

Infant feeding in emergencies: experiences from Lebanon

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The provision of infant formula and milk for infants and young children is a very emotive subject, especially during emergencies. NGOs have been struggling with how to tackle this problem since the early 1990s, when emergencies in countries such as Iraq revealed that a significant percentage of women had been using breastmilk substitute (BMS) before the crisis occurred. Previously, relief work had focused on countries where the pre-crisis breastfeeding rate was nearly 100% and although breastfeeding practices were often less than ideal, at least that lifeline for infants was there. However, even when relief agencies knew the benefits of breastfeeding and the dangers of BMS, especially during emergencies, they felt that they had to do something to support affected infants, and so often distributed infant formula – untargeted, unmonitored and without follow-up.

Since then, agencies have been developing infant feeding in emergencies (IFE) policies, initiatives and training materials. However, the conflict in Lebanon has again highlighted the difficulties in supporting formula-fed infants, while at the same time promoting breastfeeding. This article outlines the background to IFE, then describes the IFE response in Lebanon and the major issues that arose from it. It draws on the findings of a Save the Children mission to Lebanon to monitor IFE and support safe infant feeding practices.

Infant feeding in emergencies

IFE is little understood, even by many health and nutrition staff, never mind other sectors. There is often a belief that it is only about promoting breastfeeding, and as such is a development issue, and so not a high priority in emergencies. In places such as Lebanon, where many women use formula and 'know how to do it', many people do not understand why formula should not be freely distributed during an emergency. Moreover, as infants are often out of sight in shelters or homes it is easy to overlook their needs and potential requirements.

The importance of breastfeeding

The benefits of breastfeeding, in terms of the infant's growth, physical and psychological development and immunological protection, and in regard to the mother's health, are well-established. The World Health Organisation (WHO) recommends that an infant is exclusively breastfed for the first six months of life, and continues breastfeeding for two years or more, with timely and adequate complementary foods. In terms of child survival breastfeeding is crucial: 13% of all under-5 deaths could be prevented if all infants were breastfed – more than any other preventative intervention.

The dangers of artificial feeding

BMS is inferior to breastmilk; it lacks breastmilk's precise balance of nutrients, is more difficult to digest, may be wrongly prepared, does not protect against illness and, if contaminated, may carry infection, leading to higher mortality. Even in the best, most hygienic conditions, artificially-fed babies are five times more likely to suffer diarrhoeal diseases. In an emergency situation, even where bottle feeding is not normally associated with increased mortality in a non-emergency setting, infant feeding methods can become an issue of life or death. Unsanitary, crowded conditions, a lack of safe water and a lack of facilities to sterilise feeding bottles and prepare formula safely and correctly means that artificially fed infants are more than 20 times more likely to die from diarrhoea and other infectious diseases than infants who are exclusively breastfed. Moreover, during an emergency people may not be able to obtain enough formula to feed their baby adequately because they are cut off from markets or because of cost.

How should infants be fed during an emergency?

It is important to protect and support breastfeeding mothers immediately an emergency occurs, so that they continue to breastfeed. Issues such as stress and lack of food affecting breastfeeding are often cited as reasons for needing BMS. However, these are myths and can be tackled by following the training guidance available.

Mothers with infants younger than six months who were mix feeding before the crisis should be encouraged to exclusively breastfeed. If formula is needed, this should be provided and given under the conditions set out below. For infants who were primarily formula-fed before the crisis, there is a need to ensure that they have a guaranteed supply of infant formula (labelled correctly and in the local language), supplies of clean water, cooking facilities and a cup to feed the baby (cups are safer than bottles as they are easier to clean; even newborns can cup-feed).

In order to ensure that the infant is healthy and gaining weight, formula distribution must be targeted, education provided and infants regularly monitored. All BMS should be purchased following an assessment of need, and procurement managed so that formula supply is always adequate, and continues for as long as the targeted infants need it (until breastfeeding is re-established, or until at least 6–12 months of age). Mothers or grandmothers may be interested in relactation (possible even if they have not breastfed for years) or wet-nursing (where a woman other than the mother breastfeeds the infant).

Findings in Lebanon

Before the conflict in Lebanon in 2006, an estimated 27% of mothers exclusively breastfed for the first four months of life. While in the south exclusive breastfeeding was traditionally more predominant, mixed feeding amongst the 'young' was increasingly common. The response of many humanitarian agencies to the crisis was to bring in infant formulas and commercial complementary foods as part of their food and health kit distribution programmes. Much of this violated the Code and the Ops Guidance. In terms of the impact on mothers, all sources indicated that the conflict had negatively affected breastfeeding practices; mothers stopped breastfeeding completely, started mixed feeding and/or reduced breastfeeding.

The lessons of Lebanon for operational agencies

Lebanon underlined that operational agencies either do not regard IFE as a mainstream and important emergency issue, and/or do not know how best to tackle IFE in the field. For those agencies that undertook IFE programming, by providing formula directly or by funding local NGOs to purchase it, there is no question that the situation in Lebanon was difficult and complex. Agencies knew that many infants had been totally or partially formula-fed before the crisis, that bombing was preventing mothers from obtaining supplies and that infants needed feeding. Not providing formula to infants that required it was not an option. However, amongst humanitarian staff questioned during the monitoring mission, the level of knowledge about programme and policy implications was very poor. The short duration of the conflict meant that infants were somewhat protected from the potential negative effects of this lack of knowledge, but the situation could have been very different if the conflict had gone on longer.

IFE is often regarded as a nutrition/health issue, when in reality it is an inter-sectoral issue – especially when handled correctly, according to the guidelines, and involving, for example, policy-makers, procurement/logistics managers and programme managers. Shelter and protection officers can support breastfeeding by ensuring that women with infants have access to privacy and safe shelter; food security officers can prioritise mothers for food, water and non-food items, so that they have time to breastfeed; psycho-social support and counselling can assist breastfeeding; and media and communications strategies provide messages on safe infant feeding practices. It is essential that sectors and staff members are aware of how IFE fits into their agendas; the significance of this was illustrated in Lebanon, where mothers used bottled water to prepare formula, but many water and sanitation staff were unaware of the potential health issues surrounding the high solute load found in some bottled water.

While inter-sectoral collaboration is essential, inter-agency cooperation is also vital in the field. UNICEF was the Nutrition Cluster lead in Lebanon, and is also the IYCF coordinating body in the field, as set out in the Ops Guidance. However, the success of a cluster rests largely with the coordinator, and in Lebanon UNICEF appeared unable to provide the leadership needed on IYCF issues in the initial phase. This meant that many field staff, unaware of IFE issues or the Ops Guidance, acted independently, violated the guidelines and did not perform best practice. As cluster lead, UNICEF was in an ideal position to provide agencies with guidance, and by highlighting IFE at the Health cluster and General Co-ordination meetings could have helped ensure an inter-sectoral, inter-agency response to IFE. It failed to do this and an opportunity was missed.

Although inter-agency ties are normally positive, the increasing trend for agencies to work together has implications in assessing the degree of responsibility that an agency has for adhering to the Code and the Ops Guidance. The accountability for violations of the Code or Ops Guidance, whether manifested in financial contributions or donations of goods, must reside both with the donor agency and the implementing agency.

One benefit of the monitoring mission's work in Lebanon was that, in trying to establish INGOs' response to IYCF and their

adherence to the Code and Ops Guidance, an opportunity was provided to look at the challenges of putting policy into practice in the field during an emergency. Moreover, while monitoring helped to raise the profile of IFE in the field, the findings also stimulated and informed policy guidelines. For example, the Lebanon findings have contributed to UNICEF's development of its Cluster response (and IFE responsibilities) and of the IFE component of the Nutrition Cluster toolkit and initial rapid assessment. Agencies in Lebanon have been reviewing their IFE policies, funding policies and programming responses. In addition, the Lebanon experience led to a further update of the Ops Guidance to deal with issues that arose in the field (updated Ops Guidance 2.1).

Emergencies can happen anywhere, and humanitarian response plans must be flexible, while still following guidelines. This is especially the case in IFE, where agencies need to react to the local context. Agencies must also be aware that IFE is important in all emergency settings, including middle-income countries, and has inter-sectoral implications. Emergencies by their nature happen fast and unexpectedly, which means that it is essential that NGOs and staff from all sectors ensure that IFE policies are in place, and that IFE is included in staff training and materials so that programming is of the highest standard, and infants are protected.

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