PROMOTING OPTIMAL FEEDING OF INFANTS AND YOUNG CHILDREN DURING EMERGENCIES, WITH SPECIAL REFERENCE TO THE SITUATION IN IRAQ[1]

The tragic humanitarian crisis unfolding in and around Iraq is an opportune moment:

- to recall internationally agreed principles governing the optimal feeding of infants and young children during emergencies, and
- to consider the implications of these principles for meeting the immediate and longer-term nutritional needs of infants and young children in Iraq.

Context

During emergencies disease and death rates among under-five children are generally higher than for any other age group. In refugee and internally displaced populations, mortality may be particularly high due to the combined impact of a greatly increased incidence of communicable diseases and diarrhoea and soaring rates of undernutrition. The fundamental means of preventing malnutrition among infants and young children is to ensure their optimal feeding and care.

No food or liquid other than breast milk, not even water, is normally needed to meet an infant's nutritional requirements during the first six months of life. After this period, to meet their evolving nutritional requirements, in addition to breast milk infants should begin to receive a variety of energy-dense and micronutrient-rich foods. The valuable protection from infection and its consequences that breast milk confers is all the more important in environments with inadequate water supply and sanitation. If breastfeeding is interrupted, every effort should be made to re-establish it either with the child's own mother through re-lactation or, if culturally acceptable, with a wet-nurse.

Support for feeding infants and young children in exceptionally difficult circumstances should include creating conditions that will facilitate exclusive breastfeeding by provision, for example, of appropriate maternity care, extra food rations and drinking-water for pregnant and lactating women, and staff who have breastfeeding counselling skills; and ensuring that suitable complementary foods are selected and fed, consistent with age and nutritional needs. The best measure of adequate feeding behaviour is growth and development that are consistent with the WHO growth reference.

For infants who do not have access to breast milk, feeding with a suitable breast-milk substitute should be demonstrated only by health workers, or other community workers if necessary, and only to the mothers and other family members who need to use it; and the information given should include adequate instructions for appropriate preparation and the health hazards of inappropriate preparation and use. Feeding should be by cup, which is a safer method than a feeding bottle and teat. There should be no general distribution of breast-milk substitutes.

Infants who are not breastfed, for whatever reason, should receive special attention from the health and social welfare system since they constitute a risk group.

Summary of recommendations

- Infants and young children in emergency-affected populations should normally be breastfed.
- Every effort should be made to identify ways to breastfeed infants and young children whose mothers are absent or who are no longer lactating, for example by a wet-nurse or through re-lactation.
- Those responsible for the care of mothers and children should be adequately informed and skilled to support mothers in breastfeeding.
- Health workers with knowledge and experience in all aspects of breastfeeding and replacement feeding should be available, when needed, to counsel HIV-positive women.

[1] Prepared by the departments of Nutrition for Health and Development, Child and Adolescent Health and Development, and Emergency and Humanitarian Action, Geneva, World Health Organization, April 2003.

- For infants who are not breastfed, a nutritionally adequate substitute, fed by cup, should be made available for as long as the infants concerned need it. In addition to conforming to relevant Codex Alimentarius standards, the labelling provisions (Article 9) of the International Code of Marketing of Breast-milk Substitutes should apply.
- There should be no general distribution of breast-milk substitutes, and care should be taken to avoid any "spillover effect" of artificial feeding into the general population.
- The policy of the UNHCR (annex) related to the acceptance, distribution and use of milk products in feeding programmes in refugee settings should be followed. In this connection, particular attention should be paid to dried milk, which should not be distributed in take-away form unless it has been previously mixed with a suitable cereal flour.
- Older infants and young children need hygienically prepared foods that are easy to eat and digest, and that nutritionally complement breast milk.
- Malnourished infants and young children should be actively sought out so that their condition can be identified and treated, they can be appropriately fed, and their caregivers can be supported.

The contemporary situation in Iraq in the light of events in 1991

Those responsible for meeting the emergency nutritional needs of infants and young children in Iraq will wish to review and apply the above internationally agreed principles. Also instructive in this regard is the pragmatic public-health stance that WHO adopted in 1991 during the earlier conflict involving Iraq. The following information was reported to the World Health Assembly in May 1992.[1]

> In the light of events in the Persian Gulf prior to the commencement of hostilities in January 1991, including the trade embargo voted by the **United Nations Security Council**, the Chairman of the Council's sanctions committee asked whether WHO considered infant formulas to be a food or a medicine; if a food, the implication was that infant formulas should be included in the list of proscribed items of trade with Iraq. In its reply to the Chairman, WHO observed that when infants are not breastfed, or are only breastfed partially, during the first four to six months of life, breast milk may be replaced by *bona fide* breast-milk substitutes, including infant formulas, to satisfy their normal nutritional requirements. Under these circumstances infant formulas could be considered as falling under the category of "medicines". On the other hand, beyond the age of four to six months, both breast milk and its *bona fide* substitute are insufficient, in the absence of complementary foods, to satisfy the normal nutritional requirements of infants. Under these circumstances, WHO concluded, infant formulas could be considered as one among various sources of nourishment for the infant, and thus fall under the more general category of "food".
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> In March 1991, following the cessation of hostilities in the region, WHO drew the attention of the Chairman of the sanctions committee to the extremely difficult nutrition situation in Iraq. In particular, in the light of the very large numbers of infants and young children whose physical well-being – and in many cases their very lives – appeared to be in serious jeopardy due to the food and medical supply shortage, WHO strongly recommended that the sanctions committee should give immediate attention to the possibility of lifting the ban on the importation of basic foodstuffs into Iraq. There was, in particular, an acute need among infants and children for infant formulas and suitable energy-dense complementary foods, both to prevent further deterioration in nutritional status and to rehabilitate those infants and children who had already been affected. WHO considered that these foods were all the more important in view of the reported decline in recent years in breastfeeding.

Additional reading

World Health Organization. Thirty-ninth World Health Assembly. *Guidelines concerning the main health and socioeconomic circumstances in which infants have to be fed on breast-milk substitutes.* Document WHA39/1986/REC/1, Annex 6, part 2.

World Health Organization. Fifty-fifth World Health Assembly. *Global Strategy for Infant and Young Child Feeding* (especially paragraphs 18 and 19 on exercising other feeding options, and 20 to 25 on feeding in exceptionally difficult circumstances). Document WHA55/2002/REC/1, Annex 2.

World Health Organization. *Guiding principles for feeding infants and young children during emergencies* (in press).

[1] *Infant and young child nutrition (progress and evaluation report; and status of implementation of the International Code of Marketing of Breast-milk Substitutes).* Report by the Director-General, Forty-fifth World Health Assembly, document WHA45/1992/REC/1, Annex 9, paragraphs 33 and 34.

Annex

POLICY OF THE UNHCR RELATED TO THE ACCEPTANCE, DISTRIBUTION AND USE OF MILK PRODUCTS[1] IN FEEDING PROGRAMMES IN REFUGEE SETTINGS

(Adopted July 1989)[2]

1. UNHCR will accept, supply and distribute donations of milk products only if they can be used under strict control and in hygienic conditions, e.g. in a supervised environment for on-the-spot consumption.

2. UNHCR will accept, supply and distribute milk products only when received in a dry form. UNHCR will not accept liquid or semi-liquid products including evaporated or condensed milk.

3. UNHCR will accept, supply and distribute dry skim milk (DSM) only if it has been fortified with vitamin A.

4. UNHCR supports the principle that in general ration programmes protein sources such as pulses, meat or fish are preferred to dried skim milk. UNHCR notes that DSM pre-mixed centrally with cereal flour and sugar is useful for feeding young children especially if prepared with oil.

5. UNHCR will advocate the distribution of dried milk in a take-away form only if it has been previously mixed with a suitable cereal flour, and only when culturally acceptable. The sole exception to this may be where milk forms an essential part of the traditional diet (e.g. nomadic populations) and can be used safely.

6. UNHCR will support the policy of the World Health Organization concerning safe and appropriate infant and young child feeding, in particular by protecting, promoting and supporting breastfeeding and encouraging the timely and correct use of complementary foods in refugee settings.

7. UNHCR will discourage the distribution and use of breast-milk substitutes in refugee settings. When such substitutes are absolutely necessary, they will be provided together with clear instructions for safe mixing, and for feeding with a cup and a spoon.

8. UNHCR will take all possible steps to actively discourage the distribution and use of infant-feeding bottles and artificial teats in refugee settings.

9. UNHCR will advocate that when donations of DSM are supplied to refugee programmes, the specific donors will be approached for cash contributions to be specifically earmarked for operational costs of projects to ensure the safe use of this commodity.

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[1] Any non-fresh milk product such as powdered, evaporated, condensed, or otherwise modified milk, including infant formula.

[2] WHO cooperated with the UNHCR in drafting this policy. WFP, in addition to instructing its field staff to apply the UNHCR policy in all refugee projects, has issued its own policy guidelines to ensure the safe use of dried milk products in all WFP projects. WFP has also informed its staff of the Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding, which was adopted by government policy-makers (Florence, Italy, 1990), while emphasizing how food-aid projects can be instrumental in promoting breastfeeding.