

INFANT AND YOUNG CHILD FEEDING: CLINICAL GUIDELINES

QUICK REFERENCE GUIDE

INFORMATION ABOUT THE TOOL	
Background:	<p>IYCF & Health are inextricably linked, with the way an infant or young child is fed having a direct impact on his or her own health, nutrition and development as well as on maternal health. Optimal breastfeeding for the first 2 years of life is the single most effective intervention to prevent child deaths worldwide¹. Artificial feeding tends to increase vulnerability to, and severity of, life-threatening morbidities and is particularly dangerous during emergencies. The 2016 Lancet Breastfeeding Series shows that around 823,000 child deaths under-5 years (~13%) and 20,000 maternal breast cancer deaths could be prevented each year by improving breastfeeding rates to near universal levels, in addition to the lives already saved by current practices (Victora et al., 2016).</p> <p>Emergency health programmes provide multiple entry points for the protection, promotion and support of appropriate infant and young child feeding (IYCF) practices. However, barriers may prevent this from being done. For example, myths and misconceptions about breastfeeding, such as that a mother should stop breastfeeding her child when she is sick, stressed or taking medication, are common – including amongst health workers. This can lead to health workers making recommendations that are ultimately damaging to the mother and her child, particularly during an emergency. It is important that health workers feel confident in recommending that a mother continues to breastfeed provided it is safe to do so. While far less common than is frequently assumed, there are also situations in which breastfeeding is not recommended. In these instances, it is important that caregivers are also given appropriate feeding recommendations and are adequately supported by adequately trained health or nutrition staff.</p>
Objective:	<p>The purpose of this tool is to act as a quick reference guide to identify appropriate feeding recommendations for children under 2 years of age in various situations of a medical nature. It is meant to summarise globally agreed upon recommendations in an easy-to-access manner.</p> <p>This tool is NOT a counselling manual or to be used as the primary tool for resolving feeding difficulties; instead this tool recognises that it is often not feasible for all health workers to be trained on IYCF counselling during an emergency, but that it is important that appropriate feeding advice is given and health workers recognise when referral to skilled IYCF counsellors is needed. IYCF counsellors should refer to existing materials Infant and Young Child Feeding Counselling: An Integrated Course. Participant’s Manual (UNICEF/WHO) and the Community Based IYCF Package (UNICEF) for these purposes.</p>
Target user:	<p>Save the Children health or nutrition programme managers and technical advisers Humanitarian Surge Team (HST) and Emergency Health Unit (EHU) staff</p>
Suggested use:	<ul style="list-style-type: none"> • To verify whether appropriate feeding advice is being issued to caregivers of children < 2 years attending health services (e.g. during clinic supervision visits) • To provide guidance to emergency response teams on appropriate management of infant and young child feeding during public health emergencies (e.g. cholera outbreak) • To act as a reference document for SC frontline health staff (e.g. EHU team members) on the appropriate management of infant and young child feeding within their services <p>This tool is unlikely to be suitable for direct usage by health workers in the majority of settings, but may be used to inform training materials and other tools.</p> <p>For each situation, an IYCF recommendation and references / further reading are provided.</p>
Development:	<p>The tool was developed by an IYCF-E Consultant and first reviewed by a Save the Children UK Health Adviser and the Tech RRT IYCF-E Adviser. The tool was then more widely reviewed by its intended users including HSTs and EHU staff members. At the time of writing (August 2017), the recommendations were based on the latest global guidance. References are provided within the tool.</p>

¹ . The Lancet, “Executive Summary of The Lancet Maternal and Child Nutrition,” 2013.

Content:	<ol style="list-style-type: none"> 1. GENERAL GUIDANCE ON FEEDING DURING ILLNESS AND RECOVERY IN CHILDREN <ol style="list-style-type: none"> a. Illness b. Recovery c. Respiratory Tract Infection 2. SPECIFIC GUIDANCE ON BREASTFEEDING IN SPECIAL SITUATIONS (CHILD) <ol style="list-style-type: none"> a. HIV b. Hypoglycaemia (at risk new-born) c. Jaundice d. Low birth weight e. Twins f. Abnormalities <ol style="list-style-type: none"> i. Cleft Lip / Palate ii. Tongue Tie iii. Muscular Weakness g. Medical Conditions h. At Risk 3. BREASTFEEDING DIFFICULTIES AND MANAGEMENT <ol style="list-style-type: none"> a. Sore Nipples / Nipple Fissure b. Candida Infection (Thrush) c. Engorgement d. Blocked/Plugged Duct and Mastitis e. Breast Abscess 4. GENERAL GUIDANCE ON FEEDING DURING ILLNESS IN MOTHERS 5. SPECIFIC GUIDANCE ON BREASTFEEDING IN SPECIAL SITUATIONS (MATERNAL) <ol style="list-style-type: none"> a. Diarrhoeal Disease b. Ebola c. Hepatitis d. Herpes Simplex Virus 1 (HSV-1) e. HIV f. Mental Health g. Tuberculosis h. Zika i. Maternal medication j. Other maternal situations <ol style="list-style-type: none"> i. Deceased ii. Caesarean iii. Family Planning iv. Substance misuse
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1. GENERAL GUIDANCE ON FEEDING DURING ILLNESS AND RECOVERY IN CHILDREN	
a. General guidance on feeding during illness	
<ul style="list-style-type: none"> Continue to breastfeed – offer the breast frequently If a child is too weak to suckle the breast, offer expressed breastmilk with a cup or spoon If the child is unable to take oral or enteral feeds, support the mother to maintain lactation Keep mothers and their breastfed children together <p>Additional messages for infants and young children > 6 months of age:</p> <ul style="list-style-type: none"> Sick children often need extra fluids and food during illness. They may wish to breastfeed more. Do not withhold food from a sick child, unless advised to do so for medical reasons Patiently encourage the child to eat and drink (responsive feeding) Feed small amounts frequently Give a variety of hygienically prepared, nutrient-rich foods which the child likes, as well as safe water 	
b. General guidance on feeding during recovery	
<ul style="list-style-type: none"> Continue to breastfeed – offer the breast frequently Mothers may need support to increase milk production or relactate <p>Additional messages for infants and young children > 6 months of age:</p> <ul style="list-style-type: none"> If appetite was poor during illness, it is important to give extra attention to feeding Support families to give extra food so that any weight loss is quickly regained Give extra meals, extra amounts, extra nutritious foods with extra patience Regularly encourage the child to drink safe water 	
c. Diarrhoeal Disease	
Cholera, Shigella, Typhoid	IYCF RECOMMENDATION
	Continue breastfeeding Express if needed
<p><i>Strong evidence suggests that about half of all diarrhoea could be avoided by breastfeeding (Horta & Victora, 2013). Breastfeeding could prevent 80 – 90% of hospital admissions and mortality in children under five (evidence mostly for LMICS). Protection is highest amongst infants who are exclusively breastfed during the first 6 months of life. Not breastfeeding during diarrhoea increases the risk of dehydration and malnutrition, as well as the likely severity and duration of the diarrhoeal disease. Exclusively breastfed infants are 11 times less likely to die from diarrhoea (Begum & Dewey, 2010).</i></p> <p><i>Artificially fed and bottle-fed infants are particularly vulnerable during diarrhoeal disease outbreaks. Infant formula directly impacts the infant's intestine so that they are more vulnerable to infection and illness (Gribble, 2007). Contaminated feeding utensils (e.g. bottles) or unsafe water (used to prepare infant formula) can introduce pathogens.</i></p> <p>During an outbreak: Strongly discourage bottle-feeding of breastmilk substitutes, semi-liquid complementary foods etc. It is safer to use open cups rather than bottles, when necessary. Promote exclusive breastfeeding under 6 months and continued breastfeeding thereafter. Hygienic preparation of complementary foods for children > 6 months is essential.</p> <p>Sick child: Refer to general guidance on feeding during illness and treat according to national protocol and / or IMCI guidelines. Children with any signs of dehydration should be treated. Children with diarrhoea should be breastfed frequently, for as long as possible. Supplement with expressed breastmilk if needed or if child is too weak to suckle.</p> <p><u>Age-specific treatment:</u> Breastfed infants < 6 months: If zinc is required for infants, administer in a small amount of expressed breastmilk. National protocols may prescribe safe water and / or ORS in addition to breastmilk. > 6 months: Provide ORS, safe water and food based liquids e.g. soups in addition to breastmilk. Do not give commercial juices and sweetened or carbonated drinks. Non-breastfed infants < 6 months: Non-breastfed infants are highly vulnerable; an appropriate BMS will be required for feeding according to protocol, in addition to water and / or ORS.</p> <p>Why Infant Formula Causes Deaths Due to Diarrhoea in Emergencies. Gribble, K., 2007. WHO 2014 IMCI Chart Booklet Cholera Toolkit. UNICEF, 2013. Annex 8D: Infant and Young Child Feeding and Cholera.</p>	
d. Respiratory Tract Infection (RTI)	
	IYCF RECOMMENDATION
<p><i>Breastfeeding prevents RTIs. Babies who are not breastfed are more likely to need medical attention or hospitalisation for respiratory illnesses than those who are breastfed. Strong evidence suggests that about a third of respiratory infections and 57% of RTI-related hospitalisations in children < 2 could be avoided by breastfeeding (Horta & Victora, 2013).</i></p> <p>Respiratory Illness. UNICEF UK Baby Friendly Initiative</p>	
Upper RTI	Breastfeed

The infant may have trouble breathing while feeding if the nose is blocked; in this case mild bulb suction or nasal saline drops may help. The mother can be taught how to use drops of salted water or breast milk, and clear the baby's nose by making a wick with a twist of tissue. She can give shorter more frequent breastfeeds, allowing the baby time to pause and breathe through the mouth until the nose clears.

Pneumonia	Breastfeed
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Malnutrition is a risk factor for developing pneumonia. Ensuring adequate nutrition is key to improving children's natural defences; this includes breastfeeding and adequate complementary feeding for infants and young children. Exclusively breastfed infants are 15 times less likely to die from pneumonia (Begum & Dewey, 2010) while non-breastfed infants are 14 times more likely to die from pneumonia than breastfed infants (Black et al., 2008). Breastfeeding also helps reduce length of illness if a child does contract pneumonia.

In the absence of severe respiratory difficulty, the infant should breastfeed responsively according to general guidance on feeding during illness and, for children > 6 months, offer food and water by spoon or cup. Severely ill children may be unable to drink or eat in which case consider admission for inpatient care.

[WHO 2014 IMCI Chart Booklet](#)

2. SPECIFIC GUIDANCE ON BREASTFEEDING IN SPECIAL SITUATIONS (CHILD)

a. HIV	Breastfeed
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If infants and young children are known to be living with HIV, mothers are strongly encouraged to exclusively breastfeed for the first six months of life and continue breastfeeding in accordance with the recommendations for the general population: that is, up to two years or beyond.

[Updates on HIV and Infant Feeding. WHO, 2016.](#)

b. Hypoglycaemia (newborn)	Breastfeed May require supplementation
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Newborn infants may be at risk of hypoglycaemia by virtue of impaired metabolic adaptation or increased glucose demand (such as those who have experienced significant intrapartum hypoxic/ischaemic stress, those who are ill and those whose mothers are diabetic). These babies may be unable to access alternative energy sources if their blood glucose runs low and are at risk of neurological impairment if they remain hypoglycaemic for long periods. They cannot be relieved on to demand feed and should be fed *at least* every 3 hours. Support skin to skin as soon as possible. Keep the infant warm to conserve energy. At risk infants should be screened and followed up as needed, with blood glucose checks as per policy. If their blood sugar fails to respond to exclusive breastfeeding or breast-milk feeding, they may require treatment with supplementation or IV glucose. The newborn can be supplemented with mother's own expressed breastmilk, donor human milk or, as a last resort, infant formula, in addition to breastfeeding. Breastmilk enhances mobilisation of alternative energy sources, whilst formula does not. Small amounts of colostrum may be more useful than large amounts of formula. The more frequently the infant receives colostrum, the better. Reassure mothers about the value of their milk and that the supplementation is only temporary. Ensure the mother is expressing milk every 3 hours / at least 8 times in 24 hours until her baby is latching and suckling well.

[Acceptable medical reasons for use of breast-milk substitutes. WHO and UNICEF, 2009.](#) P. 7

[ABM Clinical Protocol: Hypoglycaemia](#) Academy of Breastfeeding Medicine, 2014.

c. Low birth weight (<2.5kg)	Breastfeed
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Low-birth-weight (LBW) can be a consequence of preterm birth (<37 weeks), small size for gestational age (SGA) or both. LBW infants should be fed mother's own milk. A baby's own mother's milk is best for LBW infants of all gestational ages. Breast milk is especially adapted to the nutritional needs of LBW infants, and strong and consistent evidence shows that feeding mother's own milk is associated with lower incidence of infections and better long-term outcomes. If this is not possible, they should be fed donor human milk (if context allows for this) or, as a last resort, standard infant formula. LBW infants who are able to breastfeed should be put to the breast as soon as possible after birth when they are clinically stable and then fed based on the infant's hunger cues, except when the infant remains asleep beyond 3 hours since the last feed. Show the mother how to hold the baby in the underarm position, or hold with the arm from the side opposite the breast. When a LBW baby first suckles, he or she may pause quite often and for long periods during a feed, and may need to continue feeding for an hour. It is important not to take the baby off the breast during these pauses. If a baby has difficulty suckling effectively, tires quickly at the breast or does not gain adequate weight, offer expressed milk by cup after the breastfeed, or give alternate breast and cup feeds. A cup or spoon can be used if the infant is unable to suckle at the breast. Keep mother and baby close together. Counsel mothers to exclusively breastfeed for 6 months, provide skilled breastfeeding support and encourage frequent skin to skin contact – ideally as part of Kangaroo Mother Care.

The baby's weight needs to be monitored, as well as baby's outputs and breastfeeding effectiveness. Babies weighing over 1500 grams at birth can be expected to regain their original birth weight after 1–2 weeks (It is expected for babies to lose weight after birth, within a defined range. *Extreme* weight loss may be accompanied by hypernatraemia which can be extremely serious).

Newborn infants who are preterm or small for gestational age may be at risk of hypoglycaemia, in which case they may require supplementation. (See *hypoglycaemia*)

[Guidelines on optimal feeding of low birth-weight infants in low- and middle-income countries. WHO, 2011](#)
[Kangaroo Mother Care Toolkit](#)
[WHO 2009 IYCF Model Chapter](#)

**d. Very low birth weight (<1.5kgs)
Very preterm (<32 weeks)**

Breastfeed
May require micronutrient supplementation
May require supplementation

Very-low-birth-weight (VLBW) infants should be fed mother's own milk. If this is not possible, they should be fed donor human milk (if context allows for this) or, as a last resort, standard infant formula. If they fail to gain weight despite adequate feeding on standard infant formula, preterm infant formula should be given if available. VLBW infants should be given 10 ml/kg per day of enteral feeds, preferably expressed breast milk, starting from the first day of life, with the remaining fluid requirement met by intravenous fluids.

A LBW baby who is not able to breastfeed usually needs care in a special newborn care unit. Every effort should be made to enable a mother to stay in or near this unit. Otherwise, she should spend as much time there as possible every day. When breastfeeding is established, care can continue at home with close follow-up. Support frequent skin to skin and, when possible, Kangaroo Mother Care (KMC). KMC is known to benefit both mother and baby, as well as health facilities.

A mother should be given skilled help to express her milk and to establish lactation, if possible within 6 hours of birth. She should express at least 8 times in 24 hours, expressing at home if she is not staying in the health facility. The baby's weight needs to be monitored, as well as baby's outputs and feeding effectiveness. Babies with a birth weight below 1500 grams can be expected to regain their original birth weight after 2–3 weeks.

VLBW infants are frequently deficient in one or more micronutrients, which may impact normal growth and development. Supplementation with certain micronutrients may reduce the risk of complications. Infants weighing between 1.0 and 1.5 kgs who are fed breastmilk should not routinely be given bovine milk-based human milk fortifier. However, those that fail to gain weight despite adequate breastmilk feeding should be given human-milk fortifiers. VLBW infants weighing between 1.0 and 1.5 kgs should be given vitamin D supplements (400 IU to 1000 IU per day until 6 months of age). Those who are fed breastmilk should be given daily calcium (120-140 mg/kg per day) and phosphorus (60-90 mg/kg per day) supplementation during the first months of life, as well as 2-4 mg/kg per day iron supplementation starting at 2 weeks until 6 months of age.

[Acceptable medical reasons for use of breast-milk substitutes. WHO and UNICEF, 2009. P. 7](#)
[Guidelines on optimal feeding of low birth-weight infants in low- and middle-income countries. WHO, 2011](#)
[Kangaroo Mother Care Toolkit](#)
[WHO 2009 IYCF Model Chapter](#)

e. Jaundice

Early Jaundice

Breastfeed

Symptoms: appear between 2 and 7 days of life. It is usually physiological, and clears after a few days. Jaundice can make a baby sleepy so that he or she suckles less. Early initiation of breastfeeding and frequent breastfeeding reduces the severity of early jaundice.

Management: Taking more breast milk helps jaundice to clear more quickly, so the mother should be encouraged to breastfeed as often as her baby is willing. She can also express her milk after feeds and give some extra by cup or tube. If she is feeding her baby on expressed breast milk, she should give 20% extra. Water and glucose water do not help, and may make a baby suckle less at the breast. If jaundice is severe, phototherapy (light treatment) may be needed.

[WHO 2009 IYCF Model Chapter](#)

Prolonged Jaundice

Breastfeed and refer

Symptoms: starts after the seventh day of life and continues for some weeks. It is usually due to hormones or other substances in the mother's milk, so it is sometimes called "breast-milk jaundice" which is harmless and clears by itself. If the jaundice is due to a more serious condition there are usually other signs, such as pale stools, dark urine, or enlarged liver and spleen.

Management: The baby should be referred for clinical assessment, to exclude a serious condition. The mother should continue breastfeeding until the infant has been fully assessed.

[WHO 2009 IYCF Model Chapter](#)

f. Twins

Breastfeed

Management should be as for singletons, with early contact, help to achieve good attachment at the breast, and exclusive on-demand feeding from birth, or from as soon as the mother is able to respond. Early effective suckling can ensure an adequate

milk supply for both infants; skilled breastfeeding help is therefore recommended. Mothers may need help to find the best way to hold two babies to suckle, either at the same time, or one at a time. They may like to give each baby its own breast, or to vary the side. Holding one or both babies in the underarm position for feeding, and support for the babies with pillows or folded clothes is often helpful. Building the mother's confidence so that she can make enough milk for two, and encouraging relatives to help with other household duties, may help her to avoid trying to feed the babies artificially.

[WHO 2009 IYCF Model Chapter](#)

g. Abnormalities

Cleft Lip / Palate

Breastfeed
May require expression

Attachment and suckling may be difficult because of the anatomical gap. If only the lip is affected, and the breast covers the cleft, the baby may be able to suckle effectively. Sometimes a baby with a cleft palate can suckle quite well, if there is enough palate for the tongue to press the nipple against.

Management: The baby should be referred for surgery. It is important for the baby to grow and to be well nourished before undergoing surgery. The mother can be helped to hold the baby in an upright sitting position at the breast with the baby's legs on either side of the mother's thigh. This makes swallowing easier and may help the baby to breastfeed, fully or partially. She can express her milk and feed it to the baby by cup or spoon until surgical help is available, or an orthopaedic device is provided to facilitate breastfeeding. The family may need a great deal of support and help.

Muscular Weakness

Breastfeed
Likely to require skilled support

Babies with Down syndrome or cerebral palsy have difficulty attaching to the breast and suckling because of the weakness.

Management: The mother should be shown how to help the baby to attach to the breast by using the dancer hand position. She supports the baby's chin and head to keep the mouth close on to the breast. These babies may feed slowly, and it may be necessary for the mother to express her milk and give some feeds by cup or tube. The mother will need extra support and counselling to bond with her baby, to feel that she is doing the best for him or her, and to persist.

Tongue Tie

Breastfeed
May require expression

The strip of tissue underneath the tongue, called the *frenulum*, is too short and holds the tongue down. This can make attachment difficult, which may cause sore nipples. The baby may not suckle effectively and may have a low intake of breast milk.

Management: If tongue-tie is causing problems with feeding, the baby will need referring for cutting of the frenulum. This is effective and can now be done simply and safely. In the meantime, support the mother to build up milk production through effective expression. The expressed milk can be fed to the infant by cup or spoon.

[WHO 2009 IYCF Model Chapter](#)

h. Infant Conditions

Do not breastfeed
Specialised formula required

Infants with certain conditions should not receive any breastmilk or any other milk. These include:

- **Classic Galactosemia** – Requires galactose-free infant formula
- **Maple Syrup Urine Disease** – Requires Leucine-, Isoleucine- and valine-free infant formula
- **Phenylketonuria** – Requires phenylalanine-free formula (some breastfeeding is possible under careful monitoring)

Support access to screening where it is available and thorough evaluation of infants that present (especially) with failure to thrive.

[Acceptable medical reasons for use of breast-milk substitutes. WHO and UNICEF, 2009. P. 7](#)

i. At Risk

Breastfeed
May require supplementation

Infants who are preterm, small for gestational age, compromised (e.g. birth asphyxia, illness), whose mother has diabetes or experienced prolonged rupture of membranes can be considered "at risk". These infants may not be able to access alternative fuels if their blood glucose level falls, thereby putting them at risk of neurological impairment if it remains low. These infants cannot be relied on to sufficiently demand feed to meet their needs and should be fed *at least* every 3 hours.

Management of at risk infants includes skin-to-skin contact, early initiation of breastfeeding, keeping warm, monitoring vital signs (including level of consciousness), blood glucose monitoring, monitoring of urine and stools, hand expression and frequent feeding of expressed breastmilk. In some cases, supplementation may be needed.

While it is normal for babies to lose some weight in first few days due to fluid loss, extreme weight loss may be accompanied

by hypernatraemia which can be extremely serious. Normal babies over 36 hours old feed at least 8 – 12 times in 24 hours with almost no upper limit. Typically, when a baby has hypernatraemia he has been 'good' and undemanding and parents were not aware baby is not feeding adequately. When counselling parents, it is important to reinforce the normality of frequent feeding as a preventative measure.

3. BREASTFEEDING DIFFICULTIES AND MANAGEMENT

a. Sore Nipples / Nipple Fissure	Continue breastfeeding
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Symptoms: Breast / nipple pain, cracks around top of nipple or base, occasional bleeding. May become infected.

Prevention: The most common cause of sore nipples and a nipple fissure is poor attachment to the breast. Improve attachment, avoid washing breasts more than once a day and do not use soap or rub with a towel. Do not use bottles, teats or pacifiers.

Management: Medicated lotions and ointments can irritate the skin; instead rub expressed breastmilk over the affected area to promote healing. Refer for skilled breastfeeding support to improve attachment. Advise mother to begin breastfeeding on the side that hurts less and to vary breastfeeding positions. Let the baby come off the breast by him / herself or remove the baby from the breast by gently breaking suction with a clean finger first. Feed before the breast is full and avoid bottles.

Suspect Candida infection (thrush) if sore nipples persist even when the baby's attachment is good (See: Candida Infection)

[Infant and Young Child Feeding Counselling: An Integrated Course. Participant's Manual](#). Page 124. WHO and UNICEF, 2006.
UNICEF [Community Based IYCF Package](#)

b. Candida Infection (Thrush)	Continue breastfeeding Treat with Nystatin
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Symptoms: Candida is a common cause of sore nipples. Infection can make the skin sore and itchy. The mother may describe a burning or stinging sensation which continues after the feed or shooting pain deep in her breast. Check the baby for thrush (white patches on tongue, rash on bottom).

Management: Treat both the mother and baby with nystatin. Counsel mother to stop using pacifiers, teats, nipple shields. Nystatin cream 100,000 IU/g: apply to nipple 4 x day, after a feed. Continue for 7 days after lesion has healed
Nystatin suspension 100,000 IU/ml: apply 1 ml by dropper to child's mouth 4 x da, after a feed for 7 days, or for as long as mother continues to be treated

[Infant and Young Child Feeding Counselling: An Integrated Course. Participant's Manual](#). Page 124. WHO and UNICEF, 2006.

c. Engorgement	Continue breastfeeding May require analgesics
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Symptoms: Engorged breasts are tender / painful, warm, oedematous, tight (especially the nipples), shiny and may look red. Engorgement affects the whole breast, and often both breasts. 24 hour fever may be present. Milk does not flow. Engorgement typically begins on the 3rd – 5th day after birth.

Prevention: Engorgement can be prevented through supporting early initiation of breastfeeding, effective milk removal and breastfeeding on demand for unrestricted lengths of time and allowing the infant to finish one breast before offering the other.

Management: Engorgement is managed through removing milk (encourage frequent feeds and/or hand expression), stimulating the oxytocin reflex to encourage let down and applying cold compresses to reduce swelling after feeds. Warmth (e.g. warm water or warm dry cloth) will help milk flow. Press around the areola to reduce oedema and help baby attach. Express milk to relieve pressure if the infant has difficulty latching. Offer both breasts. Refer to a skilled counsellor to ensure good attachment and effective milk removal.

Engorgement may also occur when a woman is trying to stop breastfeeding. She should express only enough milk to relieve discomfort, a few times per day. A simple analgesic may be used to reduce inflammation and discomfort.

Ibuprofen, Paracetamol

[Infant and Young Child Feeding Counselling: An Integrated Course. Participant's Manual](#). Page 119. WHO and UNICEF, 2006.
[Managing Complications in Pregnancy and Childbirth. WHO, 2007](#). S-108.
[Mastitis: Causes and Management. WHO, 2000](#).

UNICEF [Community Based IYCF Package](#)

d. Blocked/plugged duct and Mastitis	Continue breastfeeding
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May require antibiotics, analgesics

Symptoms: A blocked duct presents as a tender lump, and sometimes redness of the skin over the lump. The woman has no fever and feels well. A woman with mastitis has pain, fever and she feels ill. Part of the breast is swollen and hard, with redness of the overlying skin. Engorgement or a blocked duct can lead to mastitis, as milk stays in the breast (milk stasis). Mastitis may be **non-infective** (inflammation of the breast tissue) or **infective** (infected with bacteria).

Prevention: Ensure good attachment, breastfeed on demand, let the infant come off the breast by him/herself, avoid holding the breast in a scissor hold, avoid tight clothing and support mother to have sufficient rest and support.

Management: Mastitis is managed through identifying and correcting the cause of poor drainage, and encouraging frequent breastfeeding in different positions, gentle breast massage during breastfeeding and applying warm compresses before feeds/cold packs after feeds. It may be helpful to start feeding on the unaffected breast if pain is interfering with let-down and to use a variety of breastfeeding positions. If breastfeeding from the affected breast is not possible, hand expression is necessary. Acute cessation of breastfeeding may worsen mastitis and increases risk of breast abscess. Continued breastfeeding will promote recovery. Apply gentle pressure to breast with flat of hand, rolling fingers towards nipple; then express milk or let baby feed every 2–3 hours day and night. Rest, adequate nutrition and fluids are important supportive measures. Analgesics may help with milk let-down. If the mother presents with severe symptoms, or a fissure is present, or there is no improvement after 24 hours of improved draining then treat with antibiotics. Refer for skilled breastfeeding support.

See HIV for management of mastitis in women living with HIV

Ibuprofen or Paracetamol for analgesia

The most common bacterium found in breast abscess is *Staphylococcus aureus*. Therefore, it is necessary to treat breast infections with a penicillinase-resistant antibiotic e.g. *Flucloxacillin, Erythromycin or Cloxacillin*.

[Infant and Young Child Feeding Counselling: An Integrated Course. Participant’s Manual. WHO, 2006.](#) . Page 122.

[Managing Complications in Pregnancy and Childbirth. WHO, 2007.](#) S112.

[Mastitis: Causes and Management. WHO, 2000.](#)

[Community Based IYCF Package UNICEF](#)

e. Breast Abscess

Breastfeed with caution
Treat with aspiration or I & D and antibiotics
Likely to require analgesics

Symptoms: If a well-defined area of the breast remains hard, red, and very tender despite appropriate mastitis management, then an abscess should be suspected. Abscesses are rare, occurring in 3% of women who have infectious mastitis or due to recurrent blocked ducts. Diagnosis is by needle aspiration or ultrasound. Abscesses may be resolved through aspiration or may require incision and drainage. Radial incision from the chest towards the nipple is recommended to preserve milk ducts. Rest, adequate nutrition and fluids are important supportive measures

Management: Counsel mothers to continue breastfeeding from the affected breast to prevent engorgement, relieve pressure on the incision and prevent the recurrence of mastitis. Apply a warm compress before breastfeeding. If the child’s mouth would be in contact with the drain or infected tissue, or the child refuses the breast, support hand expression instead. Milk from an infected breast will not harm the baby. Do not recommend immediate cessation of breastfeeding.

Ibuprofen, Paracetamol.

The most common bacterium found in breast abscess is *Staphylococcus aureus*. Therefore, it is necessary to treat breast infections with a penicillinase-resistant antibiotic e.g. *Flucloxacillin, Erythromycin or Cloxacillin*.

With an abscess, the possibility to MRSA (methicillin-resistant staph aureus) increases so may require e.g. *Clindamycin* or *Cotrimoxazole*

[Managing Complications in Pregnancy and Childbirth. WHO, 2007.](#) S113.

[Mastitis: Causes and Management. WHO, 2000.](#)

4. GENERAL GUIDANCE ON FEEDING DURING ILLNESS IN MOTHERS

There are very few diseases which are a contraindication to breastfeeding. Withholding breastfeeding during illness tends to increase the chances of the child becoming sick, because breastmilk contains tailored antibodies.

Maternal infections do not pose a risk to infants except in the rare circumstances when septicaemia occurs and bacteria might reach the milk. Given this event, continued breastfeeding while the mother receives appropriate antibiotic therapy that is compatible with breastfeeding is the safest course for the infant. If the infecting organism is especially virulent or contagious, breastfeeding should continue after a temporary suspension during the first 24 hours of maternal therapy. Exceptions exist (see Ebola). Promote good hygiene and support breastfeeding mothers to remain hydrated.

a. Severe maternal illness

May require temporary feeding support

When a mother is so severely ill that it prevents her from caring for her infant, the provision of temporary feeding support

(see definitions) is justified. It is likely that in this case, the mother will also not be able to express her milk regularly. Provide support to prevent engorgement or mastitis. Once her condition has improved, she may require skilled breastfeeding support to increase her milk production or to re-lactate.

[Acceptable medical reasons for use of breast-milk substitutes. WHO and UNICEF, 2009. P. 8](#)

5. SPECIFIC GUIDANCE ON BREASTFEEDING IN SPECIAL SITUATIONS (MATERNAL)

a. Diarrhoeal Disease

Cholera, Typhoid, Shigella

Continue breastfeeding

Provide temporary feeding support if needed

During an outbreak: Strongly discourage bottle-feeding of breastmilk substitutes, semi-liquid complementary foods etc. It is safer to use open cups rather than bottles, when necessary. Promote exclusive breastfeeding under 6 months and continued breastfeeding thereafter. Hygienic preparation of complementary foods for children > 6 months is essential.

Sick mother: Do not separate mothers from their breastfed children, but try to separate the pair from other patients to prevent cross infection. If this is not possible, consider having a relative care for the child outside the treatment centre and for the child to be brought in for breastfeeding. Counsel mothers to continue breastfeeding and wash breasts and hands with water and soap/chlorine water. Rinse with safe clean water or breastmilk to remove smell of soap / chlorine if necessary. Support mother with adequate fluids; dehydration may reduce breastmilk volume but can be rapidly reversed with ORS or IV fluids. Mothers are likely to require substantial support in caring for their child while they are ill. If the mother is too ill to breastfeed, provide temporary feeding support (informal or formal donor human milk or, as a last resort, infant formula) and support her to restart breastfeeding as soon as possible. Ready-to-Use Infant Formula (RUIF) is preferred over Powdered Infant Formula (PIF) during diarrhoeal disease outbreaks. For mothers of artificially fed children, consider separation from mother if an alternative caregiver is available and support safe preparation of infant formula (demonstrations, counselling, resources etc.)

[Cholera Toolkit. UNICEF, 2013.](#) Annex 8D: Infant and Young Child Feeding and Cholera.

b. Ebola

Child is asymptomatic → Replacement Feeding

Child has developed Ebola or is a suspected Ebola case

→ Breastfeed if mother's condition allows it

Pregnant after recovering from EVD → Breastfeed

Breastmilk can contain the Ebola virus. While it is not known whether the virus can be transmitted through breastmilk the close contact required for a mother who has EVD to breastfeed puts the infant at high risk of infection regardless.

If a mother is suspected or confirmed to have EVD, feeding decisions must be made on a case-by-case basis by weighing the risk of transmitting Ebola virus to the baby through breastfeeding against the risk of stopping breastfeeding for the baby. (Consider age, availability and feasibility of safe replacement feeding, overall sanitary conditions and access to care for the mother). **For the breastfed infant of an Ebola-infected mother where the infant is asymptomatic,** it is recommended that the infant is separated from the mother and is replacement fed. **For the breastfed infant of an Ebola-infected mother where the infant has developed Ebola or is a suspected Ebola case,** the risks of not breastfeeding outweigh any possible benefits of replacement feeding. If the mother is well enough to breastfeed, she should be supported to continue to do so. If the mother is too ill to breastfeed, then replacement feeding is needed. Mothers who stop breastfeeding will need to express milk to alleviate pain and prevent inflammation.

Replacement feeding with formal donor breast milk or an appropriate BMS is preferred over wet nursing in the context of Ebola, as there is a risk of transmission from a wet-nurse to an infant and vice versa if either develops symptoms. The safest replacement feeding for infants aged less than 6 months is likely to be ready-to-use infant formula (RUIF). Nutrition support to Ebola infected mothers and their children who remain with them, is needed during treatment. Ensure provision of safe drinking water and appropriate complementary foods for infants > 6 months.

There is not enough evidence to provide guidance on precisely when it is safe to resume breastfeeding after recovery. However, breastfeeding should be recommended for women who become pregnant and give birth *after* recovering. Consult WHO for the latest guidance.

[Infant Feeding in the Context of Ebola - Updated Guidance. ENN, 2014.](#)

[Nutritional care of children and adults with Ebola virus disease in treatment centres: Interim Guideline. WHO, UNICEF, WFP, 2014.](#)

[Recommendations for Breastfeeding/Infant Feeding in the Context of Ebola Virus Disease. CDC, 2016.](#)

c. Hepatitis

Hepatitis B

Breastfeed

Vaccinate

Infants should be given hepatitis B vaccine.

Provide skilled breastfeeding counselling to ensure good attachment to the breast and to prevent nipple damage.	
Breastfeeding and Hepatitis B. CDC, 2015. Hepatitis B and Breastfeeding. WHO, 1996. Acceptable medical reasons for use of breast-milk substitutes. WHO and UNICEF, 2009. P. 9	
Hepatitis C	Breastfeed with caution May require temporary feeding support
<p>The hepatitis C virus is transmitted by infected blood, not by human breastmilk. Mothers are likely to need additional support to continue breastfeeding when they feel unwell. Provide skilled breastfeeding counselling to ensure good attachment to the breast and prevent nipple damage. If the mother's nipples and / or surrounding areola are cracked or bleeding, provide temporary feeding support (formal or informal donor human milk or an appropriate BMS). Counsel the mother to express and discard her breastmilk until her nipples are healed, then resume breastfeeding.</p>	
Breastfeeding and Hepatitis C. CDC, 2015. Acceptable medical reasons for use of breast-milk substitutes. WHO and UNICEF, 2009. P. 9	
d. Herpes Simples Virus 1 (HSV-1)	Breastfeed with caution May require temporary feeding support
<p>Support adequate diet, rest and psychosocial wellbeing for pregnant women to prevent herpes sores from flaring up.</p> <p>HSV-1 is spread through contact. <u>Direct contact</u> between lesions on the mother's breasts and the infant's mouth should be avoided until all active lesions have resolved. If a herpes sore appears on the mother's breast she should cover it, prevent the baby from touching the sore and stop breastfeeding <u>on that side</u> until the sore is healed. Expressing milk from the affected breast will minimize the risk of engorgement as well as keep up her supply. If the milk, the mother's hand or her breast pump touch the sore, the milk should be discarded. Observe strict hygiene. The mother can continue to nurse from the unaffected breast. However, for very young infants for whom infection is very dangerous, temporary feeding support may be advisable.</p>	
Herpes and Breastfeeding. Breastfeeding Support.	
e. HIV	Breastfeeding OR replacement feeding
<p><i>Infant feeding practices recommended to mothers known to be living with HIV should support the greatest likelihood of HIV-free survival of their children and not harm the health of mothers. To achieve this, giving priority to preventing HIV transmission needs to be balanced with meeting the nutritional requirements of infants and protecting them from non-HIV morbidity and mortality.</i></p> <p>National or subnational recommendations should be followed and will either be to: 1) breastfeed and receive ARV drug interventions, or 2) avoid all breastfeeding and provide replacement feeding. If replacement feeding is the policy, consider whether the policy is in line with the latest WHO recommendations and addresses emergency situations.</p> <p>Support breastfeeding mothers living with HIV to breastfeed for at least 12 months (exclusively for the first 6 months) and to continue breastfeeding for up to 24 months or longer while being fully supported for adherence to ART. Where ARV drugs are likely to be unavailable, breastfeeding of HIV-exposed infants during emergencies is recommended in the interests of child survival. Heat-treatment of expressed breastmilk may be considered as an <i>interim</i> feeding strategy but may not always be realistic in emergency settings. Breastfeeding should only stop once a nutritionally adequate and safe diet without breastmilk can be assured.</p> <p>Conditions of the breast or of the child's mouth are factors which can affect mother-to-child transmission of HIV. Nipple fissure (particularly if bleeding), mastitis, or breast abscess may increase the risk of HIV transmission therefore access to skilled breastfeeding support is particularly important for this group. The recommendation to increase frequency and duration of breastfeeding to manage mastitis is not appropriate for women living with HIV; instead counsel women to avoid breastfeeding <u>from the affected breast</u> as long as the condition persists. Hand expression is essential. Feed more often, and for longer, <u>from the unaffected breast</u>. If both breasts are affected, provide temporary feeding support. Good positioning and attachment plays an important role in preventing these conditions. Mouth sores or thrush in the child's mouth may facilitate entry of the virus and must be treated promptly.</p> <p>Mothers should be counselled to exclusively breastfeed for the first 6 months, as this lowers the risk of HIV transmission compared to mixed feeding. However, practising mixed feeding is not a reason to stop breastfeeding in the presence of ARV drugs.</p>	
The Code on the Marketing of Breastmilk Substitutes remains relevant for mothers living with HIV and covers needs.	
Infants receiving replacement feeding should urgently be identified and supported during emergencies. Prospective wet	

nurses should undergo HIV counselling and testing where available. In the absence of testing, consider undertaking an individual HIV risk assessment.

[Guidelines on HIV and Infant Feeding. WHO, 2010.](#)

[Updates on HIV and Infant Feeding. WHO, 2016.](#)

HIV and Infant Feeding in Emergencies. WHO, 2017.

[Operational Guidance on Infant Feeding in Emergencies. Version 3. IFE Core Group, 2017. "HIV and Infant Feeding"](#)

[Infant and Young Child Feeding Counselling: An Integrated Course. Participant's Manual. WHO, 2006.](#) Session 17.

f. Mental Health

Emergency contexts can negatively impact caregivers' mental health. Caregivers' mental health problems might hamper their ability to feed, care for and stimulate their children. Abandonment, non-responsive care and caregiver stress are all serious threats to infant and young child wellbeing and development.

Pregnancy: Intense and chronic forms of stress can negatively impact fetal growth and development. It is important to handle this information sensitively and not cause further anxiety to mothers to be, however it is useful for her to know that taking even a little time out each day to sit and think about / talk to her baby will help. Even in circumstances where it is not possible to protect mother from stressful experiences appropriate support will empower her to regulate her reactions to stressors. Health workers can talk about the baby's developmental stages or ask about baby's movements to help her connect with her unborn child and can discuss strategies to obtain support and rest. Babies who may have been exposed to prolonged stress in pregnancy will benefit from frequent and prolonged skin-to-skin contact after birth to help calm them.

Breastfeeding: Physical and emotional stress can reduce women's confidence in their ability to breastfeed and diminish the capacity of other family members to support them. Stress, exhaustion, trauma and grief may reduce a mother's ability to see what her baby needs, can lead to the misconceptions that breastmilk has "dried up" or that emotions are transmitted through breastfeeding or can temporarily inhibit the milk let-down (oxytocin inhibition). Research into mothers experiencing depression shows a strong link between depression and a mother ceasing to breastfeed her infant. However, depression is *not* an indication to stop breastfeeding. Breastfeeding supports infant and maternal wellbeing and helps mothers to sensitively care for their babies. Therefore, mothers experiencing symptoms of depressions should receive skilled breastfeeding counselling and support from a trained counsellor as well as mental health support. Ensure a high level of care; both breastfeeding problems and a poor-quality counselling can negatively impact maternal wellbeing.

Mental Health and Psychosocial Support: Humanitarian health workers should be sensitive and responsive to the psychosocial wellbeing of caregivers at all times. If difficulties are encountered, health workers who are appropriately trained should:

- 1) Apply active listening and emotional support skills and competencies to reduce initial distress. If caretaker recently experienced crisis event and is highly distressed, apply PFA action principles.
- 2) Use grounding techniques to re-orient a person to the present moment
- 3) Look for red flags that indicate a caregiver in acute distress and refer to specialised services if necessary
- 4) Keep mothers and their children close together, encourage regular skin to skin and support responsive feeding, nurturing and comfort (regardless of whether the child is breast or formula-fed).

In the event that psychiatric drugs which are a contraindication to breastfeeding are necessary, or the mother is experiencing acute mental distress or there are child protection concerns, temporary or longer term feeding support (formal / informal donor human milk or, as a last resort, infant formula) may be necessary.

In the event of severe trauma or rape, mothers may reject their child or not wish to breastfeed. Feeding support for the infant may be necessary, while the mother receives supportive care.

[Psychological First Aid: Guide for Field Workers. WHO, War Trauma Foundation and World Vision, 2011](#)

[Psychosocial Impact of Humanitarian Crises. ACF, 2014](#)

[Guidelines on Mental Health and Psychosocial Support in Emergency Settings: What should Humanitarian Health Actors know? IASC, 2010.](#)

[First Aid Training Manual for Child Practitioners. Save the Children, 2013](#)

g. Tuberculosis

Breastfeed with caution

The best way to prevent TB infection in infants is to enable prompt access to appropriate maternal treatment. Mothers with TB should be managed according to national guidelines. After active TB in the baby is ruled out, the baby should be given preventive therapy, followed by BCG vaccination.

WHO advises for mothers and babies to be kept together and to breastfeed. National feeding recommendations will vary. Decisions should be made by weighing the risk of transmitting TB to the child through breastfeeding against the risk of not breastfeeding the child, to support the greatest likelihood of TB-free child survival. (Consider age, availability and feasibility of safe and continuous replacement feeding, availability of treatment for mother, whether mother has MDR TB etc.) Because TB

cannot be transmitted through breastmilk, feeding of the mother's expressed breastmilk by another caregiver may be an alternative in some instances. Breastfeeding mothers can be counselled on the use of a face mask, appropriate cough hygiene and hand washing. If a mother is severely ill breastfeeding may not be possible.

Note that breastfeeding women are at higher risk of peripheral neuropathy and should receive preventive treatment.

[Acceptable medical reasons for use of breast-milk substitutes. WHO and UNICEF, 2009.](#) P. 9

[Breastfeeding and Maternal Tuberculosis, WHO 1998](#)

[Guidelines for treatment of tuberculosis. WHO, 2010](#)

[Management of newborn infant born to mother suffering from tuberculosis: Current recommendations & gaps in knowledge. Mittal et al., 2014](#)

h. Zika

Breastfeed

There are currently no documented reports of Zika virus being transmitted through breastfeeding and no adverse neurological outcomes have been reported to date in infants with postnatally acquired Zika virus disease. Infants born to mothers with suspected, probable or confirmed Zika virus infection, or who reside in or have travelled to areas of ongoing Zika virus transmission, should be fed according to normal infant feeding guidelines.

Mothers and families of infants born with congenital anomalies (e.g. microcephaly), or those presenting with feeding difficulties, should receive skilled support to breastfeed their infants.

[Infant feeding in areas of Zika virus transmission. WHO, 2016](#)

i. Maternal Medication

Dependant on medication

Most maternal medication is compatible with breastfeeding due to the low proportion which reaches the breastmilk. Always consider the effect of maternal medication on a breastfeeding mother's ability to feed her child and explore whether safe alternatives are available. In the vast majority of cases, stopping breastfeeding is detrimental to both mother and child. However, the following are examples of maternal medications that may justify temporary avoidance of breastfeeding and require temporary feeding support:

- Sedating psychotherapeutic drugs, anti-epileptic drugs and opioids and their combinations (may cause side effect such as drowsiness and respiratory depression, better avoided if a safer alternative is available)
- Radioactive iodine-131- a mother can resume breastfeeding about two months after receiving this substance (better avoided given that safer alternatives are available)
- Excessive use of topical iodine or iodophors (e.g., povidone-iodine), especially on open wounds or mucous membranes, can result in thyroid suppression or electrolyte abnormalities in the breastfed infant
- Cytotoxic chemotherapy requires that a mother stops breastfeeding during therapy.

While the infant or young child receives temporary feeding support, support the mother to continue to remove (and discard) milk from her breast to maintain milk production. Mothers may require skilled breastfeeding support in order to increase milk production or to re-lactate once it is safe to resume breastfeeding. If the mother needs to stop breastfeeding altogether, she will require counselling and skilled support to prevent engorgement or mastitis.

[Acceptable medical reasons for use of breast-milk substitutes. WHO and UNICEF, 2009.](#) P. 8

[ABM Clinical Protocol: Anaesthesia and Analgesia for the Breastfeeding Mother. Academy of Breastfeeding Medicine, 2009.](#)

[ABM Clinical Protocol: Use of Antidepressants in Breastfeeding Mothers. Academy of Breastfeeding Medicine, 2015.](#)

Medication package inserts are not reliable sources of information on drug safety and breastfeeding. Consult:

<http://www.e-lactancia.org/>

<https://toxnet.nlm.nih.gov/newtoxnet/lactmed.htm>

<https://www.sps.nhs.uk/>

<http://www.medsmilk.com/>

<https://www.breastfeedingnetwork.org.uk/drugs-factsheets/>

j. Other situations

Deceased

Long term feeding support

Infants whose mother is deceased will require a context-specific, coordinated package of care and skilled feeding support which can be comprised of donor human milk or a breastmilk substitute. The only appropriate BMS for infants less than 6 months of age is infant formula. Alternative milks may be used as a BMS in children aged six months and older.

Caesarean Section

Breastfeed

Mothers and babies delivered by caesarean section can breastfeed normally, unless there is some other complication, such as illness or abnormality.

If the mother has had spinal or epidural anaesthesia, the baby should be delivered onto her chest, and she can start skin-to-skin contact and initiate breastfeeding during the first hour in a similar way to that after vaginal delivery. If she has had a general anaesthetic, she should start skin-to-skin contact and initiate breastfeeding as soon as she is able to respond, usually about 4 hours after delivery. A baby who is full term and in good condition can wait for the first feed until the mother

responds.

Babies who are at risk of hypoglycaemia may need an alternative feed by cup until they can start breastfeeding (see *hypoglycaemia*).

After caesarean section, a mother should continue to feed her baby on demand, but she will need help for a few days to hold the baby, to learn how to breastfeed lying down, and to turn over and to position herself comfortably for feeds. Most mothers can breastfeed normally after a caesarean delivery if they are given appropriate help in the post-operative period and unnecessary supplements are not given.

If a baby is too ill or too small (see: Low Birth Weight) to be fed from the breast soon after delivery, the mother should be helped to express her milk to establish the supply, starting within 6 hours of delivery or as soon as possible.

[WHO 2009 IYCF Model Chapter](#)

Family Planning

The harmful effects of pregnancies too close together are well recognized. Birth-to-pregnancy intervals of around 18 months or less are associated with a significantly higher risk of neonatal and infant mortality, low birth weight, small size for gestational age and preterm birth.

Lactational Amenorrhoea Method (LAM) is an important method of family planning, because it is available to women who are unable for social or other reasons to obtain or use modern contraceptives. Hormones produced when a baby suckles prevent ovulation, and so delay the return of menstruation and fertility after childbirth. New mothers should be counselled on LAM and informed about its limitations. LAM is 98% effective 1) if menstruation has not returned 2) if she is breastfeeding exclusively 3) the baby is less than 6 months old.

Non-hormonal methods are all suitable and have no effect on lactation.

Hormonal methods can have an effect on lactation, and reduce breast-milk production. None should be used within 6 weeks of delivery. *Progestogen-only* methods can be used from 6 weeks after delivery. *Combined oestrogen-progesterone* methods are the least suitable, as they may sometimes reduce a mother's milk supply even after 6 weeks. However, if no other method is available, then it is better for both mother and child if she uses the combined pill than if she risks an early pregnancy. Encourage frequent breastfeeding to maintain milk production.

[WHO 2009 IYCF Model Chapter](#)

Substance Misuse

Breastfeed with caution

Infants of women with substance use disorders, at risk for multiple health and developmental difficulties, stand to benefit substantially from breastfeeding and human milk, as do their mothers. Maternal use of nicotine, alcohol, ecstasy, amphetamines, cocaine and related stimulants has been demonstrated to have harmful effects on breastfed babies. Alcohol, opioids, benzodiazepines and cannabis can cause sedation in both the mother and the baby. Alcohol also interferes with the milk ejection reflex, which may ultimately reduce milk production. Mothers should be actively supported not to use these substances, and given opportunities and individualised, patient-centred support.

[Acceptable medical reasons for use of breast-milk substitutes. WHO and UNICEF, 2009. P. 9](#)

[ABM Clinical Protocol: Guidelines for Substance Use or Substance Use Disorder. Academy for Breastfeeding Medicine, 2015.](#)

<http://e-lactancia.org/>

<https://toxnet.nlm.nih.gov/newtoxnet/lactmed.htm>

DEFINITIONS²

Breastmilk Substitute (BMS): Any food (solid or liquid) being marketed, otherwise represented or used as a partial or total replacement for breastmilk, whether or not suitable for that purpose. The only suitable breastmilk substitute for in infant less than 6 months of age is infant formula. Alternative milks may be used as a BMS in children aged 6 months and older, such as pasteurised or boiled full-cream animal milk (cow, goat, sheep, camel, buffalo), Ultra High Temperature (UHT) milk, fermented milk or yogurt. (*Source: Operational Guidance on IFE, Version 3*).

Donor Human Milk: Expressed breastmilk voluntarily provided by a lactating woman to feed a child other than her own. *Informal donor human milk* involves informal milk sharing (e.g. peer to peer, community-based) to breastmilk feed a child with

² Source: Operational Guidance on Infant and Young Child Feeding in Emergencies. IFE Core Group, 2017

unprocessed expressed breastmilk. *Formal donor human milk* is sourced from a Human Milk Bank to breastmilk feed a child with screened and processed expressed breastmilk. (Source: Operational Guidance on IFE, Version 3).

Relactation: The resumption of breastmilk production (lactation) in a woman who has stopped lactating, recently or in the past in order to breastfeed her own or another infant, even without a further pregnancy.

Replacement Feeding: Feeding a child who is not receiving any breastmilk with a nutritionally adequate diet until the age at which they can be fully fed on family foods.

Supplementation: The provision of additional fluids to a breastfed infant before 6 months of age. These fluids may include donor human milk, infant formula or other BMS. Direct breastfeeding may also be supplemented with mother's own expressed breastmilk.

Feeding Support: In order of preference, the provision of mother's own expressed breastmilk, human donor milk, or infant formula. This may replace or supplement direct breastfeeding at the mother's breast, and must be accompanied by counselling and access to necessary resources. Counselling and support to the mother to increase milk production or to relactate should also be included if the feeding support is deemed to be only temporarily necessary.

Wet Nursing: Breastfeeding of a child by someone other than the child's biological mother

KEY RESOURCES

IYCF-E Toolkit. Version 3. Save the Children, 2017.

<https://sites.google.com/site/stcehn/documents/iycf-e-toolkit-v3>

IYCF: Model Chapter for Textbooks for Medical Students and Allied Health Professionals. WHO, 2009. English and www.who.int/nutrition/publications/infantfeeding/9789241597494/en/

Operational Guidance on IFE. Version 3. IFE Core Group, 2017.

<http://www.enonline.net/operationalguidance-v3-2017>

Position Paper on IYCF-E. Emergency Nutrition Working Group – Save the Children, 2016.

<https://drive.google.com/file/d/0B5uBNDhrtqbNndidU91Ym1hNGM/view>