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ADS Chapter 212

Breastfeeding and Infant and Young Child Nutrition Promotion, Protection, and Support

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 Promotion, Protection, and Support
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ADS Chapter 212 – Breastfeeding and Infant and Young Child Nutrition Promotion, Protection, and Support

212.1 OVERVIEW

Effective Date: 08/08/2019

This chapter provides the policies and procedures for breastfeeding and infant and young child nutrition promotion, protection, and support. The objectives of this chapter are to:

- Define USAID policy and responsibilities related to breastfeeding protection, promotion, and support during the first two years of life or beyond, and the introduction of appropriate complementary feeding practices from six months of life, and acceptable use of breast milk substitutes during the first year of life;
- Provide references for optimal breastfeeding practices and breastfeeding program support approaches for USAID strategic objective areas;
- Address breastfeeding programming as related to mother-to-child transmission (MTCT) of the Human Immunodeficiency Virus (HIV) and other infectious diseases; and
- Delineate processes and procedures for the procurement, distribution, and use of breast milk substitutes in times of crisis, infectious disease outbreaks, emergencies, and natural disasters.

In line with [USAID Multi-sectoral Nutrition Strategy 2014-2025](#), the [U.S. Surgeon General's Call to Action to Support Breastfeeding 2011](#), and the recommendations of the World Health Organization (WHO) [Global Strategy for Infant and Young Child Feeding](#), the goals of USAID-supported breastfeeding activities are to:

- Improve the health and development of populations by increasing the number of newborns and infants who are nourished early and exclusively with breast milk for the first six months,
- Promote appropriate complementary foods in addition to breast milk from six months of age, and
- Promote the continuation of breastfeeding for two years or longer along with appropriate complementary foods.

Research has conclusively established the positive and cost-effective impact of breastfeeding on child survival and development, birth spacing, reduction of the risk of some non-communicable diseases and communicable diseases, and women's health. Breastfeeding in comparison to non-breastfeeding provides cost-effective, high-quality food for infants and young children, boosting nutritional status, immune response, brain

development, health, and survival, especially in places where the infant and child morbidity and mortality rates are high. Breastfeeding ensures micronutrient, protein, and energy status and promotes growth and development, all of which contribute to later gains in academic performance and labor productivity. Breastmilk is the safest form of adequate nutrition for infants six months of age and under, and in addition to safe and adequate complementary foods for young children 6-23 months affected by humanitarian crises. In any emergency context, it is critical to assess and support the nutrition and care needs of breast-fed and non-breastfed infants by promoting recommended infant and young child feeding practices and minimizing potential risks. Breastfeeding lowers family expenditures for food and health care.

The United States and international organizations recommend various policies and programs to support optimal infant and young child nutrition, including improving quality of maternity facilities and access to skilled lactation counseling, enacting family leave and workplace breastfeeding policies, and implementing the International Code of Marketing of Breast-milk Substitutes and subsequent World Health Assembly (WHA) resolutions (hereinafter called “the Code”). For comprehensive guidance on optimal feeding of infants and young children, please see the

- [World Health Organization \(WHO\) Global Strategy for Infant and Young Child Feeding](#),
- [WHO Planning Guide for National Implementation of the Global Strategy](#),
- [Guiding Principles for Complementary Feeding of the Breastfed Child](#),
- [Guiding Principles for Feeding of Non-breastfed Children 6-24 Months of Age](#), and
- [UNICEF’s Programming Guide for Infant and Young Child Feeding](#).

212.2 PRIMARY RESPONSIBILITIES

Effective Date: 08/08/2019

- a. **Program Managers/Project and Program Design Teams** in all sectors in USAID/Washington (USAID/W) and Missions that integrate promotion, protection, and support of breastfeeding and infant and young child nutrition into multi-sectoral strategies, activity designs, and projects.
- b. **USAID Mission Directors** ensure that programs implemented through their Missions conform to USAID’s policy on breastfeeding and infant and young child nutrition.
- c. The **Bureau for Global Health (GH)** and the **Bureau for Democracy Conflict and Humanitarian Assistance (DCHA)** provide detailed guidance, technical assistance, and field support to Missions and other Bureaus, as needed, to routinely

reinforce the support, promotion, and protection of optimal breastfeeding and infant and young child nutrition.

In the context of emergencies or other humanitarian settings, if a Mission or the DCHA Office of U.S. Foreign Disaster Assistance (OFDA) or Office of Food for Peace (FFP) identifies a potential need to procure breast milk substitutes, GH will expeditiously and carefully review and process all requests for exceptions to this ADS chapter (see [ADS 212maa, Guidelines for Documenting Exceptions to ADS Chapter 212](#)).

d. The **Contracting Officers/Agreement Officers (COs/AOs)** are authorized to communicate USAID's approval pursuant to [ADS 312.3.3.1](#) to the awardee in accordance with the procedures outlined in [ADS 212maa](#) and [ADS 312mac](#).

212.3 POLICY DIRECTIVES AND REQUIRED PROCEDURES

212.3.1 Current Accepted Norms of Optimal Breastfeeding

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Due to its nutritional value, disease prevention immunological benefits, effects on cognitive development, birth spacing, and maternal health, USAID promotes breastfeeding and the consumption of human milk as optimal for infant and young child nutrition. Breastfeeding improves the survival of infants, especially in countries where infectious diseases continue to be the leading cause of mortality among children under five years of age. Among all preventive health and nutrition interventions, optimal breastfeeding and appropriate complementary feeding have the greatest potential to reduce under-five mortality rates. Longer durations of breastfeeding are associated with greater health benefits for the mother, including reduced risk of certain breast and ovarian cancers and type 2 diabetes. Longer durations are also associated with reduced annual deaths from breast cancer among women.

The optimal breastfeeding practices associated with the best health outcomes for mothers and children is early and exclusive breastfeeding for six months, with continued breastfeeding for two years or more. Early breastfeeding is the initiation of breastfeeding within one hour of birth, along with skin-to-skin contact between mother, parent, or other caregiver and baby (also known as 'kangaroo mother care,' or KMC in regards to pre-term infant care). Colostrum is breast milk produced at an early stage, which provides the newborn with essential antibodies and nutrients to protect against infections. Exclusive breastfeeding is when the newborn and infant receives only breast milk and no other liquids or solids, with the exception of medically prescribed liquid vitamin/mineral supplements or medicines. Exclusive breastfeeding for the first six months of life is optimal. At the age of six months, breastfeeding should continue with the addition of appropriate complementary foods. Breastfeeding is encouraged to continue along with an age-appropriate diet for two years or more. Adequate maternal nutrition and health are important for the breastfeeding parent for the entire period they breastfeed.

USAID programs should provide parents and families with accurate information on the risks and benefits of various feeding options and support them to make informed decisions about infant nutrition. In the case that a parent cannot or decides not to breastfeed, health providers should help the parent, their family, and other caregivers understand how to safely prepare, feed, and store breast milk substitutes (BMS) or expressed human milk, and to safely use, clean, and store feeding vessels, such as cups, spoons, bottles, and nipples, as well as understand the risks of contamination of powder infant formula, feeding vessels, and/or water supply. Acceptable medical reasons for use of BMS are included in [ADS 212maa, section A](#). Health providers should take special care to comprehensively assess and positively support the mother and infant as a unit; promote adequate nutrition and optimal health for mothers, especially when lactating; and provide practical support and counseling to prevent and manage any potential challenges and problems. As an example, when prolonged separation of the mother and infant occurs, for instance upon return to work or school, positive efforts to support mothers to achieve their feeding goals are essential.

212.3.1.1 Guiding Principles on Feeding of Pre-Term/Low Birth Weight Infants

Effective Date: 08/08/2019

Pre-term births are those that occur before 37 weeks gestation. Low birth weight (LBW) is less than 2,500 grams. Approximately 80 percent of pre-term and LBW newborns are between 32-37 weeks gestational age, and between 1,000 and 2,500 grams at birth. These newborns are an important concern for USAID programs. The World Health Organization (WHO) has developed evidence-based guidelines for the optimal feeding of LBW infants in low-and middle-income countries. Evidence shows that human milk is the most appropriate milk for the pre-term/LBW newborn and has demonstrated multiple benefits, including improved neurodevelopmental outcomes and lower rates of the following: necrotizing Enterocolitis (NEC), late-onset sepsis, feeding intolerance, and mortality. Parents need support to provide frequent human milk feedings to these children. In order to do this, lactating parents need to rest and consume an adequate diet in order to produce sufficient volume and quality of breast milk. If the parent is unable to breastfeed, an acceptable nutritious alternative is appropriately screened donor milk. Infant formula is a last option only if human milk is not available.

Fortification of breast milk is recommended only for very low birth weight (VLBW) infants (less than 1,500 grams) and only if the baby fails to gain weight. The WHO guidelines recommend that human milk-based fortifiers are preferred over animal milk-based fortifiers, and VLBW infants should not routinely receive human milk fortifiers that are cow milk-based. Research has demonstrated clear benefits among infants who have received human milk diets versus those that receive cow-milk based fortifiers. If the baby fails to gain weight, a health care provider may suggest that in addition to breast milk, the pre-term or VLBW infant may be fed or supplemented with standard infant formula, never liquid or powdered animal milk. Babies weighing less than 1,500 grams should receive vitamin and mineral supplements for calcium, phosphorus, iron, and vitamin D, according to WHO guidelines. Support for breastfeeding and KMC in facilities providing maternity and newborn services, and continued support in the

community is vital to ensure optimal growth and development for pre-term and LBW infants.

212.3.1.2 Kangaroo Mother Care

Effective Date: 08/08/2019

The World Health Organization defines Kangaroo Mother Care (KMC) as early, continuous, and prolonged skin-to-skin contact (SSC) between the newborn and parent or other caregiver, exclusive breastfeeding, early discharge from the health facility, and close follow-up at home. This is an intervention commonly provided for pre-term and LBW newborns in health facilities, and can also be provided to full-term newborns. Kangaroo Mother Care has numerous benefits, including successful breastfeeding initiation, breastfeeding exclusivity at discharge and breastfeeding duration (e.g., weeks, months), as well as lower risk for mortality. KMC should be integrated in maternal and child health programs along with other efforts to reduce neonatal death due to premature birth or LBW. Most evidence on KMC is from studies conducted in health facilities. While KMC may be useful for home deliveries, to date there is no effectiveness data on KMC in communities.

212.3.1.3 Complementary Feeding

Effective Date: 08/08/2019

In 2002, the 55th World Health Assembly urged Member States to promote exclusive breastfeeding for six months, with consensus that all nutritional needs can be met by human milk alone for the first six months. Following the exclusive breastfeeding period, the period between six months and 23 months of age is also considered a critical window for optimal growth promotion. During this period, infants and young children are subject to increased vulnerability to illness, malnutrition, and failure to thrive as they progress from exclusive breastfeeding to a varied diet.

USAID supports the introduction of adequate and appropriate complementary foods to address the energy and other nutrient needs of growing children starting at six months in addition to continued breastfeeding, both in a “responsive-feeding” manner (see [WHO Guiding Principles for Complementary Feeding of the Breastfed Child](#) and [WHO Guiding Principles of Feeding Non-Breastfed Children 6-24 Months of Age](#)). Complementary feeding should include a variety of nutrient-rich foods given in amounts, frequency, and consistency to cover the nutritional needs of the growing child. The introduction of complementary foods should not undermine breastfeeding, as human milk remains the optimal infant and young child food during the rest of the first year of life and an important contributor to young children’s nutrition during the second year of life and subsequent years.

212.3.1.4 The Use of Donor Human Milk

Effective Date: 08/08/2019

A mother’s own milk from the breast is the first choice for feeding an infant, with the mother’s own expressed breast milk as the second best choice. Human milk from a

suitable wet nurse and/or a human milk bank is the third best choice for optimal infant feeding. USAID supports the development of human milk banks and the use of donor breast milk in the context of a comprehensive national infant and young child feeding strategy to provide the best nutrition to infants and young children. USAID supports the use of human milk from suitable wet nurses and human milk banks in accordance with international and national safety guidelines, including testing for HIV and other pathogens. Cultural practices and other contextual factors should be taken into account when considering the options of wet nurses and donor human milk.

212.3.1.5 Breastfeeding and HIV/AIDS

Effective Date: 08/08/2019

In 2010, guidance from the WHO called for national or sub-national health authorities to decide upon a single strategy that will most likely give infants born to HIV-positive mothers the greatest chance of HIV-free survival by:

1. Breastfeeding with antiretroviral (ARV) treatment and/or prophylaxis, or
2. Avoidance of all breastfeeding and replacement feeding from birth.

The 2010 WHO guidance notes that when ARV treatment is not available, breastfeeding may still provide infants born to HIV-positive mothers a greater chance of HIV-free survival. Health services should principally counsel and support mothers to follow the national strategy unless the mother individually chooses not to do so.

This national health authority decision on the feeding strategy for infants born to HIV-positive mothers should be based on international recommendations and consideration of the:

- Socio-economic and cultural contexts of the populations served by maternal, newborn, and child health services;
- Availability and quality of health services including ARVs;
- Local epidemiology, including HIV prevalence among pregnant women;
- Main causes of maternal and child malnutrition, and infant and child mortality;
- Availability of donor human milk; and
- Continuous availability of safe replacement feeding.

The key factor to minimize the risk of mother to child transmission (less than 1-2 percent) is for HIV-positive mothers to be adherent to ARV treatment. In 2013, the WHO recommended lifelong antiretroviral therapy (ART) for all mothers living with HIV.

Breastfeeding mothers who were tested and HIV-negative in pregnancy should be retested postpartum according to national guidelines since the risk of MTCT is very high when primary infection occurs during lactation.

Following the recommendation of life-long ART treatment, WHO updated the [guidelines on HIV and infant feeding in 2016](#). These updated guidelines extended the recommended duration of breastfeeding, so that a mother living with HIV should breastfeed for at least 12 months and may continue breastfeeding for up to 24 months or beyond while being fully supported for ART adherence. Other recommendations from 2010 remain valid, including that when mothers known to be living with HIV decide to stop breastfeeding, they should stop gradually within one month, as stopping breastfeeding abruptly is not advisable. All breastfed infants of HIV-infected mothers should be tested for HIV infection following complete weaning.

212.3.1.6 Breastfeeding with Other Viral Infections

Effective Date: 08/08/2019

Breastfeeding provides the optimal nutrition for growth, development, and survival of infants and young children in almost all circumstances. When emerging infections and diseases arise, like the Ebola and Zika virus, it is important for USAID to seek guidance from health authorities such as the U.S. Department of Health and Human Services Centers for Disease Control (CDC) or WHO for recommendations on breastfeeding practices during outbreaks. Many times, the risk of transmission may be low, and risks of not breastfeeding are greater than those of continuing to breastfeed when safe alternatives are not available; however, it is best to seek and follow guidance from the health authorities listed above.

In the context of Ebola, WHO, UNICEF, and CDC provided guidance and updates as evidence became available. In general, since the Ebola virus is found in breast milk, the risk of transmission should be weighed against the risk of mortality with replacement feeding. In 2014, recommendations from [WHO/UNICEF/World Food Program \(WFP\)](#) included:

- In a breastfed infant of an Ebola-infected mother where the infant is asymptomatic, the risk of transmission was greater than the risks associated with replacement feeding, and the infant should be separated from the mother and given a safe replacement feeding; and
- In a breastfed infant of an Ebola-infected mother where the infant has developed Ebola or has a suspected case, the risks of not breastfeeding are greater than the risk of replacement feeding.

In the context of Zika, the latest interim guidance from the [WHO](#) was released in June 2016 and the [CDC](#) in August 2016. To date, there were no reports of infants developing the Zika virus from transmission via breast milk. Therefore, current WHO breastfeeding recommendations of initiating breastfeeding within one hour of birth, exclusive breastfeeding for six months with continued breastfeeding for two years or beyond

remain valid in the current context. Given the current evidence, the benefits of breastfeeding are greater than the risks of mortality associated with replacement feeding.

212.3.1.7 Breastfeeding and Family Planning

Effective Date: 08/08/2019

The Lactational Amenorrhea Method (LAM) is a modern postpartum, temporary family planning method that also promotes breastfeeding while providing family planning protection for parents to extend birth intervals, promoting both maternal and child survival. When appropriately used, LAM is more than 98 percent effective in preventing pregnancy for up to six months after birth and facilitates the transition to other modern family planning methods. The three criteria for LAM effectiveness are:

- The baby is “exclusively or nearly exclusively breastfed,” meaning the woman breastfeeds her baby day and night and does not give the baby any other food, water, or liquids (except for medicine, vitamins, or vaccines);
- The woman’s menstrual bleeding has not returned since her baby was born; and
- The baby is less than six months old.

Studies have shown that LAM can also increase transition to use of modern contraceptive methods, while those who do not practice LAM are much more likely to become pregnant within 6-12 months postpartum. Promoting LAM provides an opportunity to increase contraceptive use among postpartum women, improve birth spacing, and support healthy breastfeeding practices that benefit infants and young children when part of a comprehensive voluntary family planning program.

The effectiveness of LAM for women who are expressing breast milk by hand or pump has not been adequately studied, and it is recommended that women who are expressing more than a few times a week be counselled to initiate an additional contraceptive method.

For additional multi-sectoral programming guidance on Breastfeeding and Infant and Young Child Nutrition Promotion, Protection, and Support, see [ADS 212saa, Cross-Sectoral Implementation Guidance](#).

212.3.2 Agency Policies on Breastfeeding

Effective Date: 08/08/2019

USAID promotes optimal breastfeeding and complementary feeding, including continued breastfeeding through two years of age or older in programs that:

- Address maternal, neonatal, infant and young child health and nutrition in child survival, family planning, nutrition, and food security programs;

- Prevent mother-to-child transmission of HIV (antenatal and postnatal counseling and support, including antiretroviral treatment);
- Promote the LAM method for family planning and optimal birth spacing as part of a comprehensive voluntary family planning program; and
- Provide support for humanitarian health and nutrition programs.

Design teams must not design projects or activities that involve the procurement of breast milk substitutes, bottles, and teats, or any other actions that would violate the Code (see [International Code of Marketing of Breast-milk Substitutes and Subsequent Relevant WHA Resolutions](#) for more information) without obtaining approval of an exception as described in [ADS 212maa](#).

Unless an exception is approved, solicitations and subsequent awards must not include a component involving procurement or distribution of BMS and related equipment, such as bottles or teats, in the budget or in the statement of work or program description (SOW/PD).

Breast milk substitutes are restricted agricultural commodities as described in [ADS 312mac](#). As provided in the terms and conditions of each individual award ([AIDAR clause 752.225-70, “Source and Nationality Requirements”](#) for contracts and the standard provision “USAID Eligibility Rules for procurement of commodities and services” for assistance awards), the Contracting Officer/Agreement Officer (CO/AO) is authorized to communicate USAID’s approval, pursuant to [ADS 312.3.3.1](#), to the awardee in accordance with the procedures outline in [ADS 212maa](#) and [ADS 312mac](#). USAID funds may not be used to purchase, transport, or distribute BMS without obtaining the approvals required in [ADS 212maa](#) and [ADS 312mac](#).

When considering procurement of Non-Fat Dry Milk for Supplementary Feeding (see [DCHA/FFP Policy on the Use of Non-Fat Dry Milk for Supplementary Feeding](#)).

If an exception is necessary to increase child survival, or to support research that conforms to USAID policy on human subjects research ([22 CFR 225](#) as implemented), the USAID Missions or Operating Units that request to fund the purchase, transport, or use of breast milk substitutes must abide by the guidelines set out in [ADS 212maa](#).

212.4 MANDATORY REFERENCES

212.4.1 External Mandatory References

Effective Date: 08/08/2019

a. [22 CFR 225, as implemented, Protection of Human Subjects](#)

212.4.2 Internal Mandatory References

Effective Date: 08/08/2019

- a. [ADS 212maa, Guidelines for Documenting Exceptions to ADS 212.3.2](#)
- b. [ADS 312, Eligibility of Commodities](#)
- c. [ADS 312mac, Agricultural Commodity Eligibility and Requirements Relating to Quality and Safety](#)
- d. [DCHA/FFP Policy on the Use of Non-Fat Dry Milk for Supplementary Feeding](#)

212.5 **ADDITIONAL HELP**
Effective Date: 08/08/2019

- a. [ADS 212saa, Cross-Sectoral Implementation Guidance for ADS 212: Breastfeeding and Infant and Young Child Nutrition Promotion, Protection and Support \(USAID/GH\)](#)
- b. [ADS 212sab, Breastfeeding USAID Background Paper, 2001](#)
- c. [Department of Health and Human Services 2011 Surgeon General's Call to Action to Support Breastfeeding](#)
- d. [HIV and Infant Feeding in Emergencies: Operational Guidance \(WHO, UNICEF 2018\)](#)
- e. [Innocenti Declaration on the Protection, Promotion, and Support of Breastfeeding, 2005](#)
- f. [International Code of Marketing of Breast milk Substitutes and Subsequent Relevant WHA Resolutions](#)
- g. [Internet Web Site of World Health Organization \(WHO\)](#)
- h. [IYCF-E Toolkit: Rapid Start-up for Emergency Nutrition Personnel 2014](#)
- i. [Operational Guidance on Infant Feeding in Emergencies, Version 3.0. October 2017](#)
- j. [PATH Resource Toolkit for Establishing and Integrating Human Milk Banks 2019](#)
- k. [USAID Commodity Reference Guide Fact Sheets, 2016 Edition, Guidelines for the Office of Food for Peace](#)
- l. [USAID Multi-Sectoral Nutrition Strategy 2014-2025](#)
- m. [WHO Global Strategy for Infant and Young Child Feeding](#)

- n. [WHO Guideline: Counselling of Women to Improve Breastfeeding Practices 2019](#)
- o. [WHO Guideline: Protecting, Promoting and Supporting Breastfeeding in Facilities Providing Maternity and Newborn Services](#)
- p. [WHO Guidelines on HIV and Infant Feeding 2016](#)
- q. [WHO Guidelines on Optimal Feeding of Low Birth-Weight Infants in Low- and Middle-Income Countries 2011](#)
- r. [WHO Guiding Principles for Complementary Feeding of the Breastfed Child](#)
- s. [WHO Guiding Principles for Feeding Infants and Young Children During Emergencies \(2004\)](#)
- t. [WHO Guiding Principles of Feeding Non-Breastfed Children 6-24 Months of Age](#)
- u. [WHO HIV and Infant Feeding: Framework for Priority Action](#)
- v. [WHO Implementation Guidance: Protecting, Promoting, and Supporting Breastfeeding in Facilities Providing Maternity and Newborn Services: The Revised Baby-Friendly Hospital Initiative 2018](#)
- w. [WHO Kangaroo Mother Care: A Practical Guide](#)
- x. [WHO, WFP, UNICEF \(2014\), Interim Guideline: Nutritional Care for Children and Adults with Ebola Virus Disease in Treatment Centres](#)

212.6 DEFINITIONS

Effective Date: 08/08/2019

See the [ADS Glossary](#) for all ADS terms and definitions.

breast milk substitutes (BMS)

Any food being marketed or otherwise represented as a partial or total replacement of breast milk, whether or not suitable for that purpose, such as powdered or liquid milks, powdered infant formula (PIF), or ready-to-use infant formula (RUIF)-commonly referred to as baby formula. (**Chapter 212**)

complementary feeding

The appropriate addition of other foods while continuing breastfeeding, starting at about six months based on the infant's developmental readiness. WHO and UNICEF recommend that all parents should have access to skilled support to initiate and sustain exclusive breastfeeding for six months and ensure the timely introduction of adequate

and safe complementary foods with continued breastfeeding up to two years or beyond. **(Chapter 212)**

complex emergency

A humanitarian crisis in a country, region or society where there is total or considerable breakdown of authority resulting from internal or external conflict and which requires an international response that goes beyond the mandate or capacity of any single agency and/or the ongoing United Nations country program. **(Chapter 212)**

exclusive breast milk feeding

May receive expressed breast milk, in addition to breastfeeding. Expressed breast milk may be from the mother, a suitable wet nurse, or human milk bank. **(Chapter 212)**

exclusive breastfeeding

The infant receives only breast milk from his/her mother, and no other liquids or solids with the exception of drops or syrups consisting of vitamins, mineral supplements or medicines. **(Chapter 212)**

International Code of Marketing of Breast Milk Substitutes and subsequent WHA resolutions (the Code)

The Code is a set of recommendations to regulate the marketing of breast milk substitutes, feeding bottles, and teats, with the principles and aims to protect, promote, and support breastfeeding. Member States were urged to translate the Code to national legislation, and food manufacturers and distributors. Health care professionals and nongovernmental and consumer organizations are also encouraged to give effect to the principles and aims of the Code. **(Chapter 212)**

Kangaroo Mother Care (KMC)

When pre-term or low birth weight newborns are carried skin-to-skin with the mother, parent, or other caregiver. KMC provides early, continuous and prolonged skin-to-skin contact between the mother and the baby; prevents hypothermia; and it promotes exclusive breastfeeding. It can be initiated at the place of delivery and continued at home. **(Chapter 212)**

Lactational Amenorrhea Method (LAM)

The use of breastfeeding as a contraceptive method based on the physiologic effect of frequent day and night suckling on suppression of ovulation. It is effective in preventing pregnancy in the first six months postpartum while the mother is exclusively or near exclusive (fully) breastfeeding and continues to not have menstrual periods. **(Chapter 212)**

optimal breastfeeding

Exclusive breastfeeding for the first six months of life, with continued breastfeeding and appropriate complementary feeding for at least two years. Breastfeeding should be initiated with skin-to-skin contact immediately postpartum. Support of adequate maternal nutrition is an important part of breastfeeding support. **(Chapter 212)**

re-lactating mother

The process of re-establishing breastfeeding after a woman has stopped breastfeeding her child, even without a further pregnancy. (**Chapter 212**)

replacement feeding

The use of a breast milk substitute that provides the nutrients the child needs. During the first six months, replacement feeding should be with a suitable breast milk substitute such as commercial standard infant formula if exclusive breastfeeding is not possible. After six months, it should preferably be with a suitable breast milk substitute until 12 months and complementary foods made from appropriately prepared and nutrient enriched foods. Replacement feeding does not include breast milk substitutes such as whole powdered milk or animal milk. (**Chapter 212**)

responsive feeding

Responsive feeding refers to a reciprocal relationship between an infant or child and his or her caregiver that is characterized by the child communicating feelings of hunger and fullness through verbal or nonverbal cues, followed by an immediate response from the caregiver. (**Chapter 212**)

wet nurse

A woman who cares for and suckles children that are not hers. (**Chapter 212**)

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