

FACT SHEET ON FEEDING BABIES IN EMERGENCIES

Do you know that donations of baby foods could do more harm than good?

Please help to raise awareness and encourage an appropriate response to infant feeding in emergencies. Highlight the importance of protecting, promoting and supporting breastfeeding in emergency situations.

A RESPONSIBLE HELP CHAIN

"Infant feeding is part of the big picture. It is important for people to make informed decisions on programme responses and to understand the implications of each choice."

Lola Gostelow, former Livelihood Adviser to Save the Children Fund, United Kingdom, 1999

FEEDING BABIES IN EMERGENCIES

In emergency situations, such as the ones caused by the December 2004 tsunami, some **essential facts** regarding infant feeding must be considered:

1. There is no clean drinking water.
2. There is no sterile environment.
3. It is impossible to ensure cleaning and sterilisation of feeding utensils.
4. Babies and young children are already weak and traumatised.

Providing infant formula and other kinds of powdered milk or foods in such circumstances is dangerous and is likely to cause more harm than good.

It is better to **provide food to the mothers** of infants (babies less than one year old) and encourage them to breastfeed their babies. Breastfeeding will give comfort and antibodies and protect babies from infection.

Breastfeeding will also help mothers to relax under difficult circumstances and give them a sense of control, empowerment and satisfaction.

The following are common concerns about breastfeeding in emergencies:

"Malnourished mothers cannot breastfeed."

Fact: Malnourished mothers CAN breastfeed, but need some extra food, fluids and especially support to breastfeed the infant very frequently. "Feed the mother and let her feed the baby."

"The mother thinks she is not producing enough milk to feed her baby."

Fact: A mother produces enough milk to feed her baby if she breastfeeds frequently and as long as the baby wants at each feed. Her breasts may seem soft but will be producing milk.

"Stress prevents mothers from producing milk."

Fact: Stress does NOT prevent milk production, but may temporarily interfere with its flow. Create conditions for mothers that lessen stress as far as possible – a protected area, a mother-baby tent, reassurance from other women – and keep the child suckling so that milk flow returns.

"A mother should stop breastfeeding if the baby has diarrhoea."

Fact: Breastmilk helps a baby recover from diarrhoea. Do NOT stop breastfeeding if the baby has diarrhoea.

"Once stopped, breastfeeding cannot be started again."

Fact: If a mother stops breastfeeding she can usually restart. She needs assistance to encourage the baby to suckle. It usually takes a week or more to start again. The process is called relactation.

“When a woman has been traumatised, she cannot breastfeed.”

Fact: Experience of trauma does not spoil breastmilk or the ability to breastfeed, but all traumatised women need special attention and support. There may be traditional practices that restore a woman’s readiness to breastfeed after trauma.

In emergency and relief situations breastfeeding is of critical importance: **it saves babies' lives**. Artificial feeding in these situations is difficult and increases the risk of malnutrition, disease and infant death. The basic resources needed for artificial feeding such as clean water and fuel are scarce in emergencies. Transport and adequate storage conditions of breastmilk substitutes (BMS) cause additional problems. Furthermore, BMS donated as humanitarian aid often end up in the local market and can have a negative influence on feeding practices in the host community.

Knowing the damage artificial feeding can do, most relief agencies are reluctant to provide breastmilk substitutes. However, evidence shows there are still many cases of unsolicited donations of BMS to emergency sites; donations that were not well targeted, coordinated, monitored, and that are usually labelled with a commercial brand. Such donations not only stand in the way of healthy infant feeding practices, but also give infant formulae companies an opportunity for free advertising and access to new markets.

“In refugee camps and other crisis affected areas, the health risks of bottle feeding and breastmilk substitutes are dramatically increased, due to poor hygiene, crowding and limited water and fuel. These conditions contribute to diarrhea and, at worst, to higher infant mortality rates.”

BFHI News, UNICEF, Sept/Oct. 1999

“Fundraising appeals portray messages which suggest that mothers cannot breastfeed. This has a damaging effect on the public perception of breastfeeding and plays into the hands of the companies.”

Source: Crucial Aspects of Infant Feeding in Emergency and Relief Situations, IBFAN-GIFA, 1996

In emergencies, breastfeeding is the optimal and safest feeding method.

The 47th World Health Assembly urges member states: “to exercise extreme caution when planning, implementing or supporting emergency relief operations, by protecting, promoting and supporting breastfeeding for infants.”

Resolution WHA 47.5 (1994)

In emergency relief operations breastfeeding should be protected, supported and promoted. Any donated supplies of baby foods may be given **only under strict conditions**:

- if the baby has no access to breastmilk (e.g. orphans),
- the supply must be continued for as long as the baby needs it,
- the supply is not used to promote the brand.

To minimize the risk of illness it is vital to follow these recommended procedures:

- Donations of formula and other baby foods, bottles and teats, should be controlled.
- Breastmilk substitutes should only be given to babies who really need them and the supply should continue for as long as the baby needs it (until maximum one year age or until breastfeeding is re-established).
- Breastmilk substitutes should NEVER be part of a general distribution of food.
- Bottles and teats should NEVER be distributed and their use should be discouraged. CUP FEEDING should be encouraged instead.

More detailed conditions and recommendations are found at: www.ennonline.net

Policies and Guidelines DO Exist

Even if there is to date no single common UN policy on infant feeding in emergencies, there is substantial consensus on the need to protect breastfeeding in emergencies. Some of the basic documents to guide policy makers, programme managers and field workers are:

Infant and Young Child Feeding in Emergencies, operational guidance for emergency and relief staff and policy-makers. Document prepared by the inter-agency working group on infant feeding in emergencies and supported by a number of key relief organisations, 2001. Request a copy from Fiona O'Reilly, Emergency Nutrition Network: foreilly@tcd.ie.

Infant Feeding in Emergencies. Policy, Strategy and Practice. Report of the Ad Hoc Group on Infant Feeding in Emergencies. May 1999. ENN, Emergency Nutrition Network: <http://www.ennonline.net>

Policy of the UNHCR related to the Acceptance, Distribution and Use of Milk Products in Feeding Programs in Refugee Settings. UNHCR, 1989.

The [International Code of Marketing of Breast-milk Substitutes](#) and relevant WHA Resolutions.

More information and a complete range of sources on this issue is provided on: <http://www.ibfan.org/english/activities/emergencies/ife04.html> and on <http://www.ennonline.net>.

The following text is adapted from CARE's instructions on

Use of Milks and Breastmilk Substitutes in Emergency Situations

[Note: BMS or breastmilk substitutes means infant formula and other milks and foods (usually powdered) given to babies. They require mixing with clean water in sterile utensils and are commonly bottle-fed, which makes them dangerous in emergency situations.]

Control the use of BMS in emergency settings

Procurement and use of breastmilk substitutes at emergency sites must be strictly controlled.

1. Large-scale donations should be systematically refused.
2. Unsolicited donations should be stored centrally by the agency responsible for infant feeding.
3. Only unbranded (generic) infant formula should be used. (If only branded formula is available and must be used, cover the brand name with black felt pen or with tape.)

Distribution and use of BMS

BMS should NEVER be distributed to all women or families. It should be given to health workers or others in charge of helping mothers with babies.

1. BMS, bottles and teats should never be **donated** to the health care system; if really necessary, they should be **purchased**.
2. If BMS is given for a particular baby (e.g. orphan), the supply must be continued until breastfeeding is reestablished (e.g. mother of another baby) or until the baby is at least 6 months old.
3. Make sure the mother or caretaker has fuel, water and equipment for preparation and knows how to prepare formula correctly.
4. Allow no distribution of feeding bottles and artificial teats. Give cups and explain cup feeding. Cups can easily be washed; bottles cannot.

Determine which babies need BMS

1. Give BMS only to mothers or caretakers of babies 0-6 months old.
2. If the mother is severely ill or temporarily incapacitated or absent for an extended period of time and no wet nurse or other source of breastmilk can be found; or if the mother is dead.
3. If the baby is solely dependent on BMS at the start of the emergency.

Orphans and unaccompanied children

1. Establish a place (house or tent) where orphans and babies whose mothers are lost can be taken care of.
2. Put a health worker in charge of that place.
3. Make sure that BMS are consumed on site, under supervision.
4. Do not use feeding bottles and teats. Show caretakers how to use cup feeding.

Handling other milks

Other milks can be distributed (e.g. to older children) if they are not given as a single commodity but are mixed with a milled staple food.

Dangers of providing BMS in a general ration

1. BMS are difficult to prepare and use safely in situations where water quality and sanitation are poor.
2. There is a high risk of bacterial growth in milk products mixed with contaminated water.
3. If a mother who is breastfeeding is allowed to give her baby BMS supplied through a general ration, this reduces the baby's suckling, resulting in decreased maternal milk production.
4. The baby thus loses the immunological protection of his mother's milk and is at risk of food insecurity, malnutrition and death if the supply of BMS is disrupted.

Support ongoing breastfeeding of the majority of babies

1. Women who have been breastfeeding before the emergency will be able to continue breastfeeding with appropriate support.
2. Feed the lactating mother (both food and water).
3. Provide support to re-establish breastfeeding as soon as possible for any mother who has stopped breastfeeding during the emergency.
4. Encourage and support mothers delivering after the emergency situation began to breastfeed **exclusively**.

For additional assistance, contact CARE's Special Advisor: Mary Lung'aho mlungaho@aol.com.
(website: www.care.org)

Rehydration Project - <http://rehydrate.org> – has lots of useful information and links on how to treat diarrhoea and how to rehydrate dehydrated children.

These recommendations on **Infant Feeding in Emergencies** have been condensed from various sources by IBFAN/ICDC Penang, as an immediate response to the emergencies created by the 26 December 2004 tsunamis. Readers are advised to refer to policies and guidelines cited above.

11 Jan. 2005 (Contact: ibfanpg@tm.net.my)

The **International Baby Food Action Network (IBFAN)** is a worldwide network of organizations in the field of infant and young child feeding. The network aims to eliminate unethical and irresponsible marketing practices that lead to the misuse of infant foods and consequent ill health and malnutrition.

The **International Code Documentation Centre (ICDC)** was established by IBFAN to lead activities aimed at the implementation of the International Code of Marketing of Breastmilk Substitutes adopted by the member states of the World Health Organization in 1981 to protect, promote and support breastfeeding.