BACKGROUND INFORMATION FOR COMMUNICATIONS EXPERTS ON
INFANT & YOUNG CHILD FEEDING in EMERGENCIES

This document complements the brief guide, "How to Write and Talk About Infant and Young Child Feeding in Emergencies."

Natural and man-made disasters put lives at risk and infants[1] and young children are amongst the most vulnerable. Communication specialists have an important role in helping to protect infants and young children in emergencies. However, this is a complex area of work and this document aims to provide background information to empower communication experts to effectively write and talk about this important area of humanitarian work. Without you the messages that encourage aid that helps infants and young children and discourages harmful aid will not be heard. Your work is vitally important.

Why are infants vulnerable?

Infants have very specific nutritional needs and are born with an undeveloped immune system. For those who are breastfed, breastmilk provides clean water, safe food and immune support. This protects them from the worst of emergency conditions. The situation is very different for infants who are not breastfed. In an emergency, food supplies can be disrupted, there may be no clean water and hygiene is often poor. This makes infants who are not breastfed vulnerable malnutrition and infection. These infections can be fatal and in resource poor contexts non-breastfed children are 14 times more likely to die from pneumonia and 10 times more likely to die of diarrhea than breastfed children[2]. Because of this, whenever there is an emergency, it is important that infants who are already being exclusively breastfed continue to be, that breastfeeding is maximized for infants who are partially breastfed, and that infants who are not breastfed re-start breastfeeding or, if this is not possible, are provided with all the support needed to artificially feed as safely as possible.

How do media communications impact infant feeding and young child feeding in emergencies?

Media communications can play an important role in promoting infant survival by sharing information that supports breastfeeding continuance and targeted and supported artificial feeding of those infants that cannot be breastfed. However, the most common message that appears in media reports is that mothers cannot breastfeed because of the emergency and so donations of breastmilk substitutes (usually described as infant formula, milk or baby milk) should be sent[3]. These messages directly result in the uncontrolled donation of breastmilk substitutes by individuals, governments, NGOs and manufacturers. These products are often excessive in quantity, not where needed, unsuitable for use, and close to or past expiry. They are commonly distributed widely, including to breastfeeding women and without the other resources necessary for artificial feeding. As a result rates of breastfeeding decrease, artificial feeding increases, and providing resources to those infants who really cannot be breastfed is made more difficult[4]

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[1] Infants under the age of 1 year

[2] Black, Robert E et al. (2008). Maternal and child undernutrition: global and regional exposures and health consequences. The Lancet, Volume 371, Issue 9608, 243 – 260

[3] Gribble, K. D. (2013). Media messages and the needs of infants and young children after Cyclone Nargis and the WenChuan Earthquake. *Disasters, 37*(1), 80-100.

[4] Hipgrave, D. B., Assefa, F., Winoto, A., & Sukotjo, S. (2012). Donated breast milk substitutes and incidence of diarrhoea among infants and young children after the May 2006 earthquake in Yogyakarta and Central Java. *Public Health Nutrition, 15*(2), 307-315.

What do communications experts need to know to help infants and young children in emergencies?

<u>The recommendations for feeding children under 2 years of age</u>

The World Health Organisation and UNICEF[5] recommend that:

- *Mothers start breastfeeding their newborns within 1 hour of birth*
  Early breastmilk is concentrated and rich in anti-infective agents including antibodies and white cells that help to prevent and fight infection. Initiation of breastfeeding within this first hour could prevent 20% of all neonatal deaths in resource poor contexts[6].

- *Infants are exclusively breastfed for the first 6 months of life (no food or liquid other than breastmilk, not even water)*
  Breastmilk contains all the nutrients that infants need to grow healthily for their first 6 months. It also contains ingredients that help the baby's immune system to mature, make the infant more resistant to infection and to fight infection if it occurs. Where other food or liquid is given before 6 months it increases infection risk by reducing breastmilk intake and changing the environment in the intestine so that it is easier for pathogens to infect the infant. Infants are particularly vulnerable to respiratory tract infections and diarrhea and worldwide more than 700 000 deaths flow from lack of exclusive breastfeeding[7]. Exclusive breastfeeding is also important to mothers as it reduces their risk of anemia and increases child spacing. It also reduces their stress response, which helps them to be more responsive to their infants. In emergencies, breastfeeding women are in a position of strength as they are able to provide a safe, reliable and sustainable food to their baby while protecting their own health.

- *Mothers continue breastfeeding for two years or more, alongside the introduction of safe, nourishing, age appropriate complementary foods[8] at 6 months of age.*
  Once children reach 6 months of age, they require foods in addition to breastmilk. Complementary foods need to be of the appropriate quality, fed in the appropriate amount, hygienically prepared and responsively fed. The transition to solid foods is a time of vulnerability for infants and if this phase is not managed well malnutrition can result. Obtaining access to clean water, a hygienic environment for preparation and appropriate foods can be extremely challenging in emergencies. It may also be difficult for parents to find the time to prepare food and feed their children during an emergency. Malnutrition that occurs during this period, if not corrected, can cause damage that is extensive and irreversible. As the amount of complementary foods a child eats increases, breastfeeding should continue as it provides a source of safe food and water and multiple mechanisms of preventing infection.

It is only where infants cannot be breastfed that it is recommended that they be fed a suitable breastmilk substitute, such as an infant formula meeting Codex Alimentarius standards. The desirability of avoiding artificial feeding whenever possible is increased in emergencies because the risks to infants are greatly

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[5] WHO, & UNICEF. (2003). *Global Strategy for Infant and Young Child Feeding*. Geneva: WHO.

[6] Edmond, K. M., Zandoh, C., Quigley, M. A., Amenga-Etego, S., Owusu-Agyei, S., & Kirkwood, B. R. (2006). Delayed Breastfeeding Initiation Increases Risk of Neonatal Mortality. *Pediatrics, 117*(3), e380-386.

[7] Victora, C.G., Bahl, R., Barros, A.J.D., França, G.V.A., Horton, S., Krasevec, J., Murch, S., Sankar, M.J., Walker, N. and Rollins, N.C. (2016) 'Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect', *The Lancet*, **387**(10017), pp. 475-490

[8] Any food, whether industrially produced or locally-prepared, suitable as a complement to breastmilk or to a BMS, introduced after 6 completed months of age.

increased. Conditions associated with emergencies that make artificial feeding dangerous include: poor hygiene, lack of clean water, lack of fuel and inconsistent supplies of infant formula. Preparing formula feeds with an acceptable level of safety in a resource poor environment can be extremely time consuming, costly and difficult and when caregivers are already struggling with the meeting daily needs, it can be impossible to do. The difficulty of obtaining health care in an emergency when infants become ill, magnifies the risk. Even in populations where formula feeding is common, this practice becomes significantly more dangerous, sometimes catastrophically so.

How emergencies impact feeding practices

Feeding infants and young children can be very challenging for mothers and caregivers affected by an emergency for numerous reasons, such as:

- Social disruption, lack of health and sanitation infrastructure, food, water and fuel shortages make completing many aspects of daily life more difficult and time consuming so time and resources for feeding and caring for infants is limited.
- Family, social and health support may be disrupted and mothers and caregivers have less assistance.
- A lack of psychological wellbeing can impact a parent's ability to see and respond to their children's needs resulting in underfeeding.
- The false belief that stress impacts milk supply can reduce a mother's confidence in her ability to breastfeed her baby.
- Organisations may distribute infant formula and other milks to breastfeeding women.

As a result, emergencies often result in a decline in breastfeeding, an increase in artificial feeding (often carried out in a very unsafe way), and poor complementary feeding practices.

Disaster myths in infant and young child feeding in emergencies

There are two common disaster myths that undermine the survival of infants in emergencies: 1) that stress or a poor diet prevents women making enough breastmilk or makes their milk of poor quality; and 2) that sending donations of milk to an emergency will help infants. These disaster myths are present in the media in virtually every emergency.

The belief that stress or poor diet will negatively impact milk supply or composition is believed all over the world including by mothers who are affected by an emergency. Any journalist or communications expert in an emergency affected area will likely be told of mothers who have not been able to breastfeed because of stress or poor food. Such beliefs cannot be considered uncritically as even women who have an abundance of milk and a healthy and well-nourished baby may believe that their milk is insufficient or of poor quality. Furthermore, the physiology of milk production is unaffected by stress and milk production and composition are remarkably resilient even when diet is poor. However, many cultures understand that specific foods are necessary in order for mothers to make milk or that stress is bad for milk production and it is therefore often concluded that emergency affected women cannot possibly make enough milk, irrespective of the evidence to the contrary. In addition, infant behaviour can change as a result of the emergency and be interpreted as indicating that milk is insufficient. This if often because infants are upset by the distress of those around them and the change associated with the emergency. It can also be because, although stress does not impact milk production, it can slow the release of milk from the breast which can result in infants wanting to feed for longer or more frequently and sometimes being unsettled when feeding. Finally, woman may have a real low milk supply due to breastfeeding their infants less frequently. This may be because of difficulties associated with the emergency, because they believe they don't have milk or because they have fed their infants milk distributed to them in aid. Women in these circumstances need assistance to be able to continue or restart exclusive breastfeeding and support from breastfeeding counsellors and health workers is remarkably

successful in enabling them to do so. However, the repetition of the myth that stress prevents women from breastfeeding directly results in donations of infant formula which, rather than supporting maternal and infant health, undermines it.

The belief that donations of breastmilk substitutes help infants and young children is similarly widespread. It often arises directly from the myth that women cannot breastfeed because of the emergency (media often report that mothers are stressed and cannot breastfeeding so donations of milk are needed). It also comes from an understanding that there will be infants affected by the emergency who have been separated from their mothers or were formula dependent at the time the emergency occurred and need infant formula. There is a lack of awareness of the problems that donations cause and a lack of awareness that infant formula is only one of the resources that is required to enable the survival of infants that cannot be breastfed. Finally, there is confusion between the need for infant formula and the need for infant formula donations.

As with all disaster myths, those associated with infant and young child feeding, have credence because they make sense to people. However, countering these myths and providing messages that support aid that assists mothers, care givers and infants, saves lives.

What supports infants and young children's survival and development in emergencies?

Supporting infants and young children in emergencies involves supporting their mothers and care givers by:

- Prioritising mother and caregiver access to resources such as food, water and shelter
- Supporting maternal and caregiver wellbeing with psychological/psychosocial support
  Providing breastfeeding women with breastfeeding counseling and practical help to overcome feeding difficulties
- Preventing donations and uncontrolled distributions of baby foods and milk products including infant formula
- Providing targeted support to the mothers and caregivers of non-breastfed infants including infant formula, clean water, preparation and feeding implements, education and health monitoring

Enabling access to appropriate complementary foods for children from 6-23 monthsWhen this support is provided, women are able to continue breastfeeding, infants who cannot be breastfed are given the assistance needed to maximize their chances of survival and caregivers are able to manage the complementary feeding transition in a way that protects the health and development of their children.

Media reporting to support the wellbeing of infant and young children in emergencies

Analysis of media from past emergencies has found that reports commonly emphasise that infants are vulnerable in emergencies and that infections, particularly diarrheoa, pose a risk but that they fail to make a link between risk of infection and use of infant formula or other milks. Rather they present donations of milk as life saving. They also commonly describe women breastfeeding but fail to mention that breastfeeding protects infants and is a sign of resilience. Rather they use breastfeeding to illustrate weakness.

The media should be encouraged to report that:

- Babies are vulnerable in emergencies
- Babies fed anything other than breast-milk are particularly vulnerable in emergencies
- Use of infant formula or other milk products is dangerous in emergencies and should be avoided
- Breastfed babies are protected in emergencies
- Breastfeeding women are providing protection to their babies by breastfeeding
- Breastfeeding is a sign of strength and resilience
- The way to help babies survive an emergency is to help their mothers continue breastfeeding
- Breastfeeding support can enabled women who believe that their milk was insufficient to continue

breastfeeding

- With support mothers or caregivers are able to increase their milk supply or restart breastfeeding in emergencies
- Caregivers of artificially fed babies need intensive support
- Donations of infant formula are not needed and are harmful
- Aid organisations need help from the media immediately after the start of the emergency to prevent the arrival of donations of infant formula and other milk products
- Monetary donations will assist aid organisations in maximising the survival of infants

Key Contacts

Get information and resources on Infant and Young Child Feeding from The Emergency Nutrition Network (ENN). https://www.ennonline.net/mediahub

Report violations of the International Code of Marketing of Breastmilk Substitutes[9], including donations and uncontrolled distributions, to IBFAN (code@ibfan-icdc.org) and to UNICEF and WHO at country or regional level. WHO HQ: cah@who.int and nutrition@who.int;. UNICEF HQ: Nutrition@unicef.org

Direct questions regarding humanitarian coordination to the nutrition country cluster coordinator. Global Nutrition Cluster: gnc@unicef.org

Direct technical and coordination questions on Infant and Young Child Feeding in Emergencies to UNICEF at country level. www.unicef.org/where-we-work For similar questions in refugee settings, contact UNHCR at country level.

Key References

Operational Guidance on Infant Feeding in Emergencies. IFE Core Group, 2017. www.ennonline.net/operationalguidance-v3-2017

The International Code on the Marketing of Breastmilk Substitutes, WHO, 1981 and subsequent relevant World Health Assembly resolutions http://ibfan.org/the-full-code

Lifeline Production Manual. BBC Media Action. www.bbc.co.uk/mediaaction/publications-and-resources/brochures/lifeline-programming

Global Breastfeeding Collective. WHO and UNICEF, 2017. www.unicef.org/breastfeeding/

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[9] Any milks that are specifically marketed for feeding children up to 3 years of age (including infant formula, follow-up formula and growing-up milks) as well as other foods and beverages (such as baby teas, juices and waters) promoted for feeding a baby during the first 6 months of life.