



Infant and Young Child Feeding in Emergencies

**Operational
Guidance for
Emergency Relief
Staff and
Programme
Managers**

**Developed by the
IFE Core Group**

Version 2.1 – February 2007

Background

The Operational Guidance was first produced by the Interagency Working Group on Infant and Young Child Feeding in Emergencies in 2001. This Working Group included members of the Infant and Young Child Feeding in Emergencies (IFE) Core Group, an inter-agency collaboration concerned with the development of training materials and related policy guidance on infant and young child feeding in emergencies. Version 2.0 was produced in May 2006 by members of the IFE Core Group (UNICEF, WHO, UNHCR, WFP, IBFAN-GIFA, CARE USA, Fondation Terre des hommes and the Emergency Nutrition Network (ENN)), co-ordinated by the ENN. This version (2.1, February 2007) includes a restructured Section 6.0, to clarify areas based on field experiences on implementation. The IFE Core Group gratefully acknowledges all those who advised on and contributed to this and earlier editions.

Mandate

This document assists with the practical application of the *Guiding Principles for Feeding Infants and Young Children in Emergencies* (WHO, (1)), the *Policy and Strategy Statement on Infant Feeding in Emergencies* (ENN, (2)), and the *International Code of Marketing of Breastmilk Substitutes and subsequent relevant World Health Assembly (WHA) resolutions* (3). It complies with the Sphere Project (4) and other international emergency standards^a. It is also a contribution that aims to assist decision-makers, planners and donors to meet their responsibilities set out in the *UNICEF/WHO Global Strategy on Infant and Young Child Feeding*^b, in *Article 24 of the Convention of the Rights of the Child*^c and the Call for Action contained in the *Innocenti Declaration 2005* on Infant and Young Child Feeding welcomed unanimously by the 2006 WHA^d.

Aim

The aim of this document is to provide concise, practical (but non technical) guidance on how to ensure appropriate infant and young child feeding in emergencies. A number of elements are also applicable in non-emergency settings.

Target groups

The Operational Guidance focuses especially on infants and young children under 2 years of age and their caregivers, recognising their particular vulnerability in emergencies.

It is intended for emergency relief staff and programme managers of all agencies working in emergency programmes, including national governments, United Nations (UN) agencies, national and international

non-governmental organisations (NGOs), and donors. It applies in emergency situations in all countries, and extends to non-emergency situations, particularly in the interest of emergency preparedness.

Layout

Beginning with a summary of key points, this document is organised into six sections of practical steps, with numbered references (*Section 7*), key contacts (*Section 8*) and definitions (*Section 9*) included at the end. Supporting information on how to implement the guidance is referenced throughout the document (*1-30*). Advocacy materials for the media and general public can be obtained in (*2,8*). The assessment and management of severely malnourished infants and young children are not addressed in this document (*see 9 and 24b for sources of this information*).

Feedback

The IFE Core Group welcomes feedback on this document and its field implementation. In addition, we are establishing agency support for the Operational Guidance. We define agency support where the Operational Guidance is in line with your own agency policies and/or is in line with the thinking within your agency and is a position you would like to work towards.

You can register agency support for the Operational Guidance and view the current list of supporters online at <http://www.enonline.net> or contact: IFE Core Group c/o Emergency Nutrition Network, 32, Leopold Street, Oxford, OX4 1TW, UK.

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Careful attention to infant and young child feeding and support for good practice can save lives. Preserving breastfeeding, in particular, is important not just for the duration of any emergency, but may have lifelong impacts on child health and on women's future feeding decisions. Every group of people has customs and traditions about feeding infants and young children. It is important to understand these and work with them sensitively while promoting best practice.

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KEY POINTS

1. Appropriate and timely support of infant and young child feeding in emergencies (IFE) saves lives.
2. Every agency should endorse or develop a policy on IFE. The policy should be widely disseminated to all staff, agency procedures adapted accordingly and policy implementation enforced (*Section 1*).
3. Agencies should ensure the training and orientation of their technical and non-technical staff in IFE, using available training materials (*Section 2*).
4. Within the United Nations (UN) Inter-agency Standing Committee (IASC) cluster approach to humanitarian response, UNICEF is likely the UN agency responsible for co-ordination of IFE in the field. Also, other UN agencies and NGOs have key roles to play in close collaboration with the government (*Section 3*).
5. Key information on infant and young child feeding needs to be integrated into routine rapid assessment procedures. If necessary, more systematic assessment using recommended methodologies could be conducted (*Section 4*).
6. Simple measures should be put in place to ensure the needs of mothers, infants and young children are addressed in the early stages of an emergency. Support for other caregivers and those with special needs, e.g. orphans and unaccompanied children, must also be established at the outset (*Section 5*).
7. Breastfeeding and infant and young child feeding support should be integrated into other services for mothers, infants and young children (*Section 5*).
8. Foods suitable to meet the nutrient needs of older infants and young children must be included in the general ration for food aid dependent populations (*Section 5*).
9. Donated (free) or subsidised supplies of breastmilk substitutes (e.g. infant formula) should be avoided. Donations of bottles and teats should be refused in emergency situations. Any well-meant but ill-advised donations of breastmilk substitutes, bottles and teats should be placed under the control of a single designated agency (*Section 6*).
10. The decision to accept, procure, use or distribute infant formula in an emergency must be made by informed, technical personnel in consultation with the co-ordinating agency, lead technical agencies and governed by strict criteria (*Section 6*).
11. Breastmilk substitutes, other milk products, bottles and teats must never be included in a general ration distribution. Breastmilk substitutes and other milk products must only be distributed according to recognised strict criteria and only provided to mothers or caregivers for those infants who need them. The use of bottles and teats in emergency contexts should be actively avoided (*Section 6*).

PRACTICAL STEPS

1 Endorse or Develop Policies

- 1.1 Each agency should, at central level, endorse or develop a policy^e that addresses:
- Infant and young child feeding in emergencies, stressing the protection, promotion and support of breastfeeding and adequate, timely complementary feeding.
 - Procurement, distribution and use of breastmilk substitutes (BMS), milk products, commercial baby foods and infant feeding equipment, and compliance with the International Code and relevant World Health Assembly (WHA) Resolutions.
- 1.2 Policies should be widely disseminated, integrated with other agency policies, and procedures at all levels adapted accordingly.

2 Train Staff

- 2.1 Each agency should ensure **basic orientation** for all relevant staff (at national and international level) to support appropriate infant and young child feeding in emergencies. This includes recognising that the cultural expectations and personal experiences of staff may present barriers to understanding and implementing suggested practice and therefore need to be addressed. *The following materials are recommended for training: the individual agency policy where it exists, this Operational Guidance and the Interagency Infant Feeding in Emergencies Modules I and II (24a and 24b).*
- 2.2 In addition, health and nutrition programme staff will require technical training using, for example, the Interagency Infant Feeding in Emergencies Module II (24b) that includes orientation on available technical guidelines (7-21), the WHO/UNICEF *Breastfeeding Counselling: A training course (26) and relactation resources (16).*
- 2.3 Specific expertise on breastfeeding counselling and support or on training for infant feeding counselling could be sought at **national level** via the Ministry of Health, UNICEF, WHO, La Leche League, or IBFAN groups (International Baby Food Action Network) and at **international level** via ILCA (the International Lactation Consultancy Association)^f, WHO, UNICEF or IBFAN-Geneva Infant Feeding Association (GIFA)^g.

3 Co-ordinate Operations

3.1 Within the United Nations (UN) Inter-agency Standing Committee (IASC) cluster approach to humanitarian response, UNICEF is likely the UN co-ordinating agency for IFE in the field. In situations where UNICEF is not present, another agency with the necessary expertise should be designated the coordinating agency. In an emergency operation, the following level of co-ordination is required:

- policy co-ordination: individual agency policies and national policies should provide the basis for agreeing the specific policy to be adopted for the emergency operation
- intersectoral co-ordination: agencies should contribute to relevant sectoral co-ordination meetings (health/nutrition, food aid, water and sanitation and social services) to ensure the application of the policy
- development of an action plan for the emergency operation that identifies agency responsibilities and mechanisms for accountability
- dissemination of the policy and action plan to operational and non-operational agencies including donors and the media (e.g. to ensure that aid shipments and donations are in compliance with the International Code and this Operational Guidance).
- evaluation of the success of infant and young child feeding interventions once the emergency operation is over.

3.2 Capacity building and technical support requirements among operational partners should be evaluated and addressed by the co-ordinating body. Unless additional funding can be secured to meet these identified requirements, co-ordination and quality of infant and young child feeding interventions will be severely compromised.

4 Assess and Monitor

- 4.1** To determine the priorities for action and response, **key information** on infant and young child feeding should be obtained during assessments. Assessment teams should include at least one person who has received basic orientation on infant feeding in emergencies (see 2.1). Assessments should be co-ordinated and results shared through the co-ordinating body.
- 4.2** Key information to obtain in the early stages through routine **rapid assessments** and by informed observation and discussion includes:
- demographic profile, specifically noting whether the following groups are under or over-represented: women, infants and young children, pregnant women, unaccompanied childrenⁿ
 - predominant feeding practices, including early initiation of exclusive breastfeeding, and whether wet-nursing is traditionally practised
 - conspicuous availability of BMS, milk products, bottles and teats and breast pumps, in emergency-affected population and commodity pipeline
 - reported problems feeding infants and young children, especially breastfeeding problems and poor access to appropriate infant complementary foods
 - observed and pre-crisis approaches to feeding orphaned infants
 - security risks to women and children.
- 4.3** If rapid assessment indicates that further assessment is necessary, **additional key information** should be obtained as part of a thorough analysis of the causes of malnutrition (1).
- 4.3.1** Use **qualitative methods** to:
- assess availability of appropriate foods for infant complementary feeding in the general ration and in targeted feeding programmes
 - assess the health environment, including water quantity and quality, fuel, sanitation, housing, facilities for food preparation and cooking
 - assess support offered by health facilities providing antenatal, delivery, postnatal and child care

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- identify any factors disrupting breastfeeding
 - identify and assess capacity of potential support givers (breastfeeding mothers, trained health workers, trained counsellors, experienced women from the community)
 - identify key decision-makers at household, community and local health facility level who influence infant and young child feeding practices
 - Identify cultural barriers to suggested use of relactation, expressing breast milk or wet nursing.

4.3.2 Use quantitative methods or existing routine health statistics to estimate:

- numbers of accompanied and unaccompanied infants and young children under two years (data stratified by age for 0-<6 months, 6-<12 months, 12-<24 months), children aged 24-<60 months (2-5 years), and pregnant and lactating women
- nutritional adequacy of the food ration
- morbidity and mortality of infantsⁱ
- infant and young child feeding practices, including feeding technique (cup/bottle; methods of encouraging infants and young children with complementary feeding) (*details on standard indicators and methodology for data collection are given in 28, 29 and 30*)
- pre-crisis feeding practices (from existing data sourcesⁱ) and any recent changes
- BMS, cup, feeding bottle and teat availability, management and use from informed observation, discussion and monitoring (*an example of a monitoring form is available in 24b*).

4.3.3 Maintain records for future analysis and share experiences and practice with other agencies and networks to help inform and improve programming and policies (*see Section 7.0 for contacts*).

5 Protect, Promote and Support Optimal Infant and Young Child Feeding with Integrated Multi-Sectoral Interventions

5.1 Basic interventions

- 5.1.1** Ensure that the **nutritional needs of the general population** are met, giving special attention to the access to commodities suitable as complementary foods for young children^f. In situations where nutritional needs are not met, advocate for a general ration, appropriate in quantity and quality. In situations where supplementary foods are available but sufficient food for the general population is not, consider pregnant and lactating women as a target group.
- 5.1.2** Where nutrient rich foods are lacking and until they become available, multiple micronutrient supplements should be given to pregnant and lactating women, and to children aged 6-59 months^l. However, in **malaria endemic areas**, *routine* supplementation with iron and folic acid containing preparations is *not recommended* in infants and young children. The safety of iron preparations administered through home fortification of complementary foods for infants and young children, i.e. powders, crushable tablets, and fat-based spreads, is uncertain because of the lack of sufficient research and experience. Current recommendations therefore emphasise treating malaria as well as iron deficiency according to existing guidelines^m.
- 5.1.3 Complementary feeding** for older infants (over six months) and young children (12-<24 months) in emergencies may comprise:
- basic food-aid commodities from general ration with supplements of inexpensive locally available foods
 - micronutrient fortified blended foods, e.g. corn soya blend, wheat soya blend, (as part of general ration, blanket or supplementary feeding)
 - additional nutrient-rich foods in supplementary feeding programmes.
- 5.1.4** In all situations, special attention should be given to the nutritional value of the food ration distributed to infants and young children whose particular nutritional requirements are often not covered by the general ration. Nutrient dense foods for children, whether fortified or non-fortified, should be chosen taking into account possible micronutrient deficiencies.

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- 5.1.5** Where a population is dependent on food aid, a micronutrient fortified food should also be included in the general ration for older infants and young children^k. Ready to Use Therapeutic Foods (RUTF) are formulated for the management of malnutrition and are not an appropriate infant complementary food (*see definitions*).
- 5.1.6** Before distributing commercial baby foods (*see definitions*) in an emergency, the cost compared to local foods of similar nutritional value and the risk of undermining traditional complementary feeding practices should be considered. As a rule, relatively expensive commercial baby foods have no place in emergency relief.
- 5.1.7** Ensure demographic breakdown at registration of children under two years with specific age categories: 0-<6 months, 6-<12 months, 12-<24 months and children aged 24-<60 months (2-5 years), to identify the size of potential beneficiary groups.
- 5.1.8** Establish registration of new-borns within two weeks of delivery, to ensure timely access to additional household ration entitlement for the lactating mother and to extra breastfeeding support (particularly for exclusive breastfeeding) if required.
- 5.1.9** In the case of refugees and displaced populations, ensure rest areas in transit and establish, where culturally appropriate, secluded areas for breastfeeding. Screen new arrivals to identify and refer any mothers or infants with severe feeding problems and refer for immediate assistance. Establish and foster mother-to-mother support, if culturally appropriate.
- 5.1.10** Ensure easy and secure access for caregivers to water and sanitation facilities, food and non-food items.

5.2 Technical interventions

- 5.2.1** Train health/nutrition/community workers to promote, protect and support optimal infant and young child feeding as soon as possible after emergency onset. Knowledge and skills should support mothers/caregivers to maintain, enhance or re-establish breastfeeding using relactation, including possible use of a breastfeeding supplementer (2, 18, 24b) if culturally appropriate and if facilities exist to ensure hygienic use (*see Section 6.2*). If breastfeeding by the natural mother is impossible, make appropriate choices among alternatives (wet-nursing, breastmilk from milk bank, unbranded (generic) infant formula, locally purchased commercial infant formula, home-modified milks) (2 and 24b).

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- 5.2.2 **Integrate** breastfeeding and infant and young child feeding training and support at all levels of health care: reproductive health services^o including ante and post-natal care, family planning, traditional birth attendants and maternity services (the *Baby Friendly 10 Steps to Successful Breastfeeding* should be an integral part of maternity services in emergencies (2)), immunisation, growth monitoring and promotion, curative services, selective feeding programmes (supplementary and therapeutic) and community health services. This may involve working with all local agencies to make sure they are doing this.
- 5.2.3 Set up areas for mothers/caregivers requiring individual support with breastfeeding and infant and young child feeding. Ensure that support for artificial feeding is provided in an area distinct from support for breastfeeding. Special attention should be given to newly responsible caregivers, and special arrangements with supervision made for women who might be building up a breastmilk supply and using both artificial feeding and breastfeeding during the relactation process.
- 5.2.4 Establish services to provide for the immediate nutritional and care needs of orphans and unaccompanied infants and young children.
- 5.2.5 Provide the necessary information and support to ensure the correct preparation of unfamiliar infant complementary foods provided through food programmes and to ensure that all food can be prepared hygienically. Help caregivers to support young children to eat the food available to them.
- 5.2.6 Emphasise primary prevention of HIV through such means as provision of condoms.
- 5.2.7 Where HIV status of the mother is unknown or she is known to be HIV negative, she should be supported to breastfeed her infant according to optimal infant and young child feeding recommendations (see *definitions*)^o.
- 5.2.8 Women who are HIV positive should be supported to make an informed decision about infant feeding. For most women in emergencies, replacement feeding or early cessation of breastfeeding (see *definitions*) is unlikely to be an **Acceptable, Feasible, Affordable, Sustainable and Safe (AFASS)** option. The risks of infection or malnutrition from using breastmilk substitutes are likely to be greater than the risk of HIV transmission through breastfeeding. Therefore, early initiation and exclusive breastfeeding for the first six

completed months, and the continuation of breastfeeding into the second year of life are likely to provide the best chance of survival for infants and young children in emergencies. The decision should be based on a woman's individual circumstances but should take greater consideration of the health services available and the counselling and support she is likely to receive. Mixed feeding, that is, breastfeeding and giving breastmilk substitutes, is the worst option, as it carries a higher risk of transmission than exclusive breastfeeding.

In all circumstances, because of the existing research and experience gaps, consult relevant senior staff for up-to-date advice. (See refs 6, 7, 13, 14, and 25. For most up-to-date scientific evidence, refer to: http://www.who.int/child-adolescenthealth/NUTRITION/HIV_infant.htm)

6 Minimise the Risks of any Artificial Feeding

In emergencies, targeting and use, procurement, management and distribution of BMS, milk products, bottles and teats should be strictly controlled based on technical advice, and comply with the International Code and all relevant WHA Resolutions (4). Section 6.1 sets the position on handling donations of BMS and the responsibility of agencies that supply BMS to others. Sections 6.2-6.4 outline how to control [purchased] supplies of BMS.

6.1 Handling BMS donations and supplies

- 6.1.1** In emergencies, donations of BMS are not needed and may put infants lives at risk. This information should be provided to potential donors (including governments and the military) and the media, both in emergency preparedness and particularly during the early phase of an emergency response.
- 6.1.2** Soliciting or accepting unsolicited donations of BMS should be avoided. Instead, interventions to support artificial feeding should budget for the purchase of BMS supplies along with other essential needs to support artificial feeding, such as fuel, cooking equipment, safe water and sanitation, staff training, and skilled personnel.
- 6.1.3** Any donations of BMS, milk products, bottles and teats that have not been prevented should be collected by a designated agency, preferably from points of entry to the emergency area, under the guidance of the co-ordinating body. These should be stored until UNICEF or the designated nutrition co-ordinating agency, together

with the government if functional, develops a plan for their safe use or their eventual destruction.

6.1.4 An agency should only supply another agency/institution with BMS if both are working as part of the nutrition and health emergency response (*see definitions*) and the provisions of the Operational Guidance and Code are met (*see 6.2 - 6.4*). Both the supplying agency and the implementing agency/institution are responsible for ensuring the provisions of the Operational Guidance and Code are met, and continue to be met for the duration of the intervention.

6.2 Establish and implement criteria for targeting and use

6.2.1 Infant formula should only be targeted to infants requiring it, as determined from assessment by a qualified health or nutrition worker trained in breastfeeding and infant feeding issues. Assessment should always explore the potential for wet nursing or donated expressed breastmilk.

6.2.2 Example criteria for temporary or longer term use of infant formula include: absent or dead mother, very ill mother, relactating mother until lactation is re-established, HIV positive mother who has chosen not to breastfeed and where AFASS criteria are met (*see 5.2.8*), infant rejected by mother, mother who was artificially feeding her infant prior to the emergency, rape victim not wishing to breastfeed (*see 24a and 24b*). Care should be taken that no stigma is attached to choosing to use infant formula.

6.2.3 Use of infant formula by an individual caregiver should always be linked to education, one-to-one demonstrations and practical training about **safe preparation**⁹, and to follow-up at the distribution site and at home by skilled health workers. **Follow-up** should include regular monitoring of infant weight at the time of distribution (no less than twice a month).

6.2.4 When the use of infant formula is indicated, UNICEF or the designated nutrition coordinating agency should **train** and support agencies in training staff and mothers on how to prepare and use the infant formula safely in a given context.

6.2.5 Availability of fuel, water and equipment for safe preparation of BMS at a household level should always be carefully considered prior to implementing a household-based programme. In circumstances where these items are unavailable and where safe preparation and use of infant formula cannot be assured, on-site

reconstitution and consumption (may be referred to as 'wet' feeding) should be initiated. When conditions are deemed suitable for artificial feeding, ongoing assessment is needed to ensure that conditions continue to be met.

6.3 Control of procurement

6.3.1 Donor agencies considering funding the supply of BMS and milk products should ensure that the provisions of the Operational Guidance and the Code are met by the implementing agency. This may have cost implications in order to meet associated needs (*see 6.1.2 and 6.3.3, for examples*). Interventions to support non-breastfed infants should always include a component to protect breastfed infants. Equal consideration should be given to funding support of breastfeeding mothers as an emergency intervention that might be entirely skills rather than commodity based.

6.3.2 The type and source of BMS to purchase should be considered:

- Generic (unbranded) infant formula is recommended as first choice, followed by locally purchased infant formula. Home-modified animal milk should only be used as temporary measure and as a last resort in infants under 6 months of age^a.
- Infant formula should be manufactured and packaged in accordance with the Codex Alimentarius standards and have a shelf-life of at least 6 months on receipt of supply.
- The type of infant formula should be appropriate for the infant, including their age. Specially formulated milks, so called 'follow-up' or 'follow-on' milks, are not necessary'. 'Growing up milks', often marketed for children over the age of 12 months, are also not necessary.

In refugee settings and in accordance with UNHCR policy^s and this Operational Guidance, UNHCR will only source infant formula after review and approval by its HQ technical units. UNICEF does not supply infant formula.

6.3.3 Labels of procured infant formula should be in an appropriate language and should adhere to the specific labelling requirements of the International Code (21). These include: products should state the superiority of breastfeeding, indicate that the product should be used only on health worker advice, and warn about health hazards; there should be no pictures of infants or other pictures idealising the use of infant formula. Purchased products may need to be relabelled prior to distribution, which will likely have considerable cost and time implications. (*An example of a generic label is available in 24a and online at <http://www.enonline.net>*).

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- 6.3.4** Procurement should be managed so that **infant formula supply** is always adequate and continued for as long as the targeted infants need it - until breastfeeding is re-established or until at least 6 months of age, and formula or some other source of milk and/or animal source food after that during the complementary feeding period (6-24 months of age)¹.
- 6.3.5** The use of **bottles and teats** should be actively discouraged in emergency contexts, due to the high risk of contamination and difficulty with cleaning. Use of cups (without spouts) should be actively promoted. The use of supplementary suckling feeding devices and breast pumps should only be considered where it is possible to clean them adequately.
- 6.3.6** **Therapeutic milk** is not an appropriate BMS, and should only be used in the management of severe malnutrition in accordance with current international guidelines (9).

6.4 Control of management and distribution

- 6.4.1** Where criteria for the use of BMS are met (*see 6.2*), infant formula *purchased* by agencies working as a part of the nutrition and health emergency response (*see definitions*) may be used in or distributed by the healthcare system². However, distribution should be carried out in a discrete manner and not as a part of the general food aid to prevent spillover.
- 6.4.2** BMS, milk products, bottles and teats should never be part of a general or blanket distribution. Dried milk products should be distributed only when pre-mixed with a milled staple food and should not be distributed as a single commodity (5). Dried milk powder may only be supplied as a single commodity to prepare therapeutic milk (using a vitamin mineral premix such as therapeutic CMV) for on-site therapeutic feeding (9).
- 6.4.3** In accordance with the International Code, provision of single tins (samples) of BMS to mothers should not occur, unless that tin is part of an assured continuous supply of formula (*see 6.3.4*).
- 6.4.4** In accordance with the International Code, there should be no promotion of BMS at the point of distribution, including displays of products, or items with milk company logos and BMS supplies should not be used as a sales inducement.

7 Key Contacts

- 7.1** **Violations** of the International Code should be reported to the WHO at the country/regional level. For field details, contact WHO at the HQ level, email: cah@who.int and nutrition@who.int. Violations can also be reported to the International Code Documentation Centre (ICDC) in Malaysia, email: ibfanpg@tm.net.my, or Fundacion LACMAT in Argentina, email: fundacion@lacmat.org.ar or Italian Code Monitoring Coalition (ICMC) in Milan, email: icmc@ibfanitalia.ie. To request **training** on the Code, contact ICDC in Malaysia, email: ibfanpg@tm.net.my
- 7.2** Any issues relating to infant and young child feeding or coordination of IFE during an emergency should be addressed to UNICEF at country/regional level. For field details, contact UNICEF at HQ level, email: pdpimas@unicef.org
- 7.3** Any issues regarding the UNHCR policy on the acceptance, distribution and use of milk products in feeding programmes in refugee settings should be reported to UNHCR at a regional and headquarters level. Contact: Technical Support Service at UNHCR: HQTS01@unhcr.org
- 7.4** To feedback on the provisions of the Operational Guidance or to share field experiences on its implementation, contact the IFE Core Group c/o The Emergency Nutrition Network (ENN). Contact: ife@enonline.net

- ^a i) Food and Nutrition Handbook. World Food Programme. 2000.
- ii) Handbook for Emergencies. United Nations High Commissioner for Refugees. 1999, second edition. Third edition due out (2006).
- iii) Technical Notes: Special Considerations for Programming in Unstable Situations. UNICEF Programme Division and Office of Emergency Programmes, January 2001.
- iv) Revised MSF Guidelines (forthcoming 2006).
- v) Management of Nutrition in Major Emergencies. WHO 2000.
- vi) IFRC Handbook for Delegates.
- vii) UNICEF Emergency Field Handbook. A Guide for UNICEF staff. July 2005.
- viii) UNICEF Core Commitments for Children in Emergencies. March 2005.
- ^b Global Strategy for Infant and Young Child Feeding, UNICEF/WHO, WHO, 2003
- ^c A/RES/44/25, Convention on the Rights of the Child. 61st plenary meeting, 20 November 1989. <http://www.un.org/documents/ga/res/44/a44r025.htm>
- ^d <http://innocenti15.net/declaration.htm>. Welcomed by the WHO 59th World Health Assembly. 4 May 2006. A59/13. Provisional agenda item 11.8. WHA 59.21
- ^e A recommended policy framework can be found in reference (2), section 7.
- ^f ILCA: email: ilca@erols.com
- ^g GIFA: email: info@gifa.org
- ^h As a guide, in a developing country population with a high birth rate, the expected proportions are: infants 0-6 months: 1.35%; 6-<12 months: 1.25%; children 12-<24 months: 2.5%; children 0-< 60 months (5 years): 12.5%; pregnant and lactating women: 5-7% depending on the average duration of breastfeeding. N.B. These figures are approximations and will depend on birth rate and infant mortality rate. Source: Personal communication, ENN with Department of Child & Adolescent Health and Development/WHO. 2006
- ⁱ Assessment of malnutrition in infants is problematic given the NCHS growth reference data available to date (April 2006); however a new WHO growth standard, based on data from breastfeeding populations, is now available. See <http://www.who.int/childgrowth/>. Assessment of diarrhoea in breastfed infants is problematic.
- ^j Multi-indicator cluster surveys: www.childinfo.org/; Demographic Health Surveys: www.macrout.com/dhs/; UNICEF statistical data by country: www.unicef.org/status/; Health Information Network for Advanced Planning: www.hinap.org/; WHO global database on malnutrition: www.who.int/nutgrowthdb/; nutrition related data for Africa: www.africanutrition.net
- ^k Food and nutrition needs in emergencies, UNHCR, UNICEF, WFP, WHO, 2003. <http://whqlibdoc.who.int/hq/2004/a83743.pdf>
- ^l Preventing and Controlling Micronutrient Deficiencies in people affected by the Asian Tsunami. Joint Statement by WHO and UNICEF. WHO 2005. For further information, contact: Dr Bruno de Benoist. Nutrition for Health and Development (NHD), WHO e-mail: debenoistb@who.int <http://www.who.int/>
- ^m Iron supplementation of young children in regions where malaria transmission is intense and infectious diseases highly prevalent. WHO Statement. http://www.who.int/child-adolescent-health/New_Publications/CHILD_HEALTH/WHO_statement_iron.pdf
- ⁿ Reproductive health care services should be initiated in the early stages of all emergencies. See Reproductive Health in Refugee Situations: an InterAgency Field Manual, UNHCR 1999.
- ^o WHA resolution 57.14 (2004):
Point 2. URGES Member States, as a matter of priority:
(3) to pursue policies and practices that promote:

- (i) promotion of breastfeeding in the light of the United Nations Framework for Priority Action on HIV and Infant Feeding and the new WHO/UNICEF Guidelines for Policy-Makers and Health-Care Managers.
- ^p Technical WHO guidelines for the safe preparation of powdered infant formula will be available soon at <http://www.who.int/foodsafety/en/>.
 - ^q Home-modified animal milk for replacement feeding: Is it feasible and safe? Discussion Paper Prepared for HIV and Infant Feeding Technical Consultation, 25-27 October 2006.
 - ^r WHA Res. 39.28 (1986).
 - ^s Policy of the UNHCR on the acceptance, distribution and use of milk products in refugee settings (2006). Available in English and French online at <http://www.enonline.net>. Contact: ABDALLAF@unhcr.org or HQT501@unhcr.org
 - ^t For guidance on when infant formula may be used for 6-12 months age-group, see Feeding the non-breastfed child 6-24 months age, p14 (11)
 - ^u Distribution of donated BMS in any part of the healthcare system is a violation of the International Code (WHA Resolution 47.5 (1994)).
 - ^v WHO HIV and Infant Feeding Technical Consultation Consensus Statement. Held on behalf of the Inter-agency Task Team (IATT) on Prevention of HIV Infections in Pregnant Women, Mothers and their Infants. Geneva, October 25-27, 2006

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(2) Infant Feeding in Emergencies: Policy, Strategy and Practice. Report of the Ad Hoc Group on Infant Feeding in Emergencies, 1999. <http://www.enonline.net>

(3) The International Code of Marketing of Breast-milk Substitutes. WHO, 1981. Full Code and relevant WHA resolutions are at: <http://www.ibfan.org/English/resource/who/fullcode.html>
http://www.who.int/nut/documents/code_english.PDF

(4) The SPHERE Project: Humanitarian Charter and Minimum Standards in Disaster Response. 2004.
<http://www.sphereproject.org/handbook>

The SPHERE Project, P.O. Box 372, 1211 Geneva 19, Switzerland

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(6) WHO HIV and Infant Feeding Technical Consultation Consensus Statement. Held on behalf of the Inter-agency Task Team (IATT) on Prevention of HIV Infections in Pregnant Women, Mothers and their Infants. Geneva, October 25-27, 2006.

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(7) Technical WHO guidelines for the safe preparation of powdered infant formula will be available soon at

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8.2 Advocacy

(8) Infant feeding in emergencies. Do you know that your generous donations of breastmilk substitutes could do more harm than good? IBFAN-Gifa, Wemos, June 2001, 2nd edition.

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(10) Guiding Principles for Complementary Feeding of the Breastfed Child. PAHO/WHO, Division of Health Promotion and Protection/ Food and Nutrition Program, Washington, DC, USA, 2003. Full text in English: http://www.who.int/child-adolescent-health/New_Publications/NUTRITION/guiding_principles.pdf

(11) Feeding the non-breastfed child 6-24 months age.

WHO/FCH/CAH/04.13,

Full text in English: http://www.who.int/child-adolescent-health/New_Publications/NUTRITION/WHO_FCH_CAH_04.13.pdf

(12) Nutrition Feeding in Exceptionally Difficult Circumstances

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(13) HIV and infant feeding. Guidelines for decision makers.

UNICEF, UNAIDS, WHO, UNFPA, 2003. http://www.who.int/child-adolescent-health/publications/NUTRITION/ISBN_92_4_159122_6.htm

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(15) Feeding in Emergencies for Infants under Six Months: Practical Guidelines. K Carter, OXFAM Public Health Team, 1996. Available from: OXFAM, 274 Banbury Road, Oxford OX2 7DZ, England.

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Office. www.who.dk/nutrition/infant.htm

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(19) Reproductive Health in Refugee Situations: an Interagency Field Manual. UNHCR, 1999.

(20) Resources from LINKAGES

Facts for Feeding:

- (i) Recommended Practices to Improve Infant Nutrition during the First Six Months (July 2004)
- (ii) Guidelines for Appropriate CF of Breastfed Children 6-24m (April 2004)
- (iii) BM: A Critical Source of Vit A for Infants and Young Children (October 2001)
- (iv) Birth, Initiation of Breastfeeding, and the First Seven Days after Birth (July 2003)

Frequently Asked Questions:

- (i) Breastfeeding and HIV/AIDS (April 2004)
- (ii) Breastmilk and Maternal Nutrition (July 2004)
- (iii) Exclusive Breastfeeding: The Only Water Source Young Infants Need (June 2004)

Also: Mother-to-Mother Support for Breastfeeding (April 2004)

The Lactational Amenorrhea Method (September 2001).

Most of these documents are available in English, French, Spanish (sometimes Portuguese). Source: LINKAGES, Academy for Educational Development,

e-mail: linkages@aed.org<http://www.linkagesproject.org>.

(21) Protecting Infant Health. A Health Workers' Guide to the International Code of Marketing of Breastfeeding Substitutes, 9th edition. IBFAN, 1999. Available from IBFAN-GIFA, P.O. Box 157, 1211 Geneva 19, Switzerland. e-mail: info@gifa.org

(22) Cup Feeding information. BFHI News, May/June 1999, UNICEF. e-mail: pubdoc@unicef.org

(23) Risks and Realities: FAQs on breastfeeding & HIV/AIDS. In: The Health Exchange, April 2001. Available from International Health Exchange, e-mail: info@ihe.org.uk

8.4 Training Materials

(24a) Module 1 Infant Feeding in Emergencies for emergency relief staff, WHO, UNICEF, LINKAGES, IBFAN, ENN and additional

contributors, November 2001.

<http://www.enonline.net/ife/module1/index.html>

(24b) Module 2 for health and nutrition workers in emergency situations. Version 1.0. December 2004. ENN, IBFAN, Terre Des hommes, UNICEF, UNHCR, WHO, WFP.

<http://www.enonline.net/ife/module2/index.html>

Both Modules I and II are available in print or on CD-ROM from the Emergency Nutrition Network (ENN), 32, Leopold Street, Oxford, OX4 1TW, UK. Tel: +44 (0)1865 324996, Fax: +44 (0)1865 324997: e-mail: ife@enonline.net, download from <http://www.enonline.net>

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(26) See Breastfeeding Counselling at: A Training Course, materials online <http://www.who.int/child-adolescenthealth/publications/NUTRITION/BFC.htm>

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WHO/CDD/SER/91.14, WHO, Geneva.

http://www.who.int/childadolescenthealth/New_Publications/NUTRITION/WHO_CDD_SER_91.14.pdf

(29) Indicators for assessing health facility practices that affect breastfeeding. WHO/CDR/93.1

http://whqlibdoc.who.int/hq/1993/UNICEF_SM_93.1.pdf

(30) Tool Kit for Monitoring and Evaluating Breastfeeding Practices and Programs. Wellstart International Expanded Promotion of Breastfeeding Program (EPB), September 1996. e-mail: linkages@aed.org; website: www.linkagesproject.org or available at <http://www.enonline.net>

Breastmilk substitute (BMS): any food being marketed or otherwise represented as a partial or total replacement for breastmilk, whether or not suitable for that purpose.

Note: In practical terms, foods may be considered BMS depending on how they are marketed or represented. These include infant formula, other milk products, therapeutic milk, and bottle-fed complementary foods marketed for children up to 2 years of age and complementary foods, juices, teas marketed for infants under 6 months.

Commercial baby foods: industrially produced and marketed infant complementary foods, such as branded jars or packets of dried, semi-solid or solid foods.

Complementary feeding (previously called 'weaning' and more accurately referred to as '**timely complementary feeding**'): the child receives age-appropriate, adequate and safe solid or semi-solid food in addition to breastmilk or a breastmilk substitute.

Exclusive breastfeeding: an infant receives only breastmilk and no other liquids or solids, not even water, with the exception of drops or syrups consisting of vitamins, mineral supplements or medicines.

Follow-on/follow-up formula: These are specifically formulated milk products defined as "a food intended for use as a liquid part of the weaning diet for the infant from the sixth month on and for young children" (Codex Alimentarius Standard 156-19871). Providing infants with a follow-on/follow-up formula is not necessary (See WHA Resolution 39.28 (1986) (para 3 (2))). In practice, follow-on formulae may be considered a BMS depending on how they are marketed or represented for infants and children under 2 years and fall under the remit of the International Code.

Note: Acceptable milk sources after six months include expressed breastmilk (heat-treated if the mother is HIV-positive), full-cream animal milk (cow, goat, buffalo, sheep, camel), Ultra High Temperature (UHT) milk, reconstituted evaporated (but not condensed) milk, and fermented milk or yoghurt. (See ref (11)).

Healthcare system: governmental, non-governmental or private institutions or organisations engaged, directly or indirectly, in healthcare for mothers, infants and pregnant women; and nurseries or childcare institutions. It also includes health workers in private practice. It does not include pharmacies or other established sales outlets.

Home-modified animal milk: a breastmilk substitute for infants up to six months prepared at home from fresh or processed animal milk, suitably diluted with water and with the addition of sugar and micronutrients.

Note: Acceptable milk sources include full cream animal milk (liquid or powdered), Ultra High Temperature (UHT) milk, or reconstituted evaporated (but not condensed) milk. These milks must be adapted/modified according to specific recipes, and micronutrients should also be given (24b). It is difficult to obtain nutritional adequacy with such milks, even with added micronutrients. Thus, home-modified animal milks should only be used as a last resort to feed infants when there is no alternative.

Infant: a child aged less than 12 months.

Infant complementary food: any food, whether industrially produced or locally-prepared, used as a complement to breastmilk or to a breastmilk substitute and that should be introduced after six months of age.

Note: The term 'infant complementary food' is used in the Operational Guidance to distinguish between complementary food referred to in the context of infant and young child complementary feeding, and complementary food used in the context of Food Aid (i.e. foods, beyond the basic food aid commodities, given to an affected population to diversify their dietary intake and complement the ration, e.g. fresh fruit and vegetables, condiments or spices. Infant complementary foods should not be marketed for infants under six (completed) months.

Infant feeding equipment: bottles, teats, syringes and baby cups with or without lids and/or spouts.

Infant formula: a breastmilk substitute formulated industrially in accordance with applicable Codex *Alimentarius* standards (developed by the joint FAO/WHO Food Standards Programme). *Commercial* infant formula is infant formula manufactured for sale, branded by a manufacturer and may be available for purchase in local markets. *Generic* infant formula is unbranded and is not available on the open market, thus requiring a separate supply chain.

International Code: The International Code of Marketing of Breast-Milk Substitutes, adopted by the World Health Assembly (WHA) in 1981, and subsequent relevant WHA resolutions, referred to here as 'the International Code' (4). The aim of the International Code is to contribute to the provision of safe and adequate nutrition for infants, by the protection and promotion of breastfeeding, and by ensuring the

proper use of breastmilk substitutes when these are necessary, on the basis of adequate information and through appropriate marketing and distribution. The Code sets out the responsibilities of the manufacturers and distributors of breast-milk substitutes, health workers, national governments and concerned organisations in relation to the marketing of breastmilk substitutes, bottles and teats.

Milk products: dried whole, semi-skimmed or skimmed milk; liquid whole, semi-skimmed or skimmed milk, soya milks, evaporated or condensed milk, fermented milk or yogurt.

Nutrition and health emergency response: For an agency to be part of the nutrition and health response, they must have staff actively involved in the healthcare system (see definition) who are responsible for targeting the BMS, monitoring the infants, and ensuring that the supply of BMS is continued for as long as the infants concerned need it.

Optimal infant and young child feeding: early initiation (within one hour of birth) of exclusive breastfeeding, exclusive breastfeeding for the first six months of life, followed by nutritionally adequate and safe complementary foods while breastfeeding continues for up to two years of age or beyond.

Ready to Use Therapeutic Food (RUTF): RUTF are specialised products for use in the management of severe malnutrition, typically in community and home based settings. They may be locally produced or manufactured at national or international level.

Note: Infants do not have the reflex to swallow solid foods before 6 months and should never be given RUTF before that age. Also, marketing or otherwise representing RUTF as a partial or total replacement for breastmilk in infants under six months of age would mean they would fulfil the definition of a breastmilk substitute and come under the remit of the International Code.

Replacement feeding: Feeding infants who are receiving no breastmilk with a diet that provides the nutrients infants need until the age at which they can be fully fed on family foods. During the first six months, replacement feeding should be with a suitable breastmilk substitute. After six months the suitable breastmilk substitute should be complemented with other foods.

Note: This terminology is used in the context of HIV and AIDS and infant feeding. The current UN recommendation (6) states that the most appropriate infant feeding option for a HIV-infected mother should continue to depend on her individual circumstances, including her health

status and the local situation, but should take greater consideration of the health services available and the counselling and support she is likely to receive. Exclusive breastfeeding is recommended for HIV-infected women for the first 6 months of life unless replacement feeding is acceptable, feasible, affordable, sustainable and safe for them and their infants before that time. When replacement feeding is acceptable, feasible, affordable, sustainable and safe, avoidance of all breastfeeding by HIV-infected women is recommended.

Supplementary foods are commodities intended to supplement a general ration and used in emergency feeding programmes for the prevention and reduction of malnutrition and mortality in vulnerable groups.

Supplies: In the context of the International Code, supplies means quantities of a product provided for use over an extended period, free or at a low price, for social purposes, including those provided to families in need. In the emergency context, the term supplies is used generally to describe quantities of a product irrespective of whether they have been purchased, subsidised or obtained free of charge.

Therapeutic milk: Term commonly used to describe formula diets for severely malnourished children, e.g. F75 and F100. Strictly speaking, these are not milks – F100 comprises only 42% milk product, and F75 less so. Therapeutic milk may be pre-formulated or prepared from dried skimmed milk (DSM), oil and sugar, with the addition of a vitamins and minerals complex.

Note: Therapeutic milks should not be used to feed infants and young children who are not malnourished. The standard dilution of F100 has too a high a solute load for infants under six months of age. Therapeutic milks contain no iron and longterm use will lead to iron deficiency anaemia.

World Health Assembly (WHA) resolutions: see definition for International Code.

Young child: a child aged 12-<24 months (12-23 completed months). This age group is equivalent to the definition of toddler (12-23 months) as defined in the World Health Report 2005, p.155 (<http://www.who.int/whr/2005/en/>).

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