



FOGSI - ICOG

Good Clinical Practice Recommendations

GCPR on

Breastfeeding



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From the Desk of Prof. Hrishikesh D Pai

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It is with great pride and enthusiasm that I present to you this well researched and scholarly Good Clinical Practice Recommendations (GCPR) on "Breastfeeding" developed under my leadership as President of FOGSI (2023). This endeavor represents a significant milestone in our ongoing commitment to improving women's healthcare across the nation.

The formulation of this GCPR has been a collaborative effort, bringing together the collective wisdom and expertise of some of the brightest minds in our field. As President of FOGSI, I had the honor of overseeing this ambitious project, and I am deeply grateful for the dedication and hard work of everyone involved.

Our Advisors, past presidents of FOGSI, Dr. Sanjay Gupte and Dr. Hema Diwakar, provided invaluable guidance and support throughout the process. The National Coordinators- Dr. CN Purandare, Dr. Rishma Pai, Dr. Nandita Palshetkar, and Dr. Jaydeep Tank, played a crucial role in coordinating efforts and ensuring the smooth progress of this project.

A pivotal role was played by Dr. Surekha Tayade, Chairperson of the Clinical Research Committee of FOGSI. As the Coordinator of the GCPR, she ensured that each step of the development process was meticulously followed. Her tireless dedication and attention to detail have been truly commendable.

I would like to thank the Convenor, Dr Charulata Bapaye, Chairperson of Study on Female Breast Committee and the Co-convenor Dr Sneha Bhuyar from ICOG who led the development of this GCPR.

This GCPR was developed through a rigorous process. A drafting committee comprising 6-7 renowned experts in the field reviewed all existing literature and evidence to formulate the initial draft, which was presented to a team of 10-12 experts who reviewed it and provided feedback. Multiple meetings were organized to review and incorporate these suggestions, ensuring the latest evidence and best practices were incorporated.

We believe this good practice recommendation will be an invaluable resource for healthcare practitioners, enabling them to provide the highest standard of care to women across India and beyond.

Warm regards,



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Fogsi Good Clinical Practice Recommendations

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LEVEL OF EVIDENCE

The levels of evidence, denoted as LE1 to LE5, provide insights into the quality of evidence regarding the benefits or harms of interventions. At LE1, the evidence is of high quality, indicating a strong likelihood that the intervention improves or reduces the specified outcome. In contrast, LE2 suggests moderate quality evidence, suggesting a probable improvement or reduction in the outcome. Moving down to LE3, the evidence is of low quality, indicating a possibility of improvement or reduction in the outcome. At LE4, the evidence quality is very low, signifying uncertainty regarding the intervention's impact on the outcome due to the evidence's poor quality. Lastly, LE5 denotes instances where no studies have examined the outcome, highlighting a lack of available evidence on the topic.

<i>Level of Evidence</i>	<i>Important benefit or harm</i>
High quality – LE 1	[Intervention] improves/reduces [outcome] (high quality of evidence)
Moderate quality – LE 2	[Intervention] probably improves/reduces [outcome] (moderate quality of evidence)
Low quality – LE 3	[Intervention] may improve/reduce [outcome] (low quality of evidence)
Very low quality – LE 4	It is uncertain whether [intervention] improves/reduces [outcome], as the quality of the evidence has been assessed as very low
No studies – LE 5	No studies looked at [outcome]

EXECUTIVE SUMMARY: GUIDELINES FOR OPTIMAL BREASTFEEDING PRACTICES

1. Antenatal Counseling for Breastfeeding

- Initiate conversations on breastfeeding as early as feasible during antenatal visits.
- Provide tailored counseling based on the individual's family and personal challenges.
- Thoroughly assess history, previous breastfeeding experience, and perform physical breast examination.
- Educate on breastfeeding importance, practical skills, and challenges.
- Share facility best practices such as skin-to-skin contact and rooming-in.

2. Staff Education for Breastfeeding Support

- Staff needs to be sensitized to provide compassionate, timely, and appropriate care for breastfeeding mothers.
- Offer a 20-hour training course with classroom and clinical practice.
- Train staff in counseling, positioning, attachment, and handling breastfeeding challenges.
- Educate staff on implementing infant feeding guidelines.

3. The Golden Hour

- Facilitate early and uninterrupted skin-to-skin contact between mother and infant.
- Encourage breastfeeding initiation within one hour after delivery.
- Promote various strategies such as immediate skin-to-skin, breast crawl, and comfortable positions.

4. Breastfeeding Post cesarean section (C-section)

- Prioritize uninterrupted skin-to-skin contact and rooming-in after C-section.
- Follow-enhanced recovery after surgery protocol for breastfeeding goals.
- Recommend suitable breastfeeding positions for C-section mothers.

5. Enhancing Milk Supply

- Check adequacy of breast milk based on infant condition and maternal perceptions.
- Address breastfeeding barriers through antenatal counseling and education.
- Focus on effective milk removal, use of galactogogues, and identifying medical causes.
- Provide psychosocial support for a positive breastfeeding experience.

6. Devices to Aid Breastfeeding

- Use devices when necessary, after explaining non-device options.
- Ensure healthcare providers are knowledgeable about device use.
- Counsel parents on device pros and cons.
- Educate mothers on device-usage, sterilization, and follow-up.

7. Breastfeeding in Special Situations

- Provide specialized support for breastfeeding in human immunodeficiency virus (HIV) infection, coronavirus disease 2019 (COVID-19), twins, cleft lip/palate, and more.

- b. Advocate for appropriate infant feeding options based on each situation.
- c. Provide information on radioactive compounds and medications that are contraindicated.
- d. Diagnostic/therapeutic radioactive agents generally necessitate interruptions of breastfeeding.
- e. Contraindications to Breastfeeding:
 - Mother on chemotherapy or current use of radioactive agents.
 - Mother with human T-cell lymphotropic viral infection, untreated Brucellosis, Ebola virus, Herpes Simplex, Varicella, open/infectious tuberculosis.

8. Working Mothers and Breastfeeding

- a. Enable flexible work arrangements, remote work, and breastfeeding breaks.
- b. Teach expressing and storing breast milk, and promote baby-friendly workplaces.
- c. Support tandem feeding and manage special circumstances.

9. Breastfeeding Beyond 6 Months and Weaning

- a. Encourage continued breastfeeding up to two years and beyond.
- b. Highlight benefits for both babies and mothers, including nutrition, immunity, and mental health.
- c. Address challenges and emphasize cognitive, developmental, and health advantages.

Intent: These guidelines underscore the importance of comprehensive support for breastfeeding mothers and infants, emphasizing tailored counseling, staff education, early initiation, breastfeeding post C-section, enhancing milk supply, using devices judiciously, addressing special situations, supporting working mothers, and promoting breastfeeding beyond 6 months. Adhering to these recommendations can significantly improve maternal and infant health outcomes.

1. ANTENATAL COUNSELING

- All pregnant women must be provided basic information about breastfeeding.
- Conversations on breastfeeding should begin as early as possible, so that there is time to discuss challenges if any. Minimum of 1 hour of lactation counseling should be done during antenatal period.
- Considering social and cultural (LE 2) contexts of family, antenatal counseling should be tailored for individual family and personal challenges to mother.
- Thorough history taking, including special concern about previous breast surgeries and previous breastfeeding experience along with noting down physical breast examination findings, is a breastfeeding friendly good clinical practice.
- Breastfeeding education should include:
 1. Information on the importance of breastfeeding and the risks of giving formula or other breast milk substitutes, along with national and health-professional recommendations for infant feeding.
 2. Practical skills, such as positioning and attachment, on-demand feeding, and recognizing feeding cues, are a necessary component of antenatal counseling.
 3. Women also need to be informed about possible challenges they might encounter (such as engorgement, or a perception of not producing enough milk) and how to tackle them.
 4. Families should be presented with up to-date information on best practices in facilities such as skin-to-skin contact, initiation of breastfeeding, supplementation protocols, and rooming-in.
- Information on breastfeeding should be provided in local language in multiple ways such as printed or online information, interpersonal or small group discussions, use of charts, etc.
- Information should be free of conflict of interest.
- As stipulated in the guidance on ending inappropriate promotion of foods for infants and young children, companies that market foods for infants and young children should not “directly or indirectly provide education to parents and other caregivers on infant and young child feeding in health facilities”.^{1,2}

An evidence-based review of practices that improve the duration or initiation of breastfeeding found that “prenatal combined with postnatal interventions are more effective than usual care in prolonging the duration of breastfeeding.”³

2. STAFF EDUCATION TO SUPPORT BREASTFEEDING

Staff cannot be expected to implement a practice or educate a patient on a topic for which they have not received training.

- Compassionate, timely, and appropriate care for breastfeeding mothers can only be achieved if training of health staff enables them to acquire knowledge, develop effective skills, give consistent messages, and implement policy standards (LE 4).¹
- A 20-hour course of the 2009 Baby-friendly Hospital Initiative (BFHI) implementation guidance can be implemented: The 20 hours may be presented in three intensive days or in shorter segments over a longer period, whichever is most suitable for the facility. The 15.5 hours of classroom training and 4.5 hours of clinical practice with mothers is recommended.
At least one of the course facilitators should have a high level of breastfeeding knowledge to answer questions and find further references. Facilitators' plan, such as teaching outline, and the use of aids such as teaching doll and cloth breast model, assessment sheets, etc. should be ready beforehand.⁴
- Hospital staff should be educated regarding:
 1. Counseling a pregnant woman about breastfeeding (LE 2);
 2. Use of listening, learning skills to counsel a mother; skills for building confidence of a mother;
 3. Helping a mother to initiate breastfeeding within the first hour after birthing (LE 2);
 4. Identifying feeding cues, helping a mother to position herself, her baby and attach baby for breastfeed (LE 2);
 5. Helping a mother to deal with the ailments of breastfeeding such as flat or sore nipples, engorgement and mastitis, low milk supply, etc.
 6. Helping a mother to express her breast milk and also feed expressed milk to baby (LE 4);
 7. Helping a mother to breastfeed a low-birth-weight baby or sick baby;
 8. Implementing the Infant Milk Substitutes Act (IMS Act) in a health facility.

3. GOLDEN HOUR

The infant is extremely alert immediately after birth, which enhances its predetermined biological behavior of breastfeeding. Hence, the initiation of breastfeeding in the 1st hour after birth (golden hour) ensures the delivery of colostrum to the baby and is also the stepping stone to exclusive and prolonged breastfeeding.

Recommendation by WHO⁵ and UNICEF

1. Early and uninterrupted skin-to-skin contact between mother and infant should be facilitated and encouraged as soon as possible after birth (LE 2).
2. All mothers should be supported to initiate breastfeeding within one hour after delivery (LE 1).

Strategies for the initiation of breastfeeding

1. Immediate skin-to-skin contact, i.e. placing infant prone on mother's abdomen or chest should be done within 10 minutes after birth. It is advisable to continue it uninterrupted for 60 minutes (LE 1).⁶
2. It is recommended to dry the healthy infant (except the hands) and allow it to crawl to the breast and get self-attached. Hypothermia should be prevented during breast crawl.
3. Encourage first and complete breastfeeding in labor room with the mother in a comfortable semi-reclined position.
4. Educate healthcare professionals to delay the procedures, such as weighing, administering vitamin K injection, suctioning, etc. till the first breastfeeding is over.
Physical injury caused by deep suctioning can disrupt baby's pre-feeding behavior, hence, routine suctioning is not indicated (Widstrom et al,1987).
5. Skin-to-skin contact and kangaroo mother care should be followed in preterm and low-birth-weight infants, when feasible (LE 2).^{7,8}
6. If the mother-baby are separated or baby has latching difficulty, it is advisable to begin hand expression within the first hour after birth, and continue expressing every 2–3 hours.

4. BREASTFEEDING POST LOWER SEGMENT CESAREAN SECTION

Breastfeeding rates are relatively low in cesarean deliveries. Proactive lactation support should be provided to mothers post cesarean section.⁹

1. Uninterrupted skin-to-skin contact should be started immediately after birth of baby and continued throughout closure in all cesarean sections, if not contraindicated (e.g., baby requiring resuscitation) (LE 1).¹⁰

2. Rooming-in should be encouraged, so that breastfeeding can be initiated within 1 hour of cesarean section, and continued regularly thereafter (LE 2).
3. Enhanced recovery after surgery protocol [post lower segment cesarean section (LSCS)], i.e., early oral intake, early mobilization, should be followed to establish breastfeeding goals post cesarean section.¹¹
4. Positions recommended for breastfeeding after LSCS are:
Football hold
and
Side-to-side lying.¹²
5. Adequate analgesia post cesarean ensures comfortable breastfeeding experience.
6. Educate pregnant women and their family members regarding breastfeeding after cesarean delivery in antenatal classes (LE 2).¹³

5. ENHANCING MILK SUPPLY





Inadequate milk production continues to be a major reason given by mothers worldwide for the discontinuation of breastfeeding.¹⁴ The incidence of low milk supply is 10–25%.¹⁵

1. Check adequacy of breast milk before emphasizing on enhancing milk production by general condition of baby, number of voids, stools frequency and color, and weight gain.¹⁶
2. Differentiate between actual low milk supply and mother's perception of producing insufficient milk.¹⁷
3. Identifying barriers to breastfeeding and addressing them by antenatal counseling as well as educating about breastfeeding in antenatal period helps to enhance low milk supply.¹⁸
4. Breastfeeding friendly labor practises, such as birth companion during labor, avoiding exogenous oxytocin or excessive intravenous (IV) fluids, and no use of opioids, should be followed.¹⁹
5. In immediate postpartum period, breast crawl, uninterrupted skin-to-skin contact and the early initiation of lactation must be followed (LE 1).
6. Evaluate the mother for medical causes of low milk supply. Treat the condition as indicated if treatment is available.
7. Assess and increase the frequency and effectiveness of milk removal. Use nonpharmacologic measures such as regular expressing by hand and/or breast pump (LE 3). Ineffective milk removal causes feedback inhibitor of lactation (FIL) and decreases milk production via negative feedback.¹⁶
8. Galactagogues are medications or other substances believed to assist initiation, maintenance, or the augmentation of maternal milk supply.
9. If the healthcare providers choose to prescribe a galactagogue, they should:
 - a. Inform women about available data concerning efficacy, timing of use, duration, and the adverse effects of the therapy of galactagogues.
 - b. Screen the mother for contraindications/allergies to, or drug interactions with the chosen medication.
 - c. Advised to take two teaspoons of galactagogue granules twice daily for four weeks, or one Shatavari root powder capsule three times daily for 30 days.²⁰⁻²²
10. Common reputed herbal galactagogues are shatavari, black cumin seed, corianderseed, drumstick, fenugreek seed, milk thistle, marshmallowroot, fennel seeds, etc. Some other ingredients like Vidari Kand (*Pueraria tuberosa*), Sowa (*Anethum Sowa*), Gokshur Panchang (*Tribulus Terrestris*), Yashtimadhu (*Glycyrrhiza Glabra*), Jeera [*Safed*] (*CuminumCuminum*), Ahliv (*Lepidium Sativum*) are also been known to be used.
11. Pharmacological galactagogues:¹⁶
 1. Domperidone: It is the only galactogogue available that has been scientifically evaluated through a randomized, double-blind, placebo-controlled study. Typical dose is 10–20 mg 3–4 times a day.
 2. Metoclopramide: It is also effective in the treatment of faltered milk supply. Some mothers might experience depression with the use of metoclopramide.¹⁶
12. Emphasis must be given on psychosocial aspects also as oxytocin is a hormone of love, safety, and trust.²³ Counseling partner and family members for tender loving care, getting BFHI recognition for the hospital, and imbibing breastfeeding-friendly community practises, such as ensuring safe environment for breastfeeding at public places, and empowering mother support groups, etc. help to navigate low milk supply.

6. DEVICES TO AID BREASTFEEDING

1. Devices should be used only if required and after mothers have been counseled about all non-device options.

2. All healthcare providers should have knowledge of when to use and how to use breastfeeding devices.
3. Before using devices, healthcare providers must counsel the parents about pros and cons of using the device.
4. List of devices, conditions where they need to be used.

Sr. No	Name of Device	Condition Where Useful
1	Silicon Nipple Shield 	<ul style="list-style-type: none"> • Helps in latching in flat/inverted nipple • Crack/sore nipple temporary interventions • To help premature infants to latch on breast • Helps to transition an infant from bottle to breast²⁴
2	Breast Pump ²⁵ 	<ul style="list-style-type: none"> • To relieve breast when engorgement • Working mothers • To stimulate breast in low milk production • Special circumstances like twins, premature baby, low-birth-weight baby, sick baby • Having difficulties to latch on breast due to nipple anomalies • Induced lactation and re-lactation management • To sustain the milk production when mother and baby separated • Useful in milk banks
3	Haberman Feeder ²⁷ 	<ul style="list-style-type: none"> • Feeding in cleft lip and cleft palate babies²⁶
4	Supplemental Nursing System 	<ul style="list-style-type: none"> • Low milk production • Re-lactation and induced lactation²⁸

5. It is advisable to provide information about several available types and options and give the choice to the mother.
6. It is important to give knowledge and skill-based training to the mother about how to use and how to sterilize the devices.
7. Follow up is must in 3–4 days for weight monitoring.
8. Information should be free of cost and no conflict of interest.

7. BREASTFEEDING IN SPECIAL SITUATIONS

Obstetricians and lactation consultants play a pivotal role in helping mothers with special situations to successfully breastfeed their babies.

Breastfeeding in HIV Infection

All HIV-positive pregnant women, including those presenting in labor and breastfeeding, should be initiated on a fixed dose combination of triple-drug regimen of Anti Retroviral Therapy (ART) [Tenofovir (300 mg) + Lamivudine (300 mg) + Dolutegravir (600 mg) to be given once daily] regardless of CD4 count and clinical stage (treat all), for preventing MTCT (mother-to-child transmission).²⁹

Breastfeeding with concurrent ART offers HIV-exposed infants the greatest chance of HIV-free survival in developing countries like India. Breastfeeding does carry a risk of transmission of HIV infection from HIV-infected

mothers to their infants. With optimal adherence to ART and a suppressed maternal viral load, breastfeeding can be given to babies with HIV-positive mothers

Feeding in infants

- Exclusive breastfeeding (EBF) or exclusive replacement feeding (ERF) are the two infant feeding options available for the HIV-positive mothers.
- **Pros and cons of both options** must be discussed so that an informed choice can be made.
- EBF maximizes the chances of survival of these infants and is **recommended as the preferred choice** of infant feeding for HIV-exposed infants in India.
- ERF—The feed must be prepared in a hygienic manner and should be given with a spoon and bowl. Bottle feeding should be avoided.
- Current evidence suggests that in continued presence of maternal ART, mixed feeding is also rendered safe and may be preferred over no breastfeeding at all (LE 1).²⁹
- Mothers living with HIV should breastfeed for at least 12 months and may continue breastfeeding for up to 24 months or beyond, like the general population, while being fully supported for ART adherence (LE 1).
- Single-drug antiretroviral (ARV) prophylaxis is advised in infants with low risk for HIV transmission for 6 weeks (regardless of type of feeding) (LE 1). Dual-drug ARV prophylaxis is advised in infants with high risk for HIV transmission, the duration of which depends on the type of feeding (for 6 weeks if on replacement feeding and 12 weeks if on breastfeeding).

Breastfeeding during COVID-19 in Pregnancy

- Breastmilk is not likely to transmit COVID-19 infection.
- The WHO recommends COVID-19 positive mothers (suspected or confirmed) should breastfeed. Benefits of breastfeeding outweigh the potential risks for transmission.
- Wearing mask (respiratory hygiene), hand hygiene, and sanitization (disinfecting surfaces regularly) are recommended.³⁰

Breastfeeding in Twins

- Start expressing within 24 hours of birth.
- Express 10–12 times (at least once in night).
- Get help and support from family members.
- Use positions - double football, double cradle, combination of cradle with football.³¹

Breast and Nipple Conditions Affecting Breastfeeding

Th early diagnosis and treatment of common breastfeeding problems, such as sore nipples, low milk production, excessive milk production, strong let-down reflex, engorgement of breast, blocked or plugged lactiferous ducts, mastitis, breast abscess, fungal infection, inverted, flat or very large nipples, vasospasm, milk blister or bleb, should be carried out .

Breast feeding should continue in all above conditions under supervision.^{32,33}

Breastfeeding in Cleft Lip and Palate

- Positions, such as straddle position, semi-upright position, football hold dancers hold, may be used.
- Feeding equipment, such as syringe feeding, spoon feeding, nipple shield, palatal obturator (dental plate, soft cup feeder), polythene squeeze bottle, and special needs feeder (Haberman feeder), can be used.³⁴

Breastfeeding in Tuberculosis

- Breastfeeding should not be discouraged for women treated with the first-line anti-TB medicine. The first-line AKT drugs are compatible with breastfeeding.
- Untreated active TB- should temporarily withhold breastfeeding, mother can feed expressed breastmilk.
- Isolation is recommended till mother is infectious, has multidrug resistant TB or is non-adherent to treatment.³⁵
- Prophylaxis with isoniazid (INH) (3 to 6 months) is recommended in neonates.

Tandem Feeding

- Mother can continue to breastfeed while pregnant.
- Mother can breastfeed newborn and elder baby.
- In a case of multifetal pregnancy or high risk for miscarriage/early delivery should be counseled regarding risks related to continuation of breastfeeding.

Tongue Tie or Ankyloglossia

- Good positioning and attachment are the key to feeding in tongue tie or ankyloglossia.
- Rarely, surgery may be needed for babies with latching difficulties in spite of good support.

Breastfeeding in Hepatitis B and C

- There is no evidence that breastfeeding increases the mother-to-child transmission.
- Both active and passive immunization, i.e., hepatitis B vaccine and immunoglobulin is recommended for neonates within 12 hours.

Breastfeeding in Chickenpox Infection

- Mothers who contract chickenpox can breastfeed as normal.
- Any vesicles on the breast should be covered to minimize the risk of transmission from virus within vesicles.
- If symptoms of chickenpox appear in the mother less than 5 days before and 2 days after delivery, the baby should receive varicella zoster immunoglobulin and IV acyclovir.

Breastfeeding for Babies Admitted in NICU

- Neonatal intensive care unit (NICU) to have facility to accommodate mothers once they are mobile post-delivery.
- Breast emptying should be started within a few hours post-delivery.

Breastfeeding in Women on Chemotherapy or Radiation

Breastfeeding to be considered under expert advice/contraindicated (LE 1).

8. WORKING MOTHER AND BREASTFEEDING

The duration of breastfeeding is negatively influenced by mothers working full time outside the home.³⁶⁻⁴⁰

Longer maternity leave, onsite childcare center (CCC), breast pump, and lactation room are commonly suggested ways of creating mother-friendly worksites.^{41,42}

1. Mother can continue breastfeeding and/or expressing breast milk even after she resumes her duty. It helps her to prevent leaking, engorgement, low milk supply, etc.
2. If a woman is having uncomplicated pregnancy, then she should be advised to utilize her maximum maternity leave after her baby's birth.
3. Every working mother should be taught breast milk expression and extra breast milk should be stored as per storage guidelines (up to 4 hours at 25°C or colder, in refrigerator at 4°C –up to 4 days, in freezer at -18°C within 6 months is best).⁴³
4. If a mother has excess amount of milk secretions than her baby needs, then advise the mother to store that extra amount of breast milk as backup during the postnatal period and the breastfeeding mother must practice pumping and the expression of breast milk for some days before returning to her work and with this also she can store some breast milk as a backup.
5. Work from home, carrying baby with mother at workplace if crèche facility is available, part-time working, flexi time working, telecommunicating, and freelancing jobs are some other options for working mother, who wants to breastfeed directly. She should directly breastfeed whenever she is with her baby.
6. If the above options are not available for working mother, then the mother can express and store breast milk at the workplace according to her baby's age and need. She can store expressed breast milk in the refrigerator, available in the pumping room, and bring home by keeping it in an insulated box or bag and again store it in a refrigerator at home.

9. BREASTFEEDING BEYOND 6 MONTHS AND WEANING

- Optimum breastfeeding could save the lives of over 8,20,000 children annually under 5 years of age.⁴⁴
- The first 1000 days of life are crucial, and hence the WHO recommends exclusive breastfeeding up to 6 months of age,⁴⁵ followed by complementary feeding along with continuation of breastfeeding at least up to 2 years and beyond.⁴⁶
- Frequency of breastfeeding:
 - At 6 to 9 months of age: two to three times a day
 - From 9 to 24 months of age: three to four times a day minimum
 - From 12 to 24 months of age: Five times or more.
- Stasis of milk, management of sore nipples due to teething, low milk supply are the challenges that need to be overcome.

Benefits to Baby

- Breastfeeding continues to provide up to 50% of nutritional needs of infants after 6 months to one year and one the third of nutritional needs during the second year of life.
- Breast milk provides significant amount of proteins (43%), fats, key nutrients such as vitamin C (60% of requirements), vitamin A (75% of daily requirements), folate (76% of daily requirements), and vitamin B (94% of daily requirement) to the infants.
- Continuation of breastfeeding protects infants and children from obesity, infections, and illnesses, such as diarrhea, gastroenteritis, colds, flu, thrush, ear, and throat, and lung infections, such as pneumonia, and childhood cancers such as acute lymphocytic leukemia (ALL) and Hodgkin's lymphoma.
- Continuation of breastfeeding reduces the chances of developing obesity, type 2 diabetes mellitus, hypertension, and cardiovascular diseases, and osteoporosis in the baby.
- It has been seen that breastfeeding beyond 6 months improves the cognitive, receptive, and expressive communication and fine motor sections among children and protects against behavioral problems too.

Benefits for Mothers

- A positive breastfeeding experience contribute to a woman feeling good about herself, raises her self-esteem and empowers her, helps to prevent emergence of mental health problems like depression and anxiety .
- It protects against osteoporosis and cancers of the breast, ovaries,⁴⁷ uterus, lower the lifelong risk of developing heart disease, type 2 diabetes, cardiovascular diseases.
- Extension of breastfeeding helps to lose the weight of mothers. Body mass index (BMI) of mothers is 1% lower for every 6 months of breastfeeding.
- Exclusive breastfeeding helps for birth control by lactation amenorrhea, although the method is not fool proof.

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