

HEALTH PROFESSIONALS' GUIDE TO: "CARING FOR YOUR BABY AT NIGHT"

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**CARING FOR YOUR
BABY AT NIGHT**



A guide for parents



INTRODUCTION

This booklet is designed to provide some background for health professionals who are using the parents' leaflet Caring for your baby at night. It will set out the text of each page of the parents' leaflet and then provide the corresponding (referenced) text for health professionals.

PARENTS' TEXT PAGES 2-4: CARING FOR YOUR BABY AT NIGHT AND GETTING SOME REST

CARING FOR YOUR BABY AT NIGHT

Becoming a parent is a very special time. Getting to know your new baby and learning how to care for her needs can be one of the most rewarding experiences of your life. However, it can also be challenging, especially when you are tired and your baby is wakeful and wanting to feed frequently during the night.

It might be reassuring to know that it is both normal and essential for your baby to feed during the night. Babies grow quickly in the early weeks and months of their lives and have very small stomachs. Therefore they need to feed around the clock to meet their needs.

While it can be frustrating when your sleep is disturbed during the night, it can also be a lovely quiet time to be with your baby away from the bustle and distractions of daytime. Babies rely on the security and comfort of being close to their parents and need this at night as well as during the day.

GETTING SOME REST

It's important to make sure you create the right environment to help you get as much rest as possible.

Keep the room fairly dark – switching on the light wakes everyone up and is not usually needed when you are feeding and comforting your baby.

“ I try to keep the room cosy and peaceful at night. ”



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Keep your baby close. The safest place for your baby to sleep is in a cot by the side of your bed. This means you can hear your baby and respond to her needs before she starts crying or becoming distressed, and reach her easily without having to get up.

EARLY FEEDING CUES

- sucking fingers
- restlessness
- murmuring sounds

Try not to stimulate your baby too much. As soon as she starts waking, offer her a feed so she doesn't get too upset and difficult to settle. Talk to her in a soft, quiet voice and avoid changing her nappy or clothing unless really necessary.



HEALTH PROFESSIONALS' GUIDE PAGES 2-4: CARING FOR YOUR BABY AT NIGHT AND GETTING SOME REST

Most young babies wake and feed frequently both day and night, regardless of whether they are breastfed or bottle fed. Parents need to know that this is normal behaviour, and not something that they should try and prevent.

It is important to take time to have a sensitive, empathetic conversation about how hard it can be to have broken sleep, whilst also providing information and tips to help parents cope. This can also be a good time to discuss how the night can be a special time for parents and their baby to have some quiet time together; you can introduce how these interactions will have a positive impact on the baby's brain development, making them feel safe and secure.

Find out more in our Building a Happy Baby Leaflet: [unicef.uk/happybaby](https://www.unicef.uk/happybaby).

However, this broken sleep means that tired parents can often fall asleep with their baby, especially at night, whatever their intention.

Therefore parents require full information regarding the various strategies for coping with their baby at night, along with the benefits and risks of all approaches such as bed-sharing, in order to allow for informed decision-making.

Minimal disturbance of a baby who has wakened only to be fed may result in the baby settling more quickly after the feed. During night feeds keeping the lights dimmed, minimising noise, speaking quietly and avoiding stimulating play will help the baby to begin to adapt to differences between day and night.¹

All parents should be advised to keep their baby in their bedroom at night for at least the first six months, regardless of how the baby is fed. Having the baby sleep in a separate room to the mother is an established risk factor for Sudden Infant Death Syndrome (SIDS).^{2,3}

"The safest place for your baby to sleep is in a cot by the side of your bed." The cot has to conform to British Safety Standards, whilst most other sleeping surfaces do not. Placing the cot at the side of the parental bed provides a safe environment whilst maintaining close observation of the baby.

Again, regardless of how the baby is fed, keeping the baby close should mean that the mother is able to respond to early feeding cues (restlessness, murmuring sounds, finger sucking) before baby wakes fully and begins to cry.

¹ Sleep J, Gillham P, St James-Roberts I, Morris S. 2002 A randomized controlled trial to compare alternative strategies for preventing infant crying and sleep problems in the first 12 weeks: the COSI study. *Primary Health Care Research & Development* (2002), 3: 176-183 Cambridge University Press.

² Carpenter RG, Irgens LM, Blair PS, England PD, Fleming P, Huber J, Jorch G, Schreuder P. Sudden unexplained infant death in 20 regions in Europe: case control study. *Lancet*. 2004 Jan 17; 363(9404):185-91.

³ Blair PS, Platt MW, Smith IJ, Fleming PJ; CESDI SUDI Research Group. Sudden infant death syndrome and sleeping position in pre-term and low birth weight infants: an opportunity for targeted intervention. *Arch Dis Child*. 2006 Feb;91(2):101-6.

BREASTFEEDING

Many women choose to feed their baby whilst lying in bed. Ask your midwife or health visitor to help you find a safe and comfortable position and also see the safety information on page 9.



TIPS FOR PARTNERS

- Make sure your breastfeeding partner is comfortable.
- Pass her things, so she doesn't have to reach for them.
- Bring her drinks and snacks and make sure that she has a glass of water at hand as breastfeeding can be thirsty work.
- Give plenty of support – breastfeeding is important for your baby's and your partner's health.

HEALTH PROFESSIONALS' GUIDE PAGE 5: BREASTFEEDING

Frequent night feeds

Breastfeeding mothers will inevitably be responsible for the night feeds, and each baby will develop their own individual pattern. It is important to remember that once lactation is established, night feeds provide babies with a substantial proportion of their 24-hour intake, and the majority of babies continue to breastfeed between one and three times a night for the first six months of life.¹

One reason for this may be the milk's relatively low protein content. Mature human milk has the lowest protein concentration among mammals.² These protein levels are designed to ensure optimal growth for human babies, but may result in them feeding more frequently. They also lead to an appropriately low solute load for the infant's immature kidneys. It has been established that a higher protein content in infant formula is associated with higher weight in the first two years of life, although there is no evidence that growth is affected in terms of length or height.³

Amount of sleep

It is often assumed that mothers who formula feed their infants get more sleep since they can share feeding duties with their partner, and function better in the day time as a result. However, despite several studies, there is still no evidence to indicate any benefit of formula feeding on maternal sleep, either exclusively or in combination with breastfeeding, by comparison with exclusive breastfeeding.⁴ The hormones responsible for milk production also have a soporific effect on mothers, helping them fall back to sleep more easily.

Feeding position

Lying in bed to feed the baby is the easiest and most comfortable position in which to feed at night. It allows the mother to continue to rest, as she does not have to support the weight of her baby whilst feeding. The safest position for the mother to adopt, so that she does not roll forwards or backwards, is also the protective position that most breastfeeding mothers seem to adopt instinctively. A variation of the "recovery" position, mothers have been repeatedly observed to lie on their side, with their knees bent, their lower arm above the baby's head and the baby about 20-30cms from her chest. This was first described by Ball⁵ and is often referred to by health professionals as the "C" position.

¹ Kent JC, Mitoulas LR, Cregan MD, Ramsay DT, Doherty DA and Hartmann PE. 2006. Volume and Frequency of Breastfeeding and Fat Content of Breast Milk Throughout the Day. *Pediatrics* 2006; 117: e387-e395.

² Akre J. 1989 (Ed). WHO Bulletin Supplement Vol. 67. Infant Feeding - the Physiological basis. Chapter 2 - Lactation. p23.

³ Koletzko B, Baker S, Cleghorn G, Fagundes U et al (2005). Global standard for the composition of infant formula: Recommendations of an ESPGHAN coordinated International Expert Group. *Journal of Pediatric Gastroenterology*, 41, 584-599.

⁴ Montgomery-Downs H, Clawges H, Santy E. 2010. Infant Feeding Methods and Maternal Sleep and Daytime Functioning. *Pediatrics* Vol. 126 No. 6 December 2010, pp. e1562-e1568 (doi:10.1542/peds.2010-1269).

⁵ Ball H 2006. Parent-Infant Bed-sharing Behavior: effects of feeding type, and presence of father. *Human Nature: an interdisciplinary biosocial perspective* 17(3): 301-318.

BOTTLE FEEDING

It is important to be organised in order to reduce disturbance when bottle-feeding at night. Powdered milk is not sterile and can cause infections if made up in advance. Therefore you will need to make up feeds during the night. However, you can make this easier by having bottles and teats ready sterilised, the powder measured out and boiled water kept in a vacuum flask. The vacuum flask does not need to be sterilised but should be clean and only used for your baby. The water used to make the feed needs to be above 70°C. If the flask is full and securely sealed, the water will stay above 70°C for several hours.

You may also choose to use ready-to-feed milk at night.

Ask your midwife or health visitor for information on how to make up bottle feeds safely.

Never force your baby to take more than she needs in the hope that she will sleep for longer as this can cause her to become colicky and distressed and may result in her becoming overweight in the long term. Don't add cereal or any other substance to feeds as this is dangerous for your baby. Always follow manufacturers' guidelines with regard to amounts.

HEALTH PROFESSIONALS' GUIDE PAGE 6: BOTTLE FEEDING

BOTTLE FEEDING

For advice on making up feeds, parents should be referred to the [Department of Health leaflet "Bottle Feeding."](#)

All babies should be fed responsively regardless of their feeding method. Parents should be reassured that the information section on the tin or packet is just a guide and each baby will have individual needs.

The information on the formula tins or cartons often suggests feeding infants higher volumes of milk, less frequently, than is suggested by health professionals. Feeding babies responsively supports them to have more control over the amount they receive, which will in turn help them to develop better appetite control.

Newborn babies may take quite small volumes to start with, but by the end of the first week of life most babies will ask for approximately 150–200ml per kg per day – although this will vary from baby to baby – until they are six months old.

Parents may need to be advised against overfeeding, particularly against giving lots of milk in one feed in the hope that the baby will sleep longer between feeds.

For more information in this, refer to Unicef UK's [Guide for Parents who Formula Feed](#) and [Responsive Feeding Infosheet](#).

WHEN BABIES DON'T SETTLE

There may be times when your baby remains unsettled after feeds. Placing your baby in skin-to-skin contact with you and gently rocking can provide comfort. Your partner can help with this too.

If you are breastfeeding you can offer your breast again even if your baby has just fed. Babies find the suckling comforting and there is no risk of overfeeding a breastfed baby.

If you have had a particularly disturbed night, try to take time out to rest during the daytime. Visitors can wait – or help by taking over chores or looking after other children while you and your baby catch up on sleep.

If your baby is crying for long periods she may be ill and require a medical check.

// Skin-to-skin really helped my baby to settle down. We enjoy the time together. //



HEALTH PROFESSIONALS' GUIDE PAGE 7: WHEN BABIES DON'T SETTLE

WHEN BABIES DON'T SETTLE

Skin-to-skin contact, provided by either parent, can be helpful in settling a restless baby.¹ It is an excellent way for parents and babies to bond, and fathers can enjoy time with their baby in this way after a feed.

However, it is important for parents to be aware of safety issues. Skin-to-skin contact with either parent should be provided in circumstances in which there is no danger of falling asleep with the baby on a chair or sofa. Carrying the baby around or lying on the parental bed is safer than sitting or lying with the baby in a chair or on a sofa.²

LEAVING BABIES TO CRY

Leaving young babies to cry, at any time, but particularly in the belief that they can be "trained" not to wake at night, not only denies them the nourishment they need, but also risks the potential consequences of leaving them exposed for long periods to high levels of cortisol (the stress hormone) whilst still in infancy.^{3,4} Evidence suggests that leaving babies to 'cry it out' may have a negative effect on the baby's growing brain, resulting in higher levels of anxiety and insecurity as they progress through childhood.^{5,6} While there may still be some professionals who advocate variations of controlled crying for babies over six months of age, many would agree that this is inappropriate for younger babies.⁷

Further reading

Sue Gerhardt "Why love matters: how affection shapes a baby's brain" (Routledge, 2004) for an interpretation of the latest findings in neuroscience, psychology, psychoanalysis and biochemistry.

Margot Sunderland 'What every parent needs to know: the incredible effects of love, nurture and play on your child's development. (Dorling Kindersley 2007)

¹ Anderson GC, Moore E, Hepworth J, Bergman N. Early skin-to-skin contact for mothers and their healthy newborn infants (Cochrane Review). In: The Cochrane Library, Issue 2 2003. Oxford: Update Software.

² Blair PS, Sidebotham P, Evason-Coombe C, Edmonds M, Heckstall-Smith EM, Fleming P. 2009. Hazardous cosleeping environments and risk factors amenable to change: case-control study of SIDS in south west England. *BMJ*. 2009 Oct 13; 339:b3666. doi: 10.1136/bmj.b3666.

³ Gunnar MR, Donzella B Social regulation of the cortisol levels in early human development. *Psychoneuroendocrinology*. 2002 Jan-Feb;27(1-2):199-220.

⁴ Bell SM, Ainsworth MD. Infant crying and maternal responsiveness. *Child Dev*. 1972 Dec;43(4):1171-90.

⁵ Schore A. 1996. The experience-dependent maturation of a regulatory system in the orbital prefrontal cortex and the origin of developmental psychopathology. *Development and Psychopathology* (1996), 8: 59-87.

⁶ Blunden SL, Thompson KR, Dawson D. Behavioural sleep treatments and night time crying in infants: Challenging the status quo. *Sleep Med Rev*. 2011 Oct;15(5):327-34.

⁷ St. James-Roberts I (2007) 'Infant crying and sleeping: helping parents to prevent and manage problems', *Sleep Medicine Clinics* 2, 363-375.

PARENTS' TEXT PAGE 8: PUTTING YOUR BABY DOWN TO SLEEP

PUTTING YOUR BABY DOWN TO SLEEP

To keep your baby safe and to reduce the risk of sudden infant death (sometimes called cot death) always make sure:

- You put your baby down on her back to sleep, never on her front or side.
- The cot is beside the parents' bed for at least the first six months.
- The mattress is firm and flat – soft beds, bean bags and sagging mattresses are not suitable.
- Your baby is not overdressed or covered with too much bedding (no more than you would use yourself).
- The bedding must not be able to cover the baby's head.
- The room is not too hot (16-20°C is ideal).
- The room where your baby sleeps is a smoke-free zone.



HEALTH PROFESSIONALS' GUIDE PAGE 8: PUTTING YOUR BABY DOWN TO SLEEP

Place the baby on his back to sleep

Epidemiological studies conducted over the last 30 years provide strong evidence of a relationship between SIDS and different infant care practices in the sleeping environment. Risk reduction strategies such as the 'Back to Sleep' campaign conducted in England in the early 1990's have led to more than a 75% reduction in the number of SIDS deaths and the same degree of reduction has been observed in many other countries conducting similar intervention strategies.¹ It is now fairly well established that one of the main reasons for this fall in the number of deaths is the advice given to parents to avoid placing their infants in the prone position. Further evidence after the 'Back to Sleep' campaign also suggests that placing infants on their side carries a degree of risk mainly because of the unstable nature of this position and possibility of the infant rolling prone.²

Keep the baby in the same room for the first six months

SIDS is one of the main causes of post neonatal infant death and often happens unobserved. Sleeping infants outside the parental bedroom in the first six months of life puts the infant at risk. Placing the cot next to the parental bed is associated with a reduced risk of SIDS.

Use a firm, flat mattress in the baby's cot

It is important that the mattress is firm and flat as both soft bedding² and old mattresses³ are associated with an increased risk.

Prevent overheating

Dressing the infant in too many layers, using duvets and thick quilts and having the sleeping environment too hot are all associated with an increased risk of SIDS. It is especially important that outdoor hats are not used indoors; the inability of young infants to easily control their own body temperature means that the head is an important area for heat regulation/dissipation² and hats should be removed when the baby is sleeping indoors. Fortunately over the last two decades manufacturers of infant bedding have withdrawn many of the high tog items from the shelves, but it is still important to get the message across that infants should not be overheated.⁴

¹ Hauck FR, Tanabe KO. 2008. International trends in sudden infant death syndrome: stabilization of rates requires further action. *Pediatrics*. 2008 Sep;122(3):660-6.

² Fleming PJ, Blair PS, Bacon C, Bensley D, Smith I, Taylor E, et al. 1996. Environment of infants during sleep and risk of the sudden infant death syndrome: results from 1993-5 case-control study for confidential inquiry into still- births and deaths in infancy. *BMJ* 1996; 313:191-5.

³ Tappin D, Brooke H, Ecob R, Gibson A. 2002. Used infant mattresses and sudden infant death syndrome in Scotland: case-control study. *BMJ*. 2002 Nov 2;325(7371):1007.

⁴ Blair PS, Sidebotham P, Berry PJ, Evans M Fleming PJ. 2006. Major changes in the epidemiology of Sudden Infant Death Syndrome: a 20 year population based study of all unexpected deaths in infancy. *Lancet* 2006;367(9507):314-9.

Ensure the baby's head does not become covered

Some SIDS infants have been discovered with the bedclothes covering the face and head and evidence is starting to emerge that using infant sleeping bags or placing the feet of the infant at the foot of the cot under a tucked cotton sheet reduce the possibility of head covering.⁵

Avoid cigarette smoke

There is also strong evidence that smoking both during and after pregnancy is associated with SIDS;^{5,6} therefore it is important that the baby sleeps in a smoke-free zone.

⁵ Blair PS, Sidebotham P, Evason-Coombe C, Edmonds M, Heckstall-Smith EM, Fleming P. 2009. Hazardous cosleeping environments and risk factors amenable to change: case-control study of SIDS in south west England. *BMJ* 2009;339:b3666. doi: 10.1136/bmj.b3666.

⁶ Blair PS, Fleming PJ, Bensley D, Bacon C, Smith I, Taylor E, Golding J, Berry J, Tripp J. 1996. Smoking and the sudden infant death syndrome: results from 1993-5 case-control study for confidential inquiry into stillbirths and deaths in infancy. *BMJ* 1996;313:195-8.

PARENTS' TEXT PAGES 9-10: IF YOU DECIDE TO SHARE A BED WITH YOUR BABY

IF YOU DECIDE TO SHARE A BED WITH YOUR BABY

Some parents choose to sleep with their baby in bed and some fall asleep with their baby during the night while feeding and comforting whether they intend to or not. Therefore it is very important to consider the following points:

- Keep your baby away from the pillows.
- Make sure your baby cannot fall out of bed or become trapped between the mattress and wall.
- Make sure the bedclothes cannot cover your baby's face or head.
- Don't leave your baby alone in the bed, as even very young babies can wriggle into a dangerous position.

BEWARE

- It is not safe to bed-share in the early months if your baby was born very small or pre-term.
- Do not sleep with your baby when you have been drinking any alcohol or taking drugs that may cause drowsiness (legal or illegal).
- Do not sleep with your baby if you or anyone else is a smoker.
- Do not put yourself in a position where you could doze off with your baby on a sofa or armchair.

WHAT'S HAPPENING TONIGHT?

Having an alcoholic drink? Don't have your baby in your bed tonight as you will be less responsive than normal. It's best to have another adult on hand to help with your baby if you have drunk alcohol or taken drugs that make you less aware than normal.

Going on holiday or staying with family or friends? Make sure your baby's sleeping position is safe even when they are not at home: bed positions, mattresses and duvets may not be the same as at home.

Letting your partner sleep? If you feed your baby in another room be aware that falling asleep with your baby on a sofa or armchair increases their risk of injury and sudden infant death.

Baby unwell? It's natural and important to keep your baby close to you if they are not well. Be careful not to overdress them or use too many covers, especially if they are running a temperature.

Remember breastfeeding protects your baby against Sudden Infant Death Syndrome (SIDS) and the more you breastfeed the greater the protection. Babies need to feed during the night so talk to your midwife or health visitor about feeding positions which help you rest and minimise risk to your baby.

Download the health professionals' guide to this leaflet at unicef.uk/caringatnight

HEALTH PROFESSIONALS' GUIDE PAGES 9-10: IF YOU DECIDE TO SHARE A BED WITH YOUR BABY

BED-SHARING

Bed-sharing (the baby sleeping in the parental bed with one or both parents) is an ancient, and still common, worldwide cultural practice.^{1,2,3,4} Although there is an association between bed-sharing and SIDS, increasingly the evidence suggests that it is not bed-sharing per se that is a risk factor, but the circumstances in which it occurs.^{5,6} The 2014 NICE review of co-sleeping and SIDS concluded it is not possible to say that 'co-sleeping causes SIDS' and so parents should be advised there is an 'association' rather than a 'risk'. NICE guidance (CG37)⁷ uses the term 'co-sleeping' as they combined bed-sharing and sofa-sharing in their analyses. They conclude that co-sleeping by parents who are smokers, drink alcohol, use drugs, or who have a premature/low birthweight baby is more strongly associated with SIDS than when these factors are not involved. Separate analyses of UK data⁶ indicate that sleeping with a baby on a sofa is particularly strongly associated with SIDS.

However, there are advantages to bed-sharing for both the mother and baby that need to be taken into account.

Health monitoring

Video studies in sleep labs and parental homes have shown that mothers frequently touch their babies, even when they are only half awake, monitoring the baby's temperature and relationship to the bedding.⁸ Furthermore, mothers who usually sleep with their babies may be more likely to notice if their baby is unwell because of their proximity.⁹

Sleep

Mothers who regularly bed-share in order to easily breastfeed through the night tend to sleep more lightly and are more easily roused in the presence of their infant than mothers who

¹ Nelson EA, Schiefenhoevel W, Haimel F. Child care practices in non-industrialized societies. *Pediatrics*. 2000 Jun; 105(6):E75.

² Blair PS, Ball HL. The prevalence and characteristics associated with parent-infant bed-sharing in England. *Arch Dis Child*. 2004 Dec;89(12):1106-10.

³ Ball, Helen L. 2007. Bed-sharing practices of initially breastfed infants in the first 6 months of life. *Infant and Child Development* 16(4): 387-401.

⁴ Blair PS, Heron J, Fleming PJ. 2010. The relationship between bed-sharing and breastfeeding: A longitudinal population-based analysis. *Pediatrics* 2010 Nov;126(5):e1119-26. Epub 2010 Oct 18.

⁵ Blair PS, Sidebotham P, Evason-Coombe C, Edmonds M, Heckstall-Smith EM, Fleming P. 2009. Hazardous cosleeping environments and risk factors amenable to change: case-control study of SIDS in south west England. *BMJ*. 2009 Oct 13; 339:b3666. doi: 10.1136/bmj.b3666.

⁶ Blair PS, Sidebotham P, Pease A, Fleming PJ. Bed-Sharing in the absence of hazardous circumstances: Is there a risk of sudden infant death syndrome? An analysis from two case-control studies conducted in the UK. *PLoS One*. 2014 Sep 19;9(9):e107799. doi: 10.1371

⁷ NICE guidance CG37: "Postnatal care up to 8 weeks after birth"

<https://www.nice.org.uk/guidance/CG37>

⁸ Ball HL 2003. Breastfeeding, bed-sharing, and infant sleep. *Birth*, September 1, 2003; 30(3): 181-8.

⁹ Young J. 1999. Night-time behaviour and interactions between mothers and their infants at low risk for SIDS: a longitudinal study of room sharing and bedsharing. PhD thesis, Institute of Infant and Child Health, University of Bristol, 1999. <http://www.bristol.ac.uk/is/library/collections/theses.html>

rarely or never bed-share.¹⁰ In spite of this, bed-sharing in order to breastfeed is associated with more restful maternal and infant sleep, partly due to the soporific effect of the lactation hormones.^{11,12,13}

Continued breastfeeding

Mothers who breastfeed and bed-share, especially those who bed-share early, are much more likely to breastfeed for longer.^{4,8,12,14} “It is difficult to tease out whether bed-sharing facilitates breastfeeding or is a consequence of it, but a recent longitudinal study suggests there is a two-way interdependent temporal relationship.”^{4,15}

Room sharing

Mothers who bed-share are more likely to follow the advice to keep the baby in the same room for the first six months of life.¹⁶

Where will the baby sleep?

The question ‘Where will the baby sleep?’ is one that is usually considered and provisionally answered in the antenatal period, even if no formal discussion takes place between the pregnant woman and those providing care. However, what is anticipated and what actually happens may differ considerably.¹⁷

It is very clear that many pregnant women who do not intend to bed-share, nevertheless actually do so (intentionally) once their baby is a reality.^{18,19} In the vast majority of cases both parents are sharing the bed with the baby. In England on any one particular night around 20%-30% of babies share the parental bed at some point during the night-time sleep.²

It is also the case that a tired mother may take her baby into bed with her to breastfeed, intending to return the baby to her cot, and inadvertently fall asleep.

¹⁰ Mosko S, Richard C, McKenna J. 1997. Maternal sleep and arousals during bedsharing with infants. *Sleep*. 1997 Feb; 20(2):142-50.

¹¹ Quillin SI, Glenn LL. 2004. Interaction between feeding method and co-sleeping on maternal-newborn sleep. *J Obstet Gynecol Neonatal Nurs*. 2004;33(5):580 –588.

¹² McKenna JJ, Mosko SS et al. Bedsharing promotes breastfeeding. *Pediatrics*. 1997 Aug; 100(2 Pt 1):214-9.

¹³ Rudzik, A. E. F., & Ball, H. L. (2016). Exploring Maternal Perceptions of Infant Sleep and Feeding Method Among Mothers in the United Kingdom: A Qualitative Focus Group Study. *Maternal and Child Health Journal*, 20(1), 33–40.

¹⁴ Ball, H. L., Howel, D., Bryant, A., Best, E., Russell, C., & Ward-Platt, M. (2016). Bed-sharing by breastfeeding mothers: Who bed-shares and what is the relationship with breastfeeding duration? *Acta Paediatrica, International Journal of Paediatrics*, 1–7. <http://doi.org/10.1111/apa.13354>

¹⁵ Vennemann M M, Bajanowski T, Brinkmann B, Jorch G, Yücesan K, Sauerland C, Mitchell E A and the GeSID Study Group (2009) Does Breastfeeding Reduce the Risk of Sudden Infant Death Syndrome? *PEDIATRICS* Vol. 123 No. 3 March 2009, pp. e406-e410.

¹⁶ Buckley P, Rigda RS, Mundy L, McMillen IC. 2002. Interaction between bed-sharing and other sleep environments during the first six months of life. *Early Hum Dev*. 2002 Feb; 66(2):123-32.

¹⁷ Ball H L, Hooker E, Kelly PJ. 1999. Where will the baby sleep? Attitudes and practices of new and experienced parents regarding co-sleeping with their new-born infants. *American Anthropologist* 101(1): 143-151.

¹⁸ Hooker E, Ball HL, Kelly PJ. (2001) Sleeping like a baby: attitudes and experiences of bedsharing in Northeast England. *Medical Anthropology* 19: 203-22.

¹⁹ McKenna JJ, Volpe LE. 2007 Sleeping with baby: An internet-based sampling of parental experiences, choices, perceptions, and interpretations in a western industrialized context. *Infant Child Dev* 2007; 16: 359-85.

In addition, mothers from many non-UK countries have a cultural tradition of sleeping with their babies, but tend not to discuss this with their midwife or health visitor for fear of disapproval.^{20,21} Although some immigrant groups are well known to have very low rates of SIDS in the UK, they are not necessarily aware of the potential hazards of UK-style beds, Western bedding, or centrally-heated houses.²² Some groups may have a higher prevalence of smoking or other potential issues that need to be considered, and where families are sleeping in temporary accommodation they may need help in ensuring the baby has a safe sleep location. Thus all parents should have the opportunity to discuss the ways in which they might care for their baby at night as soon as possible after the birth and at the latest before they leave the hospital, (if that is where they have given birth).

The bed-sharing discussion

It is in no-one's interest to avoid this discussion with the mother on the grounds that it is complex, or to only discuss it once the mother reports that she has already slept with her baby in bed. (One would not apply the same thinking to teaching a child how to cross a road). In fact, NICE recommends⁷ that health professionals acknowledge that co-sleeping may happen intentionally or unintentionally, and should discuss this with parents to empower them to consider their individual circumstances and make an informed decision.

Furthermore, if parents who have found bed-sharing an effective option fear the disapproval of health professionals, they are likely to conceal this fact.¹⁷

What is becoming clear is that sharing a bed results in complex interactions between mothers and babies that are completely different from isolated sleeping,²³ and that bed-sharing takes place for a wide variety of different reasons, which include convenience, ideology, enjoyment, necessity and anxiety.^{8,24}

Thus, irrespective of one's personal beliefs,²⁵ taking up the simplistic position of regarding bed-sharing as either 'safe' or 'unsafe' without considering the particular circumstances in which bed-sharing occurs, is unhelpful, may undermine parents, and is likely to put babies at risk.²⁶

Blanket 'permission' may expose infants to the hazards associated with parental smoking or incapacity due to alcohol or drug use.

²⁰ Crane, D., & Ball, H. L. (2016). A qualitative study in parental perceptions and understanding of SIDS-reduction guidance in a UK bi-cultural urban community. *BMC Pediatrics*, 16(1), 23. <http://doi.org/10.1186/s12887-016-0560-7>

²¹ Ball HL, Moya E, Fairley L et al (2011) Infant care practices related to sudden infant death syndrome in South Asian and White British families in the UK. *Paediatric and Perinatal Epidemiology*. DOI: 10.1111/j.1365-3016.2011.01217.x

²² Ball, H. L., Moya, E., Fairley, L., Westman, J., Oddie, S., & Wright, J. (2012). Bed- and sofa-sharing practices in a UK biethnic population. *Pediatrics*, 129(3), e673–81. <http://doi.org/10.1542/peds.2011-196>

²³ Mosko S, Richard C, McKenna J. (1997). Infant arousals during mother-infant bed-sharing: implications for infant sleep and sudden infant death syndrome research. *Pediatrics* 100(5):841-9.

²⁴ Ball HL. (2002) Reasons to bed-share: why parents sleep with their infants. *Journal of Reproductive and Infant Psychology* 20(4): 207-21.

²⁵ Mitchell E. 2010. Bed-sharing and the Risk of Sudden Infant Death: Parents Need Clear Information. *Current Pediatric Reviews*, 2010, 6, 63-66 63.

²⁶ Ball, H L. (2009) Bed-sharing and co-sleeping : research overview., *NCT New Digest.*, 48 . pp. 22-27.

Blanket ‘prohibition’ may constrain cultural practices, impose economic hardship, undermine breastfeeding, or otherwise inadvertently compromise infant health;²⁷ by, for example, leading parents to swap bed-sharing for a more dangerous practice, such as sofa-sharing.

Undermining breastfeeding will expose the baby to the nutritional, immunological and developmental risks of not breastfeeding,^{28,29,30} as well as (ironically) increasing the incidence of SIDS.^{29,15} Health professionals thus need to ensure that the advice they give to the breastfeeding mother does nothing to compromise breastfeeding without a robust risk/benefit analysis of the evidence for that particular mother’s circumstances.

Telling adults that they must or must not behave in a certain way is rarely successful. It can induce guilt, secrecy and possibly anger towards third parties who are perceived as disapproving.^{17,27} A recent trial from the US suggests that such an approach can increase the practice of bed-sharing rather than decrease it.³¹ For more information on this, see Unicef UK’s [Co-Sleeping and SIDS: A Guide for Health Professionals](#).

In recognition of all this, the Unicef UK Baby Friendly Initiative has for some time been working to assist health professionals to discuss bed-sharing with parents so that risks can be identified and minimised, rather than attempting to promote restrictions which cannot be applied in parents’ everyday lives. This approach is now recommended by NICE in their guidance on co-sleeping and SIDS.³²

Two studies from the UK^{5,33} have highlighted specific circumstances during the last sleep that have put the co-sleeping infant at risk. These include the parental consumption of alcohol in the hours leading up to the sleep, the parental use of sleep-inducing drugs, legal or illegal, prior to the sleep, if one or both parents are smokers and the use of a sofa to sleep with the infant.

In the absence of these hazardous circumstances the number of co-sleeping SIDS deaths was no more than expected in the general population; in fact, it was slightly less.

The fact that some of the circumstances around how and where a baby sleeps may be modifiable has important implications in terms of social policy and health education,³³ but health professionals should not attempt to modify parental decisions about infant sleep other than on good evidence.

Thus the over-riding message to parents in relation to bed-sharing should be:

²⁷ O’Hara MA. (2001) Evidence supports respecting informed parental preference. *West J Med* 174:301.

²⁸ Heinig MJ, Dewey KG. 1996. Health advantages of breast feeding for infants: a critical review. *Nutr Res Rev.* 1996 Jan;9(1):89-110.

²⁹ Ip S et al (2007) Breastfeeding and Maternal Health Outcomes in Developed Countries. AHRQ Publication No.07-E007. Rockville, MD: Agency for Healthcare Research and Quality.

³⁰ Horta B.L. et al (2007) Evidence on the long-term effects of breastfeeding. WHO.

³¹ Moon RY, Mathews A, Joyner BL, Oden RP, He J, McCarter R. Health Messaging and African-American Infant Sleep Location: A Randomized Controlled Trial. *J Community Health.* 2016 Jul 28. [Epub ahead of print].

³² NICE guidance CG37: “Postnatal care up to 8 weeks after birth”
<https://www.nice.org.uk/guidance/CG37>

³³ Blair PS, Fleming PJ, Smith IJ, Ward Platt M, Young J, Nadin P, Berry PJ, Golding J. (1999) Babies sleeping with parents: case-control study of factors influencing the risk of the sudden infant death syndrome. *BMJ* 319:1457-62.

- Do not sleep with your baby when you have been drinking any alcohol or taking drugs (legal or illegal) that might make you sleepy
- Do not sleep with your baby if you or anyone else in the bed is a smoker
- Do not put yourself in the position where you could doze off with your baby on a sofa / armchair

Vulnerable babies

There are also other circumstances involving especially vulnerable babies and lone sleeping in the parental bed that parents should be made aware of:

- It is unsafe to sleep with your baby after immediate discharge from NICU or in early infancy if your baby was pre-term or of low birthweight.
- It is unsafe to let your baby sleep alone in an adult bed.

If you are bed-sharing, make sure that your baby cannot:

- Fall out of bed.
- Get stuck between the mattress and the wall.

Further reading

Blair PS, Ward Platt M, Smith I J, Fleming P J. 2006 Sudden infant death syndrome and sleeping position in pre-term and low birth weight infants: an opportunity for targeted intervention. Arch Dis Child. 2006 February; 91(2): 101–106.

More information on the work of the Parent Infant Sleep Lab can be found here:

www.isisonline.org.uk