

Infant Feeding in Emergencies

Module 1

for emergency
relief staff

Manual

for orientation,
reading and
reference



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

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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.

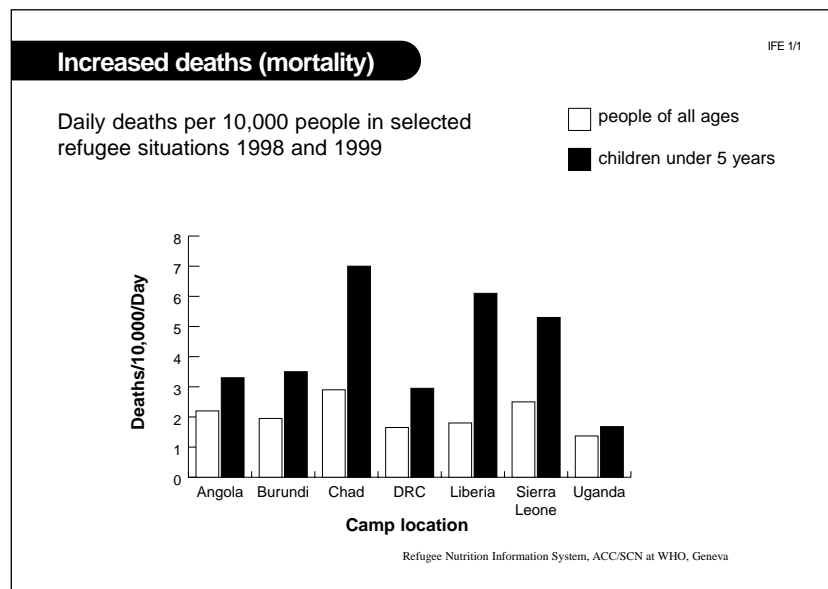
Although we shall be talking about infants, that is babies under one year, breastfeeding can and should continue with other foods up to two years or beyond.

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.

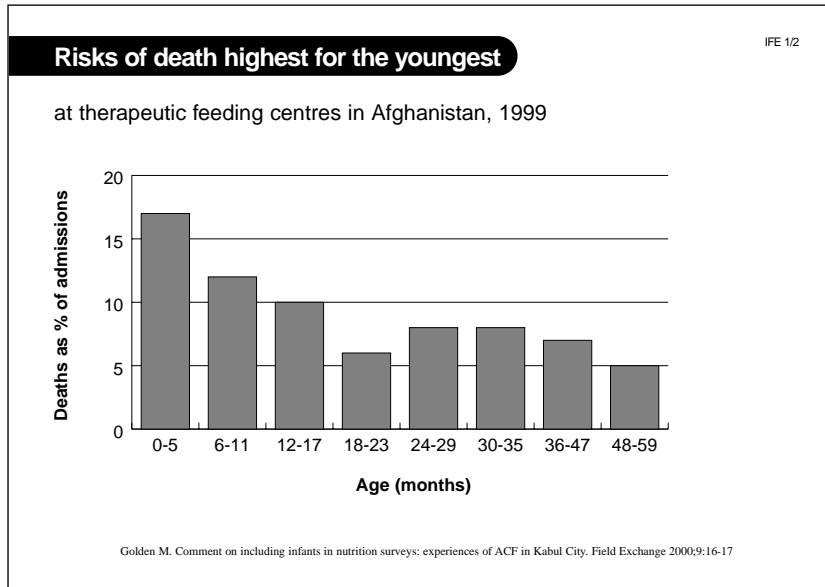
But this graph does not show the highest death rate, in the very vulnerable infants.

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

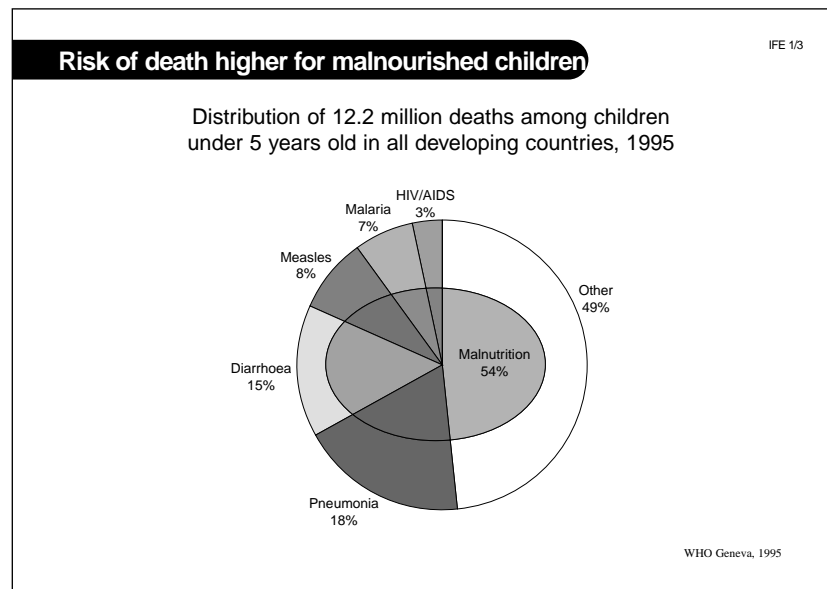
Malnourished infants are much more likely to die than are well-nourished infants.

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 about 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.

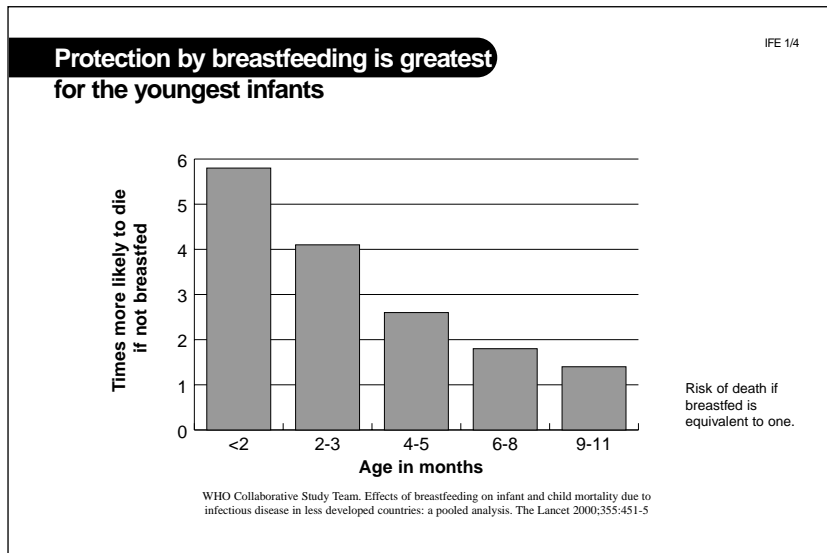
Substitutes are inferior to breastmilk

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 be breastfed increases risks of dying between 9 and 12 months of age 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 protect against some cancers.
- It promotes bonding between mother and baby, and psychosocial development.
- 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
<ul style="list-style-type: none"> • Start breastfeeding within one hour of birth. • Breastfeed exclusively for about six months [if possible*] • From about six months add adequate complementary foods • Continue breastfeeding up to two years or beyond. <p style="font-size: small; margin-top: 10px;">[*All infants should be exclusively breastfed for at least four full months.]</p>	

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 about six months] and grow well. Every infant should be exclusively breastfed through the fourth month of life, that is until he or she has actually reached the age of at least four months.

Most babies do not need complementary foods before six months.

At some time between the ages of four and six months, some infants begin to need foods in addition to breastmilk. The mother should begin to offer complementary foods only if

- the child shows interest in semisolid foods,
- appears hungry after breastfeeding, or
- is not gaining weight adequately — in spite of very frequent and exclusive breastfeeding.

From about six months, all infants 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.

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.

But 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.

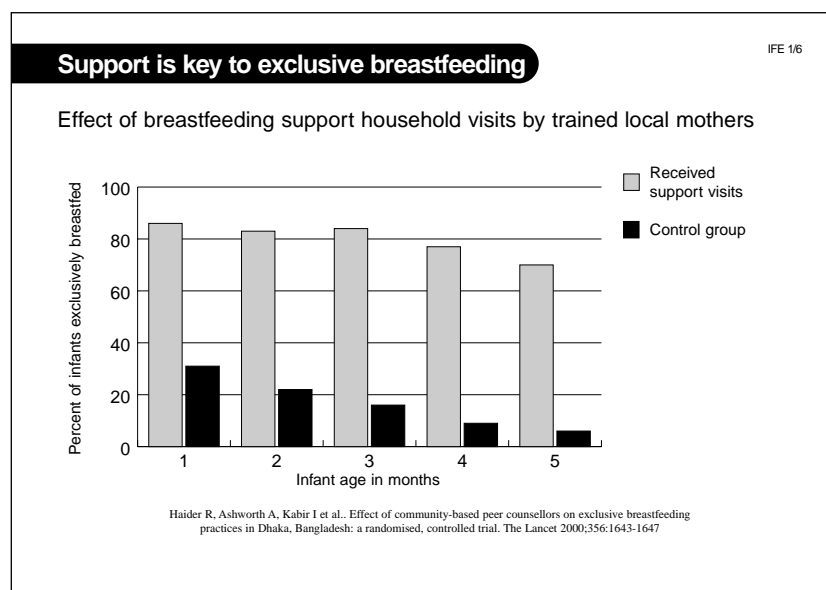
2.1 Factors that interfere with breastfeeding

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 breastfeeding counselling in more detail.)

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 feeding if the baby has diarrhoea.”
- Do not stop feeding 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 	<i>priority access</i>	
<ul style="list-style-type: none"> lack of protection, security, and (where valued) privacy 	<i>shelters</i>	
<ul style="list-style-type: none"> lack of social support and the familiar social network 	<i>groups of women who support each other</i>	
<ul style="list-style-type: none"> free availability of breastmilk substitutes, undermining mothers' confidence in breastfeeding 	<i>effective controls on availability</i>	

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.

Adapting powdered skim milk to the requirements of infants requires substantial and precise modification with other ingredients — oil, sugar, minerals and vitamins. It should be undertaken 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, few infants under one year may 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, TEARFUND

Bereaved mother with sick child, 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.

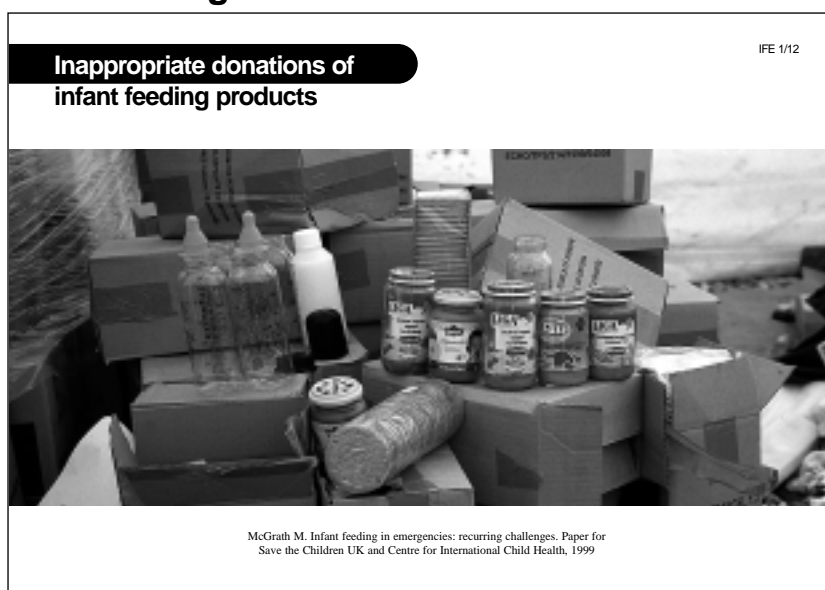
Uncertainty about implementing global policies on HIV (See also section 3.4)

- 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

IFE1/12



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.

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 go away 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 staff (Module 2 will address this need.)

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.

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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 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 to breastfeeding. 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

**Code violation —
promotion of bottle-fed tea**

Tetovo Government Hospital,
Macedonia

from McGrath M. The reality
of research in emergencies.
Field Exchange 9, March 2000

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, LINKAGES and IBFAN. There has been a long consultation process and many other agencies' comments have been incorporated (notably all the 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, and sufficient by itself [for all children to four months of age, and for most to about six months of age]

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 about 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 about 6 months. 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?

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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.

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

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

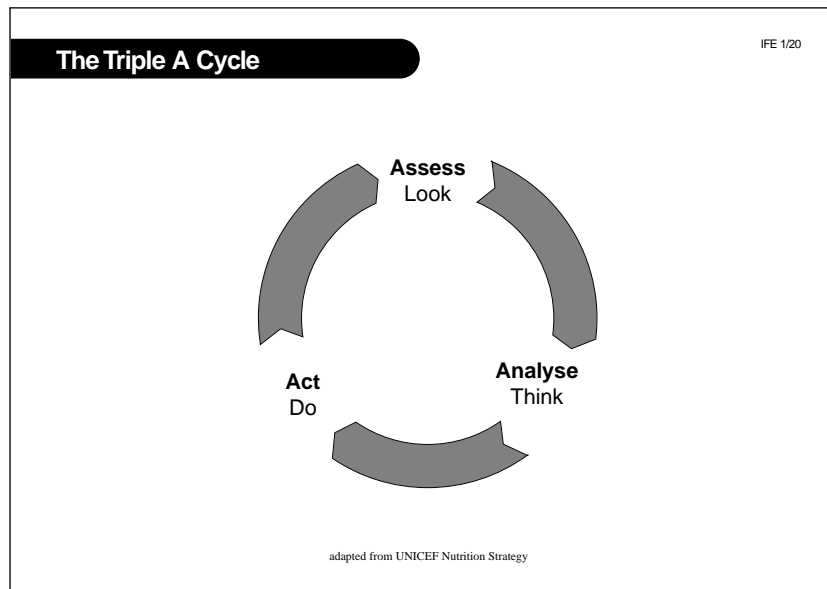
4.1 Assessment and analysis

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.

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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

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.

- availability, management and use of breastmilk substitutes.

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 fine print which gives 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 into the second year and beyond, they need other supportive conditions also.

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Conditions to support breastfeeding	
	IFE 1/21
	<ul style="list-style-type: none"> • recognition of vulnerable groups • shelter and privacy • reduction of demands on time • increased security • adequate food and nutrients • 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</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</i>	Arrange priority access (shorter queues) to relief items on time 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>Educate the mothers</i>	Trained staff should 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>	Assist population to settle in familiar community or family groups. Provide meeting places for mothers with young children to facilitate woman-to-woman support.
<i>Adequate health services</i>	Ensure staff skilled in support of breastfeeding. Provide Baby-Friendly maternity care. Help mothers express their milk and cup feed any infant too small or sick to breastfeed. Provide continued support to prevent and overcome any breastfeeding difficulties. Provide equipment and systems to monitor child growth. Admit mothers of sick or malnourished infants to the health or nutrition rehabilitation clinic with their children. Help mothers of malnourished infants to relactate and achieve adequate breastfeeding before discharge from care.

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 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 temporarily until achievement of relactation) <p>* Babies born after start of emergency should be exclusively breastfed from birth.</p>
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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:

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<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 infants 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>	<p>Trained staff should</p> <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; and 4) check that each infant receives at least six months' supply, unless breastfeeding is resumed, and is growing adequately.
<i>Dispose</i>	<p>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.</p>
<i>Communicate</i>	<p>If excess was caused by unneeded or inappropriate donations, inform source and agency headquarters, to prevent future problems.</p>
<i>Monitor</i>	<p>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.</p>

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" and that it 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 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 **1992 Resolution** (WHA 45.34) reaffirms that during the first four to six months of life, no food or liquid other than breastmilk, not even water, is required. It endorses the WHO/UNICEF Baby Friendly Hospital Initiative.

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.

Key Points

1. Every agency should develop or endorse a policy relating to infant and young child feeding in emergencies (that they must institutionalise); 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 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 existing 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. Infant 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 should be refused in emergency situations (section 6).
9. Unsolicited donations should be under the control of a single designated agency (section 6).
10. Breast-milk substitutes, 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 who need them (section 6).

Based on:

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)

Aim

The aim of this document is to provide concise guidance on how to ensure appropriate infant and young child feeding in emergencies.

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 international emergency standards¹. Further practical details of how to implement the guidance are referenced throughout the document (1-14). The assessment and management of severely malnourished infants and young children are not addressed in this document.

Practical steps

1 Endorse or Develop Policies

- 1.1 Each agency should, at central level, endorse or develop a policy² 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 breast-milk substitutes (BMS), commercial baby foods and drinks and infant feeding equipment in 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 (HQ and field) to support appropriate infant and young child feeding in emergencies, using the following materials: the agency policy, this operational guidance and the Interagency Infant Feeding in Emergencies Module I (12)
- 2.2 In addition, health and nutrition program staff will require technical training using the Interagency Infant Feeding in Emergencies Module II (12), that includes orientation on available technical guidelines (4-11)
- 2.3 Specific expertise on breastfeeding counselling and support is generally available at national level. Contact: Ministry of Health, UNICEF, La Leche League, or IBFAN (International Baby Food Action Network) groups. At international level, contact: ILCA (the International Lactation Consultancy Association), or IBFAN-GIFA³

3 Co-ordinate Operations

- 3.1 In an emergency operation, an agency or group of agencies should be identified by the health or nutrition co-ordinating body to take the responsibility for the co-ordination of infant and young child feeding activities. The infant and young child feeding co-ordinating body should be responsible for the following:
- 3.1.1 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: 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)
- 3.2 Evaluation of capacity building and technical support requirements among operational agencies. Unless funding can be secured to meet the identified requirements, co-ordination and quality of infant feeding and young child interventions will be severely compromised

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 assessment. Therefore, the assessment team should include at least one person who has received basic orientation on infant feeding in emergencies (see Section 2 above)
- 4.2 Key information to obtain in the early stages through rapid assessment 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 children⁴
 - predominant feeding practices
 - conspicuous availability of breast-milk substitutes and bottles in emergency-affected population and commodity pipeline
 - reported problems feeding infants and young children, especially breastfeeding problems
 - potential support givers for infant and young child feeding (experienced caregivers and women from the community)
 - observed and pre-crisis approaches to feeding orphaned infants
- 4.3 If rapid assessment indicates that further assessment is necessary, key information must be obtained.
- 4.3.1 Use qualitative methods to:
- assess availability of appropriate foods for complementary feeding in general ration or through targeted feeding programs
 - 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, mortality and malnutrition in infants gathered from routine statistics (surveys using indicators of malnutrition and morbidity in infants are problematic, further technical developments are required before systematic assessments can be conducted)
 - infant and young child feeding practices pre-crisis (from existing data sources⁵) and recent changes (details on how to gather quantitative data on infant and young child feeding are given in 13 & 14)
 - breast-milk substitute availability, management and use (i.e. compliance with The International Code - from informed observation, discussion and monitoring (12))

5 Protect, Promote and Support Breastfeeding with Integrated Multi-Sectoral Interventions

5.1 Basic interventions

- 5.1.1 Establish where culturally appropriate, secluded areas for breastfeeding, including rest areas in transit
- 5.1.2 Screen new arrivals to identify and refer any mothers or infants with severe feeding problems and refer for immediate assistance
- 5.1.3 Ensure easy access for caregivers to water and sanitation facilities, food and non food items; ensure security for women and children
- 5.1.4 Establish registration of new-borns within two weeks of delivery
- 5.1.5 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
- 5.1.6 Ensure that the nutritional needs of the general population are met, giving special attention to the inclusion of commodities suitable as complementary foods for young children⁶. 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

5.2 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 (7). If breastfeeding by the natural mother is impossible make appropriate choices among alternatives (2)
- 5.2.2 Integrate breastfeeding and infant and young child feeding training and support at all levels of health care: reproductive health services⁷ including ante and post-natal care, family planning, traditional birth attendants and maternity services (the 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)⁸ 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 care-givers
- 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 Emphasise prevention of HIV/AIDS; where HIV status of the mother is unknown or she is known to be HIV negative, apply the UN recommendation to exclusively breastfeed;⁹ Where a mother has been tested and is known to be HIV positive, replacement feeding with breast-milk substitutes can be considered an option if it can be done in a safe and sustainable manner. However, in most

emergencies the risks of infection or malnutrition from using breast-milk substitutes are likely to be greater than the risk of HIV transmission. Therefore, if a mother is known to be HIV positive, exclusive breastfeeding is likely to remain her safest choice. 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 breast-milk substitutes, bottles and teats should be strictly controlled and comply with The International Code (3)

6.1 Control of the procurement of breast-milk substitutes, bottles, teats and commercial Complementary Foods

- 6.1.1 Donations or subsidised breast-milk substitutes, bottles and teats and commercial baby foods should be systematically refused
- 6.1.2 Unsolicited donations should be collected from all ports of entry and recipient agencies and stored centrally under the control of a single agency and under the guidance of the infant feeding co-ordinating body. A plan for their safe use, monitored and under supervision, or their eventual destruction, will need to be developed by the infant feeding 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 at central level and the infant feeding co-ordinating body
- 6.1.4 If generic formula is unavailable at short notice, or locally unacceptable, infant formula can be purchased on the local market and relabelled (to be in compliance with The International Code). UNICEF is responsible for making generically labelled infant formula available in situations where the UNICEF/WFP Memorandum Of Understanding applies¹⁰. Information on obtaining generic formula is available from UNICEF-New York (Nutrition section)
- 6.1.5 Purchased products should be manufactured and packaged in accordance with the Codex Alimentarius standards (international food standard setting agency) and have a shelf-life of at least 6 months at time of receipt in country. Labels must be in the language of the beneficiary population and must adhere to the specific labelling requirements of The International Code (10)
- 6.1.6 Bottles and teats should never be purchased for distribution in emergency situation. Their use should be actively discouraged. Use of cups should be actively promoted instead (10a)

6.2 Implement criteria for targeting and use of breast-milk substitutes

- 6.2.1 Breast-milk substitutes should never be part of a general or blanket distribution
- 6.2.2 Breast-milk substitutes should only be targeted to infants requiring them, as determined from assessment by a qualified health or nutrition worker trained in breastfeeding and infant feeding issues. For those infants requiring infant formula, supply should be continued for as long as the infants concerned need it (until at least 6 months and a maximum 12 months or until breastfeeding is re-established)
- 6.2.3 In accordance with The International Code, there should be no promotion of breast-milk substitutes at the point of distribution,

including displays of products

- 6.2.4 Distribution of breast-milk substitutes to an individual mother should always be linked to education, demonstrations and 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)
- 6.2.5 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 breast-milk substitutes cannot be assured, an on-site “wet” feeding programme should be initiated

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. <http://www.tcd.ie/enn/InfantFeedingReport/>
- (3) The International Code of Marketing of Breast-milk Substitutes. WHO, 1981. Full Code and Relevant WHA resolutions at: <http://www.ibfan.org/English/resource/who/fullcode.html>

7.2 Technical Information

- (4) 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.
- (5) Helping Mothers to Breastfeed in Emergencies. WHO European Office, <http://www.who.dk/nutrition/infant.htm>
- (6) Helping Mothers to Breastfeed. F. Savage King, AMREF, 1992.
- (7) Relactation: Review of Experiences and Recommendations for Practice. WHO, 1998.
- (8) Reproductive Health in Refugee Situations: an Interagency Field Manual. UNHCR, 1999.
- (9) 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, linkages@aed.org; website: www.linkagesproject.org
- (10) 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 info@gifa.org
- (11) Cup Feeding information. BFHI News, May/June 1999. UNICEF (pubdoc@unicef.org)

7.3 Training Materials

- (12) Forthcoming: InterAgency Training Modules on Infant Feeding in Emergencies. Contact Emergency Nutrition Network (ENN): e-mail: foreilly@tcd.ie; website: www.tcd.ie/enn

7.4 Assessment, Monitoring and Evaluation

- (13) Indicators for Assessing Breast-feeding Practices. WHO/CDD/SER/91.14, WHO, Geneva.
- (14) Tool Kit for Monitoring and Evaluating Breastfeeding Practices and Programs. Wellstart International Expanded Promotion of Breastfeeding Program (EPB), September 1996. email: linkages@aed.org; website: www.linkagesproject.org

¹ 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.
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

² A recommended policy framework can be found in (2)

³ ILCA: ilca@erols.com , GIFA: info@gifa.org

⁴ 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)

⁵ Multi-indicator cluster surveys: www.childinfo.org/; Demographic Health Surveys www.macoint.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

⁶ 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

⁷ 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.

⁸ forthcoming information on Infant Feeding in Emergencies on the IBFAN website: www.ibfan.org for more details about Mother Baby Tents and Breastfeeding Corners

⁹ HIV and Infant Feeding. WHO/UNICEF/UNAIDS. 1998

¹⁰ UNICEF/WFP Memorandum of Understanding in Emergency and Rehabilitation Interventions, February 1998. The MOU covers situations caused by natural and man made disasters where there are no refugees.

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.

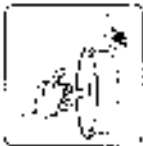
The milk in pack is similar to all the brands of infant formula on sale. It is made from dried cow's milk and is suitable for babies from birth. When mixed with clean bottled drinking water it will provide all the food a baby needs until about six months of age. There is no need to add other foods unless 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 breast 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.


PREPARATION INSTRUCTIONS FOLLOW THESE CAREFULLY




1. Wash your hands and sterilize the feeding bottle and teat.



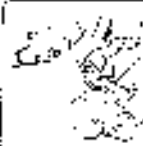
2. Measure 30 ml of clean, boiled and cooled water.



3. Wash a flat cap with hot soapy water and dry it.



4. The top of the cap will hold the mixture well. Shake the mixture until the water and powder are fully mixed.



5. Feed your baby. The formula should be given to the baby within 2 hours of preparation. Discard any remaining formula.

FEEDING GUIDE

Age	Volume (ml)	Frequency
0-3 months	100-150	8-12 times a day
3-6 months	150-200	6-8 times a day
6-12 months	200-300	5-6 times a day

Use a spoon to mix the formula with water. Do not use a feeding bottle. The formula should be given to the baby within 2 hours of preparation. Discard any remaining formula.

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 sterilizing the feeding bottle and teat?
3. Do you understand the importance of using clean, boiled and cooled water?
4. Do you understand the importance of using a flat cap to hold the mixture?
5. Do you understand the importance of shaking the mixture well?
6. Do you understand the importance of giving the formula to the baby within 2 hours of preparation?
7. Do you understand the importance of discarding any remaining formula?

IF YOU CAN SAY YES TO ALL THESE QUESTIONS, YOU CAN USE THIS MILK.

AVERAGE COMPOSITION

Ingredient	g/100g of powder	g/100ml of milk
Energy (kcal)	450	100
Protein	15	3.5
Lactose	11	2.5
Glucose	11	2.5
Starch	11	2.5
Other carbohydrates	11	2.5
Fat	11	2.5
Calcium	0.24	0.055
Phosphorus	0.24	0.055
Iron	0.002	0.0005
Zinc	0.002	0.0005
Copper	0.0002	0.00005
Manganese	0.0002	0.00005
Selenium	0.0002	0.00005
Chloride	0.002	0.0005
Sodium	0.002	0.0005
Potassium	0.002	0.0005
Magnesium	0.0002	0.00005
Other minerals	0.0002	0.00005
Water	0.002	0.0005
Other ingredients	0.002	0.0005

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 staff 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

