

Infant and Young Child Feeding in Emergencies

Journal of Human Lactation

1–4

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DOI: 10.1177/0890334414537118

jhl.sagepub.com



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Keywords

breastfeeding, breast milk, emergencies, emergency preparedness, human milk, infant feeding, lactation

Position Statement

Infants and young children are vulnerable in any emergency. It is the position of the International Lactation Consultant Association that supporting their wellbeing should be a priority of governments, aid agencies, health workers, and members of the public. Such support should include assistance for exclusive and continued breastfeeding, safe artificial feeding where breastfeeding or provision of human milk is not possible, and appropriate complementary feeding for all infants and young children.

Introduction

Emergencies can be catastrophic events, either acute or long-term, that result in significant destruction, loss of life, and/or threat to life.¹ Emergencies encompass natural disasters as well as those resulting from war, acts of terrorism, or civil disturbance, and they occur in both developed and developing countries. In emergency situations, infants and young children can account for a large percentage of deaths. Published total mortality rates for children younger than 1 year in emergencies are as high as 53%.^{2–5} The most common causes of death for infants and young children in emergencies are diarrheal disease and respiratory tract infections, with malnutrition commonly associated with both illnesses.^{2–6} Following recommended infant feeding practices, including breastfeeding, helps protect infants from disease and death.

Background

The World Health Organization recommends that infants be exclusively breastfed from within an hour of birth to 6 completed months of age, and then continue to be breastfed, with the addition of an appropriate type and amount of complementary foods, for up to 2 years or more.⁷ Where infants and young children are not fed in line with these recommendations, morbidity and mortality rates are elevated. It has been estimated that exclusive and continued breastfeeding with appropriate complementary feeding could prevent nearly 20% of all deaths of children younger than 5 years worldwide.⁸

Human milk works actively and passively to protect infants from infections.⁹ It also provides a secure and safe source of food and water. Infants who are not breastfed are deprived of the disease-prevention and infection-fighting actions of human milk, and the development of their immune system is impaired.¹⁰ Without the external immune support provided by human milk, infants are immune compromised.¹¹ In addition, breast milk substitutes (BMS), including artificial baby milks (ABM), can act as vectors of infection via intrinsic contamination, contaminated water, poor hygiene, and improper cleaning of feeding implements as well as alter the intestinal environment in a way that leads to increased risk of infection.¹² Babies who do not receive human milk are more likely to be infected with pathogens, more likely to be malnourished, and more likely to suffer from multiple bouts of more serious illnesses leading to death.¹³

High morbidity and mortality rates have been observed in artificially fed infants in emergencies.^{14–16} A diarrheal outbreak during a flood in Botswana in 2005–2006 resulted in the death of more than 500 infants. Babies who were artificially fed were 30 times more likely to present for hospital treatment with diarrhea than babies who were breastfed.¹⁵ Death rates were similarly elevated in artificially fed infants. For example, in a Botswana village, no breastfed infants died, whereas 30% of artificially fed infants perished.¹⁷ Even in developed countries, the method of infant feeding can affect infant and young child survival in an emergency, as a breakdown in infrastructure places caregivers in a situation akin to that of a developing country.¹⁸

Aid in the form of donations of ABM and other milks is common in emergencies.^{19–25} Such donations are often close to or past expiration dates, of the wrong type, in the wrong

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Date submitted: February 28, 2014; Date accepted: May 4, 2014.

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place, and labeled in the wrong language.^{14,16,20} Emergencies can be used by ABM manufacturers as a promotional opportunity.²⁶ The magnitude of donations often vastly exceeds what is required. For example, during the Balkans crisis of the 1990s, it was estimated that 40% of the 3500 tons of aid that the North Atlantic Treaty Organization (NATO) transported into Macedonia in the first weeks of the emergency was baby food.²⁰ Distributions of ABM and other milks are often made irrespective of whether infants are breastfed, do not include the other resources necessary to artificially feed, and increase rates of artificial feeding, diarrhea, and therefore infant death.^{14,16} After the 2006 Yogyakarta earthquake in Indonesia, 75% to 80% of households with babies received donations of BMS despite low levels of artificial feeding prior to the emergency.¹⁶ Rates of diarrhea in infants in households that received these donations more than doubled as a result.¹⁶

In line with international recommendations, donation of BMS should be avoided and any donations that arrive should be placed under the control of a designated agency.²⁷ Refusal of donations does not mean that ABM should not be supplied to the caregivers of infants who cannot breastfeed. These needs should be met by purchasing ABM suitable for their needs and distributing it properly with appropriate support. Purchase of ABM not only ensures the supply of a suitable type and amount of ABM but also encourages appropriate distribution, since the cost of purchase comes out of organizational budgets.

Recommendations and Strategies

- Use the following international documents as the basis for emergency preparedness planning and delivery of nutritional aid to infants and young children:
 - *Operational Guidance on Infant and Young Child Feeding in Emergencies*²⁷;
 - *The Sphere Handbook: Humanitarian Charter and Minimum Standards in Disaster Response*²⁸; and
 - *International Code of Marketing of Breast-milk Substitutes*²⁹ and subsequent relevant World Health Assembly (WHA) resolutions.³⁰
- Develop emergency plans for governments and aid organizations that take into account the nutritional needs of infants in emergencies and ensure that individuals are appropriately trained in the plans and associated policies.
- Assess the number of infants and young children affected by an emergency, feeding practices, availability of BMS, and infant feeding support within the affected community to determine the priorities for emergency response.
- Follow priorities for support:
 - Assist women who are breastfeeding.
 - Encourage and assist mothers who have weaned to relactate, if possible.
 - Explore wet nursing from an already lactating mother, or relactation from another woman, for infants who do not have mothers.
 - Support artificial feeding only where mothers have weaned and relactation is not possible or wet nursing is not acceptable.
- Support breastfeeding women to continue exclusive breastfeeding, to resume exclusive breastfeeding, or to continue breastfeeding in emergencies. Women may be concerned that stress or lack of food may affect their ability to make milk and require reassurance that this is not the case. They may also receive donations of ABM and not understand the risk that use of this product poses to their infants. They will also encounter breastfeeding challenges that are unrelated to the emergency. Methods of providing this support include provision of peer counseling or breastfeeding support groups, access to health professionals in clinics or evacuation centers, structural supports that keep mothers and infants together, and use of the media to promote key messages.
- Support safe artificial feeding where breastfeeding is not possible.
 - Conduct individualized assessment and support for artificial feeding.
 - Provide caregivers of artificially fed infants with all the resources necessary to feed their babies safely, including ABM, clean water, fuel, feeding and cleaning implements, education, and health care.
 - Feed infants with a cup instead of a bottle (unless unlimited hot water for cleaning is available).
- Consider donations of expressed milk or milk sharing from a local source in limited circumstances, such as in an evacuation center where refrigeration is available or where a wet nurse is available but feeding expressed milk is more culturally acceptable. Breast pumps should not be used unless unlimited hot water is available. International donations of expressed breast milk in emergencies are not appropriate; past experience of such donations has been that they detract from the provision of aid.
- In relation to the risk posed by transmission of human immunodeficiency virus (HIV) via wet nursing, the dangers of artificial feeding in the emergency environment should be weighed against the risk of HIV transmission.³¹
- Discourage donations and indiscriminate distribution of ABM and other milk products in an emergency. Donations that do occur should be collected together to prevent inappropriate distribution.
- Give priority to pregnant women and all those caring for infants to access resources such as food, fuel, water, and shelter.
- Ensure that foods appropriate for complementary feeding are available.

- Mobilize media outlets to support appropriate infant and young child feeding.
 - Alert mothers, caregivers, and the public about the importance of exclusive breastfeeding and the risks associated with artificial feeding.
 - Help mothers find support for safe infant feeding practices.
 - Discourage the donation of ABM and other milk products²⁶ and encourage financial contributions, instead, to support the actual needs of the community.

Role of the IBCLC

The International Board Certified Lactation Consultant (IBCLC) is a health care professional with an international certification in lactation. International Board Certified Lactation Consultants specialize in the clinical management of breastfeeding based on consistent standards of worldwide, evidence-based clinical competencies. As experts in lactation, IBCLCs advocate for mothers, babies, and the breastfeeding relationship and are in a unique position to promote, protect, and support breastfeeding with governments, health care professionals, disaster preparedness and response organizations, caregivers, and families. To support the wellbeing of infants and young children in emergencies, IBCLCs should:

- Advocate with governments and organizations to ensure that the needs of infants and young children (including infant and young child nutrition) are specifically and appropriately addressed in national and local emergency policies and plans.
- Develop partnerships with academe, global, regional, national, and local pediatric and other professional medical groups to ensure that the international standards are applied in preservice curricula, in professional society codes of conduct, and in their membership.
- Undertake training in emergency preparedness with local emergency organizations as well as specialized training in infant feeding in emergencies.
- Follow the guidelines of the *Operational Guidance on Infant and Young Child Feeding in Emergencies*,²⁷ *The Sphere Handbook: Humanitarian Charter and Minimum Standards in Disaster Response*,²⁸ and the *International Code of Marketing of Breast-milk Substitutes* and subsequent WHA resolutions.^{29,30}
- Train emergency workers, health care providers, and other caregivers on the principles of infant and young child feeding in emergencies.
- Provide education to pregnant women, new mothers, and caregivers about breastfeeding as an emergency preparedness activity and the resources needed to prepare for an emergency if an infant is artificially fed.

- Provide professional support to mothers and other caregivers of infants affected by an emergency. Help mothers maintain or increase milk production.
- Address breastfeeding problems that might arise.
- Facilitate wet nursing, relactation, or induced lactation as appropriate. Assist mothers with expressing breast milk.
- Educate caregivers about safe artificial feeding and cup feeding.
- Address infant feeding questions and concerns of mothers and caregivers.
- Educate media outlets to broadcast messages that support appropriate infant and young child feeding in the lead-up to and during an emergency.
- Foster support through local mother-to-mother breastfeeding support organizations and other local resources, make referrals to medical providers, and collaborate with local resources in emergency preparedness and response.
- Actively discourage donations of ABM, other milk products, bottles and teats, breast pumps, and international donations of expressed breast milk in emergencies.
- Actively encourage monetary donations to organizations with infant and young child feeding in emergency programs.

Acknowledgments

The authors wish to thank Hope Allyson Dwiggin, MLS, for her contributions and the ILCA review committee, including Robbie Albert-Jones, BA, AS, IBCLC, Patricia Alfieri, RN, IBCLC, Julia Amos, MPH, IBCLC, Sharon Economides, LM, CPM MMid, IBCLC, Lisa Mandell, MBA, IBCLC, Becky Spencer, PhD, RN, IBCLC, and Linda Wieser, MA, IBCLC.

Authors' Note

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Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the authorship and/or publication of this article.

Funding

The authors received no financial support for the authorship and/or publication of this article.

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