3 January 2005
Nutrition Section NYHQ
Ref: Indian Ocean Crisis

Information on
INFANT AND YOUNG CHILD FEEDING IN EMERGENCIES
for UNICEF Offices and Partners

I. PREVENTIVE POLICIES ON INFANT FEEDING: to mitigate emergencies and for general child survival, growth and development:

- Breastfeeding should be initiated within the first hour after birth
- Exclusive breastfeeding protected and supported for 6 months
- Continue breastfeeding up to 2 years and beyond.
- Complementary feeding – which "tops up" human milk - starts from 6 months of age and continues to 2 years and beyond as child becomes more able to eat family foods.

Suggested actions: Implement the Global Strategy for Infant and Young Child Feeding (see Exec Dir 04-022 and related guidance) - Support:

- National policy and Code law;
- Health system support for Baby-friendly, curriculum updates and data collection;
- Community mobilization for support of breastfeeding and complementary feeding;
- Attention to special issues of HIV/AIDS and emergencies.

ll. INFANT AND YOUNG CHILD FEEDING IN EMERGENCY SETTINGS:

--UNICEF has a Core Corporate Commitment in the first 6-8 weeks of an emergency to "Provide child and maternal feeding and nutritional monitoring: support infant and young child feeding, therapeutic and supplementary feeding programmes with WFP and NGO partners. Introduce nutritional monitoring and surveillance." These activities should continue after 8 weeks as well.

As the lead UN Children's Agency, this area remains UNICEF responsibility no matter which agency is the lead.

Suggested actions:

A. Immediate attention must be given to the protection and support for breastfeeding, especially exclusive breastfeeding.

1. This includes:

   a. *Support*: immediate establishment of "**safe havens**", or safe spaces, where stress is reduced, counselling provided, and appropriate rations and water can be assured for pregnant and lactating women. Also, ensure that pregnant women have access to **iron/folate supplementation and iodized salt** (or supplements).

   b. *Protection:* follow guidance to stop acceptance in emergencies of powdered milks or other breastmilk substitutes. Donations of powder milk carry special concerns. Given poor infrastructure and living conditions in emergencies, and in other settings in need, all necessary measures must be taken to ensure the safe use of any donation. ***Lack of potable water, lactose-intolerance, and bacterial growth that occurs in powdered milks or formulas may result in increased risk of diarrhoeal disease and increased risk of fatalities amongst children.***

c. *Lactation maintenance and relactation support*: skilled workers should be made available to ensure support, protection and relactation. **"Supplementer" devices should be provided** that allow supplementation during suckling.

2. Concerning donations of breastmilk substitutes

a. Donations of powder milk carry special concerns. There are at least 4 reasons that powdered milks and formulas remain dangerous in emergencies, even with trained staff:

i. In populations with lactase-deficiency (most developing country settings), a sudden increase in milk as a percentage of intake can cause diarrhea in infants, children and adults.
ii. Milk powders and prepared milks can serve as growth media for bacteria. Where storage is not optimal, there can be rapid increases in contamination of all sorts.
iii. Where there is no guarantee of potable water for mixing or cleaning, or sterile water for younger infants, formula preparation and feeding cannot be carried out safely.
iv. If powdered milks or formula are used to replace or substitute for breastmilk, the child loses protection against disease that is gained from breastfeeding, and the family becomes dependent on artificial feeding, with all its costs and risks.

b. Donations of breastmilk substitutes, infant formula, bottles and teats should be refused.
c. Dried skimmed milk should not be given as a single commodity or as part of a general food distribution, because of the risk that it will be used as breastmilk substitutes.
d. Ensure that there are available rations that may be used for complementary feeding for breastfed children 6 months to 2 years. These rations may include milks mixed with a milled staple food.
e. Every effort should be made to place unaccompanied young children with family or foster care.
f. Infant formula should be used **only** under strict conditions, when:
   i. Lactation status of mother has been assessed, in the case where relactation is not possible
   ii. An HIV-positive mother has chosen not to breastfeed.
   iii. Children no longer have access to breastmilk, e.g. orphaned children, unaccompanied children, etc, and where there is assurance of supply of infant formula or as long as the infant needs it.
   iv. Infant formula can be provided under close supervision, monitoring, and follow up by trained health staff, and mothers/caretakers are provided with adequate information and counseling on safe preparation of infant formula and appropriate infant feeding practices.

3. Special concerns:

a. Infant formula must meet the International Code and Codex Alimentarius standards, including labeling and language standards.
b. Condensed milk and UHT milk (liquid) cannot be provided to infants less than 12 months of age.
c. Bottles and teats should never be distributed, and their use should be discouraged. Feeding should be done using a cup.

4. To reduce the danger of artificial feeding, the following conditions should be met:

- Easily cleaned cups, and soap and clean water for cleaning them
- Clean surface and safe storage for preparation
- Means of measuring water and milk powder (not a feeding bottle)
- Adequate fuel and potable water (if possible and available, use bottled water)
- Home visit to lessen difficulties in preparing feeds
- Follow up with extra care and supportive counseling
- Continued promotion for breastfeeding to prevent spillover of infant formula use to those mothers still able to breastfeed

B. Support for continued breastfeeding with complementary feeding:
Suggested Actions:

1. Ensure that there are available **rations (quantity and quality) that may be used for complementary feeding** for breastfed children 6 months to 2 years. These rations may include milks mixed with a milled staple food. (See section 6.2 of Annex 1: Infant and Young Child Feeding in Emergencies, appended and at http://www.ennonline.net/ife/ifeops.html)
2. Nutrition education on safe preparation and storage of complementary foods prepared from locally available foodstuff should be initiated as soon as feasible.
3. Support continued frequent, responsive breastfeeding.

C. Support therapeutic and supplementary feeding programmes with WFP and NGO partners.

Suggested actions:
Establish therapeutic feeding programmes (both within health facilities and community-based) and provision of related supplies and equipment and staff to run the therapeutic feeding centres
- (This WHO manual is in the process of update)
http://www.who.int/nut/documents/manage_severe_malnutrition_eng.pdf
- WHO- and UNICEF-approved Infant Feeding in Emergencies, Modules 1 and 2 Version 1.0, for health and nutrition workers in emergency situations.
http://www.ennonline.net/ife/module2/m2pdf/m2annexes.pdf

D. Related activities:
1. Provide nutrition education materials in collaboration with other partners including the elaborating standard IEC materials and methods.
2. UNICEF will support capacity building on caring practices through training of institutional caretakers/health workers or others

lll. FALSE MYTHS AND RESPONSES

Myths about breastfeeding can undermine both a mother's confidence and the support she receives. The five most common myths are:

A. "Stress makes milk dry up"

While extreme stress or fear may cause milk to stop flowing, this response, like many other physiological responses to anxiety, is usually temporary and **milk flow will generally resume when stress is reduced.** Safe havens/spaces for lactating women, where they can be sure to receive water and rations for themselves, and help their sisters relactate as needed, is the best intervention. When milk flow is supported, breastfeeding will also produces hormones that reduce tension, calm the mother and the baby and create a loving bond.

B. "Malnourished mothers cannot breastfeed"

Food should go to the lactating mothers so that they can feed their babies and maintain the strength to care for older children in the family as well. In the case of severe malnutrition, the use of

breastfeeding supplementers (devices that allow supplements to be delivered while the infant sucks at the breast) can be used to overcome the malnutrition while ensuring increased breastmilk production.

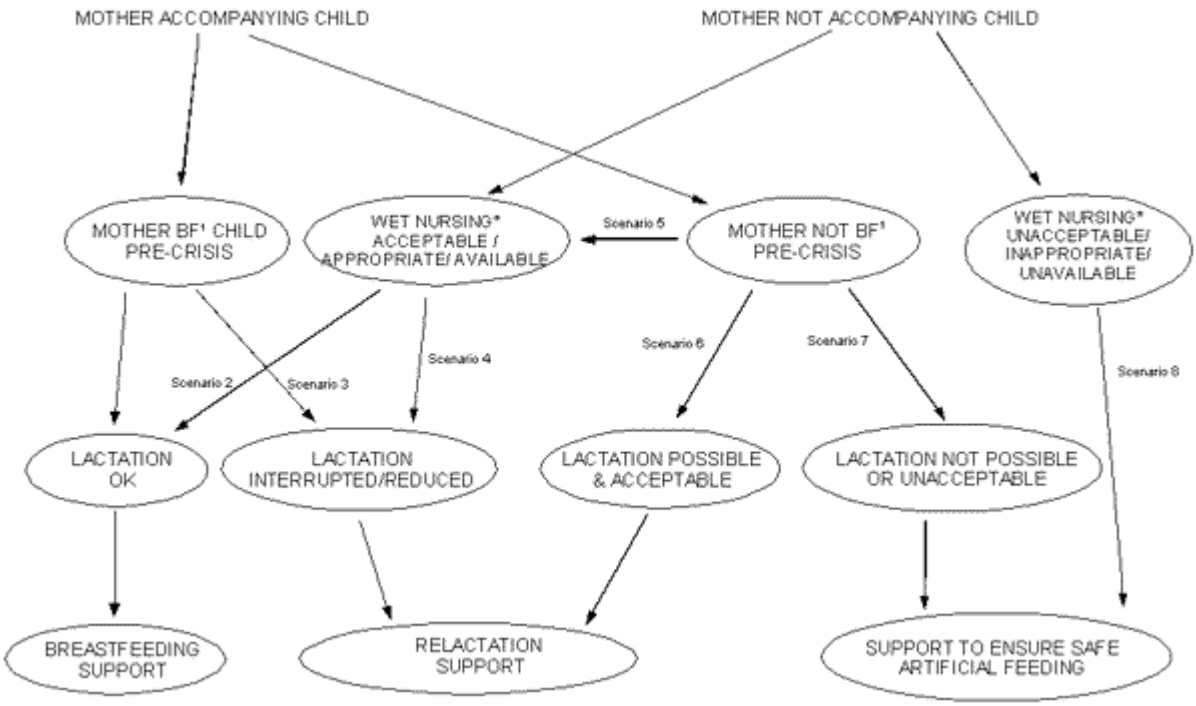
C. "Babies with diarrhoea need water or tea"

As breastmilk is about 90% water, exclusively breastfeeding babies with diarrhoea do not usually need additional liquids such as glucose water or tea. What is more, water is often contaminated in emergency situations. In the case of severe diarrhoea however, oral rehydration therapy (administered by cup) may be required, besides breastmilk.

D. "Once breastfeeding has stopped, it cannot be resumed"

With an adequate relactation technique and support, it is possible to help mothers and their babies to restart breastfeeding after they have switched to infant formula. This is vital in emergency.

**Feeding Infants Under Six Months in Emergencies: a Triage Approach to Decision-Making



** Added by Wellstart from The Emergency Nutrition Network: www.ennonline.net/ife/report/index.html