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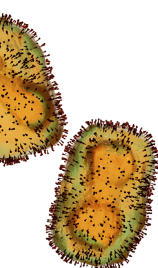

FREQUENTLY ASKED QUESTIONS:
Breastfeeding in the context of mpox – information for health workers

(Version 1.2 – 7th October 2024)

These Frequently Asked Questions (FAQs) have been developed by the Infant Feeding in Emergencies (IFE) Core Group Infectious Disease Taskforce based on the most recent recommendations, collective knowledge and evidence on mpox, taking into account the specific contexts affected by the current mpox outbreak. The FAQs also draw on infant and young child feeding (IYCF) recommendations from the World Health Organization (WHO) and the IFE Core Group. These FAQs are intended to provide answers to health workers and the public – including mothers who are breastfeeding or expressing milk – on breastfeeding during the current mpox outbreak. A decision tree shows how health workers in maternity services, paediatric units, nutritional units and community settings may implement these recommendations as part of their daily work with mothers and families.

The FAQs reflect:

- The available evidence regarding the transmission risks of mpox virus through breastmilk and breastfeeding WHO's mpox guidance (2022);
- The protective effects of breastmilk and breastfeeding; and
- The harmful effects of inappropriate use of breastmilk substitutes.

We acknowledge that guidance on mpox will evolve over time as more information becomes available, and so may these FAQs. We welcome suggestions for improvements at ife@ennonline.net.

General questions on mpox

1. Can the mpox virus be transmitted through breastmilk?

It is currently not known whether or not the mpox virus or antibodies are present in the breastmilk of breastfeeding mothers with mpox.

2. Should mothers breastfeed in communities where mpox is prevalent?

Yes. The known risks associated with withholding the protection from breastfeeding, and the distress caused by the separation of mother and infant, must be given greater weight in a risk/benefit calculation than the potential and unknown risk of infection from mpox in the infant.

If the mother of an infant or young child has a known or suspected exposure to mpox and no symptoms suggestive of infection, they should continue breastfeeding while closely monitoring for signs and symptoms of mpox (in both mother and infant). Advise the mother to wash her hands before touching the infant and to wear a face mask, if possible, while breastfeeding.

3. What are key messages for a mother who wants to breastfeed and is not a confirmed/suspected mpox case, but who is scared about passing mpox virus to her infant?

There is no evidence that the virus is transmitted through breastmilk. However, the known risks associated with withholding the protection from breastfeeding, and the distress caused by the separation of mother and infant, must be given greater weight in a risk/benefit calculation than the potential and unknown risk of infection from mpox in the infant.

As part of counselling, a mother's or family's anxiety about mpox should be acknowledged and responded to with the following messages:

- Breastfeeding reduces the risk of death in newborns and young infants and provides immediate and lifelong health and development advantages. Breastfeeding also reduces the risk of breast cancer and ovarian cancer for the mother.
- The more the mother breastfeeds, the more breastmilk a mother can produce for the child.
- The numerous benefits of breastfeeding most likely outweigh the potential transmission and illness risks associated with mpox.
- Always wash hands before and after each feed with soap and clean water.

If the mother stops breastfeeding temporarily, help her maintain breastmilk supply via regular breastmilk expression. This will help the mother maintain supply and facilitate restarting breastfeeding as soon as possible.

4. What advice should be given to a mother who is a contact of a confirmed mpox case but who does not have confirmed/suspected mpox herself?

In this case advise the mother as if she were a suspected mpox case who is asymptomatic. The benefits of breastfeeding most likely outweigh interruption of breastfeeding during a mpox outbreak.

If the mother of an infant or young child is a contact of a confirmed mpox case but has no symptoms suggestive of an mpox infection, they should continue breastfeeding while closely monitoring for signs and symptoms of mpox (in both mother and infant). Advise the mother to wash her hands before touching the infant and to wear a face mask, if possible, while breastfeeding.

5. What are the infection prevention and control (IPC) considerations for mpox cases in a community?

- WHO recommends that a patient with mild, uncomplicated mpox cared for at home should be isolated in an area separate from other household members and away from shared areas of the home (for example a separate, well-ventilated room, or area with a curtain or screen).
- Patients at home with mpox should be able to manage their self-care. Clinical follow-up should be conducted using methods other than in-person visits (for example by telephone).
- Household members and patients with mpox should clean their hands with soap and water or an alcohol-based hand sanitiser frequently.
- If the designated person that is facilitating self-care needs to enter the isolation area, they should maintain a distance of at least 1m from the patient and wear a mask and gloves. They should clean their hands with either soap and water or an alcohol-based hand sanitiser, before and after contact with the patient or surrounding environment and before putting on and after removing their gloves.
- Items such as eating utensils, linens, towels, electronic devices or beds should be dedicated to the person with mpox. Avoid sharing personal items.
- The patient with mpox should wear a mask and cover lesions when in close proximity of others and when moving outside of the designated isolation area (for example to use the toilet).
- If a health worker is required to provide care to persons with mpox in the home, they should wear appropriate personal protective equipment (for example gloves, gown, eye protection and respirator if available), perform hand hygiene, and clean and disinfect any patient care equipment used.
- If persons with mpox leave their household to seek medical attention, they should preferably inform their health practitioner or the facility they will visit in advance of arrival.
- Patients with mpox who are cared for at home should remain in isolation and refrain from close contact until their skin lesions have crusted, the scabs have fallen off and a fresh layer of skin has formed underneath.

For more information see WHO's mpox guidance (2022).

6. Is it acceptable for health facilities to accept free supplies of breastmilk substitutes for infants/ young children of mothers with confirmed/ suspected mpox?

No. Donations of breastmilk substitutes like infant formula milk should not be sought or accepted. If needed, supplies should be purchased based on assessed need after assessment through the government or UNICEF as a first provider. Donated formula milk is commonly of variable quality, of the wrong type, supplied disproportionate to need, labelled in the wrong language, not accompanied by an essential package of care, distributed indiscriminately, not targeted to those who need it and is not sustained. It also takes excessive time and resources to reduce risks associated with handling donations of breastmilk substitutes.

Reach out to your local Nutrition Cluster focal person or the nutrition focal person from UNICEF for more information.

When the mother has confirmed/ suspected mpox (is positive) but the infant is not confirmed/suspected to have mpox (is negative)

7. Following delivery, should an infant still be immediately placed skin-to-skin if the mother is confirmed/suspected to have mpox?

There is currently no clear guidance on this but the mpox virus can be transmitted through close contact. Therefore, if the mother or the infant has confirmed/suspected mpox, do not place the infant in direct skin-to-skin contact with the mother, unless it is for breastfeeding (and the mother does not have lesions on her areola). In this case ensure only the areola touches the infant's skin. For all other circumstances, ensure both the mother and infant are fully clothed when in proximity to each other, that the mother wears a mask (if possible) to avoid transmission through saliva droplets and that the mother wears gloves. Additionally, skin-to-skin contact can be initiated with an alternative caregiver who is not confirmed/suspected to have mpox.

For more information see WHO's mpox infographic.

8. Following delivery, should an infant still be immediately breastfed if the mother has confirmed/suspected mpox?

If the mother has confirmed/suspected mpox but does not have lesions on at least one areola, she should initiate breastfeeding with the precautions listed below:

- Wash hands with soap and clean water, before and after each feed.
- Wear a mask (if possible) and gloves when breastfeeding.
- Cover any lesions (on the areola or on any other area that could have direct contact with the infant). *Note: if the areola has lesions, do not breastfeed from that breast or use expressed milk from that breast for the infant.*
- Ensure the infant and mother are fully clothed (except for lesion-free areolas) to avoid any contact with the mother's skin.
- If the areola has no lesions but the breast has lesions elsewhere, clean the area around the areola with water and cover all lesions.
- If only one of the areolas has lesions, feed from the non-affected breast. Maintain lactation in the affected breast through expression but discard that milk and provide help with pain management if needed.

If the mother has lesions on both areolas, direct breastfeeding should be delayed until the lesions on her areolas are fully healed.

Recommendations for maintaining breastfeeding and handling expressed breastmilk are below.

9. How should a mother with confirmed mpox breastfeed her infant if she has at least one areola without lesions?

If the infant is not separated from the mother:

- Wash hands with soap and clean water, before and after each feed.
- Wear a mask (if possible) and gloves when breastfeeding.
- Cover any lesions (on the areola or on any other area that could have direct contact with the infant). *Note: if the areola has lesions, do not breastfeed from that breast or use expressed milk from that breast for the infant.*
- Ensure the infant and mother are fully clothed (except for lesion-free areolas) to avoid any contact with the mother's skin.
- If the areola has no lesions but the breast has lesions elsewhere, clean the area around the areola with water and cover all lesions.
- If only one of the areolas has lesions, feed from the non-affected breast. Maintain lactation in the affected breast through expression but discard that milk and provide help with pain management if needed.

If the infant is separated from the mother:

- The mother should be supported to initiate and maintain her supply of breastmilk.
- Expressed milk from the non-affected breast (a breast without lesions on the areola) may be fed to the infant.
- Expressed milk from an affected breast with lesions on the areola should be discarded.

10. How should a mother with confirmed mpox breastfeed her infant if both areolas have lesions?

The mother should be supported to initiate and maintain her supply of breastmilk. Expressed milk from an affected breast with lesions on the areola should be discarded.

The infant should instead be fed with:

- Milk through wet nursing from a woman that is not suspected or confirmed as having mpox.
- Donor human milk.
- An appropriate breastmilk substitute, informed by feasibility, safety, sustainability, cultural context, acceptability to mother and service availability (trained health or nutrition professional). The safest option is Ready-to-Use Infant Formula (RUIF). Powdered Infant Formula (PIF) may also be used, but only when it can be made up with clean, boiled water (cooled to approximately 70ºC) or bottled water, to minimise contamination risks. Once made up, the formula should be fed immediately, using cups and spoons, with any leftovers discarded.

For more information on planning and managing artificial feeding interventions and supporting infants dependent on artificial feeding during emergencies, see the IFE Core Group IYCF-E infographic series and the UNICEF Programming Guidance on the Procurement and Use of Breastmilk Substitutes in Humanitarian Settings and contact your local Nutrition Cluster focal person.

11. If a mother is confirmed/suspected to have mpox, should she continue breastfeeding?

Protecting the child's survival while maintaining the nutritional intake of the infant is the priority. So, provide counselling explaining the following to the mother:

- The risk of mpox infection in the infant from breastfeeding.
- That it is not known whether or not breastmilk contains the mpox virus if the mother has confirmed mpox.
- IPC measures that can be applied/used (washing hands with soap and water, wearing masks, wearing gloves and so on).
- What a mother can do to continue breastfeeding if she chooses.
- What a mother can do to maintain breastfeeding and breastmilk supply.
- Options for replacement feeding if needed (for example wet nursing, donor human milk, or use of breastmilk substitutes depending on the age of the child).
- If a mother wants to stop breastfeeding during her infectious period (3–4 weeks), how she can restart when she is no longer infectious.

12. What are the hygiene recommendations (IPC measures) for a breastfeeding mother confirmed/suspected to have mpox?

General protective IPC measures should be taken by mothers with mpox when handling and feeding their infants:

- Wash hands with soap and clean water, before and after each feed.

- Wear a mask (if possible) and gloves when breastfeeding.
- Cover any lesions (on the areola or on any other area that could have direct contact with the infant). *Note: if the areola has lesions, do not breastfeed from that breast or use expressed milk from that breast for the infant.*
- Ensure the infant and mother are fully clothed (except for lesion-free areolas) to avoid any contact with the mother's skin.
- If the areola has no lesions but the breast has lesions elsewhere, clean the area around the areola with water and cover all lesions.
- If only one of the areolas has lesions, feed from the non-affected breast. Maintain lactation in the affected breast through expression but discard that milk and provide help with pain management if needed.

13. Is it necessary for a mother with confirmed/suspected mpox to wash her breasts before she breastfeeds directly or before expressing milk?

Yes, it is advised for a mother with confirmed/suspected mpox to wash her breasts before she breastfeeds or before expressing milk.

The following IPC measures should also be applied:

- Wash hands with soap and clean water, before and after each feed.
- Wear a mask (if possible) and gloves when breastfeeding.
- Cover any lesions (on the areola or on any other area that could have direct contact with the infant). *Note: if the areola has lesions, do not breastfeed from that breast or use expressed milk from that breast for the infant.*
- Ensure the infant and mother are fully clothed (except for lesion-free areolas) to avoid any contact with the mother's skin.
- If the areola has no lesions but the breast has lesions elsewhere, clean the area around the areola with water and cover all lesions.
- If only one of the areolas has lesions, feed from the non-affected breast. Maintain lactation in the affected breast through expression but discard that milk and provide help with pain management if needed.

14. If a mother confirmed/suspected to have mpox decides not to breastfeed, what is the best way to feed her newborn/infant aged under six months?

If the infant is under six months old and is separated from the mother who has mpox, the infant should be fed with:

- Milk through wet nursing from a woman that is not suspected or confirmed as having mpox.
- Donor human milk.
- An appropriate breastmilk substitute, informed by feasibility, safety, sustainability, cultural context, acceptability to mother and service availability. The safest option is Ready-to-Use Infant Formula (RUIF). Powdered Infant Formula (PIF) may also be used, but only when it can be made up with clean, boiled water (cooled to approximately 70ºC) or bottled water, to minimise contamination risks. Once made up, the formula should be fed immediately, using cups and spoons, with any leftovers discarded.

If the mother stops breastfeeding temporarily, help her maintain breastmilk supply via regular breastmilk expression. This will help the mother maintain supply and facilitate restarting breastfeeding as soon as possible.

For more information on planning and managing artificial feeding interventions and supporting infants dependent on artificial feeding during emergencies, see the IFE Core Group IYCF-E infographic series and the UNICEF Programming Guidance on the Procurement and Use of Breastmilk Substitutes in Humanitarian Settings and contact your local Nutrition Cluster focal person.

15. If a mother confirmed/suspected to have mpox decides not to breastfeed, what is the best way to feed her infant/young child aged 6–23 months?

If the infant is aged 6–23 months and is separated from the mother who has mpox, the infant/young child should be fed with:

- Milk through wet nursing from a woman that is not suspected or confirmed as having mpox.
- Donor human milk.

If neither of these options are available:

- For infants aged 6–11 months who are fed milks other than breastmilk, either formula milk or whole cream pasteurised animal milk should be fed.
- For young children aged 12–23 months who are fed milks other than breastmilk, whole cream pasteurised animal milk should be fed. Follow-on formulas are not recommended.

If the mother stops breastfeeding temporarily, help her maintain breastmilk supply via regular breastmilk expression. This will help the mother maintain supply and facilitate restarting breastfeeding as soon as possible.

16. Is it safe to give a child expressed breastmilk from a mother confirmed/suspected to have mpox?

It is currently not known whether or not the mpox virus or antibodies are present in the breastmilk of breastfeeding mothers with mpox. However, the known risks associated with withholding the protection from breastfeeding, and the distress caused by the separation of mother and infant, must be given greater weight in a risk/benefit calculation than the potential and unknown risk of infection from mpox in the infant.

Therefore, breastfeeding can continue while using IPC measures to minimise the risk of transmission to the child.

If there are no lesions on the areola, expressed breastmilk can be fed to the infant/young child.

If there are lesions on the areola, expressed breastmilk should be discarded from that breast.

17. If a mother with confirmed/suspected mpox is not able to breastfeed or to express breastmilk, can wet nursing be recommended?

If wet nursing is accepted, then wet nursing can be recommended as an option. However, it is important to only facilitate wet nursing when both the infant/young child and the wet nurse have been confirmed as not having mpox (no symptoms, negative mpox (PCR) test).

18. If a mother confirmed/suspected of having mpox temporarily halts breastfeeding, when can she start to breastfeed again?

If the mother stops breastfeeding temporarily, help her maintain breastmilk supply via regular breastmilk expression. This will help the mother maintain breastmilk supply and facilitate restarting breastfeeding as soon as possible.

When the mother recovers (asymptomatic, negative mpox (PCR) test), she can start breastfeeding again. This is only advised when all lesions to which the infant can be exposed have resolved, the scabs have fallen off and a fresh layer of intact skin has formed.

If the mother is still symptomatic and/or has a positive mpox (PCR) test but wants to restart breastfeeding, provide counselling explaining the following to the mother:

- The risk of mpox infection in the infant from breastfeeding.
- That it is not known whether or not breastmilk contains the mpox virus if the mother has mpox.
- The IPC measures that can be applied/used (washing hands with soap and water, wearing masks, wearing gloves and so on).
- What a mother can do to continue breastfeeding if she chooses.
- What a mother can do to maintain breastfeeding and breastmilk supply.
- Options for replacement feeding if needed (for example wet nursing, donor human milk, use of breastmilk substitutes depending on the age of the child).

The following general protective IPC measures should be taken by mothers with mpox when handling and feeding their infants:

- Wash hands with soap and clean water, before and after each feed.
- Wear a mask (if possible) and gloves when breastfeeding.
- Cover any lesions (on the areola or on any other area that could have direct contact with the infant). *Note: if the areola has lesions, do not breastfeed from that breast or use expressed milk from that breast for the infant.*
- Ensure the infant and mother are fully clothed (except for lesion-free areolas) to avoid any contact with the mother's skin.
- If the areola has no lesions but the breast has lesions elsewhere, clean the area around the areola with water and cover all lesions.
- If only one of the areolas has lesions, feed from the non-affected breast. Maintain lactation in the affected breast through expression but discard that milk and provide help with pain management if needed.

All mothers should receive comprehensive assistance to return the infant to the breast, including support for relactation if the milk supply has been compromised.

19. Is it advisable for a mother with confirmed/suspected mpox who is breastfeeding to give a ‘top-up’ with a breastmilk substitute?

There is no benefit to providing ‘top-ups’ with breastmilk substitutes. Mixed feeding is not known to directly increase the risk of mpox infection, but use of breastmilk substitutes does increase the risk of infant morbidity and mortality when appropriate constitution and hygienic preparation cannot be guaranteed.

20. What is recommended regarding IYCF to a mother with confirmed/suspected mpox who was not breastfeeding before contracting the disease?

Provide quality IYCF counselling to the mother that includes:

1. Assessing the current feeding practices used;
2. Monitoring the growth of the child;
3. Providing information on recommended IPC practices during feeding and verifying if the mother can fulfil them; and
4. Helping her improve feeding practices as much as possible depending on assessment, including support with initiating breastfeeding once recovered.

When the infant has confirmed/suspected mpox but the mother is not confirmed/suspected to have mpox

21. If an infant has confirmed/suspected mpox and the mother is not infected, should the mother continue to breastfeed?

Breastfeeding can continue while using IPC measures to minimise transmission to the mother.

For pregnant or immunosuppressed mothers, case-by-case advice should be provided regarding breastfeeding, weighing up the risks and benefits of continuing breastfeeding.

The use of milk expression and cup feeding (with IPC measures) could be considered as long as the mother is negative.

22. What is the advice on infant feeding for an immunosuppressed mother who is not a confirmed/suspected mpox case, who has a child that is a confirmed/ suspected mpox case?

There are currently conflicting statements from authorities regarding this. According to WHO, children, pregnant women and people with weak immune systems (including people living with HIV that is not well controlled) are at higher risk for serious illness and death due to complications from mpox.

For pregnant women and immunosuppressed mothers, case-by-case advice should be provided regarding breastfeeding that properly weighs up the risks and benefits of continuing breastfeeding.

Advise the mother to strictly follow the recommended IPC measures. Expressing breastmilk and allowing another caregiver to feed the infant/young child is the best solution. If this is not possible, discuss with the mother the following feeding options to minimise any risk of infection from the child confirmed/suspected as an mpox case:

- For all infants/young children, donor human milk can be fed.
- For infants under six months an appropriate breastmilk substitute, informed by feasibility, safety, sustainability, cultural context, acceptability to mother and service availability, should be considered. The safest option is Ready-to-Use Infant Formula (RUIF). Powdered Infant Formula (PIF) may also be used, but only when it can be made up with clean, boiled water (cooled to approximately 70ºC) or bottled water, to minimise contamination risks. Once made up, the formula should be fed immediately, using cups and spoons, with any leftovers discarded.
- For infants aged 6–11 months who are fed milks other than breastmilk, either formula milk or whole cream pasteurised animal milk should be fed.
- For young children aged 12–23 months who are fed milks other than breastmilk, whole cream pasteurised animal milk should be fed. Follow-on formulas are not recommended.

Please note that in this case wet nursing is not recommended, given the infant is a confirmed/ suspected mpox case.

For more information on planning and managing artificial feeding interventions and supporting infants dependent on artificial feeding during emergencies, see the IFE Core Group IYCF-E infographic series and the UNICEF Programming Guidance on the Procurement and Use of Breastmilk Substitutes in Humanitarian Settings and contact your local Nutrition Cluster focal person.

When both the mother and the infant have confirmed/suspected mpox

23. How should a mother feed her infant/young child when both the mother and infant/young child are confirmed mpox cases?

Breastfeeding can continue while using IPC measures. Evaluate the best feeding options on a case-by-case basis, considering factors such as the child's age and disease severity and the mother's wellness. Provide breastfeeding support to infected mothers who have interrupted breastfeeding to maintain milk supply.

Mpox vaccinations and breastfeeding

24. Are mpox vaccines (for example MVA-BN) safe for breastfeeding women?

In 2024, WHO stated that there is a lack of data to evaluate the effects of MVA-BN on breastmilk supply or the safety of MVA-BN for infants who are breastfed (WHO's mpox guidance (2022)).

While we need more evidence, the initial evidence outlined in the WHO guidance from 2022 suggests that the MVA-BN vaccine can be used by breastfeeding women. This is based on the following considerations:

- Breastfeeding offers substantial health benefits to breastfeeding women and their breastfed children.
- Data are not available on the potential benefits or risks of the MVA-BN vaccine to breastfed children.
- As the MVA-BN vaccine is a non-replicating live virus vaccine, it is biologically and clinically unlikely to pose a risk to the breastfed child.

Meanwhile, many countries have stated that breastfeeding should not be discontinued when the mother receives the MVA-BN or Modified Vaccinia Ankara-Bavarian Nordic vaccine (marketed under the brand names JYNNEOS®, IMVANEX® and IMVAMUNE®).

For more information see WHO's mpox guidance (2022).

DECISION TREE for breastfeeding in context of mpox: Guidance for health care and community settings

Mother of child aged under two years (child is not confirmed/suspected to have mpox)

Mother mpox status confirmed — NO → Mother mpox status suspected; YES → Child aged <6 months

Mother mpox status suspected — NO → Continue recommended IYCF practices with IPC measures; YES → With symptoms

With symptoms — NO → Continue recommended IYCF practices with IPC measures; YES → Child aged <6 months

Child aged <6 months — YES → Feeding options (with IPC measures) [left box]; NO → Feeding options (with IPC measures) [lower box]

Continue recommended IYCF practices with IPC measures

Feeding options (with IPC measures)

Breastfeeding, if the mother wishes to, and no lesions on the areola (cover all lesions elsewhere and follow all IPC measures).

If there are lesions on both areolas, consider:

1. Wet nursing from a woman that is not confirmed/suspected to have mpox; or
2. Donor human milk

or

3. As a last resort an appropriate breastmilk substitute, informed by feasibility, safety, sustainability, cultural context, acceptability to mother and service availability.

If the mother stops breastfeeding temporarily, help her maintain breastmilk production via regular breastmilk expression. This will help the mother maintain supply and facilitate restarting breastfeeding as soon as possible.

Feeding options (with IPC measures)

Breastfeeding, if the mother wishes to, and no lesions on the areola (cover all lesions elsewhere and follow IPC measures).

If there are lesions on both areolas consider:

1. Milk through wet nursing from a woman that is not confirmed/suspected as having mpox
2. Donor human milk
3. If above not possible and infants/young children aged 6–23 months are fed milks other than breastmilk:

- For infants aged 6–11 months who are fed milks other than breastmilk, either formula milk or whole cream pasteurised animal milk should be fed.
- For young children aged 12–23 months who are fed milks other than breastmilk, whole cream pasteurised animal milk should be fed. Follow-on formulas are not recommended.

If the mother stops breastfeeding temporarily, help her maintain breastmilk production via regular breastmilk expression. This will help the mother maintain supply and facilitate restarting breastfeeding as soon as possible.

IPC measures to be followed when breastfeeding (mother confirmed/suspected to have mpox)

1. Wash hands with soap and clean water, before and after each feed.
2. Wear a mask (if possible) and gloves when breastfeeding.
3. Cover any lesions (on the areola or on any other area that could have direct contact with the infant). *Note: if the areola has lesions, do not breastfeed from that breast or use expressed milk from that breast for the infant.*
4. Ensure the infant and mother are fully clothed (except for lesion-free areolas) to avoid any contact with the mother's skin.
5. If the areola has no lesions but the breast has lesions elsewhere, clean the area around the areola with water and cover all lesions.
6. If only one of the areolas has lesions, feed from the non-affected breast. Maintain lactation in the affected breast through expression but discard that milk and provide help with pain management if needed.

ENN (2024) En-net Post on Mpox and Breastfeeding: https://www.en-net.org/forum/question/5125

IFE Core Group IYCF-E Infographic Series: https://www.ennonline.net/ifecoregroupinfographicseries

IYCF-E Hub, Mpox and IYCF-E Resource Collection: https://iycfehub.org/collection/mpox-iycfe/

UNICEF (2024) Internal Technical Note: Nutrition and Mpox Case Management: https://iycfehub.org/document/unicef-internal-technical-note-interim-recommendations-on-nutrition-and-mpox-case-management/

WASH Cluster (2024) Mpox in Humanitarian WASH Response: https://www.washcluster.net/Mpox-in-humanitarianWASH

WHO (2022) Clinical Management and Infection Prevention and Control for Monkeypox – Interim Rapid Response Guidance: https://www.who.int/publications/i/item/WHO-MPX-Clinical-and-IPC-2022.1

WHO (2022) Interim Guidance on Vaccines and Immunization for Monkeypox (WHO's mpox guidance (2022)): https://iris.who.int/bitstream/handle/10665/364527/WHO-MPX-Immunization-2022.3-eng.pdf?sequence=1

WHO Mpox External Situation Reports: https://www.who.int/emergencies/situation-reports

WHO (2022) Recovering from Monkeypox at Home Infographic: https://www.who.int/multi-media/details/recovering-from-monkeypox-at-home?gad_source=1&gclid=Cj0KCQjwrp-3BhDgARIsAEWJ6SyGXyeicRn39l8i3L3YWsRnOtMueioPEjvm1KaZWWDufR_U_ytZRK8aAnLzEALw_wcB

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