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INFANT & YOUNG CHILD FEEDING IN EMERGENCIES

(IYCF-E)

and

WHY IT MATTERS

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Session Objectives

- Define optimal infant and young child feeding practices and relevance in emergencies
- Identify key policy guidance for IYCF-E & WV commitments
- Describe key multi-sectoral and technical interventions on IYCF-E
- Appreciate importance of strong coordination, communication and orientation/training
- Locate sources of resources and shared experiences

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What is IYCF-E?

- IYCF-E concerns the protection and support of **safe** and **appropriate (optimal) feeding** for **infants** and **young children** in all types of emergencies, wherever they happen in the world
- Promotion and protection of **breastfeeding**
- Protection of non-breastfed infants by minimising the risks of artificial feeding
- The **well-being of mothers** (nutritional, mental, and physical health) is critical to the well-being of their children.

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Why Does IYCF-E Matter?

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Infants and young children are the MOST vulnerable

Pakistan, post-earthquake

USA, Hurricane Katrina

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Even in healthy populations

child morbidity

and crude mortality

can increase by

20% in two weeks

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In emergencies, rates of

child mortality

can soar from

2 to 70 times higher than average

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Emergencies can happen ANYWHERE

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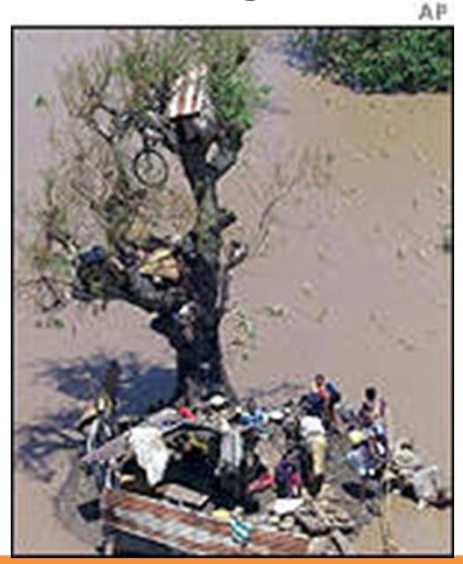
Nepal Earthquake 2015

Philippines Typhoon Haiyan, 2013

IYCF-E is relevant in all emergencies

Asia Tsunami, 2004



Mozambique

USA Hurricane, 2005

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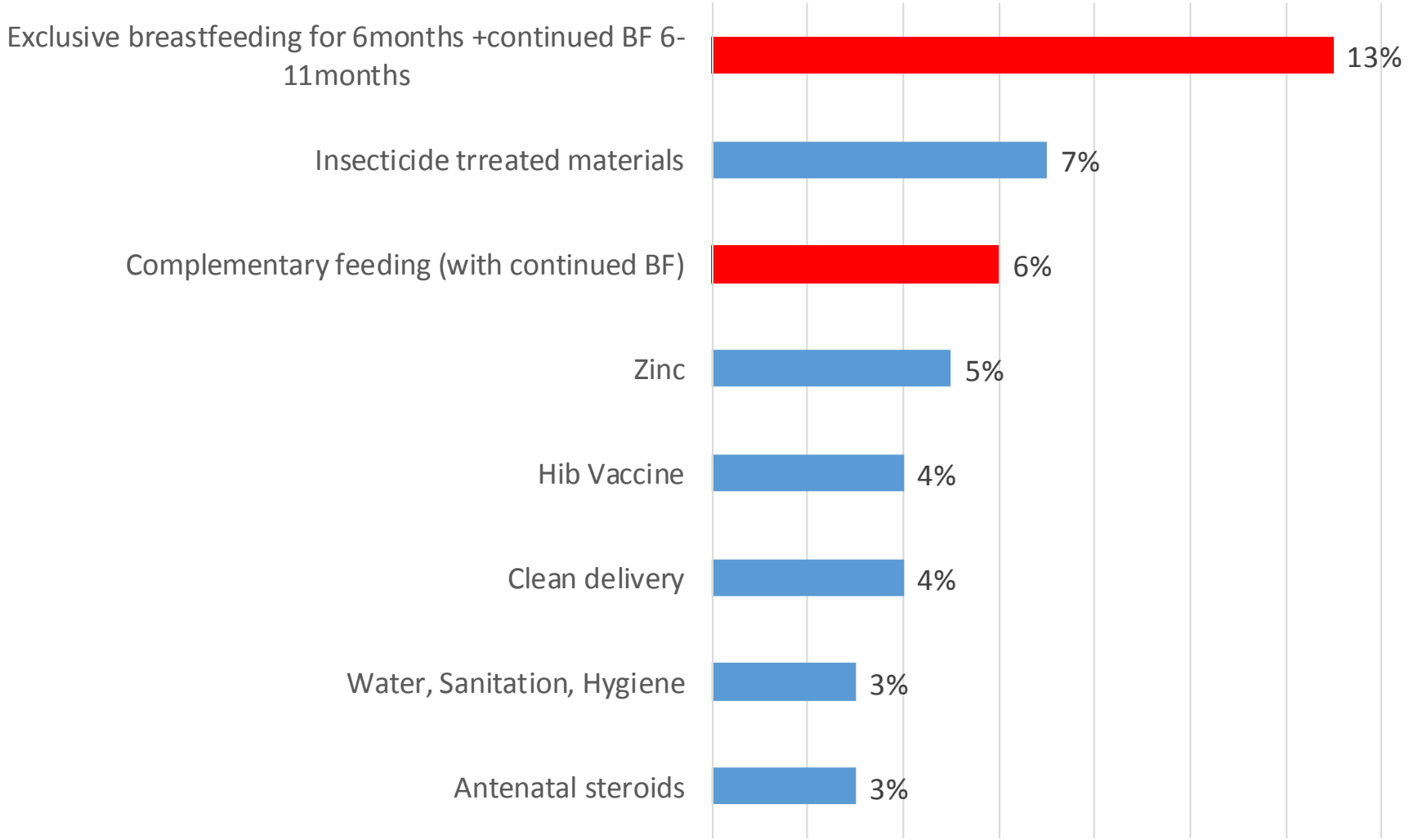
Importance of IYCF in Child Survival



Source: Lancet Child Survival Series 2003

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50 times greater risk of being hospitalised with diarrhoea if artificially fed than breastfed

AND **10.5 times more likely to DIE** if not breastfed

Sources: Botswana 2006 and Multi-centre Data

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WHY?

Why is there high infant morbidity and mortality due to artificial feeding in emergencies compared to breastfeeding?

WHY? 1. Due to contamination of infant formula

WHY? 2a. Due to lack of water

Water for sale in Pakistan, post-earthquake

- A 3-month-old bottle-fed baby needs 1 litre of water per day to mix with the formula powder.
- Another 2 litres are needed to sterilize the bottles and teats.

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WHY? 2b. Due to contamination of water

(poor water and sanitation conditions)

Bangladesh

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Not helped by overcrowded conditions and people on the move

Banda Aceh, Indonesia, post-tsunami

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WHY? 3. Due to mode of feeding

(bottles and teats difficult to sterilise, esp. with lack of water, fuel, equipment, etc.)

Bangladesh, post Cyclone Sidr, 2007

Pakistan, post-earthquake

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WHY? 4. Due to infant formula being prepared incorrectly (over or under-diluted)

Mother with donated formula, worried it was going to run out. Lebanon, conflict, 2006

Mothers in rural Bangladesh where there are high illiteracy rates

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WHY? 5. Due to lack of supporting resources (e.g. fuel, cleaning equipment, cooking pots, time constraints)

People have lost cooking pots and other supplies after floods

People queuing for relief items after cyclone in Bangladesh, 2007

WHY? 6. Due to a change in circumstances

Even if artificial feeding before the crisis was ‘safe’, the emergency **removes those conditions**, along with the mother’s ability to **safely prepare and procure** formula.

Mothers formula feed in the Super Dome, USA post-Hurricane Katrina.

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WHY? 7. Infant formula does not have the protective properties of breast milk

Artificial feeding – avoid like landmines, but deal with it

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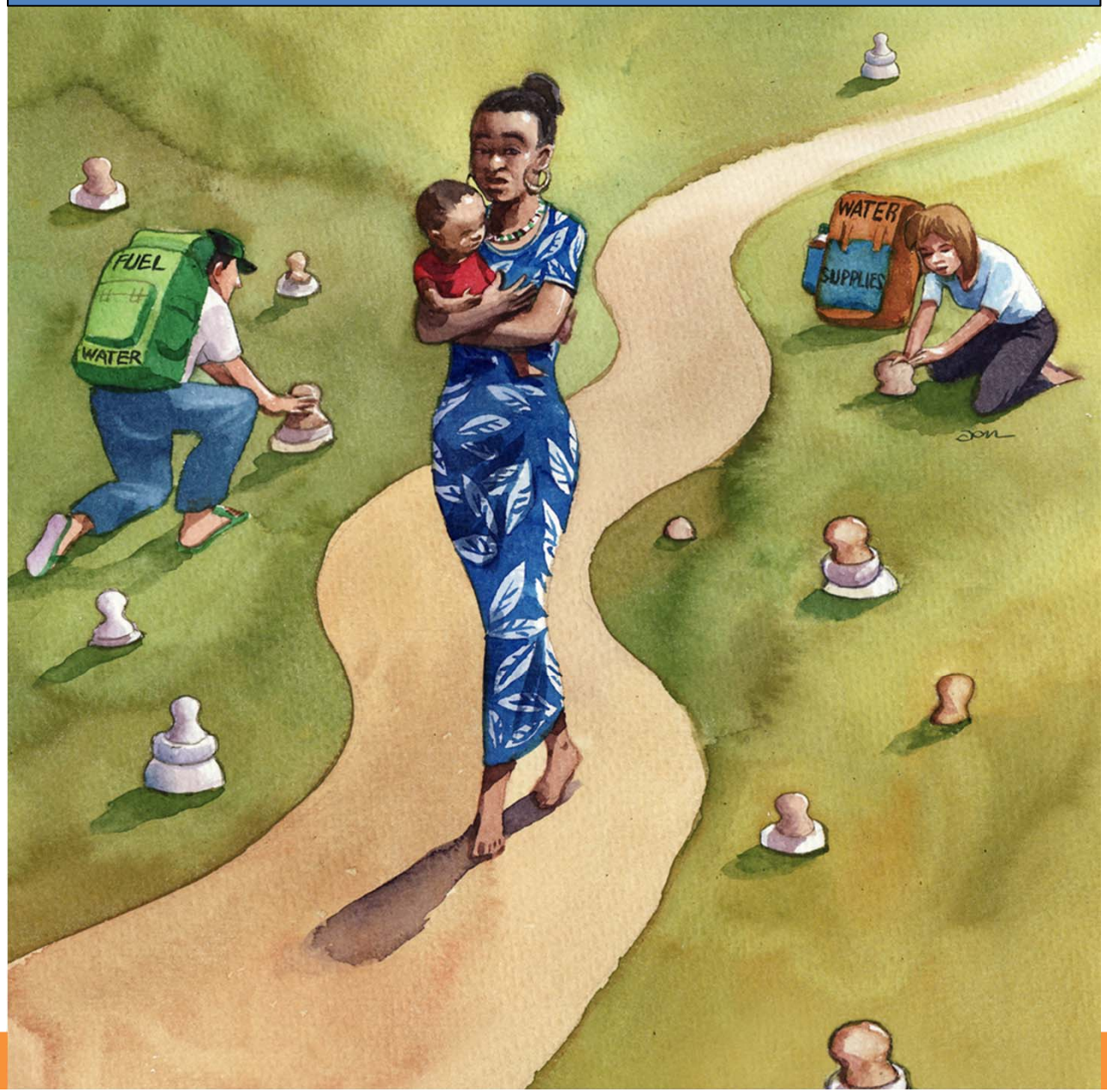

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Recap

- **Promotion and protection of breastfeeding** is always the **priority approach**. Exclusive breastfeeding for the first 6 months of life is the most effective child survival intervention – in any context.
- However, IYCF-E ensures **ALL infants and young children have safe and appropriate nutrition**, which means ensuring safe feeding for children in populations who are predominantly formula-fed
- IYCF-E ensures the **needs of caregivers are met** so that they can care for and feed their children

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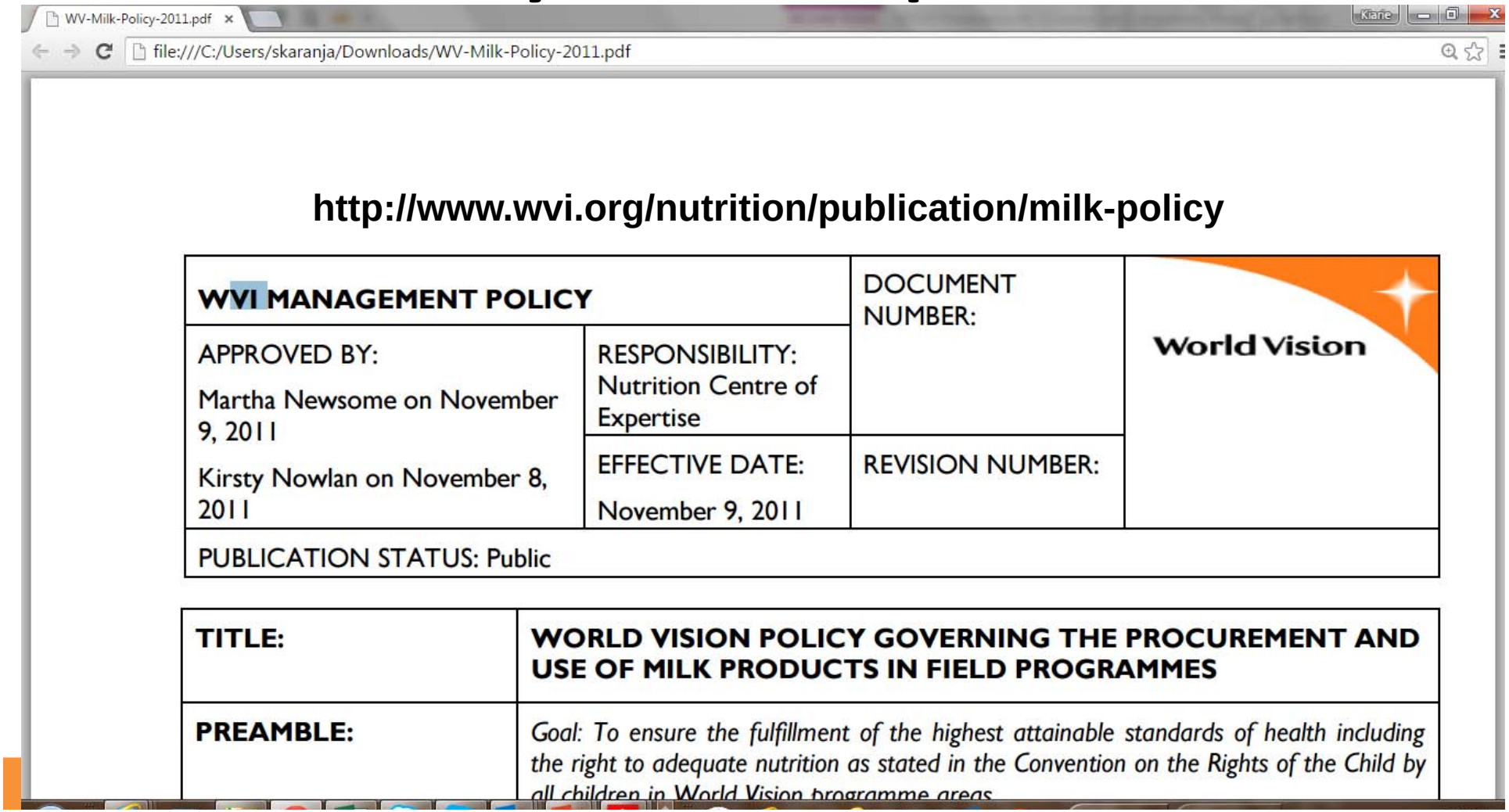
World Vision Commitments
Milk Policy and IFE Ops Guidance



Brief History

- WVI's **Policy Governing the Procurement and Use of Milk Products** developed in 1991
- Reviewed in 2007, to address constraints:
  - Some aspects were not applicable to emergency contexts, such as the requirement for approval from recipient country's government
  - Therapeutic milk was not addressed.
- The 2007 version of World Vision's Milk Policy was updated in 2011 to **include recommendations** in the World Health Organization's (WHO) 2010 Guidelines **on HIV and Infant Feeding**.

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Scope

- WVI Milk Policy applies to all World Vision corporate entities (including all WVI branch offices; Global Centre offices; Regional offices; National Offices, and programme/project offices).
- Applies to all programming contexts: EMERGENCY and NON-EMERGENCY

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Milk Policy Key Points

WV

- Will not accept unsolicited donations of breast milk substitute and milk products.

WV

- **ONLY** source and distribute infant formula in an **exceptional situation** where the infant cannot or should not be breastfed.
  - *Identified by an infant and young child feeding needs assessment*
  - *Using established and agreed criteria , conducted by personnel who have received training on IYCF*
- If Milk Products have to be used, follow UNCHR Policy on Use of Milk Products

Milk Policy Key Points cont'd

Only distribute to the infants requiring it and ensure that the supply is continued for as long as the infants concerned require it.

Assess the availability of fuel, water and equipment for safe preparation and use of breast milk substitute and milk products prior to distribution.

Budget for the purchase of breast milk substitute supplies along with other essential needs to support artificial feeding, such as fuel, cooking equipment, safe water and sanitation, and staff training.

Will not accept unsolicited donations of breast milk substitute and milk products or donations for general distribution to pregnant women and lactating mothers.

Accountability

- Acceptance of donations and procurements of all milk products, infant formula and BMS **MUST BE APPROVED** by the Operations Director (National Office) or Response Manager (Category 3 response) based on and CONSISTENT WITH the Milk Policy on advice from National Health/Nutrition Advisor

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Accountability cont'd

- **training**, or access to training to technical- and non-technical staff: **to promote, protect and support optimal IYCF practices**
- including breastfeeding management and relactation, assessment and targeting needs for BMS.
- Health, HIV, Nutrition, FPMG, and Water, Sanitation and Hygiene (WASH) **trained to understand the evidence around negative impact** (that is, much higher risk of death) **of using infant formula.**

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So what really happens in emergencies?

- Breastfeeding support?
- Appropriate (optimal) infant feeding?

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NO! (rarely)

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Reality often is:

Large-scale donations and distribution of:

- **INFANT FORMULA**
- **BOTTLES/TEATS**

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In Reality,

Breastfeeding in emergencies is often undermined by

MYTHS

X MYTH: Stress ‘dries up’ breast milk

A soldier’s wife feeds her baby at a rest stop in Phnom Penh, Vietnam during the conflict in 1990

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X MYTH: Malnourished mothers can't breastfeed

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X MYTH: HIV-positive Mothers Should NOT Breastfeed

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X MYTH: Babies with diarrhoea need additional liquids like water or tea

X MYTH: Mothers can automatically breastfeed and don't need support

Uganda

Photo credit: Ali Maclaine

Darfur

Bangladesh

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'REALITY' of IYCF in Emergencies

- Increase in infant and young child morbidity and mortality **DURING** emergency
- Reduction in breastfeeding
- Increase in infant and young child morbidity and mortality **AFTER** emergency as optimal IYCF has been undermined.

IYCF-E is Everyone's Issue

AWARENESS of IYCF-E as an issue by **ALL players** in emergencies, including:

- **Governments**
- **Military**
- **Donors**
- **International NGOs**
- **Local NGOs**
- **Media**

One-month-old child post-earthquake, Indonesia 2006

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Minimum IYCF-E Response and Interventions

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A. Pre-Emergency

1. Familiarize all staff to WV Milk Policy and Operational Guidance
2. Orientation, Capacity Building and Training on IYCF-E
    - Orientation on IYCF-E and WVI Milk Policy for HEA, Technical, GIK, Operations staff
    - Technical training for staff on IF counselling, breastfeeding support and artificial feeding
3. Understand the IYCF context pre-emergency, and include basic IYCF interventions in DRR plan and emergency health and nutrition response plan

B. During Emergency

- Prioritize HH with children U2 (shelter, water, food, security to U2 households)
- Registration of vulnerable groups, e.g. orphans
- Supportive places to breastfeed
- Assure/provide for nutritional needs of pregnant and lactating women
- Safe and appropriate complementary feeding needs for children 6 to 24 months
- Newborns: early initiation of breastfeeding
- Frontline support: breastfed and non-breastfed infants, BF and HIV

Interventions during Emergencies, cont'd

- Policy: dissemination, guidelines, the Code (BMS)
- Capacity building: orient decision makers, train medical staff
- Coordination: engage with clusters
- Communication/media: communication strategy, educate donors, pre-emergency preparation
- **If basic IYCF interventions are implemented in an emergency, the need for more in-depth technical intervention is reduced.**

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Remember,
IYCF-E interventions should ensure:

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1. Care for the breastfed child

- Active support for exclusive and continued breastfeeding and supportive counselling
- Appropriate support by all actors in emergencies, including the military, to ensure that breastfeeding is not undermined.

An evacuee feeds her baby after fleeing fighting between government forces and rogue Muslim rebels in Thailand

2. Care for the non-breastfed child

Relactation, wet nurses, and milk banks are preferred options and safer than infant formula

Relactation using supplemental-suckling by grandmother in Afghanistan

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- Targeted provision of BMS only to those who have been assessed and need it
- Provision of additional resources, support and monitoring
- Continuous supplies of BMS for as long as infant concerned needs it

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Promotion of cup feeding rather than bottles or teats

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3. Support Appropriate Complementary Feeding in Emergencies

- Support for continued breastfeeding for 2 years and beyond
- Introduce safe and appropriate complementary foods (e.g. **nutritious foods rich in zinc and iron, energy dense**)
- **Frequent** feeding, **adequate** food, appropriate **texture** and **variety, active** feeding, **hygienically** prepared

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4. Care of Malnourished Infants and Young Children in Emergencies

- Nutrition screening
- Referral for therapeutic feeding
- Community-based Management of Acute Malnutrition (CMAM)

Using MUAC to screen for acute malnutrition in Somalia

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5. Monitoring is Important

- So players can ensure that their interventions are **DOING NO HARM**
- They can change and develop new interventions and/or programmes as required

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SO WHY IS IYCF-E IMPORTANT?

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Because while infants have always been affected by emergencies . . .

World War II, Nagasaki, Japan

Nepal 2015

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Too many children become sick or die due to poor feeding practices in emergencies

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Resources

1. **WV Breastfeeding in Emergency Guidance**
   http://www.wvi.org/nutrition/publication/breastfeeding-emergencies
2. **WV Women, Adolescent and Young Child Spaces in Emergencies Guidance**
   http://www.wvi.org/health/publication/women-adolescent-and-young-child-spaces
3. **WV Milk policy** http://www.wvi.org/nutrition/publication/milk-policy
4. **IFE Operational Guidance** http://www.ennonline.net/operationalguidanceiycfv2.1
5. **UNHCR policy on Use of Milk** http://www.unhcr.org/4507f7842.html
6. **UNICEF online IFE training** http://www.unicef.org/nutrition/training/
7. **More info on WV's work in emergencies:**
   http://www.wvi.org/nutrition/iycf-e, http://www.wvi.org/nutrition/nutrition-emergencies, http://www.wvi.org/emergencies , http://www.wvi.org/nutrition/cmam, http://www.wvi.org/disaster-management

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Thank you!!