In this webinar, we shall learn what to feed – in other words, the sources of nutrition –in low birth weight infants.

We all know that **Breastmilk is the IDEAL feed for all infants until 6 months of age.**

This applies to even LBW infants – **so All LBW infants should be fed only mother's milk** – either by direct breastfeeding or as expressed breast milk.

Because breast milk feeding is the key in care of LBW infants, we should know how to improve that…

The important strategies to improve breast milk feeding include **Psychological** and **social support** of mothers **right from birth or admission, admitting mothers in the same hospital,** which is **particularly important** for **outborn babies,** encouraging bedding-in or visit to nursery, promoting **KMC** once the baby is **stable,** facilitating mother to **express breast milk** from day 1 itself, and ensuring adequate **nutrition** and rest of mother.

There is no role for drugs like metoclopramide in promoting breastfeeding.

While breast milk is the ideal feed, it alone cannot meet the daily requirements of some nutrients, like iron, in LBW infants. Therefore, all LBW infants weighing 1500 to 2499 g should be given daily supplements of iron and vitamin D.

Iron has to be given in the dose of 2 mg/kg/day while vitamin D is to be given 400 IU/day.

Both should be started at 2 weeks of age and stopped at 1 year.

In very low birth weight infants, in addition to iron and vitamin D, we must supplement multivitamins and **calcium & Phosphate** also.

Multivitamins are given in the dose of 0.3 mL/day from 2 weeks to 1 year of age; it is preferable to use multivitamin drops containing zinc.

Calcium and phosphate should be given in the dose of 120-140 mg/kg of calcium and 60-90 mg/kg/d of phosphate. They should be started when the baby reaches full enteral feeds and stopped when the baby reaches 2 kg.

Some VLBW babies may not gain weight adequately i.e. 15 to 18 g/kg/day, even after taking optimal amount of breast milk. These babies should be given fortified milk – by adding human milk fortifiers to expressed breast milk.

The fortifier is available in powder form – it should be mixed in the concentration of 1 g per 25 mL of breast milk. It has to be continued till the baby reaches 2 to 2.5 kg weight.

Now, let us focus on feeding in special circumstances.

Rarely, the mother's milk may not be available for a LBW baby – for example the mother has died or is very sick. In that case, the alternatives, in order of preference, are expressed donor milk; infant formula; and animal milk.

While the preferred option is donor milk from healthy donors, it requires the services of human milk banking, which is not available in many parts of the country.

Formula milk can be either in the form of standard term formula or special preterm formula.

Animal milk is the least preferred option, particularly in preterm LBW infants.

Babies born to HIV positive mothers should be given **exclusive breastfeeds** till 6 months of age.

Top feeds – formula or cow's milk – should be given ONLY if mother has died/has terminal illness or decides not to breastfeed despite adequate counseling.

Even in them, the AFASS criteria – i.e. Acceptable, Feasible, Affordable, Sustainable and Safe - should be met before starting the formula feeds.

Remember these babies should be either on exclusive breastfeeding or on exclusive top feeds – there is no role of mixed feeding!

Babies born to mothers with active pulmonary tuberculosis should be started on exclusive breastfeeding.

There is no need to separate the mother and the baby, unless the mother has multi-drug resistant - TB or is very sick.

Thank you