 20 May 1905, p 6)

WETNURSE, at once. After 10 o’clock, A.M, 63 Kerr-st, Fitzroy. (Age, 8 July 1907, p 12)

Institutions such as the Neglected Children’s Home in the suburb of Brunswick also advertised repeatedly for wet nurses during this period. Advertisements in the ‘Situations Wanted’ column were less frequent but as these women had a service to sell, they emphasised their suitability, commonly stating they had medical references. Occasionally, the wet nurse offered to board the baby, as in the last example.

WETNURSE, young, healthy, wants engagement, doctor’s references. By letter or personally, 2 Lennox-st, N. Richmond. (Age, 22 June 1907, p 8)
WETNURSE, young married woman, doctors’ references exchanged, dark boy preferred. [name illegible] S. Melb. (Age, 29 June 1907, p 8)

WETNURSE, milk three weeks old, would take baby; doctor recommends mother. (Age, 6 July 1907, p 8, repeated on 8–9 July 1907)

Advice books and public health sources emphasized health among the selection criteria for a wet nurse. A 1916 household guide published in Western Australia recommended the employment of a wet nurse, provided she had been examined by ‘a medical man’ (Anon. 1916). A 1923 home nursing handbook for mothers, published in Victoria, considered that hiring a wet nurse was ‘next best’ where a mother was not breastfeeding, and specified the nurse must have a good constitution, be healthy and in the middle range of ages (James 1923). An article on premature infants provided to the Brisbane Courier by the Queensland Baby Clinics in 1930, recommended a cross-feeding arrangement with a family member be tried, if the mother did not produce enough milk, since wet nurses were no longer to be found (Anon. 1930). If there were any doubt about the source of the breastmilk, the article recommended that the milk be boiled until the donor could have a medical examination and ‘a test’, which was presumably the Wasserman test for syphilis.

In the 1970s, screening procedures for donated human milk focused on bacterial infections such as Staphylococcus aureus and Haemolytic streptococci (NMAA 1977). From the 1980s, health concerns about sharing bodily fluids shifted to the potential for transmission of the human immunodeficiency virus (HIV) and hepatitis C. The HIV/AIDS panic is largely why, during the 1980s, the pooling of human milk in Australian maternity hospitals ceased, despite the fact that Holder pasteurisation at 62.5º C for 30 minutes destroys the HIV virus.

Human milk banking
For many years previously, mothers in maternity hospitals had been encouraged to express their breastmilk after feeding their infants, and this milk was pooled for topping up their own babies or given to premature or sick infants (Thorley 2000). From the early-1960s, milk kitchens funded by commercial interests for the preparation of artificial feeds were beginning to replace the use of pooled human milk in the large Brisbane Women’s Hospital (Patrick 1988). However, breastmilk from the maternity wards was still being used for sick or premature infants in the early-1970s and beyond in some Australian hospitals (Harmer 1974).

The response to the HIV epidemic was the cessation of collecting and pooling expressed breastmilk in maternity wards, and the closure also of the unique community-based human milk bank at the Townsville General Hospital. This milk bank was housed in the paediatric ward, not the maternity section, and dispensed expressed breastmilk collected from mothers in the community (Beal et al 1978). Only recently has human milk banking resumed in Australia, with two pilot milk banks on the Gold Coast in Queensland, and in Perth (Brophy 2006; Mothers Milk Bank 2007). Both follow rigorous screening procedures for donors (similar to those for blood banks) and provide pasteurized human milk to the recipient babies.

The potential for cross-infection, along with community feelings that putting a baby to another mother’s breast was distasteful and perhaps even a form of child abuse, was apparent in discourses on sharing breastfeeding in the late-20th and early-21st centuries (Lee-St John 2007; Long 2003; Shaw 2004). Through the 1990s and early 2000s, sporadic media reports of outraged mothers whose newborns had been mistakenly put to the breasts of other mothers reinforced the idea that, while maternal breastfeeding was advisable, breastfeeding by someone else was unacceptable. By this period, mothers of babies breastfed by the wrong mother in the hospital were concerned about the theoretical risk of transmission of HIV or hepatitis C, rather than the previous health concerns.

CONCLUSION
This historical review has explored the cultural attitudes and health implications surrounding wet nursing and cross-feeding. Cross-feeding, in particular, continues to occur in the community although the mother may not raise the subject with health professionals with whom she comes in contact. Nevertheless, if the subject is raised, an understanding of the issues will help the maternal child health nurse, the IBCLC lactation consultant or the breastfeeding counsellor to work in partnership with the mothers involved to provide non-judgmental and confidential guidance.

Competing Interests: None. No funding for this or any previous study has been accepted by the author from the manufacturers and distributors of artificial baby milk, bottles or teats. A Graduate School Research Travel Grant was received from the University of Queensland in 2005.

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