Infant Feeding in Emergencies

Module 1
for emergency relief staff

Overhead figures

for use as transparencies or flip chart

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

Increased deaths (mortality)

Daily deaths per 10,000 people in selected refugee situations 1998 and 1999

![Graph showing daily deaths per 10,000 people in selected refugee situations, with bars for people of all ages and children under 5 years, and camp locations including Angola, Burundi, Chad, DRC, Liberia, Sierra Leone, and Uganda.](image)

Refugee Nutrition Information System, ACC/SCN at WHO, Geneva
Risks of death highest for the youngest at therapeutic feeding centres in Afghanistan, 1999

Golden M. Comment on including infants in nutrition surveys: experiences of ACF in Kabul City. Field Exchange 2000;9:16-17
Risk of death higher for malnourished children

Distribution of 12.2 million deaths among children under 5 years old in all developing countries, 1995

![Pie chart showing the distribution of deaths

- Malnutrition: 54%
- Pneumonia: 18%
- Diarrhoea: 15%
- Measles: 8%
- Malaria: 7%
- HIV/AIDS: 3%
- Other: 49%]
Protection by breastfeeding is greatest for the youngest infants

Times more likely to die if not breastfed

Risk of death if breastfed is equivalent to one.

Recommendations for infant feeding

Called ‘Optimal infant feeding’

• Start breastfeeding within one hour of birth.
• Breastfeed exclusively for six completed months.
• From about six months of age add adequate complementary foods.
• Continue breastfeeding up to two years or beyond.
Support is key to exclusive breastfeeding

Effect of breastfeeding support household visits by trained local mothers

## Care for the individual breastfeeding mother

### Concerns for mother
- her own nutrition and fluid intake
- her own health
- physical difficulties (e.g. sore nipples)
- misinformation, misconceptions

### Staff should ensure
- extra rations and fluids
- attentive health care
- skilled breastfeeding counsellors
- correct information and breastfeeding counselling
Common misconceptions on infant feeding in emergencies

**Misconception**

- “Stress makes the milk dry up”
- “Malnourished mothers cannot breastfeed”
- “Once breastfeeding has stopped, it cannot be resumed”

**Fact / Recommendation**

- Stress might temporarily affect the milk let down reflex, but does not affect milk production. Mothers need reassurance and support.
- Feed the mother and let her feed her infant. All mothers need extra fluids, food to maintain strength and breastfeeding.
- It is usually possible to re-lactate. Mothers need support to do this.
Common misconceptions on infant feeding in emergencies

Misconception
- “If the mother is stressed, she will pass the tension on to the baby”.
- “Babies with diarrhoea need water or tea”
- Women formula-fed here before the crisis & ‘know how to do it’ (We are ‘developed’ and only formula feed)

Fact / Recommendation
- Breastfeeding will relax both mother and baby. Mothers need reassurance and support.
- Breastmilk provides all the fluids an infant under 6 months needs, also when it has diarrhea
- The emergency means that the circumstances that made formula-feeding acceptable, feasible, affordable, sustainable & safe have gone. Breastfeeding is best anyway – but especially in an emergency
Improving conditions to make breastfeeding easier

Mothers’ difficulties

- time constraints
  long time to fetch water, queue for food
- lack of protection, security, and (where valued) privacy
- lack of social support and the familiar social network
- free availability of breastmilk substitutes, undermining mothers’ confidence in breastfeeding

Staff should ensure

- priority access
- shelters
- groups of women who support each other
- effective controls on availability
Household in camp near Goma, Zaire/Congo
Households destroyed by cyclone, Bangladesh
Family with baby post-conflict, Lebanon

Problems of artificial feeding in emergencies

- 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
Inappropriate donations of infant feeding products

McGrath M. Infant feeding in emergencies: recurring challenges. Paper for Save the Children UK and Centre for International Child Health, 1999
Pakistan 2005

Lebanon, 2006

Ali Maclaine, Nutrition Consultant, Lebanon
Some important points from the 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
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
Operational Guidance: what to do

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
Points of agreement 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 (following assessment) use infant formula if available. It must be targeted only to those who need it.
More points of agreement

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 after 6 full months.
8. Avoid commercial complementary foods.
9. Include pregnant and lactating women in supplementary feeding when general ration is insufficient.
- All HIV negative mothers and mothers of unknown status should follow the optimal infant feeding guidelines

- The most appropriate infant feeding option for an HIV-infected mother should continue to depend on her individual circumstances, but should take greater consideration of the health services available and the counselling and support she is likely to receive.

- Exclusive breastfeeding is recommended for HIV-infected women for the first 6 months of life unless replacement feeding is acceptable, feasible, affordable, sustainable and safe (AFASS) for them and their infants before that time.

- When replacement feeding is AFASS, avoidance of all breastfeeding by HIV-infected women is recommended.
Replacement feeding by tested HIV+ mothers

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, especially during an emergency, be made:

• acceptable,
• feasible,
• affordable,
• sustainable, and
• safe?
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
The Triple A Cycle

Assess
Look

Act
Do

Analyse
Think

adapted from UNICEF Nutrition Strategy
Conditions to support breastfeeding

- recognition of vulnerable groups
- shelter and privacy
- reduction of demands on time
- increased security
- adequate food and nutrients
- community support
- adequate health services
Example of agreed criteria for use of alternatives to mother’s milk

- 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)

* Babies born after start of emergency should be exclusively breastfed from birth.
Conditions to reduce dangers of artificial feeding:

the breastmilk substitutes

- Infant formula with directions in users’ language
- 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

- Home-modified animal milk must be adapted/modified according to specific recipes and micronutrients added, HOWEVER, nutritional adequacy is unlikely to be reached. Therefore, this should only be used as a last resort.

However, caregivers need more than milk.
Conditions to reduce dangers of artificial feeding:

additional requirements

- 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