

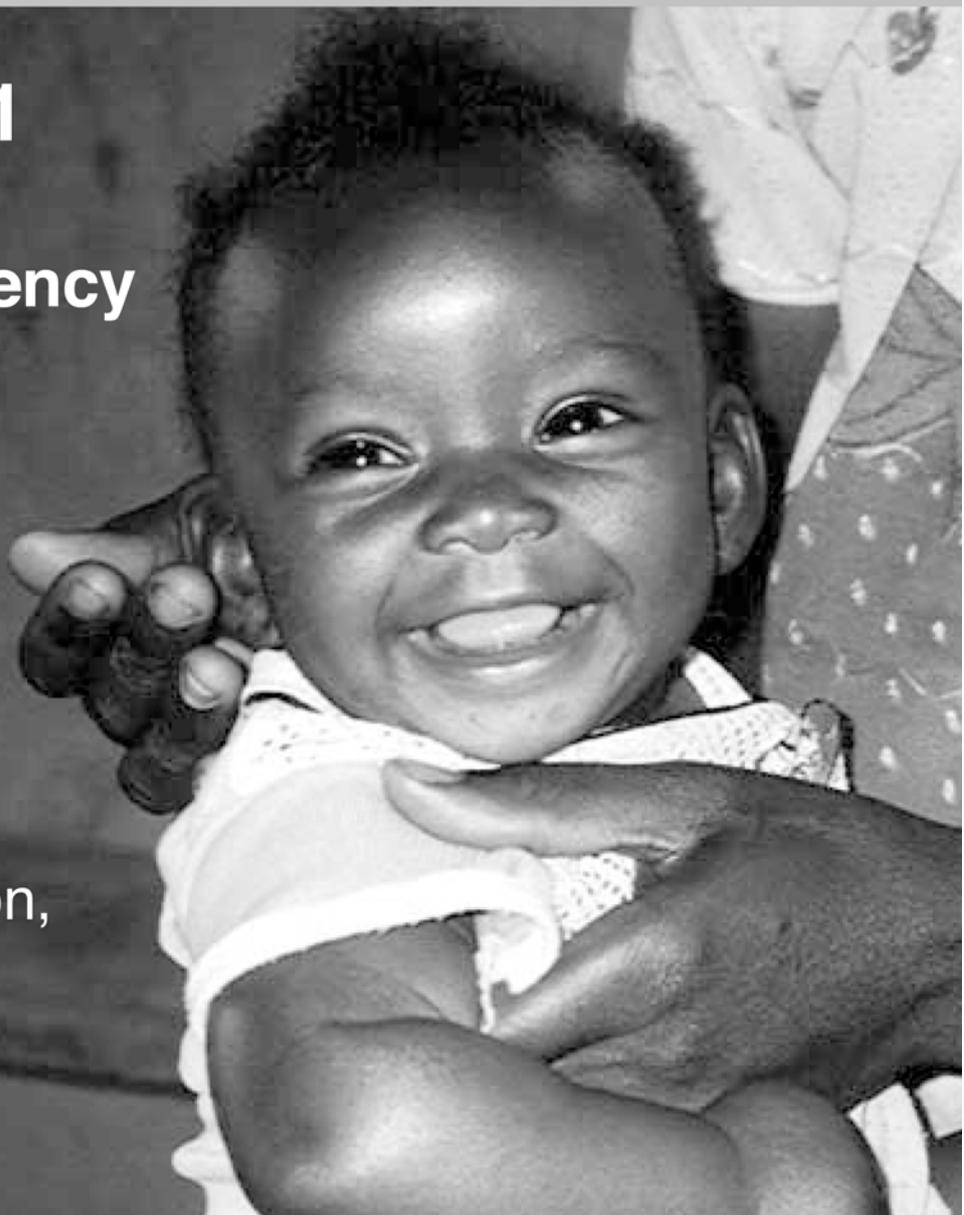
Infant Feeding in Emergencies

Module 1

for emergency relief staff

Manual

for orientation,
reading and
reference



Revision 1

Draft material developed through collaboration of:
WHO, UNICEF, LINKAGES, IBFAN, ENN and additional contributors

November 2001

Sections of Module 1 require updating, to reflect the latest version of the Operational Guidance on Infant and Young Child Feeding in Emergencies (v2.1, Feb 2007) and the latest policy guidance on infant feeding in the context of HIV. Please refer to these latest documents in planning any orientation on IFE. Module 1 will be updated in 2008.

The agencies whose staff contributed to this draft material include WHO, UNICEF, LINKAGES, IBFAN, and ENN. The views expressed herein are those of the various authors and commentators, and do not necessarily reflect the official position of any agency. Nevertheless, all rights are jointly reserved by the five agencies named above.

This material is not a formal publication of the World Health Organization. The designations employed and the presentation of the material do not imply the expression of any opinion whatsoever on the part of the Secretariat of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.

This material is not a formal publication of UNICEF, but a provisional draft circulated by Nutrition Section, UNICEF New York to relevant agencies and individuals for comment and further development.

LINKAGES: Breastfeeding, Complementary Feeding and Maternal Nutrition Program is supported by USAID under Cooperative Agreement No. HRN-A-00-97-00007-00 and managed by the Academy for Educational Development, Washington DC.

IBFAN, the International Baby Food Action Network, was represented in the early development of these materials by their Regional Coordinating office in Geneva. Field testing was organized by the IBFAN Africa Regional Office in Mbabane, Swaziland.

ENN, the Emergency Nutrition Network based at Trinity College, Dublin publishes a quarterly newsletter (Field Exchange) which communicates field level articles and current research and evaluation findings relevant to the emergency food and nutrition sector.

This material may be freely reviewed, abstracted, reproduced or translated, in part or in whole, but not for sale or for use in conjunction with commercial purposes.

To order copies please contact:
Emergency Nutrition Network
Unit 2.5, The Tower
Trinity Enterprise Centre
Pearse Street
Dublin 2
Ireland
Tel: +353 (0)1 675 2390
Fax: +353 (0)1 675 2391
email: fiona@enonline.net

1 Introduction to infant feeding in emergencies	4
1.1 Infant death and disease	4
Increased deaths (mortality)	
Risks of death highest for the youngest	
Increased illness (morbidity)	
Risks of death higher for malnourished children	
Examples: Effects of pre-crisis patterns of infant feeding (optional)	
1.2 Infant feeding	7
Breastfeeding is the best way to feed an infant	
Exclusive breastfeeding	
Substitutes are inferior to breastmilk	
Additional advantages of breastfeeding	
Recommendations	
1.3 Common concerns about breastfeeding	9
2 Challenges to infant feeding in emergencies	10
2.1 Factors that interfere with breastfeeding	10
The help that mothers need	
Common misconceptions (optional)	
Improving conditions to make breastfeeding easier	
2.2 Alternatives to breastmilk and their problems	14
Alternatives to a mother's own breastmilk	
Problems with artificial feeding	
Nutritional difficulties for non-breastfed infants beyond six months (optional)	
Identifying risk factors: photos of emergency settings (optional)	
2.3 Challenges for emergency relief staff	19
Staff capacity	
Unaccompanied children	
Uncertainty about implementing global policies on HIV	
2.4 Donations of infant formula in emergencies can be dangerous	19
The problems with donations	
Additional dangers of unlimited supplies	
3 Policies and Guidance for Appropriate Infant Feeding.....	21
3.1 The International Code of Marketing of Breastmilk Substitutes	21
What is the Code?	
Important points of the Code	
Breastmilk substitutes should be purchased by the health care system	
What the Code says about donated supplies	
Targeting	
Obligation to continue to supply each infant	
No sales inducement	
Monitoring the Code	
A brief exercise in monitoring Code compliance (optional)	
3.2 Operational Guidance	25
3.3 Policy gaps: achieving coordination	27
Overcoming policy gaps	
Responsibility for unsolicited donations (optional)	
Responsibility for monitoring NGO activities (optional)	
3.4 HIV Guidelines (optional)	28
Access to testing	
Risks of transmission by breastfeeding	
Breastfeeding	
Replacement feeding	
4 Supporting appropriate infant feeding practices in emergencies	30
4.1 Assessment and analysis	31
The Triple A cycle	
Key information to obtain early	
Qualitative information to obtain when there is more time (optional)	
Quantitative information to obtain through surveys and monitoring (optional)	
Case studies: analysing how to help mothers in emergencies (optional)	
4.2 Action: conditions to support breastfeeding	35
What women need	
Possible actions	
4.3 Action: conditions to support relactation	36
4.4 Alternatives to breastfeeding by the natural mother	37
Wet nursing	
Milk banking (optional)	
Artificial feeding	
4.5 Conditions to reduce dangers of artificial feeding	37
Agreed criteria	
Conditions needed for artificial feeding (optional)	
4.6 Management of artificial feeding (optional)	40
Annex 1 The International Code of Marketing of Breastmilk Substitutes....	42
Annex 2 Infant and Young Child Feeding in Emergencies	45
Annex 3 The Ten Steps to Successful Breastfeeding of the	
Baby-Friendly Hospital Initiative	53
Annex 4 Cup feeding	54
Annex 5 Sample of a generic label for infant formula.....	55
Annex 6 Monitoring form.....	56

1 Introduction to infant feeding in emergencies

In emergencies, children under five are more likely to become ill and die from malnutrition and disease than anyone else. In general, the younger they are, the more vulnerable they are. Inappropriate feeding increases their risks.

This module covers how to feed infants, by breastfeeding and, when necessary, other options. It also addresses existing recommendations and protective policies, and gives guidance on how to provide adequate support for appropriate infant feeding.

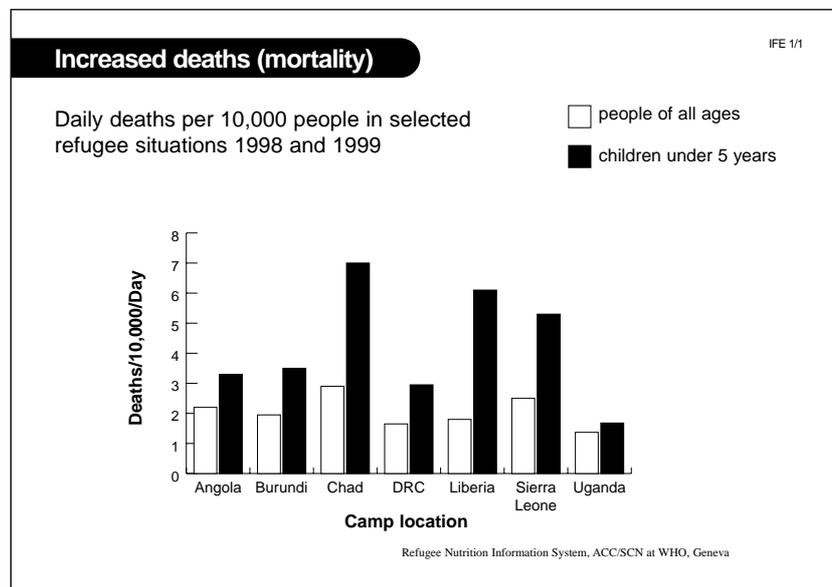
Although we shall be talking about infants, that is babies under one year, breastfeeding can and should continue with other foods up to two years or beyond.

1.1 Infant death and disease

Increased deaths (mortality)

This figure shows deaths among refugees of all ages, and among children under five years old, in various emergencies.

IFE 1/1



- All of the situations in the above figure can be described as emergency situations because the death rate exceeds 1/10,000/day. In emergency situations, children under five are more likely to die than the rest of the population.

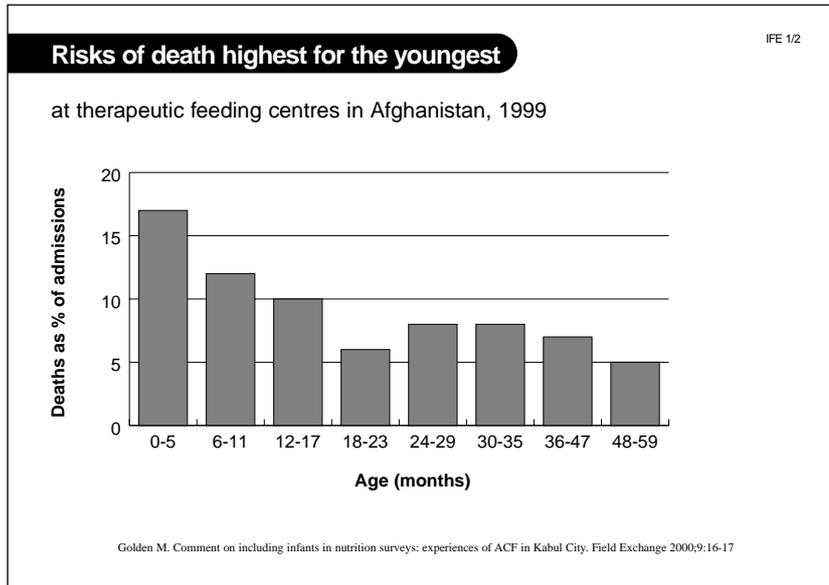
But this graph does not show the highest death rate, in the very vulnerable infants.

Risks of death highest for the youngest

Around the world, in non-emergency situations two thirds of under-five deaths occur during the first 12 months of life. Whether this proportion changes in an emergency depends in part on how infants are fed.

The next figure shows that in therapeutic feeding centres, where up to 10% of the malnourished children admitted were under six months old, most deaths were among younger children.

IFE 1/2



Increased illness (morbidity)

- Lack of food, adequate water and shelter,
- overcrowding,
- inadequate sanitation,
- separation of parents and children, and
- trauma

are characteristic of emergencies. Many of these increase child illness.

Risks of death higher for malnourished children

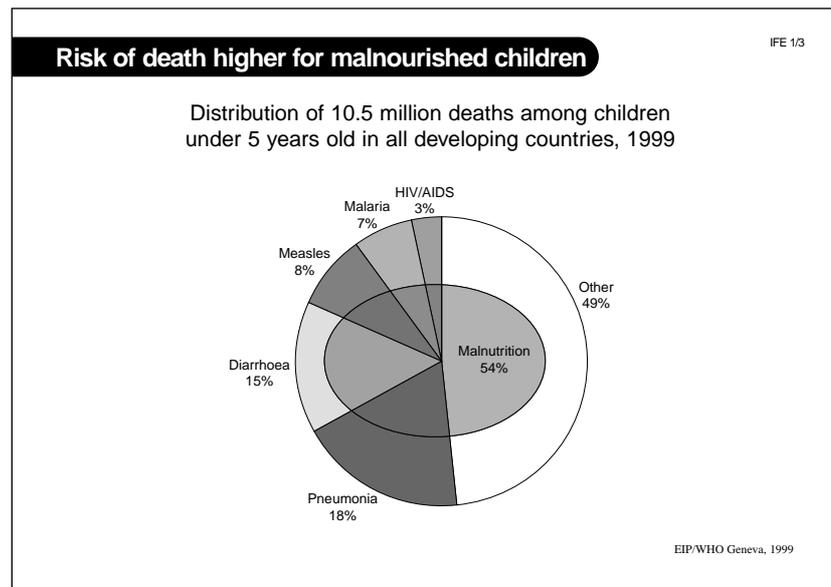
Malnourished infants are much more likely to die than are well-nourished infants.

An underweight child who falls ill is much more likely to die.

Anemia and other micronutrient deficiencies make children even more vulnerable.

Low birth weight due to malnutrition of pregnant mothers also is associated with higher infant mortality.

IFE 1/3



The outer circle of this diagram shows that about 51% of deaths of children under five years old are due to pneumonia, diarrhoea, measles and malaria. The inner circle suggests that over half of the deaths, about 54%, are connected with underlying malnutrition.

For that reason, a major part of both prevention and treatment is to improve infant and young child feeding as well as maternal nutrition.

Examples: Effects of pre-crisis patterns of infant feeding (optional)

Where there is not a pre-existing tradition of exclusive and continued breastfeeding, infants may be more at risk in a crisis situation.

Darfur, Sudan 1984/85, **Breastfeeding protects infants in famine**

In the early 1980s, several years of drought and crop failures triggered famine in the Darfur region of Sudan during 1984-85. A survey in eight villages during 1986 showed deaths were closely related to age. Children of one to four years were six times as likely to die as adults. But they were also three times as likely to die as the infants under one year, a difference that might be correlated with the almost universal breastfeeding.

Kurdish refugees 1991, **Bottle feeding makes infants vulnerable**

In February 1991, more than 1.5 million Kurds fled Iraq toward Turkey and Iran, becoming stranded in several remote mountain passes without food or shelter against freezing cold. Food and blankets were dropped from planes, but there was very high mortality among infants, of whom 10% died. 75% of the deaths were from diarrhoea.

Existing Kurdish patterns of combining breast and bottle feeding, with many infants not breastfed, are considered to have made them particularly vulnerable

1.2 Infant feeding

Breastfeeding is the best way to feed an infant

The best quality food for infants, in emergencies or non-emergencies, is breastmilk for these reasons:

- It is nutritionally perfect, providing all the energy, nutrients and fluid that the baby needs for the first six months. It is still an important food through the second year.
- It is clean, safe, at the right temperature and easily digestible.
- It helps to protect against infections, particularly diarrhoea, chest and ear infections.

The food most suitable for infants is breastmilk.

Exclusive breastfeeding

The infant under six months benefits most from exclusive breastfeeding. *Exclusive breastfeeding* means giving only breastmilk, and no other foods or fluids, not even water. (Medicines and vitamins not diluted with water may be given, if medically indicated.)

Exclusive breastfeeding provides what each young infant requires. The baby’s suckling determines the amount of milk. The more the baby suckles and takes in milk, the more milk the mother produces. If the baby suckles less, for example because other fluids or foods are given, the mother will produce less milk.

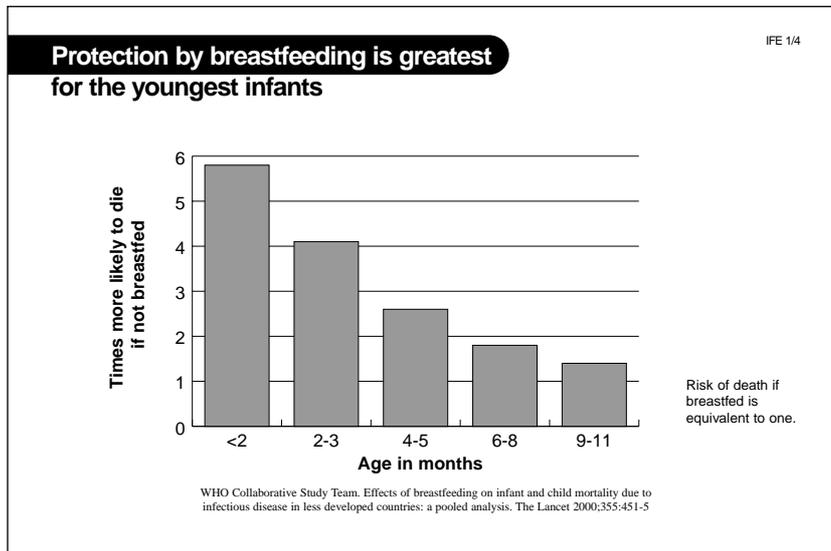
Substitutes are inferior to breastmilk

Breastmilk substitutes, including infant formula, are all inferior to breastmilk.

- They lack breastmilk’s precise balance of nutrients, for example those needed for brain growth and development.
- They may be unclean or wrongly prepared and they are more difficult to digest.
- They do not protect against illness, and if contaminated may carry infection, leading to higher death rates.

Protection by breastfeeding is greatest for the youngest infants, even in non-emergency settings, as this study of six countries makes clear.

IFE 1/4



Not to breastfeed increases the risk of dying by six times in infants less than two months old, and even between 9 and 11 months the risk is increased by 40%. Breastfeeding continues to provide the best quality of food during the second year, and to reduce the impact of illness.

Additional advantages of breastfeeding

Breastfeeding has these additional advantages:

- It provides food security for the infant without dependence on supplies.
- It reduces maternal bleeding after delivery by helping the uterus to contract.
- It can help to space births, and reduces the risk of some cancers.
- It promotes bonding between mother and baby, and psychosocial development of the child.
- It makes caring for the baby easier.
- It may give the mother her only sense of control of the situation and of well-being.
- It reduces the health care challenge for emergency relief staff.

For all these reasons, breastfeeding is especially important in crisis conditions.

Recommendations

There is consensus on recommendations for the best, the optimal infant feeding for ordinary conditions. These are not changed for emergencies.

IFE 1/5

Recommendations for infant feeding

IFE 1/5

- Start breastfeeding within one hour of birth.
- Breastfeed exclusively for six months.
- From six months, add adequate complementary foods.
- Continue breastfeeding up to two years or beyond.

Breastfeeding should start early. Skin-to-skin contact from birth keeps the infant warm.

The first milk, called *colostrum*, is particularly valuable for preventing infections. Newborns should not get any water or other feeds before they start breastfeeding.

Most babies can breastfeed exclusively for six months and grow well.

Most babies do not need complementary foods before six months.

At about six months, infants begin to need complementary foods in addition to breastmilk.

They should be introduced gradually to nutritious non-milk foods, while breastfeeding continues. This is called *complementary feeding*.

Between six and 24 months, children still need breastmilk, both as a food and to lessen the dangers of illness.

1.3 Common concerns about breastfeeding

Many people may have heard that breastfeeding is difficult or does not work in emergency situations.

Some of the concerns are based in experience, and some are deeply held but mistaken beliefs. Here are some very important common concerns:

Common concerns

“Malnourished mothers cannot breastfeed.”

Malnourished mothers can breastfeed, but need extra food and fluids and encouragement to breastfeed the infant very frequently. “Feed the mother and let her feed the baby.”

“The mother thinks she is not producing enough milk to feed her baby.”

A mother produces enough milk to feed her baby if she breastfeeds frequently and as long as the baby wants at each feed. Her breasts may seem soft but will be producing milk.

“Stress prevents mothers from producing milk.”

Stress does not prevent milk production, but may temporarily interfere with its flow. Create conditions for mothers that lessen stress as far as possible — a protected area, a mother-baby tent, reassurance from other women — and keep the child suckling so that milk flow returns.

“The mothers may have HIV and transmit it through breastfeeding.”

First arrange to make testing available. If testing is not possible, all mothers should breastfeed. Alternatives to breastmilk are too risky to offer if a woman does not know her status.

If a mother chooses to be tested and is HIV positive, she needs individual counselling on the risks of transmission and her infant feeding options. Then she needs support for the method that she chooses. (There is more on this topic in Sections 2.3 and 3.4)

2 Challenges to infant feeding in emergencies

In both ordinary life and emergencies, women may sometimes have difficulties with breastfeeding. These may have physical or social causes, or simply be due to lack of confidence.

These difficulties can in most cases be prevented and overcome.

Breastfeeding is possible for most mothers if they get the help they need. So it is necessary to support breastfeeding as much as possible, and to lessen the need for alternatives.

If alternatives are unavoidable, it is important to reduce the risks of using them as much as possible.

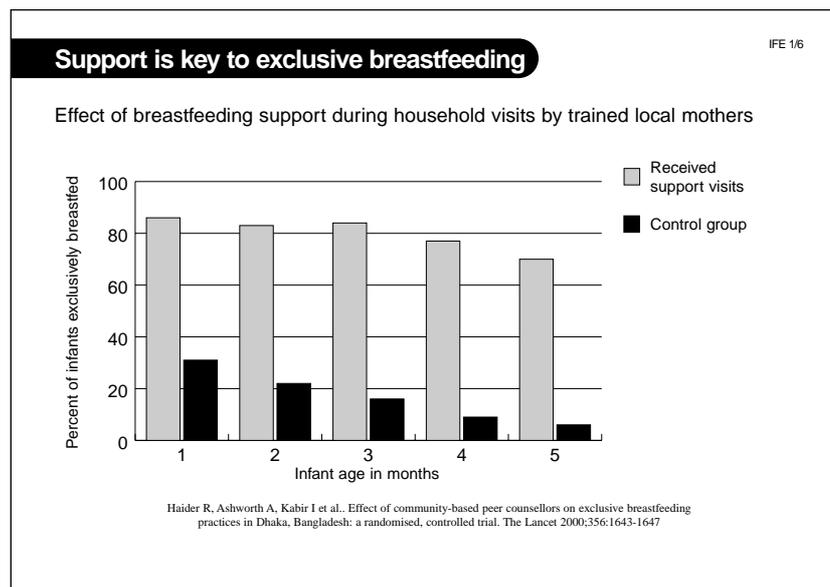
2.1 Factors that interfere with breastfeeding

The help that mothers need

Breastfeeding counselling for mothers in ordinary circumstances can prevent and overcome most difficulties. For example, in an Asian capital, when trained local mothers visited households to support breastfeeding, exclusive breastfeeding dramatically increased.

At five months, 70% of mothers who had received counselling were breastfeeding exclusively, compared to 6% of mothers who had received standard care that favoured breastfeeding but did not provide ongoing personal support.

IFE 1/6



The breastfeeding counsellor has four main tasks to do:

1. She **builds the mother's confidence** that she can breastfeed and that she has enough breastmilk.
2. She **gives accurate information** to correct misconceptions, and answers questions.
3. She helps ensure that the mother breastfeeds in a way that **helps milk production**.
4. She **makes sure that the mother is supported** in other ways as far as possible, for example with supplementary food if necessary, and by joining a group of other mothers.

These will mainly be the tasks of the health and nutrition sector in an emergency, but everyone should know something about what is needed. Others may have administrative and managerial responsibility for making it happen. (Module 2 explains in more detail how to help mothers).

In addition to supportive counselling, in emergencies there are special concerns that need to be addressed at the level of the individual mother. The mother may be concerned about these herself. Alternatively, the staff may be concerned for her, for example if they know she has mistaken beliefs that will make it difficult for her to breastfeed.

IFE 1/7

Care for the individual breastfeeding mother	
Concerns for mother	Staff should ensure
• her own nutrition and fluid intake	<i>extra rations and fluids</i>
• her own health	<i>attentive health care</i>
• physical difficulties (e.g. sore nipples)	<i>skilled breastfeeding counsellors</i>
• misinformation, misconceptions	<i>correct information and breastfeeding counselling</i>

Common misconceptions (optional)

Health and nutrition staff need to be aware of beliefs that may affect breastfeeding practices. Are any of these beliefs common among the people you are working with?

A brief true statement follows each one.

- “A mother should stop breastfeeding if the baby has diarrhoea.”
- Do not stop breastfeeding if the baby has diarrhoea. Breastmilk helps a baby recover from diarrhoea.
- “Babies need extra fluids such as tea or water.”
- Breastmilk provides all the fluids a baby needs under six months, even in hot weather. Any extra fluids or use of bottles and teats may interfere with suckling and reduce breastmilk production.

- ✘ *“Women with small, flat or soft breasts or nipples cannot breastfeed.”*
- ✔ Women with small, flat or soft breasts can breastfeed and make plenty of milk. So can women with any shape of nipple.

- ✘ *“The first milk should not be given to the newborn.”*
- ✔ Colostrum, the first milk, is an important early source of nutrients as well as giving strong protection against infections. This protection is not available from any other milk.

- ✘ *“Breastmilk just goes away; after a few weeks or months, all mothers lose their milk.”*
- ✔ Breastmilk diminishes when something interferes with frequency of suckling, such as giving other fluids instead of breastfeeding. Breastmilk does not go away if the baby suckles frequently. Breastfeeding can continue through two years or more.

- ✘ *“Once stopped, breastfeeding cannot be started again.”*
- ✔ If a mother stops breastfeeding she can usually restart. She needs assistance to encourage the baby to suckle. It usually takes a week or more to start again. The process is called relactation. (Module 2 gives more detail.)

- ✘ *“Infant formula is superior because it’s based on science.”*
- ✔ Formula is inferior to breastmilk nutritionally and in many other ways. Its use may lessen mother and infant health, and is only justified in some specific circumstances. (See Section 4.5)

- ✘ *“A pregnant mother cannot breastfeed.”*
- ✔ A pregnant mother can continue to breastfeed her baby. She should get additional food.

- ✘ *“When a woman has been raped, she cannot breastfeed.”*
- ✔ Experience of violence does not spoil breastmilk or the ability to breastfeed, but all traumatised women need special attention and support. There may be traditional practices that restore a woman’s readiness to breastfeed after sexual trauma.

You may also make your own list of common beliefs affecting infant feeding practices:

What can staff do to correct mistaken beliefs that interfere with breastfeeding?

Consider this question for yourself, before looking at the ideas given below. *They are not the only possible answers.* You may have ideas that are much more appropriate for the local culture.

*Possible actions could include:

Training the health care workers who support parents, ensuring they do not share local misconceptions. Providing scientific information to decision-makers and medical trainers. Reaching women before and during pregnancy with accurate information. Giving special attention and ongoing support to mothers who are being asked to go against their older customs and beliefs. Giving intensive help to a small group of respected mothers to breastfeed in an optimal way, and (if they agree) then showing others how their infants have developed. Using such experienced mothers to change the practices of others, by visiting them at home. Ensuring that any materials such as posters or booklets for mothers that include misinformation are replaced with better materials. Providing education through community groups to influential people (grandparents, local leaders, religious leaders, and friends and relatives of young mothers) and enlisting their help in supporting the mothers. Focussing public communications on correcting the most damaging beliefs.

Improving conditions to make breastfeeding easier

Some breastfeeding difficulties might arise from the surrounding conditions in emergencies. Improving camp arrangements could create the conditions that mothers need to breastfeed more easily.

IFE 1/8

Improving conditions to make breastfeeding easier		IFE 1/8
Mothers' difficulties	Staff should ensure	
<ul style="list-style-type: none"> time constraints long time to fetch water, queue for food 	<p><i>priority access</i></p>	
<ul style="list-style-type: none"> lack of protection, security, and (where valued) privacy 	<p><i>shelters</i></p>	
<ul style="list-style-type: none"> lack of social support and of a familiar social network 	<p><i>groups of women who support each other</i></p>	
<ul style="list-style-type: none"> free availability of breastmilk substitutes, undermining mothers' confidence in breastfeeding 	<p><i>effective controls on availability</i></p>	

Women who are all alone find it difficult to care well for their infants even in ordinary conditions. Groups that help women to talk to each other, known as *mother-to-mother support groups*, can give a shy, isolated or grieving mother the contact she needs.

Providing special help, support and new connections to a woman who has lost her family and home may be an important part of enabling her to care for her infant.

2.2 Alternatives to breastmilk and their problems

In emergencies, there may be infants who have become separated from their mothers.

In a few cases, mothers may also choose not to breastfeed, or be unable to restart after having stopped.

Alternatives to a mother's own breastmilk

(discussed in more detail in 4.4)

Alternatives include **breastmilk from others**:

- *wet-nursing* (a woman who is not the mother breastfeeds the infant)
- *milk banks* (storage and use of heat-treated breastmilk from other mothers)

and **artificial feeding** (the use of non-human milk):

- infant formula
This usually is provided as a powder, which needs to have water added. Both generic and proprietary brands of commercial formula meet international standards and are equally nutritious
- animal milk (cow, buffalo, goat or camel milk)
- powdered full cream milk.
Both of these need to be suitably adapted, by adding water, sugar, minerals and vitamins. (Recipes are given in Module 2.)

Condensed milk is not suitable for feeding infants.

Powdered skim milk requires substantial and precise modification with other ingredients — oil, sugar, minerals and vitamins to meet the requirements of infants. It should be used only temporarily, in situations of extreme crisis, while a better option is sought.

If artificial feeding is given, use of feeding bottles should be avoided.

Cup feeding is possible from birth and a safer option. (See Annex 4.)

Problems with artificial feeding

Mothers or other caregivers will face particular difficulties in giving any non-human milk with reasonable safety.

What difficulties do these two photos suggest?

IFE 1/9



Possible comments on IFE 1/9: The water will be very contaminated, by drainage from the camp, by mud, by the faeces of the grazing animals, and by the human bacteria from the people walking and perhaps washing in it. To make this water clean enough for infants and young children will require a great deal of caregiver attention, time and utensils to let mud settle out, fuel for boiling, and a safe utensil to store it in once boiled.

IFE 1/10



Possible comments on IFE 1/10: Here the family have only a small shelter, open to the rain and dust, and a mat. There is no clean surface to prepare feeds, no firewood or other cooking facilities to be seen, probably water available only at a distance. Preparing several clean artificial feeds a day under these conditions would be almost impossible even for a caregiver experienced in artificial feeding.

Artificial feeding is dangerous in these circumstances. It increases the risks of disease and malnutrition, which in turn substantially increase the risk of infant deaths.

To summarise the common problems:

IFE1/11

Problems of artificial feeding in emergencies	IFE 1/11
<ul style="list-style-type: none"> • lack of water • poor sanitation • inadequate cooking utensils • shortage of fuel • daily survival activities take more time and energy • uncertain, unsustainable supplies of breastmilk substitutes • lack of knowledge on preparation and use of artificial feeding 	

Nutritional difficulties for non-breastfed infants beyond six months (optional)

After six months, the diet of an infant who is not breastfed should preferably continue to include a suitable breastmilk substitute, along with complementary foods.

- The general take-home rations may not be adequate for infant growth and health.
- Key nutrients are difficult to provide without milk in some form.
- Blended foods containing dry skim milk powder in at least a 1:6 ratio with cereal may be helpful. But because of the volume of the cooked cereal, infants under one year may not take in enough every day to get all the nutrients that they need.
- After six months, if infant formula is not continued, an artificially fed infant may be given unmodified full cream animal milk or fermented milks such as yoghurt if locally available.

All of the conditions that lessen the risks of artificial feeding must continue to be fulfilled (See Section 4.5).

Identifying risk factors: photos of emergency settings (optional)

Consider what difficulties for both breastfeeding and artificial feeding you can see in the following four photographs, or in other pictures from emergency settings. As before, develop your own ideas about each, before reading the fine print at bottom of page.

Queueing for food, Sudan



UNICEF/4612/ROGER LEMOYNE

Unaccompanied children, Rwanda



UNICEF/94-0164/BETTY PRESS

- Long tight queues in the hot sun are not suitable for babies, who may be left alone in shelters. Mothers cannot leave the queue to breastfeed the infant on demand or prepare other feeds; they will lose their place.
- Children without adult caregivers may have carried infants long distances to a camp, but cannot manage artificial feeding. Infants lacking adult care may have to be brought into an organised care setting. In neither of the situations shown above will distribution of breastmilk substitutes solve the problems.

Food distribution, Albania



ALBANIA, TEARFUND

Mother who has lost all her own children caring for a sick orphan, Rwanda



UNICEF/94-0991/BETTY PRESS

- Where men have best access to distributions, unaccompanied women may have special difficulty in getting what they need. A woman with an infant may be specially handicapped in obtaining food, if she must struggle with crowds and then carry the food away in addition to her child. Providing special priority distribution systems for mothers with infants may lessen these difficulties.
- The stress and sadness of a mother cannot be removed, but measures to lessen her isolation may help her to cope with her feelings and care for her infant. Seek any relatives, clan members, or women who speak her home language might to be with her. If this infant is sick partly because he or she is not getting enough breastmilk, the mother also needs encouragement and help to relactate.

2.3 Challenges for emergency relief staff

Staff capacity

- At all levels, emergency relief staff may be unaware of infant feeding issues.
- Health and nutrition staff may not have been trained to help with either breastfeeding or artificial feeding under difficult conditions.
- There may be readiness among staff who are inexperienced with breastfeeding to prescribe infant formula.
- Health facility and other staff may feel they lack time for infant feeding counselling.

Unaccompanied children

- Some crises produce large numbers of unaccompanied children.
- In 1994, in camps in the Great Lakes region of Africa there were about 10,000 at one time.
- A small percentage were infants under six months of age, separated from their mothers, who needed alternatives to mother's milk.
- The effect of HIV in certain areas in the world has increased the numbers of unaccompanied infants and children.

Uncertainty about implementing global policies on HIV (See also section 3.4)

- Emergencies often hit the areas of the world with high prevalence of HIV.
- There is a one-in-seven (about 15%) risk of transmission of HIV through breastfeeding.
- In industrialised countries women who are HIV positive generally are advised not to breastfeed.
- Giving this advice is not appropriate unless women can be tested to learn their HIV status.
- Because of the risks associated with artificial feeding in emergency settings, it may be safer for HIV-positive women to breastfeed. Ultimately this is a choice for the mother.

Another challenge is how to deal with needless donations of infant feeding products.

2.4 Donations of infant formula in emergencies can be dangerous

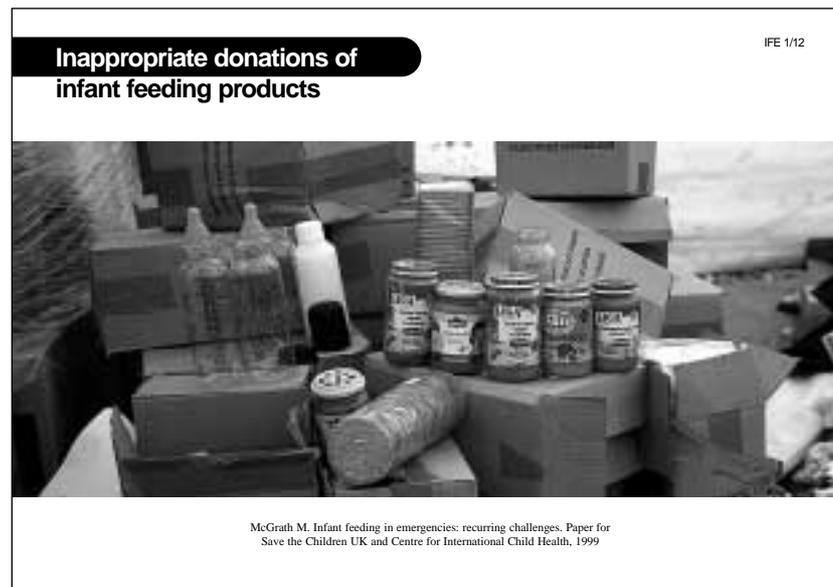
Donations of infant foods and feeding bottles may come from many sources, including well-intentioned but poorly informed small groups or individuals. Media coverage may have led these donors to believe that women cannot breastfeed in the crisis.

The problems with donations

A 1999 study of large unsolicited donations of infant formula and feeding products in the Balkan emergency found:

- Without assessment of need, too much infant formula was sent.
- Donations served to advertise commercial brands.
- Bottles and teats were included (but only cup feeding is recommended in emergencies).
- Some donated formulas were expired, making them unsafe to use.
- No instructions in local languages were provided.

IFE1/12



Additional problems encountered were:

- Where to store the donated products?
- Who should control or distribute them?
- How to dispose of the excess?

In Macedonia, 20 metric tonnes of infant food had to be disposed of, not having been used.

Additional dangers of unlimited supplies

If supplies of infant formula are widely available and uncontrolled, there may be *spillover*. **Spillover** means that mothers who would otherwise breastfeed lose their confidence and needlessly start to give artificial feeds. As mothers lessen or stop breastfeeding, their breastmilk diminishes and may indeed dry up due to lack of suckling.

Infants and their families become dependent on infant formula. If the free supply is unreliable, they are put at risk of malnutrition in addition to the health risks of artificial feeding.

Large donations may come from companies who, by donating formula to the area in crisis, intend to **create a new market** for later sale of their products to the emergency-affected population or the host population.

3 Policies and Guidance for Appropriate Infant Feeding

We have discussed why infant feeding is important, and some of the challenges for both breastfeeding and artificial feeding in emergencies. An appropriate response requires

- policies and guidance
- supportive help with infant feeding for mothers
- appropriate management of supplies, and
- skilled health and nutrition workers.

A *policy* states what everyone has agreed to do, and *guidance* helps them know how to do it.

We will summarise some policies, but they may not cover all situations, and in an emergency there is usually no regulatory body to make sure they are followed.

For these reasons, in crisis situations it is extremely important for emergency relief staff and agencies to develop a coordinated approach.

3.1 The International Code of Marketing of Breastmilk Substitutes

What is the Code?

The International Code of Marketing of Breastmilk Substitutes is intended to protect breastfeeding, to ensure that mothers' confidence in their own milk is not undermined by commercial influences. The Code does not ban use of formula or bottles, but controls how they may be promoted and provided. In emergencies this protection is vital to the survival of infants.

The *World Health Assembly* (WHA) is the governing body of the World Health Organisation, attended by Ministers of Health from member states. The Code was adopted in 1981 by the WHA as a minimum recommendation to all governments and agencies. That document and the relevant WHA Resolutions of following years are collectively referred to as *the Code*.

At least 48 countries have national legislation based on the Code. These laws provide minimum legal standards that need to be upheld by relief agencies involved in infant feeding. However, the Code is intended for **universal** implementation, and should be followed even where there is no national legislation.

The Code sets out the responsibilities of the infant food industry, health workers, governments and organizations in relation to the marketing of breastmilk substitutes, feeding bottles and teats. *Marketing* includes everything that is done to increase sales of a product.

Breastmilk substitutes are defined as: “**any food being marketed or otherwise represented as a partial or total replacement of breastmilk, whether or not suitable for that purpose.**”

This means that breastmilk substitutes include infant formula, follow-on formula, bottled water, juices, teas, glucose solutions, cereals and other foods and fluids if they are promoted for use under six months of age, or as replacements for breastmilk from six months of age. These products are said to be *within the scope of the Code*.

Important points of the Code

Annex 1 summarizes key portions of the Code that are important in emergencies.

IFE 1/13

Some important points from the

IFE 1/13

International Code of Marketing of Breastmilk Substitutes

- no advertising or promotion to the public
- no free samples to mothers or families
- no donation of free supplies to the health care system
- health care system obtains breastmilk substitutes through normal procurement channels, not through free or subsidised supplies
- labels in appropriate language, with specified information and warnings

No advertising or other promotion to the general public of products within the scope of the Code is permitted. This includes all kinds of breastmilk substitutes, feeding bottles and teats (artificial nipples).

No free samples of products (small quantities) may be given to pregnant women, mothers, or families. An infant needs 20 kg of powdered infant formula in the first six months of life. Providing just a few tins is not permitted by the Code.

No free supplies of products (large quantities) **may be given to any part of the health care system**, which includes organizations engaged in health care for mothers and children, nurseries and child care institutions.

Normal procurement channels (i.e. purchase) must be used by maternity wards and hospitals to obtain the small amounts of breastmilk substitutes that they need.

Labels on products must be in appropriate languages, give specified information, and warn of hazards.

Breastmilk substitutes should be purchased by the health care system

Note that the Code does not allow donations of breastmilk substitutes, bottles or teats to the health care system for distribution.

However, if the health care system **purchases** these products, it may distribute them to mothers.

In many emergency settings, the camp administration or relief agency may purchase breastmilk substitutes centrally and give them to the various parts of the camp health care system for distribution. This permits health and nutrition staff to follow up their use and take steps to lessen risks.

What the Code says about donated supplies

A1994 WHA Resolution urges that governments and agencies:

“**exercise extreme caution** when planning, implementing or supporting emergency relief operations by protecting, promoting and supporting breastfeeding for infants and ensuring that **donated supplies** of breastmilk substitutes or other products covered by the scope of the International Code be given only if the following conditions apply:

- (a) infants **have to** be fed on breastmilk substitutes...
- (b) **the supply is continued for as long as the infants concerned need it;**
- (c) the supply is **not** used as a **sales inducement.**”

Targeting

Infants who have to be fed on breastmilk substitutes must be individually identified by agreed criteria, that is targeted for supplies. Breastmilk substitutes should neither be part of general food distributions nor of supplemental distributions given to all mothers.

Obligation to continue to supply each infant

Providing an infant with breastmilk substitutes for only a short time violates the Code.

For how long does an infant need a full supply of breastmilk substitutes?

This should be until the infant is **at least six months old** or until breastfeeding is re-established. However consideration should also be given to the difficulty of feeding non-breastfed infants adequately after the age of six months unless milk in some form is provided.

No sales inducement

One way to avoid the danger of supplies becoming a sales inducement is to use *generic labelling*, without any brand name. (Sample text for a generic label is provided in Annex 5.)

If *proprietary* formula — with familiar brand names — is distributed by relief agencies, people may believe that these brands must be superior. They will tend to buy the same brands later.

Another way to prevent inducement of sales is to ensure that a continuing full supply is provided to each targeted infant, so parents are not forced to buy more.

Monitoring the Code

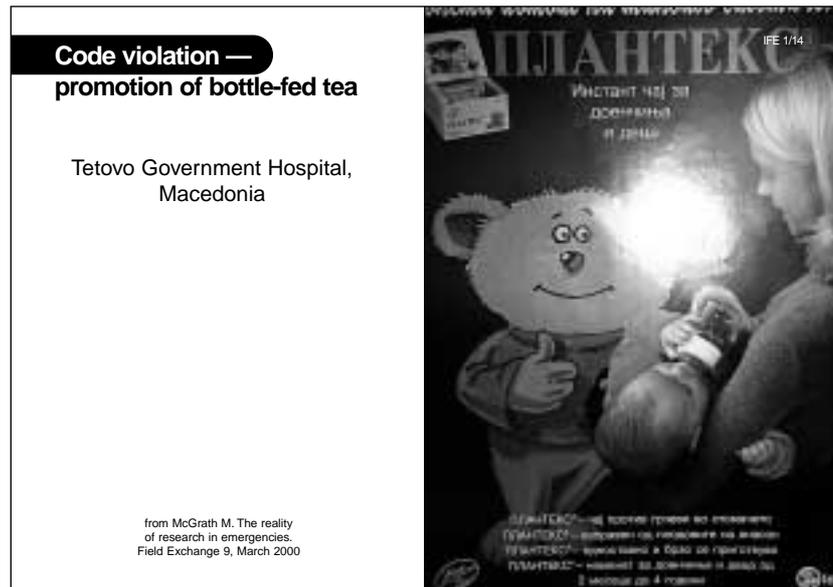
Emergency situations provide environments in which it is easy for the Code to be violated and breastfeeding be undermined. Infant health will decrease as caregivers start using products under the scope of the Code.

It is necessary to monitor implementation of the Code, and hold accountable those who break it.

If the Code is not followed, inform your agency policy makers, the interagency body that establishes infant feeding policy in the emergency, and the NGOs that monitor Code implementation.

Here, for example, is an advertisement for bottle-fed tea found during the Balkan crisis and reported to Code monitors:

IFE 1/14



A brief exercise in monitoring Code compliance (optional)

These questions below are taken from the fuller Monitoring Form (Annex 6). These questions concern some important aspects of Code implementation in an emergency setting.

Donated supplies

Are breastmilk substitutes, feeding bottles or teats being distributed?
 Were these products purchased by the distributing agency?
 If not, what is the origin of the products?

Distribution

Are the products distributed as part of the general food distribution to all families?
 If not, to whom are they distributed?
 to all infants less than six months
 to all infants less than one year
 to targeted infants with an identified need, such as orphans not wet-nursed
 other (please specify)

Is each infant guaranteed a full supply as long as needed?

Labels

Are labels in the appropriate language? (Please indicate languages)
 Do the labels explain how to use the product?
 Do they give warnings of the health hazards of improper preparation?

Promotion

Is there any advertising or promotion of the products for infants under six months?

3.2 Operational Guidance

Annex 2 provides practical guidance on what needs to be done. This document has been drafted by Save the Children, Institute of Child Health – London, LINKAGES and IBFAN. There has been a long consultation process and many other agencies' comments have been incorporated (notably relevant UN agencies, other NGOs and some bilateral agencies). The process of endorsement of the document by many agencies is now underway.

IFE 1/15

Operational Guidance: what to do

IFE 1/15

1. Endorse or develop policies on infant feeding.
2. Train staff to support breastfeeding and to identify infants truly needing artificial feeding.
3. Coordinate operations to manage infant feeding.
4. Assess and monitor infant feeding practices and health outcomes.
5. Protect, promote and support breastfeeding with integrated multi-sectoral interventions.
6. Reduce the risks of artificial feeding as much as possible.

from *Operational Guidance for Emergency Relief Staff and Policy-Makers*
by the Interagency Working Group on Infant Feeding in Emergencies

How can a relief programme carry out point 5, “protect, promote and support breastfeeding”? There is clear agreement on the following nine points:

IFE 1/16

Points of agreement

IFE 1/16

on how to protect, promote and support breastfeeding

1. Emphasise that breastmilk is best.
2. Actively support women to breastfeed.
3. Avoid inappropriate distribution of breastmilk substitutes.
4. When necessary, use infant formula if available.





To say a little more about each of these nine points:

1. Breastmilk is the best food for infants for the first six months.
2. Active support for breastfeeding, and restarting it, is the first choice for preventing or solving infant feeding problems. This is of particular importance in emergencies where psychosocial stress may be high, hygiene poor, and alternative feeding methods unsafe.

3. The number of babies requiring breastmilk substitutes in most situations is likely to be small. Identification of infants who need substitutes must be carried out by appropriately trained staff, according to agreed criteria. Breastfeeding should not be undermined by the inappropriate distribution of breastmilk substitutes.

4. Where a need for a breastmilk substitute is established, infant formula should be used if available. Alternatively, home prepared formula can be made from fresh or powdered full cream milk, with appropriate modification and the addition of micronutrients.

IFE 1/17

More points of agreement

IFE 1/17

on how to protect, promote and support breastfeeding

5. Do not distribute feeding bottles/teats; promote cup feeding.
6. Do not distribute dried skim milk unless mixed with cereal.
7. Add complementary foods to breastfeeding at 6 months.
8. Avoid commercial complementary foods.
9. Include pregnant and lactating women in supplementary feeding when general ration is insufficient.



5. Feeding bottles and teats should never be distributed or used due to risk of interference with suckling, reduced caregiver attention while feeding, and contamination with pathogens. Feeding from an open cup is recommended.

6. In general powdered skimmed milk, by itself, should not be distributed as part of a dry take-home ration. It should be mixed in a proportion of 1:6 with cereal flour.

7. Appropriate complementary foods should be made available and given in addition to breastfeeding from 6 months of age. These should include foods rich in energy and nutrients that are easily eaten and digested by infants and young children.

8. Commercial complementary foods are not recommended for general use. Suitably prepared locally available foods are preferred.

9. A general ration adequate to meet the nutritional needs of the population, including pregnant and lactating women, should be distributed. If it is inadequate, advocate for a general ration appropriate in quality and quantity. In situations where supplementary foods are available but sufficient food for the general population is not, consider pregnant and lactating women as a vulnerable group. The needs of lactating women should be met as long as breastfeeding continues, often through the second year.

3.3 Policy gaps: achieving coordination

Policies set out what everyone agrees will be done. Some specific body, often a UN agency following an existing agreement with other agencies, should coordinate development of a common policy, ideally based on the Operational Guidance in Annex 2. Otherwise there may be confusion in the field.

Within each agency, someone needs to make sure that the policy is followed in practice, that is, *implemented*.

Overcoming policy gaps

All emergency relief agencies should:

- know and operate within the framework of whatever national policies exist (such as a national Code of Marketing or infant feeding directive);
- have or endorse common policies on
 - infant feeding and
 - procurement and distribution of infant feeding products;
- ensure that they are implementing the agreed policies;
- designate a specific person with responsibility for infant feeding issues including monitoring how breastfeeding is supported, and how any alternatives are used;
- advocate for, cooperate with and support coordination mechanisms; and
- monitor and report breaches of the International Code.

Responsibility for unsolicited donations (optional)

In a coordinated programme, the organisation handling supplies of breastmilk substitutes would be responsible for:

- procuring supplies, based on needs assessment by health and nutrition field staff according to agreed criteria;
- receiving and evaluating the content and quality of any donations of infant feeding products;
- managing distribution of breastmilk substitutes as appropriate;
- monitoring use and leakage; and
- disposing of inappropriate or excess supplies.

Without such coordination, during the Kosovo crisis of 1999, agencies transported and distributed breastmilk substitutes without assuming responsibility for their targeting or use.

Suppose there are donated supplies that are truly needed, and during the acute phase their distribution is only possible through the health care system.

In that case, the responsible agency and staff should be aware that **this temporary arrangement is not in compliance with the Code**.

As the emergency enters a more stable phase, they should reassess the need for breastmilk substitutes. The need is likely to have diminished if there is adequate support to breastfeeding. They can then arrange for purchase of the alternatives that are actually needed.

Responsibility for monitoring NGO activities (optional)

In situations where services are provided by NGOs not under contract to UN agencies, there may be no specified coordination mechanism. This can affect many aspects of the assistance effort.

People outside the crisis area respond strongly to images of hungry infants. Media and fund raising appeals often feature infants. Such messages increase the risk that public and commercial donations will include

breastmilk substitutes and bottles, especially for middle-income countries.

In these situations, many relief organisations may need to learn more about the International Code and the Interagency Operational Guidance, and that there are effective ways to support breastfeeding for the majority of infants despite crisis conditions.

3.4 HIV Guidelines (optional)

The majority of women are not infected with HIV. It is recommended that

- women who do not know their status, and
- those who are HIV-negative

should breastfeed in the generally recommended way.

Access to testing

A major problem may be lack of testing for HIV. Every woman has a right to know her HIV status if she wishes. Where possible **arrange access to voluntary, confidential counselling and testing**.

If testing for HIV is not possible, all mothers should breastfeed. Alternatives to breastmilk are too risky to offer if a woman does not know her status.

Risks of transmission by breastfeeding

If they are breastfed by mothers who were HIV-infected before giving birth, about 15% of infants may become infected through breastfeeding.

To estimate the percentage of infants at risk of HIV through breastfeeding in the population, multiply the prevalence of HIV by 15%.

For example, if 20% of pregnant women are HIV-positive, and every woman breastfeeds, about 3% of infants may be infected by breastfeeding.

Breastfeeding

If HIV-positive mothers choose to breastfeed, **exclusive breastfeeding** is recommended during the first six months of life because a combination of breastfeeding and artificial feeding may increase risks of transmission.

It is advisable for a confirmed HIV-positive woman to stop breastfeeding as soon as she is able to prepare and give her infant adequate, safe and hygienic replacement feeding. If this is not possible, then she should continue breastfeeding.

Replacement feeding

If a woman has been tested and knows she is HIV-positive, or if she is already clinically ill with HIV/AIDS, she may want to consider *replacement feeding*.

Replacement feeding means the process of feeding a child who is not receiving any breastmilk with a diet that provides all the nutrients the child needs.

During the first six months, this should be with a suitable breastmilk substitute, and after that preferably with a suitable breastmilk substitute and complementary foods.

Replacement feeding by tested HIV+ mothers

IFE 1/18

The process of feeding a child not receiving any breastmilk with a diet that provides all needed nutrients:

- First six months — a suitable breastmilk substitute
- After six months — a suitable breastmilk substitute and complementary foods

Can replacement feeding be made

- acceptable,
- feasible,
- affordable,
- sustainable, and
- safe?

If replacement feeding can be done in a way that is

- acceptable
- feasible
- affordable
- sustainable and
- safe,

then the mother may want to consider it as an option. The choice should be hers.

When HIV-positive mothers choose not to breastfeed, either from birth or by stopping later on, they should be provided with specific guidance and support for at least the first two years of the child's life, to ensure adequate replacement feeding.

In many situations, including most emergencies, the risks of infection and malnutrition from inadequate replacement feeding are greater than the risk of HIV transmission.

The conditions that reduce the risks of artificial feeding, outlined in Section 4.5, should be provided to all mothers who are using replacement feeding. Breastmilk substitutes should not be distributed to HIV-positive mothers who choose replacement feeding, except with supportive health and nutrition services.

Note: For areas of high HIV prevalence, it is important that the joint WHO/UNAIDS/UNICEF publications titled HIV and Infant Feeding (UNAIDS 98.3, 98.4, and 98.5) should be consulted by decision-makers and health care managers and supervisors. These provide fuller information and guidance in development of adequate policies and services, and may be requested from any office of WHO, UNAIDS or UNICEF.

4 Supporting appropriate infant feeding practices in emergencies

It is an important principle that people affected by emergencies

- first cope by their own efforts;
- then are helped by their own government; and
- then may need to rely on outside assistance.

Therefore the approach of aid agencies is to support a population and a country in their own efforts.

What does this mean for infant feeding?

IFE 1/19

IFE 1/19

Supporting people in their own efforts

First, do no harm

- Learn customary good practices.
- Avoid disturbing these practices.

Then, provide active support for breastfeeding

General support
establishes the conditions that will make breastfeeding easy

Individual support
is given to mothers and families through breastfeeding counselling, help with difficulties, appropriate health care.

It is useful to start from these principles:

First, do no harm.

- Learn the good practices that are customary.
- Avoid disturbing these practices, for example by uncontrolled distribution of breastmilk substitutes, or staff providing misinformation.

Then provide active support for breastfeeding.

- *General support* establishes the conditions that will make breastfeeding easy. For example, the camp layout, which is usually the responsibility of people not specialised in health and nutrition, can ease mothers' access to resources and help.
- *Individual support* is given to mothers and families through breastfeeding counselling, help with difficulties, and appropriate health care.

This section in Module 1 focuses on general support, involving emergency relief staff from all sectors.

Module 2 focuses on giving health and nutrition workers the skills they need to provide individual infant feeding support.

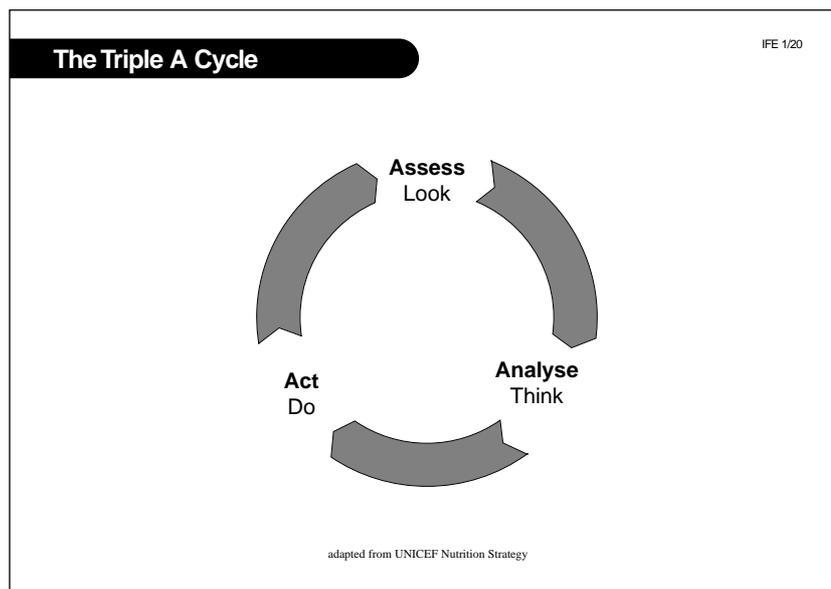
4.1 Assessment and analysis

The Triple A cycle

The first thing to do is to get key information, to assess the situation, to **look** at it. The next step is analysis, to **think** about the situation considering what causes difficulties and what might be done,

Action or interventions, what an agency decides to **do**, should follow assessment and analysis.

IFE 1/20



An assessment team needs to include a person who knows about infant feeding issues, who knows what to look for and ask about.

The most important points to remember are

- 1) to include infant feeding in the general needs assessment of a refugee situation**
- 2) to base any infant feeding interventions on assessment and analysis**

Key information to obtain early

Early in the emergency, by informed observation and discussion, learn whether:

- there are many infants and pregnant women;
- there are many unaccompanied or motherless infants;
- people have any difficulties in feeding their infants and young children, especially breastfeeding difficulties;
- many mothers fed artificially before the emergency;
- wet nursing is culturally acceptable;
- breastmilk substitutes and feeding bottles are very obviously available; and
- someone might be able to help with infant feeding, such as project staff, experienced caregivers and women from the community.

Qualitative information to obtain when there is more time (optional)

As the acute phase recedes, there is more to learn, including:

- mistaken beliefs that may make breastfeeding difficult;
- other factors that might be disrupting breastfeeding (See Transparencies 1/6 and 1/7);
- who might be able to support breastfeeding mothers individually, such as trained health workers, trained breastfeeding counsellors, community women experienced with breastfeeding, relactation, wet nursing; and
- practices in health facilities providing antenatal, delivery, postnatal and child care.

Quantitative information to obtain through surveys and monitoring (optional)

When surveys and monitoring activities are carried out, they should include:

- numbers of children aged 0-6 months, 6-12 months, 12-24 months, 2-5 years;
- numbers of unaccompanied infants and young children (same age divisions);
- morbidity and mortality of infants;
- whether infant feeding practices are changing due to the crisis (measuring both spillover of artificial feeding and any increases in breastfeeding as support is improved); and
- availability, management and use of breastmilk substitutes.

Data by itself does not indicate what will improve infant outcomes. Analysis that considers causes, and discussion with members of the emergency-affected population, are vital. Then effective actions can be decided upon.

Case studies: analysing how to help mothers in emergencies (optional)

Consider these cases from real crisis situations.

- What additional useful information might one **learn** from each mother?
- How can the information be used to **intervene** in a way that will be helpful?

First focus on the boxed story and develop your own ideas, before looking at the responses, giving one group's suggestions.

Case study 1

New mother, Rwanda border, 1997

What more might be done?

A severely underweight woman had been walking for about 100 days before she arrived at a border point where immunization was provided and enriched biscuits (BP5) were distributed. She had spent the last trimester of her pregnancy walking away from her home, and had given birth ten days before.

She had been separated from her husband and children, and did not know if they were alive or not. Fortunately, she was still breastfeeding.

She was given a BP5 biscuit.

The question is: Could anything more have been done?

Here is a woman who had no one she could call family or community.

What could have been done better than offering her a biscuit?

from Olivia Yambi, Regional Nutrition Advisor, UNICEF Nairobi

Responses from one group

The responses below are *not the only possible answers*, and may stimulate more.

Learn:

What is her own postpartum condition? Have her checked by a midwife, and tested for anemia.

How frequently she has been able to feed? What are the weight and condition of the baby?

Observe how the baby suckles the breast. (See Module 2.)

Learn if she has any support from other mothers or health workers.

Intervene:

Congratulate mother for breastfeeding, and encourage exclusive breastfeeding.

Observe her breastfeeding and talk with her to identify any difficulties that need skilled help.

Register mother and infant for dry general ration distribution and ensure that adequate facilities for preparation are available, provide shelter, water, other basic needs. If general ration is not adequate, consider enrolling the mother into a supplementary feeding programme. Help her find relatives, clan members, or others who share her language and background, for support.

Follow up frequently to ensure that her weight and well-being are improving.

Provide counselling and encouragement to nurture the baby.

Immunise the infant.

Case study 2

Mother of two, Pakor, Sudan
How can one help a worried mother?

A 19-year old mother in a refugee camp has two children. The older boy is two years old and severely malnourished. He was put on the breast after birth, but had been given salt and water solution for the first four days, a common practice among mothers in the area. The mother's milk flow was slow to become established.

The second son is one and a half months old and being breastfed. He looks healthy.

However, his mother feels that she does not have enough breastmilk. The mother is also worried about her malnourished two-year-old.

What kinds of help might this mother be given?

from Joyce Meme, Kenya Food and Nutrition Action Network

Responses from one group

The responses below are *not the only possible answers*, and may stimulate more.

Learn:

Whether the mother has experience and confidence to breastfeed easily, and why early water feeds are given.

Is the mother alone at the camp, or might there be relatives or other familiar people?

What contributed to the close birth spacing? Was the older child taken off the breast as soon as the new pregnancy was identified? How was the older child fed from birth to the present?

Might the malnutrition of the first child be related to complementary feeding given too early? In the second year, were foods given with inadequate amounts or frequency?

Intervene:

Counsel the mother and explain how milk is produced in response to suckling.

Reassure her that she is capable of producing enough breastmilk if she breastfeeds exclusively.

Observe breastfeeding to ensure correct attachment at the breast, and feeds going on long enough.

Ensure proper food rations for the mother.

Build support systems around her; put her in touch with other mothers who have breastfed exclusively.

Provide nutritional rehabilitation for the two-year-old, and monitor the growth of both children.

4.2 Action: conditions to support breastfeeding

Women need help both to get breastfeeding started, and to continue. To get started, they particularly need help around the time of delivery, and soon after. They need help from both the health care system and the community. To continue breastfeeding in the first months after delivery, into the second year and beyond, they need other supportive conditions also.

IFE 1/21

Conditions to support breastfeeding	
	IFE 1/21
	<ul style="list-style-type: none"> • recognition of vulnerable groups • Baby-Friendly maternity care • shelter and privacy • reduction of demands on time • increased security • adequate food and nutrients • skilled help • community support • adequate health services

What women need	Possible actions
<i>Recognition of vulnerable groups</i>	Count pregnant women, infants under 6 months and between 6 and 12 months separately. Register newborns immediately, making the household eligible for an additional ration that can nourish the breastfeeding mother.
<i>Baby-Friendly maternity care</i>	Provide maternity care applying the Ten Steps (see care Annex 3) to both home and health centre deliveries. Arrange for skilled support in the first weeks, from trained breastfeeding counsellors and community groups.
<i>Shelter and privacy</i>	Provide rest areas in transit. Set up private areas for breastfeeding women (where culturally required) at distribution or registration points. Provide family rather than communal shelters.
<i>Reduction of demands on time</i>	Arrange priority access (shorter queues) to relief items such as food, water, and fuel. Set up sanitary washing facilities near area for women with infants.
<i>Increased security</i>	Increase security (e.g. with lighting) for access to facilities.
<i>Adequate food and nutrients</i>	Ensure adequate general ration. If full general ration is not possible, provide food and micronutrient supplements for pregnant and lactating women.

<i>Skilled help</i>	<p>Trained workers should</p> <ol style="list-style-type: none"> 1) teach mothers how to breastfeed and continue support until their child reaches 24 months; 2) identify and help mothers with problems, or refer to more skilled breastfeeding counsellors; 3) follow up by observing how mothers breastfeed at home and help them overcome practical difficulties; and 4) check that each infant is growing well, and reassure the mother about breastfeeding.
<i>Community support</i>	<p>Assist population to settle in familiar community or family groups.</p> <p>Provide meeting places for mothers with young children to facilitate woman-to-woman support.</p>
<i>Adequate health services</i>	<p>Ensure staff skilled in support of breastfeeding.</p> <p>Help mothers express their milk and cup feed any infant too small or sick to breastfeed.</p> <p>Provide continued support to prevent and overcome any breastfeeding difficulties.</p> <p>Provide equipment and systems to monitor child growth.</p> <p>Admit mothers of sick or malnourished infants to the health or nutrition rehabilitation clinic with their children.</p> <p>Help mothers of malnourished infants to relactate and achieve adequate breastfeeding before discharge from care.</p>

4.3 Action: conditions to support relactation

Women who have breastfed in the past, or whose breastmilk production has diminished, can be helped to breastfeed again.

They may produce milk for their own infant or for another.

What is needed is for the woman to be motivated, and for the infant to suckle frequently. Giving milk through a fine plastic tube at the breast can encourage suckling, and any additional extra milk may be cup fed.

Helpful conditions include

- skilled staff with adequate time to spend helping mothers;
- a designated area where progress can be followed;
- fine plastic tubes (such as naso-gastric tubes);
- cups (to feed the infant until the mother is producing milk);
- a small supply of infant formula to use until breastmilk production is re-established; and
- whenever possible, women who themselves have relactated giving help to others.

While a woman is relactating and thereafter, she needs all the conditions for continued breastfeeding, including extra rations and micronutrient supplements when necessary.

4.4 Alternatives to breastfeeding by the natural mother

It is important to remember that women under stress can breastfeed. They should be given appropriate care and nutrition.

Wet nursing

Consider this if it is culturally acceptable, and a woman willing to breastfeed another's infant can be found.

If a woman breastfeeds her own infant and wet nurses another, her milk production will increase.

A woman who has recently lost her own infant may be willing to feed another.

A woman who has breastfed in the past may be willing to relactate, especially if she is related to the infant.

In conditions of high HIV prevalence, potential wet nurses should be tested.

The selected wet nurse needs all the conditions for relactation and continued breastfeeding, including extra rations and micronutrient supplements when necessary.

Milk banking (optional)

The storage and use of heat-treated breastmilk from other mothers may be considered mainly where there is already expertise in managing milk banks. However, in most emergency settings, a milk banking programme would demand resources and knowledge that are not readily available.

If circumstances make use of expressed breastmilk possible or necessary, any breastmilk not going to a mother's own infant should be heat treated to ensure it does not transmit infections, including HIV.

Artificial feeding

This includes commercial infant formula, generic or proprietary (branded), and home-prepared formula made from suitably modified full cream milk with micronutrients added. (Recipes are given in Module 2).

Artificial feeding should be given by cup, not by bottle. (See Annex 4.)

4.5 Conditions to reduce dangers of artificial feeding

Agreed criteria

The coordinating group should agree upon the criteria for use of alternatives to breastfeeding. They should record the agreed criteria, inform emergency agency staff and the population, and make sure that the criteria are understood.

IFE 1/22
<p>Example of agreed criteria</p> <p>for use of alternatives to mother's milk</p> <ul style="list-style-type: none"> • Mother has died or is unavoidably absent. • Mother is very ill. (temporary use may be all that is necessary) • Mother is relactating. (temporary use) • Mother tests HIV positive and chooses to use a breastmilk substitute. • Mother rejects infant. (temporary use may be all that is necessary) • Infant dependent on artificial feeding.* (use to at least six months or use temporarily until achievement of relactation) <p>* Babies born after start of emergency should be exclusively breastfed from birth.</p>

A draft list of agreed criteria for situations in which an alternative to breastfeeding may be needed, often only for a short time, could include:

- The mother has died or is absent for an unavoidable reason.
- The mother is very ill. The mother and infant need to be cared for together and breastfeeding maintained or re-established as their condition improves.
- The mother's milk production has become very low, and some formula or other milk is needed while relactation progresses.
- The mother has been tested, found to be HIV positive and received counselling to enable her to make an informed choice about feeding options. Understanding the health risks of not breastfeeding under local conditions, she chooses to use a breastmilk substitute.
- The mother rejects the infant due to having experienced rape or psychological trauma. Counselling and care may help her accept the infant and to breastfeed.
- The infant has become dependent on artificial feeding and needs to continue until his mother has relactated, or until he is at least six months old.

The decision that an infant has to be fed on a breastmilk substitute should be taken individually.

Assessment should be done according to the agreed criteria by a health care worker who has breastfeeding counselling skills, awareness of the dangers of artificial feeding, and some understanding of the misconceptions that may lead women to believe they need breastmilk substitutes. This worker should also have knowledge of the relevant provisions of the Code, including the obligation to continue any supply as long as needed by the infant.

Within six months of the start of an emergency, artificial feeding should have been reduced to a minimum, as all new mothers receive help to breastfeed from birth.

Conditions needed for artificial feeding (optional)

For infants who have to be fed on breastmilk substitutes, the following must also be guaranteed:

IFE 1/23

IFE 1/23
<p>Conditions to reduce dangers of artificial feeding:</p> <p>the breastmilk substitutes</p> <ul style="list-style-type: none"> • Infant formula with directions in users' language • Alternatively, ingredients and knowledge for home-prepared formula • Supply of breastmilk substitutes until at least six months or until relactation achieved. For six months, 20 kg of powdered formula is required, or equivalent in other breastmilk substitutes. • Milk and other ingredients used within expiry date <p>However, caregivers need more than milk.</p>

- commercial infant formula (preferably unbranded) with product information and directions in a language understandable to users;
- alternatively, ingredients and knowledge for making home-prepared formula.
- formula or ingredients within expiry date when used.
- supply until the infant is at least six months old or until breastfeeding has been re-established (for 6 months, 20 kg of powdered formula); this should only be dispensed at regular short intervals (for example weekly).

However, more than milk is needed for adequate artificial feeding:

IFE 1/24

IFE 1/24
<p>Conditions to reduce dangers of artificial feeding:</p> <p>additional requirements</p> <ul style="list-style-type: none"> • Easily cleaned cups, and soap for cleaning them • A clean surface and safe storage for home preparation • Means of measuring water and milk powder (not a feeding bottle) • Adequate fuel and water • Home visits to lessen difficulties preparing feeds • Follow-up with extra health care and supportive counselling • Monitoring and correction of spillover

- supply of easily cleaned cups for feeding, and soap for cleaning them;
- in homes, a clean surface for preparation, and a safe place to store the milk and other ingredients;
- means of measuring when making up feeds, such as a measure for water and a measure for powder, provided in generic formula (feeding bottles not being appropriate as measures);
- adequate fuel and water to prepare infant feeds as safely as possible;

- home visits to observe and lessen any difficulties in preparing feeds;
- follow-up including additional health care and support until the infant is fed on family foods and growing well; and
- monitoring of spillover in the emergency-affected or host populations, and actions to correct it so other infants are not put at needless risk by artificial feeding.

If monitoring shows the need, additional control measures should be put in place and support to breastfeeding be strengthened.

4.6 Management of artificial feeding (optional)

Administrative and logistics staff with health and nutrition staff of the agency can set up conditions that will lessen the dangers of artificial feeding. Measures must be taken to prevent leakage of products and spillover of artificial feeding to the host population as well as within the emergency-affected population.

Needs	Actions
<i>Plan</i>	Establish which agency/group/individuals are responsible for coordinating infant feeding. Agree on and record criteria for infants needing breastmilk substitutes. Identify infants in need, using trained staff to assess. Estimate amounts needed, 20 kg/infant of infant formula for the first six months, or ingredients for home prepared formula (= 92 litres of fresh milk, 9 kg sugar). Plan for all of the steps below, including monitoring
<i>Procure</i>	Refuse donations of breastmilk substitutes; buy according to assessed need; ensure not close to expiry date. Refuse donations of feeding bottles; obtain open cups. If purchasing formula, buy variety of locally available brands to avoid promoting any one brand. Re-label with instructions in local language if necessary (See Annex 5). Ensure each recipient infant is guaranteed a full supply for at least six months, and milk in some form thereafter. Provide needed fuel, water, and utensils for home preparation of artificial feeds.
<i>Store</i>	Store breastmilk substitutes in clean, lockable place. Protect from excessive heat if possible. Keep clear records to control misuse and leakage. Rotate stock to ensure use before expiry date.
<i>Dispense</i>	Do not include breastmilk substitutes in general distribution. Dispense purchased supplies to targeted recipients via a well baby centre, Health Care centre or MCH site, or elsewhere, at regular short intervals (for example weekly). Health specialists may not have time to dispense after first identification of need, but should both authorise dispensers (e.g. by prescription) and follow up infants.

<i>Educate caregivers</i>	Trained staff should <ol style="list-style-type: none">1) teach caregivers how to make up feeds;2) refer those with problems to appropriate services;3) follow up by observing how caregivers use breastmilk substitutes at home, and helping overcome difficulties; and4) check that each infant receives at least six months' supply, unless breastfeeding is resumed, and is growing adequately.
<i>Dispose</i>	Dispose of excess breastmilk substitutes, mixing into blended foods or using for elderly or other groups that will not be harmed. Burn or bury feeding bottles, teats and unusable excess supplies of breastmilk substitutes.
<i>Communicate</i>	If excess was caused by unneeded or inappropriate donations, inform source and agency headquarters, to prevent future problems.
<i>Monitor</i>	Record numbers of infants identified as needing artificial feeding, and criterion used. Ensure formula receipt, usage, leakage, spillover and disposal are recorded. Monitor and report violations of the Code. Monitor health outcomes among infants.

Annex 1

The International Code of Marketing of Breastmilk Substitutes: summary of portions relevant to emergencies

In 1979, WHO and UNICEF organised an international meeting on infant and young child nutrition. One of the recommendations made was that there should be an international code of marketing of infant formula and other products used as breastmilk substitutes. Member states of WHO and other groups and individuals who had attended the 1979 meeting, including representatives of the infant food industry, were then involved in a consultative process which culminated in the production of the International Code. This Code was endorsed by the World Health Assembly in 1981 in a Resolution which stressed that the Code is a **minimum requirement** to be enacted **in its entirety** by **all countries**.

The Code sets out the responsibilities of the infant food industry, health workers, national governments and concerned organisations in relation to the marketing of breastmilk substitutes, feeding bottles and teats as well as information regarding the use of these products. Since 1981, subsequent WHA Resolutions have been passed which aim to strengthen and clarify the Code. These Resolutions have the same status as the Code itself and should be read with it.

The most important parts of the Code which relate to infant feeding in emergencies are:

The aim

“The aim of this Code is to contribute to the provision of safe and adequate nutrition for infants, by the protection and promotion of breastfeeding, and by ensuring the proper use of breast-milk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution.”

The scope

The Code applies to any product which is marketed or otherwise represented as a partial or total replacement for breastmilk, and to feeding bottles and teats. Only certain products are suitable as breastmilk substitutes, but many other unsuitable products (such as baby cereals, fruit or sugar drinks and follow-on formulas) fall under the scope of the Code when they are marketed inappropriately.

Advertising

No advertising of above products to the public.

Samples

No free samples to mothers, their families or health care workers.

Health care facilities

No promotion of products i.e. no product displays, posters or distribution of promotional materials. No use of mothercraft nurses or similar company-paid personnel. No free or low-cost supplies.

Health care workers

No gifts or samples to health care workers. Product information must be factual and scientific.

Supplies

No free or low-cost supplies of breastmilk substitutes to maternity wards and hospitals. (The 1994 WHA Resolution states that they should not be in any part of the health care system).

Information

Governments have the responsibility to ensure that “objective and consistent information is provided on infant and young child feeding”. Such information should never promote or idealise the use of breastmilk substitutes and should include specified points. It should also explain the benefits and superiority of breastfeeding and the costs and hazards associated with artificial feeding. Manufacturers should provide only scientific and factual information to health workers and should never seek contact with mothers.

Labels

Product labels must clearly state the superiority of breastfeeding, the need for the advice of a health worker and a warning about health hazards. No pictures of infants, or other pictures idealising the use of infant formula.

Products

Unsuitable products, such as sweetened condensed milk, should not be promoted for infants. All products should be of high quality and take account of the climatic and storage conditions of the country where they are used. Manufacturers and distributors should comply with the Code **independently** of government action to implement it. Non-governmental organisations (NGOs) have a responsibility to report any violations to governments and to manufacturers.

The WHA Resolutions most relevant to emergencies

The **1981 Resolution** (WHA 34.22) stresses that the Code is a “minimum requirement” to be enacted “in its entirety” by all countries, that it should be translated into “national legislation, regulation or other suitable measures” and that compliance should be monitored.

The **1986 Resolution** (WHA 39.28) states that any food or drink given before complementary feeding is nutritionally required may interfere with the initiation or maintenance of breastfeeding and therefore should neither be promoted nor encouraged for use by infants during this period.

The small amounts of breastmilk substitutes needed for a minority of infants in maternity units should be made available through normal procurement channels and not through free or subsidised supplies.

The practice being introduced in some countries of providing infants with specially formulated milks (so-called “follow-up milks”) is not necessary.

The **1994 Resolution** (WHA 47.50) states that mothers should be supported in their choice to breastfeed, obstacles should be removed and interference prevented in health services, the workplace or the community.

Complementary feeding should be introduced from about 6 months.

There should be no free or subsidised supplies of breastmilk substitutes or other products covered by the Code in any part of the health care system.

In emergency relief operations, breastfeeding for infants should be protected, promoted and supported. Any donated supplies of breastmilk substitutes (or other products covered by the Code) may be given only under three conditions: the infant has to be fed with breastmilk substitute; the supply is continued for as long as the infant concerned needs it; and the supply is not used as a sales inducement.

The **1996 Resolution** (WHA 47.15) states that financial support for professionals working in infant and young child health should not create conflicts of interest.

Monitoring of the Code and subsequent relevant resolutions should be carried out in a transparent independent manner, free from commercial influence.

Annex 2

Infant and Young Child Feeding in Emergencies

Operational Guidance for Emergency Relief Staff and Policy-Makers

Interagency Working Group on Infant Feeding in Emergencies

Final draft for endorsement: February 2001

Key Definitions

Breastmilk substitutes (BMS): any food being marketed or otherwise represented as a partial or total replacement of breastmilk, whether or not suitable for that purpose; in practical terms this includes milk or milk powder marketed for children under 2 years and complementary foods, juices and teas marketed for children under 6 months.

Complementary feeding (previously called “weaning”): the giving of complementary foods in addition to breastmilk or infant formula.

Complementary foods: any food, whether manufactured or locally-prepared, suitable as a complement to breastmilk or infant formula when either becomes insufficient to satisfy the nutritional requirements of the infant (from the age of 6 months). Complementary foods marketed for children under 6 months are breastmilk substitutes. Note: complementary foods should not be confused with supplementary foods which are commodities intended to supplement a general ration and used in emergency feeding programmes for the prevention and reduction of malnutrition and mortality in vulnerable groups.

Commercial baby foods (industrially-formulated complementary foods): branded jars, teas and juices, or packets of semi-solid or solid foods.

Exclusive breastfeeding: only breastmilk and no other foods or fluids (no water, no juices, no tea, no pre-lacteal feeds), with the exception of drops or syrups consisting of micronutrient supplements or medicines.

Infants: children less than 12 months.

Infant feeding equipment: bottles; teats; syringes that are inappropriately used to feed infants outside an institutional setting; or baby cups sometimes fitted with lids.

Infant formula: a breastmilk substitute formulated industrially in accordance with Codex Alimentarius Standards (joint FAO/WHO food standards programme) to satisfy the normal nutritional requirements of infants up to six months of age.

The International Code: The International Code of Marketing of Breast-Milk Substitutes, adopted by the World Health Assembly (WHA) in 1981 and relevant WHA resolutions, referred to here as “the International Code” (4). The aim of the International Code is to contribute to the provision of safe and adequate nutrition for infants by the protection and promotion of breastfeeding and by ensuring the proper use of breastmilk substitutes (see definition above) when these are necessary, on the basis of adequate information and through appropriate marketing and distribution. The Code sets out the responsibilities of the infant food industry, health workers, national governments and concerned organisations in relation to the marketing of breastmilk substitutes, bottles and teats.

Optimal infant and young child feeding: exclusive breastfeeding for the first six months of life, followed by continued breastfeeding with adequate complementary foods for up to two years and beyond.

Other milks: dried whole, semi-skimmed or skimmed milk; liquid whole, semi-skimmed or skimmed milk; soy milks.

Young children: children between 12 and 24 months.

Key Points

1. Every agency should develop or endorse a policy relating to infant and young child feeding in emergencies (that should be institutionalised); the policy should be widely disseminated to all staff and agency procedures adapted accordingly (Section 1).
2. Agencies need to ensure the training and orientation of their technical and non-technical staff, using available training materials (Section 2).
3. There must be a designated body responsible for co-ordination of infant and young child feeding for each emergency; that body must be resourced and supported in order to carry out specific tasks (Section 3).
4. Key information on infant and young child feeding needs to be integrated into routine rapid assessment procedures; if necessary, more systematic assessment using recommended methodologies can be conducted (Section 4).
5. Simple measures should be put in place to ensure the needs of mothers and infants are addressed in the early stages of an emergency (Section 5).
6. Breastfeeding and Infant and young child feeding support should be integrated into other services for mothers, infants and young children (Section 5).
7. Foods suitable to meet the nutrient needs of older infants and young children must be included in the general ration for food aid dependent populations (Section 5).
8. Donations of breast-milk substitutes, bottles and teats should be refused in emergency situations (Section 6).
9. Any well-meant but ill-advised donations should be under the control of a single designated agency (Section 6).
10. Breast-milk substitutes, other milks, bottles or teats must never be included in a general ration distribution; these products must only be distributed according to recognised strict criteria and only provided to mothers or caregivers for those infants who need them (Section 6).

Aim

The aim of this document is to provide concise, practical (but non technical) guidance on how to ensure appropriate infant and young child feeding in emergencies.

It is intended for all agencies working in emergency programmes, including national governments, United Nations (UN) agencies, national and international Non Governmental Organisations (NGOs), and donors.

This document assists with the practical application of the Guiding Principles for Feeding Infants and Young Children in Emergencies (WHO, (1)) and the Policy and Strategy Statement on Infant Feeding in Emergencies (ENN, (2)) and complies with the Sphere Project (3) and other international emergency standards.^a Further practical details of how to implement the guidance are referenced throughout the document (1-17). Advocacy materials for the media and general public can be obtained in (2,5) The assessment and management of severely malnourished infants and young children are not addressed in this document.

^a Food and Nutrition Handbook. World Food Programme. 2000. Handbook for Emergencies. United Nations High Commissioner for Refugees. 1999, second edition. Technical Notes: Special Considerations for Programming in Unstable Situations. UNICEF Programme Division and Office of Emergency Programmes, January 2001. MSF Guidelines (forthcoming 2001). Management of Nutrition in Major Emergencies. WHO 2000. IFRC Handbook for Delegates.

Practical steps

1 Endorse or Develop Policies

1.1 Each agency should, at central level, endorse or develop a policy^b that addresses:

1.1.1 Infant and young child feeding in emergencies, stressing the protection, promotion and support of breastfeeding and adequate complementary feeding

1.1.2 Procurement, distribution and use of breastmilk substitutes, other milks, commercial baby foods and drinks and infant feeding equipment, and compliance with the International Code

1.2 Policies should be widely disseminated and procedures at all levels adapted accordingly

2 Train Staff

2.1 Each agency should ensure basic orientation for all relevant staff (at national and international level) to support appropriate infant and young child feeding in emergencies. The following materials are recommended for training: the agency policy, this operational guidance and the Interagency Infant Feeding in Emergencies Module I (15)

2.2 In addition, health and nutrition program staff will require technical training using, for example, the Interagency Infant Feeding in Emergencies Module II (15) that includes orientation on available technical guidelines (6-14)

2.3 Specific expertise on breastfeeding counselling and support could be sought at national level via the Ministry of Health, UNICEF, WHO, La Leche League, or IBFAN groups (International Baby Food Action Network) or at international level via ILCA (the International Lactation Consultancy Association), WHO, UNICEF or IBFAN-GIFA^c

3 Co-ordinate Operations

3.1 In an emergency operation, an agency or group of agencies should be identified by the food, health or nutrition co-ordinating body to take responsibility for the co-ordination of infant and young child feeding activities. The infant and young child feeding co-ordinating body (hereafter the co-ordinating body) should be responsible for the following:

- Policy co-ordination: Individual agency policies and national policies should provide the basis for agreeing the specific policy to be adopted for the emergency operation
- Intersectoral co-ordination: Agencies should contribute to relevant sectoral co-ordination meetings (health/nutrition, food aid, water and sanitation and social services) to ensure the application of the policy
- Development of an action plan for the emergency operation that identifies agency responsibilities and mechanisms for accountability
- Dissemination of the policy and action plan to operational and non-operational agencies including donors (e.g., to ensure that aid shipments and donations are in compliance with the International Code)

3.2 Capacity building and technical support requirements among operational partners should be evaluated and addressed by the co-ordinating body. Unless additional funding can be secured to meet these identified requirements, co-ordination and quality of infant feeding and young child interventions will be severely compromised

^b A recommended policy framework can be found in (2).

^c ILCA: ilca@erols.com, GIFA: info@gifa.org

4 Assess and Monitor

- 4.1 To determine the priorities for action and response, key information on infant and young child feeding should be obtained during assessments. Assessment teams should include at least one person who has received basic orientation on infant feeding in emergencies (see Section 2 above). Assessments should be co-ordinated and results shared through the co-ordinating body
- 4.2 Key information to obtain in the early stages through routine rapid assessments and by informed observation and discussion includes:
- demographic profile, specifically noting whether the following groups are under or over-represented: women, infants and young children, pregnant women, unaccompanied children^d
 - predominant feeding practices
 - conspicuous availability of breastmilk substitutes, other milks, bottles and teats in emergency-affected population and commodity pipeline
 - reported problems feeding infants and young children, especially breastfeeding problems and poor access to appropriate complementary foods
 - observed and pre-crisis approaches to feeding orphaned infants
 - security risks to women and children
- 4.3 If rapid assessment indicates that further assessment is necessary, additional key information should be obtained as part of a thorough causal analysis of malnutrition (3)
- 4.3.1 Use qualitative methods to:
- assess availability of appropriate foods for complementary feeding in the general ration and in targeted feeding programmes
 - assess the health environment, including water quantity and quality; fuel; sanitation; housing; facilities for food preparation and cooking
 - assess support offered by health facilities providing antenatal, delivery, postnatal and child care
 - identify any factors disrupting breastfeeding
 - identify and assess capacity of potential support givers (breastfeeding mothers, trained health workers, trained counsellors, experienced women from the community)
 - identify key decision-makers at household, community and local health facility level who influence infant and young child feeding practices
- 4.3.2 Use quantitative methods or existing routine health statistics to estimate:
- numbers of accompanied and unaccompanied infants and young children (data stratified by age for 0-<12months, 12-<24months, 24-59 months) and pregnant and lactating women
 - morbidity and mortality of infants^e
 - infant and young child feeding practices, including feeding technique (cup/bottle)
 - pre-crisis (from existing data sources^f) and recent changes (details on how to gather quantitative data on infant and young child feeding are given in 16 & 17)
 - breastmilk substitute, cup, feeding bottle and teat availability, management and use from informed observation, discussion and monitoring (an example of a monitoring form is available in (15))

^d In a normal population, the expected proportions are: infants 0-<12 months: 2.6%; children 12-<24 months: 2.5%; children 0-5 years: 15%; pregnant and lactating women: 5%. (WHO, 2000).

^e Assessment of malnutrition in infants is at present problematic given the existing NCHS reference data; assessment of diarrhoea in breastfed infants is problematic.

^f Multi-indicator cluster surveys: www.childinfo.org/; Demographic Health Surveys www.macrotint.com/dhs/; UNICEF statistical data by country: www.unicef.org/status/; Health Information Network for Advanced Planning www.hinap.org/; WHO global database on malnutrition www.who.int/nutgrowthdb/; nutrition related data for Africa www.africanutrition.net

5 Protect, Promote and Support Optimal Infant and Young Child Feeding with Integrated Multi-Sectoral Interventions

5.1 Basic interventions

- 5.1.1 Ensure that the nutritional needs of the general population are met, giving special attention to the access to commodities suitable as complementary foods for young children.^g In situations where nutritional needs are not met, advocate for a general ration (appropriate in quantity and quality). In situations where supplementary foods are available but sufficient food for the general population is not, consider pregnant and lactating women as a target group
- 5.1.2 Ensure demographic breakdown at registration of children under five with specific age categories: 0-<12months, 12-<24 months, 24-59 months to identify the size of potential beneficiary groups
- 5.1.3 Establish registration of new-borns within two weeks of delivery to ensure timely access to additional household ration entitlement
- 5.1.4 In the case of refugees and displaced populations, ensure rest areas in transit and establish where culturally appropriate secluded areas for breastfeeding; screen new arrivals to identify and refer any mothers or infants with severe feeding problems and refer for immediate assistance
- 5.1.5 Ensure easy and secure access for caregivers to water and sanitation facilities, food and non food items

5.2 Technical interventions

- 5.2.1 Train health/ nutrition/ community workers to promote, protect and support optimal infant and young child feeding as soon as possible after emergency onset. Knowledge and skills should support mothers/caregivers to maintain, enhance or re-establish breastfeeding using relactation, including possible use of a breastfeeding supplementer (2,9). If breastfeeding by the natural mother is impossible, make appropriate choices among alternatives (wet-nursing, breastmilk from milk bank, unbranded infant formula, locally purchased infant formula, home-made infant formula) (2)
- 5.2.2 Integrate breastfeeding and infant and young child feeding training and support at all levels of health care: reproductive health services^h including ante and post-natal care, family planning, traditional birth attendants and maternity services (the Baby Friendly 10 Steps to Successful Breastfeeding should be an integral part of maternity services in emergencies (2)); immunisation; growth monitoring and promotion; curative services; selective feeding programmes (supplementary and therapeutic); and community health services
- 5.2.3 Set up areas (e.g., breastfeeding corners or mother and baby tents)ⁱ for mothers/caregivers requiring individual support with breastfeeding and infant and young child feeding; ensure that support for artificial feeding is provided in an area distinct from support for breastfeeding; special attention should be given to newly responsible caregivers

^g Food aid dependant populations should receive ration types according to UNHCR/WFP ration types (page 63, The management of nutrition in major emergencies, WHO 2000). Specifications and examples of blended foods are provided in Food and Nutrition Handbook, World Food Programme, 2000.

^h Reproductive health care services should be initiated in the early stages of all emergencies. See Reproductive Health in Refugee Situations: an InterAgency Field Manual, UNHCR 1999.

ⁱ Infant Feeding in Emergencies. Do you know that your generous donations of breastmilk substitutes could do more harm than good? IBFAN-Gifa, Wemos, June 2001, 2nd edition. www.ibfan.org for more details about Mother Baby Tents and Breastfeeding Corners.

- 5.2.4 Establish services to provide for the immediate nutritional and care needs of orphans and unaccompanied infants
- 5.2.5 Provide the necessary information and support to ensure the correct preparation of unfamiliar complementary foods provided through food programmes and to ensure that all food can be prepared hygienically
- 5.2.6 Emphasize prevention of HIV/AIDS. Where HIV status of the mother is unknown or she is known to be HIV negative, she should be supported to exclusively breastfeed.^j Women who are HIV positive should be supported to make an informed choice about infant feeding. In most emergencies, alternatives to breastmilk cannot be used in a safe, feasible, acceptable, sustainable and affordable manner since the risks of infection or malnutrition from using alternatives are likely to be greater than the risk of HIV transmission through breastfeeding. Therefore, early initiation and exclusive breastfeeding for the first six months, and the continuation of breastfeeding into the second year of life are likely to provide the best chance of survival for infants and young children in emergencies. In all circumstances, because of the existing research gaps, consult senior staff at central level for up-to-date advice

6 Minimise the Risks of Artificial Feeding

Procurement, management, distribution, targeting and use of breastmilk substitutes, other milks, bottles and teats should be strictly controlled and comply with the International Code (4)

6.1 Control of procurement

- 6.1.1 Donations or subsidised breastmilk substitutes, bottles and teats and commercial baby foods should be systematically refused
- 6.1.2 Any well-meant but ill-advised donations that have not been prevented should be collected from all ports of entry by recipient agencies and stored centrally under the control of a single agency and under the guidance of the co-ordinating body. A plan for their safe use (monitored and under supervision), or their eventual destruction, will need to be developed by the co-ordinating body to prevent indiscriminate distribution
- 6.1.3 For those few infants requiring infant formula, generic (unbranded) formula is recommended after approval by a senior staff member and the co-ordinating body. UNICEF is responsible for making generically labelled infant formula available in situations where the UNICEF/WFP Memorandum of Understanding applies. Information on obtaining generic formula is available from UNICEF-New York (Nutrition Section)
- 6.1.4 If generic formula is unavailable at short notice or locally unacceptable, infant formula can be purchased, ideally locally. Purchased products should be manufactured and packaged in accordance with the Codex Alimentarius standards and have a shelf-life of at least 6 months at time of arrival in country
- 6.1.5 Labels should be in an appropriate language and should adhere to the specific labelling requirements of the International Code (12). Products should state the superiority of breastfeeding, indicate that the product should be used only on health worker advice, and warn about health hazards; there should be no pictures of infants or other pictures idealising the use of infant formula. Purchased products may need to be relabelled prior to distribution. An example of a generic label is available in (15)
- 6.1.6 The use of bottles and teats should be actively discouraged. Use of cups should be actively promoted

^j HIV and Infant Feeding. WHO/UNICEF/UNAIDS. 1998 www.unaids.org.

6.2. Control of distribution and management

- 6.2.1 Breastmilk substitutes, other milks, bottles and teats should never be part of a general or blanket distribution
 - 6.2.2 Other milks can be distributed if they are not given as a single commodity but are mixed with a milled staple food
 - 6.2.3 Breastmilk substitutes, bottles and teats should never be donated to the health care system in accordance with the International Code. Agencies operating within the health care system may purchase breastmilk substitutes for use within the health care system (see also 6.1.6)
 - 6.2.4 Infant formula should only be distributed to caregivers who need it through a separate distribution channel directly linked to the assessment by a qualified health or nutrition worker
 - 6.2.5 For those infants requiring infant formula, supply should be continued for as long as the infants concerned need it (until breastfeeding is re-established or until at least 6 months and a maximum of 12 months of age)
 - 6.2.6 In accordance with the International Code, there should be no promotion of breastmilk substitutes at the point of distribution, including displays of products
 - 6.2.7 Availability of fuel, water and equipment for safe preparation should always be carefully considered prior to distribution. In circumstances where these items are unavailable and where safe preparation and use of infant formula cannot be assured, an on-site “wet” feeding programme should be initiated
- 6.3 Establish and implement criteria for targeting and use
- 6.3.1 Infant formula should only be targeted to infants requiring it, as determined from assessment by a qualified health or nutrition worker trained in breastfeeding and infant feeding issues
 - 6.3.2 Example criteria for temporary or longer term use of infant formula include (15): absent or dead mother, ill mother, relactating mother, HIV positive mother who has chosen formula, infant rejected by mother, infant artificially fed prior to the emergency, rape victim not wishing to breastfeed
 - 6.3.3 Distribution of infant formula to an individual mother should always be linked to education, demonstrations and practical training about safe preparation, and to follow-up at the distribution site and at home by skilled health workers. Follow-up should include regular monitoring of infant weight at the time of distribution (no less than bimonthly)

7 References

7.1 Policies and Guidelines

- (1) Guiding Principles for Feeding Infants and Young Children during Emergencies. Annex to: The Management of Nutrition in Major Emergencies. WHO, 2000.
- (2) Infant Feeding in Emergencies: Policy, Strategy and Practice. Report of the Ad Hoc Group on Infant Feeding in Emergencies, 1999.
- (3) The SPHERE Project: Humanitarian Charter and Minimum Standards in Disaster Response. 1st FINAL edition, 1998 (2000). Available from: OXFAM Publishing, 274 Banbury Road, Oxford OX2 7DX, UK. e-mail: publish@oxfam.org.uk; fax: +44 1865 313713.
- (4) The International Code of Marketing of Breast-milk Substitutes. WHO, 1981. Full Code and Relevant WHA resolutions at: www.ibfan.org/English/resource/who/fullcode.html

7.2 Advocacy

(5) Infant feeding in emergencies. Do you know that your generous donations of breastmilk substitutes could do more harm than good? IBFAN-Gifa, Wemos, June 2001, 2nd edition.

7.3 Technical Information

(6) Feeding in Emergencies for Infants under Six Months: Practical Guidelines. K Carter, OXFAM Public Health Team, 1996. Available from: OXFAM, 274 Banbury Road, Oxford OX2 7DZ, England.

(7) Helping Mothers to Breastfeed in Emergencies. WHO European Office, www.who.dk/nutrition/infant.htm

(8) Helping Mothers to Breastfeed. F. Savage King, AMREF, 1992.

(9) Relactation: Review of Experiences and Recommendations for Practice. WHO, 1998.

(10) Reproductive Health in Refugee Situations: an Interagency Field Manual. UNHCR, 1999.

(11) Facts for Feeding: Recommended Practices to Improve Infant Nutrition during the First Six Months (January 1999); Guidelines for Appropriate Complementary Feeding of Breastfed Children 6-24 Months of Age (November 1998); Breastmilk: A Critical source of Vitamin A for Infants and Young Children; Frequently Asked Questions on: Mother-to-Mother Support for Breastfeeding (August 1999), Breastfeeding and Maternal Nutrition (June 2000). LINKAGES, Academy for Educational Development, e-mail: linkages@aed.org; website: www.linkagesproject.org

(12) Protecting Infant Health. A Health Workers' Guide to the International Code of Marketing of Breastfeeding Substitutes, 9th edition. IBFAN, 1999. Available from IBFAN-GIFA, P.O. Box 157, 1211 Geneva 19, Switzerland. e-mail: info@gifa.org

(13) Cup Feeding information. BFHI News, May/June 1999, UNICEF. e-mail: pubdoc@unicef.org

(14) Risks and Realities: FAQs on breastfeeding & HIV/AIDS. In: The Health Exchange, April 2001. Available from International Health Exchange, e-mail: info@ihe.org.uk

7.4 Training Materials

(15) InterAgency Training Modules on Infant Feeding in Emergencies. Module I available, Module II forthcoming, Contact Emergency Nutrition Network (ENN): e-mail: fiona@enonline.net.

7.5 Assessment, Monitoring and Evaluation

(16) Indicators for Assessing Breast-feeding Practices. WHO/CDD/SER/91.14, WHO, Geneva.

(17) Tool Kit for Monitoring and Evaluating Breastfeeding Practices and Programs. Wellstart International Expanded Promotion of Breastfeeding Program (EPB), September 1996. e-mail: linkages@aed.org; website: www.linkagesproject.org

Based on:

Infant and Young Child Feeding in Emergencies: Operational Guidance for Emergency Relief Staff and Programme Managers.

Interagency Working Group on Infant and Young Child Feeding in Emergencies (July 2001)

Comments on this document should be sent to Fiona O'Reilly at Emergency Nutrition Network: fiona@enonline.net

Annex 3

The Ten Steps to Successful Breastfeeding of the Baby-Friendly Hospital Initiative

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers to initiate breastfeeding within a half-hour of birth.
5. Show mothers how to breastfeed and how to maintain lactation, even if they should be separated from their infants.
6. Give newborn infants no food or drink other than breastmilk, unless medically indicated.
7. Practise rooming-in — allow mothers and infants to remain together — 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

In addition, a Baby-Friendly Hospital accepts no free or subsidised supplies of breastmilk substitutes, feeding bottles or teats.

Annex 4

Cup feeding

Advantages of cup feeding

- Risk of contamination is lower than with bottles.
- Infections are less likely.
- Cup feeding ensures adult attention.
- Feeding is quicker than with spoon.



WHO, UNICEF. HIV and Infant Feeding Counselling: a training course. 2000

- Newborn infants are able to take milk from an open cup. Small and preterm infants can be cup fed as well as older babies.
- Cups are easily available in most situations. No special cup is needed. An open, smooth surfaced cup is easiest to clean. Avoid cups with spouts, lids and tubes, or with rough surfaces where milk could stick and allow bacteria to grow.
- Cups are easier to clean than feeding bottles, so the risk of contamination is less. A cup only needs to be washed and scrubbed in hot soapy water each time it is used. (If possible, dip the cup into boiling water, or pour boiling water over it just before use, but boiling is not essential.)
- Cup feeding is associated with lower risk of diarrhoea, ear infections, and tooth decay.
- A cup cannot be propped beside the infant; a caregiver has to hold the baby for feeds. This ensures social contact, and adult attention if the baby is having any difficulties.
- Spoon feeding is acceptable. However, it is slow for anything more than small amounts. There is a risk that the caregiver may become tired and stop giving feeds before the baby has taken all that is needed.

Bottles are not necessary to give milk to an infant.

If mothers are used to feeding bottles, they may need information on cup feeding and to see babies feeding by cup. (Module 2 will explain how to teach cup feeding.)

Annex 5

Sample of a generic label for infant formula

INFANT FORMULA

Suitable from birth

A mother's breastmilk is the best food for her infant. Only use this milk if there is a medical reason to do so or if it is not possible for the baby to have breastmilk.

The milk in pack is similar to all the brands of infant formula on sale. It is made from dried cow's milk and is suitable for babies from birth. When mixed with clean bottled drinking water it will provide all the food a baby needs until about six months of age. There is no need to add other foods unless this is advised by a health worker. However, like all artificial formulas it does not contain the living antibodies which are in mother's milk. It will not protect your baby against infections such as diarrhoea, coughs or colds.

Consult an independent health worker before you stop breastfeeding or before you give any disease milk substitute to your baby. Once you start using this milk it might not be easy to start breastfeeding again. People working for baby food and feeding bottles companies should not give you advice on how to feed your baby.

500g

PREPARATION INSTRUCTIONS FOLLOW THESE CAREFULLY

1. Use the scoop provided to measure the powder.
2. Wash a clean cup, sterilise and fill with water.
3. Wash a clean spoon and use for the feeding.
4. Add the powder to the water. Stir well until the milk is smooth.
5. Add the water to the milk. Stir well until the milk is smooth.

FEEDING GUIDE

Age	Volume (ml)	Frequency
0-3 months	30-60	8-12
3-6 months	60-120	6-8
6-12 months	120-180	5-6

CONTRAINDICATIONS

Do not use if your baby is allergic to cow's milk or soybeans. Do not use if your baby has a severe allergy to any of the ingredients. Do not use if your baby has a severe allergy to any of the ingredients.

IMPORTANT WARNING

USE THIS MILK ONLY IF YOU CAN SAY YES TO ALL THESE QUESTIONS -

1. Do you understand the instructions on the pack?
2. Do you understand the importance of sterilising the equipment?
3. Do you understand the importance of using clean water?
4. Do you understand the importance of using a clean spoon?
5. Do you understand the importance of using a clean cup?
6. Do you understand the importance of using a clean bottle?
7. Do you understand the importance of using a clean teat?
8. Do you understand the importance of using a clean nipple?
9. Do you understand the importance of using a clean pacifier?
10. Do you understand the importance of using a clean dummy?

AVERAGE COMPOSITION

Ingredient	per 100g of powder	per 100ml of milk
Energy (kcal)	450	100
Protein (g)	18	3.5
Lactose (g)	10	2.0
Glucose (g)	5	1.0
Starch (g)	5	1.0
Other carbohydrates (g)	5	1.0
Fat (g)	10	2.0
Calcium (mg)	100	20
Iron (mg)	10	2
Vitamin A (IU)	1000	200
Vitamin B1 (mg)	0.1	2
Vitamin B2 (mg)	0.1	2
Vitamin B6 (mg)	0.1	2
Vitamin C (mg)	10	20
Vitamin D (IU)	100	20
Vitamin E (IU)	10	2
Vitamin K (IU)	10	2
Vitamin B12 (mg)	0.1	2
Vitamin B9 (mg)	0.1	2
Vitamin B5 (mg)	0.1	2
Vitamin B3 (mg)	0.1	2
Vitamin B7 (mg)	0.1	2
Vitamin B8 (mg)	0.1	2
Vitamin B10 (mg)	0.1	2
Vitamin B11 (mg)	0.1	2
Vitamin B12 (mg)	0.1	2
Vitamin B13 (mg)	0.1	2
Vitamin B14 (mg)	0.1	2
Vitamin B15 (mg)	0.1	2
Vitamin B16 (mg)	0.1	2
Vitamin B17 (mg)	0.1	2
Vitamin B18 (mg)	0.1	2
Vitamin B19 (mg)	0.1	2
Vitamin B20 (mg)	0.1	2
Vitamin B21 (mg)	0.1	2
Vitamin B22 (mg)	0.1	2
Vitamin B23 (mg)	0.1	2
Vitamin B24 (mg)	0.1	2
Vitamin B25 (mg)	0.1	2
Vitamin B26 (mg)	0.1	2
Vitamin B27 (mg)	0.1	2
Vitamin B28 (mg)	0.1	2
Vitamin B29 (mg)	0.1	2
Vitamin B30 (mg)	0.1	2
Vitamin B31 (mg)	0.1	2
Vitamin B32 (mg)	0.1	2
Vitamin B33 (mg)	0.1	2
Vitamin B34 (mg)	0.1	2
Vitamin B35 (mg)	0.1	2
Vitamin B36 (mg)	0.1	2
Vitamin B37 (mg)	0.1	2
Vitamin B38 (mg)	0.1	2
Vitamin B39 (mg)	0.1	2
Vitamin B40 (mg)	0.1	2
Vitamin B41 (mg)	0.1	2
Vitamin B42 (mg)	0.1	2
Vitamin B43 (mg)	0.1	2
Vitamin B44 (mg)	0.1	2
Vitamin B45 (mg)	0.1	2
Vitamin B46 (mg)	0.1	2
Vitamin B47 (mg)	0.1	2
Vitamin B48 (mg)	0.1	2
Vitamin B49 (mg)	0.1	2
Vitamin B50 (mg)	0.1	2
Vitamin B51 (mg)	0.1	2
Vitamin B52 (mg)	0.1	2
Vitamin B53 (mg)	0.1	2
Vitamin B54 (mg)	0.1	2
Vitamin B55 (mg)	0.1	2
Vitamin B56 (mg)	0.1	2
Vitamin B57 (mg)	0.1	2
Vitamin B58 (mg)	0.1	2
Vitamin B59 (mg)	0.1	2
Vitamin B60 (mg)	0.1	2
Vitamin B61 (mg)	0.1	2
Vitamin B62 (mg)	0.1	2
Vitamin B63 (mg)	0.1	2
Vitamin B64 (mg)	0.1	2
Vitamin B65 (mg)	0.1	2
Vitamin B66 (mg)	0.1	2
Vitamin B67 (mg)	0.1	2
Vitamin B68 (mg)	0.1	2
Vitamin B69 (mg)	0.1	2
Vitamin B70 (mg)	0.1	2
Vitamin B71 (mg)	0.1	2
Vitamin B72 (mg)	0.1	2
Vitamin B73 (mg)	0.1	2
Vitamin B74 (mg)	0.1	2
Vitamin B75 (mg)	0.1	2
Vitamin B76 (mg)	0.1	2
Vitamin B77 (mg)	0.1	2
Vitamin B78 (mg)	0.1	2
Vitamin B79 (mg)	0.1	2
Vitamin B80 (mg)	0.1	2
Vitamin B81 (mg)	0.1	2
Vitamin B82 (mg)	0.1	2
Vitamin B83 (mg)	0.1	2
Vitamin B84 (mg)	0.1	2
Vitamin B85 (mg)	0.1	2
Vitamin B86 (mg)	0.1	2
Vitamin B87 (mg)	0.1	2
Vitamin B88 (mg)	0.1	2
Vitamin B89 (mg)	0.1	2
Vitamin B90 (mg)	0.1	2
Vitamin B91 (mg)	0.1	2
Vitamin B92 (mg)	0.1	2
Vitamin B93 (mg)	0.1	2
Vitamin B94 (mg)	0.1	2
Vitamin B95 (mg)	0.1	2
Vitamin B96 (mg)	0.1	2
Vitamin B97 (mg)	0.1	2
Vitamin B98 (mg)	0.1	2
Vitamin B99 (mg)	0.1	2
Vitamin B100 (mg)	0.1	2

PRODUCTION DATE

EXPIRY DATE

In the package, two scoops are provided, one for 30 ml of water and one for about 4.5 g of powder. This eliminates any need to measure water with a feeding bottle.

Annex 6

Monitoring form

This form permits responsible agency staff to do initial monitoring. Fuller assessment of infant feeding policies and practices in the emergency (IFE) is desirable when possible.

Is there any national policy on infant feeding or the Code? Yes No

Is there an interagency coordinating body for IFE policy and decisions? Yes No

Is there an organisation responsible for handling all supplies of
breastmilk substitutes?..... Yes No

Does your agency have a clear policy on IFE?..... Yes No

Are there agreed criteria for use of artificial feeding?..... Yes No

Have health and nutrition workers been trained to support breastfeeding?..... Yes No

Are all maternity services using Baby-Friendly practices? Yes No

Do mothers have easy access to help with any breastfeeding difficulties? Yes No

Do mothers receive adequate nutrition through two years of breastfeeding? . Yes No

Have the conditions to support breastfeeding (4.2) been put into
practice throughout the service area? Yes No

Are breastfeeding rates increasing compared to pre-crisis levels? Yes No

Are breastmilk substitutes, feeding bottles or teats being distributed? Yes No

If yes, were these products purchased by the distributing agency? Yes No

If not purchased, what is the origin of the products? _____

Are the products distributed as part of the general food distribution
to all families? Yes No

If not, to whom are they distributed?

___to all infants less than six months

___to all infants less than one year

___to targeted infants with an identified need, such as orphans not wet nursed

___other, using the following criteria: _____

Is each infant needing artificial feeding identified by appropriately
trained staff? Yes No

Is there any spillover in the emergency-affected or the host population? Yes No

Have the conditions to reduce dangers of artificial feeding (4.5) been
put into practice throughout the service area?..... Yes No

Is each infant guaranteed a full supply as long as needed? Yes No

Are labels in the appropriate language? Yes No

Do the labels explain how to use the product? Yes No

Do they give warnings of the health hazards of improper preparation?..... Yes No

Is there any advertising or promotion of the products for infants
under six months?..... Yes No

over six months, as a partial replacement for breastmilk? Yes No

