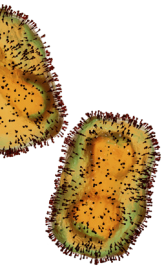


FREQUENTLY ASKED QUESTIONS:
Breastfeeding in the context of mpox – information for health workers

(Version 2.0 – 18th December 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), UNICEF 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 an mpox outbreak. A decision tree shows how health workers in maternity services, paediatric units, nutritional units and community settings may use 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. Please ensure that you are accessing the latest version by checking this link: https://www.ennonline.net/faqs-breastfeeding-context-mpox-information-health-workers

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 more importance 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 more importance 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 (at least every 3 hours). 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 an 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). Alternative for in-person support should still be identified in case of need, especially if the medical condition of the isolated person is deteriorated.
- Household members and patients with mpox should clean their hands with soap and water or an alcohol-based hand sanitiser frequently.
- If the person with mpox is the mother of an infant and/or young child, please ensure to follow the IPC recommendations for feeding an infant (see questions 8 and 12).
- 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 (e.g., with clothes or bandages) 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 mask 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 on IPC considerations, cleaning and disinfection see WHO's mpox guidance (2022) and WHO's mpox infographic.

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?

The mpox virus can be transmitted through close contact.

Skin-to-skin is possible if the mother has confirmed/suspected mpox and doesn't have lesions on her chest, breasts or areolas. Place the infant skin-to-skin on mother's chest and ensure the mother wears a mask (if possible), to avoid transmission through saliva droplets, and gloves and follow general IPC measures.

Do not place the infant in direct skin-to-skin contact with the mother, if the mother has confirmed/suspected mpox and has lesions on her chest and/or breasts. Breastfeeding is possible if the areola is lesion-free by ensuring only the areola touches the infant's skin (see question #8). 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.

Skin-to-skin contact or kangaroo care can be initiated with an alternative caregiver who is not confirmed/suspected to have mpox. For those unable to practice skin-to-skin contact or kangaroo mother care immediately after delivery, encourage them to begin these practices once they and their infants have recovered. This practice supports bonding and attachment, which may have been disrupted due to the illness, and can help initiate breastfeeding as soon as possible.

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

If the mother has confirmed/suspected mpox and 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 and do not 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 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 (lesions crusted, the scabs have fallen and a fresh layer of skin has formed underneath).

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 and do not 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 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 through skilled infant feeding counselling and follow up.
- 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 through skilled infant feeding counselling and follow up. Expressed milk from an affected breast with lesions on the areola should be discarded. Collection cups and utensils should be cleaned with water and soap and disinfected regularly.

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 such as commercial milk formula (CMF), informed by feasibility, safety, sustainability, cultural context, acceptability to mother and service availability (trained health or nutrition professional). Ready-to-Use Infant Formula (RUIF) is an option. Powdered Infant Formula (PIF) may also be used, but only when it can be made up with clean, boiled water (cooled to approximately 70°C) to minimise contamination risks. Once made up, the commercial milk formula should be fed immediately, using cups and spoons, with any leftovers discarded after 2 hours. Skilled infant feeding counselling and follow-up should be provided.

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.

Upon recovery, advise and support mothers to initiate or resume breastfeeding. This will also assist them in bonding and attachment which may have been impeded by the illness.

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 during separation.
- 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), support the restart of breastfeeding 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 and do not 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 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?

No, there is no need for a mother with confirmed/suspected mpox to wash her breasts before she breastfeeds or before expressing milk. It is important however to follow the IPC measures 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 and do not 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 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, such as commercial milk formula (CMF), informed by feasibility, safety, sustainability, cultural context, acceptability to mother and service availability. Ready-to-Use Infant Formula (RUIF) is an option. Powdered Infant Formula (PIF) may also be used, but only when it can be made up with clean, boiled water (cooled to approximately 70ºC) to minimise contamination risks. Once made up, the commercial milk formula should be fed immediately, using cups and spoons, with any leftovers discarded after 2 hours. Skilled infant feeding counselling and follow-up should be provided.

If the mother stops breastfeeding temporarily, help her maintain breastmilk supply via regular breastmilk expression (at least every 3 hours). Upon recovery encourage prolonged skin-to-skin time with her infant or kangaroo mother care. This will help the mother maintain supply and facilitate restarting breastfeeding as soon as possible and will assist her in the bonding and attachment which may have been impeded by the illness.

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?

Alongside appropriate complementary foods, 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 commercial milk formula (CMF) or whole cream pasteurised animal milk should be fed alongside appropriate complementary foods.
- For young children aged 12–23 months who are fed milks other than breastmilk, whole cream pasteurised animal milk should be fed, alongside appropriate complementary foods. Follow-on formulas are not recommended.

If the mother stops breastfeeding temporarily, help her maintain breastmilk supply via regular breastmilk expression (at least every 3 hours). Upon recovery encourage prolonged skin-to-skin time or close contact with her infant. This will help facilitate frequent, unimpeded access to the breast and will assist her in the bonding and attachment which may have been hindered by the illness. This will help the mother maintain supply and will 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 more importance 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.

Collection cups and utensils should be cleaned with water and soap and disinfected regularly.

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) and are not considered as contact cases.

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 (at least every 3 hours). This will help the mother maintain breastmilk supply and will facilitate restarting breastfeeding.

When the mother recovers (asymptomatic, negative mpox (PCR) test and skin lesions cured), she can start breastfeeding again. This is only advised when all lesions to which the infant can be exposed to 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 and do not 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 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 (such as covering skin lesions, avoiding skin contact or washing hands after handling the baby).

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, such as commercial milk formula (CMF), informed by feasibility, safety, sustainability, cultural context, acceptability to mother and service availability, should be considered. Ready-to-Use Infant Formula (RUIF) is an option. Powdered Infant Formula (PIF) may also be used, but only when it can be made up with clean, boiled water (cooled to approximately 70ºC), to minimise contamination risks. Once made up, the commercial milk 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 commercial milk formula (CMF) or whole cream pasteurised animal milk should be fed alongside appropriate complementary foods.
- For young children aged 12–23 months who are fed milks other than breastmilk, whole cream pasteurised animal milk should be fed alongside appropriate complementary foods. 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?

WHO has outlined that the MVA-BN vaccine can be used by breastfeeding women. (Smallpox and mpox (orthopoxviruses): WHO position paper, August 2024).

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.

WHO does not recommend discontinuing breastfeeding because of vaccination.

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) 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

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

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)

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).

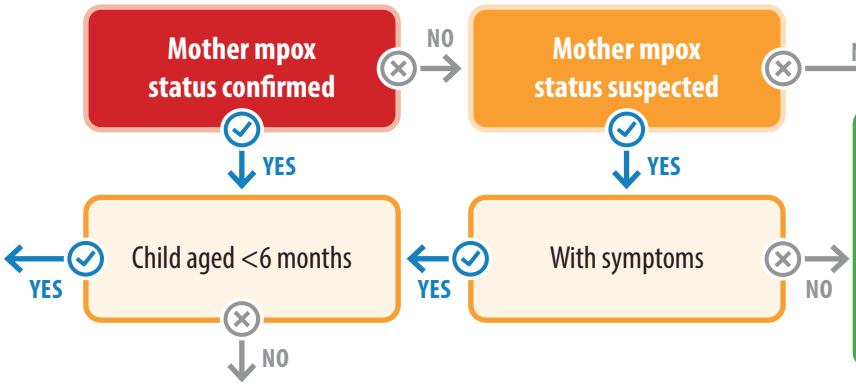
If there are lesions on both areolas, consider:

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 (at least every 3 hours). This will help the mother maintain supply and facilitate restarting breastfeeding as soon as possible.



Feeding options (with IPC measures)

Breastfeeding alongside appropriate complementary foods, 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 the options below alongside appropriate complementary foods:

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 commercial milk formula (CMF) or whole cream pasteurised animal milk should be fed alongside appropriate complementary foods.

• For young children aged 12–23 months who are fed milks other than breastmilk, whole cream pasteurised animal milk should be fed alongside appropriate complementary foods. 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 and do not 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 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.

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