Infant and Young Child Feeding in Emergency Situations

Infants and young children are particularly vulnerable to serious illness in emergency situations and feeding must be carefully done. Because of the increased risk of diarrhoeal diseases and other infections, supporting the continuation of breastfeeding is particularly important. In addition, the security and warmth provided by breastfeeding is crucial for both mothers and children in chaotic circumstances of an emergency. The risks associated with bottle and formula feeding are dramatically increased due to poor hygiene, crowding and limited water and fuel. The role of breastfeeding is even more important in emergency situations where it may be the only sustainable element of food security for infants and young children. Exclusive and prolonged breastfeeding is often the only form of family planning available to women in emergency situations. Last but not least, women need validation of their own competence, BF is one of their important traditional roles that can be sustained during a stressful situation.

Misconceptions about breastfeeding in emergencies

- Women under stress cannot breastfeed
- Malnourished women don't produce enough milk
- Weaning cannot be reversed
- General promotion of BF is enough
- Human milk substitutes (infant formula and/or milk) are a necessary response to an emergency

Women under stress *CAN* successfully breastfeed

Milk release (letdown) is affected by stress. Milk production is NOT. Different hormones control these two processes. The treatment for poor milk release is increased suckling which increases the release of oxytocin, the *letdown* hormone. Research suggests that lactating women have a lower response to stress, so helping women to initiate or continue to BF may help them relieve stress.

Malnourished women *DO* produce enough milk

It is extremely important to distinguish between true cases of insufficient milk production (very rare) and perceptions. Milk production is relatively unaffected in quantity and quality except in extremely malnourished women (only 1% of women). When women are malnourished it is the mother who suffers, not the infant. The solution to helping malnourished women and infants is to ***feed the mother not the infant.*** The mother will be less harmed by pathogens and she obviously needs more food. By feeding her, you are helping both the mother and child and harming neither. Remember that giving supplements to infants can decrease milk production by decreasing suckling. The treatment for true milk insufficiency is increased suckling frequency and duration.

A mother who has weaned *CAN* redevelop her milk supply

With enough nipple stimulation and milk removal, it is possible for women to re-lactate, that is to redevelop a milk supply. The stimulation can be provided by a willing baby or even older child, by hand expression and stimulation and/or pumping. The process may take several days or even a couple of weeks. Mothers need much encouragement, a reasonable supply of food and water and protection from stress to the extent possible. Babies, of course, need to be fed in the least hazardest manner until the milk supply returns.

Breastfeeding women need *SPECIFIC ASSISTANCE*; general promotion of breastfeeding is not enough.

Lessons learned in development programs show that most health practitioners have little knowledge of breastfeeding and lactation management; these lessons apply equally to emergency programs. Women who suffer through violent situations leading to displacement and emergency situations are at increased risk of breastfeeding problems. Mothers need help, not just motivational messages. Relief agencies and field workers need training in milk production physiology and on how to counsel mothers to help them optimally breastfeed; how to assess proper positioning and effective suckling and remedy when needed. In some situations, breastfeeding specialists may be useful. Maternal perception of risk of breastmilk insufficiency is an important factor in a women's decision for early termination of breastfeeding. These perceptions may be intensified by the stress of emergency situations. Our first concerns should be ensuring optimal breastfeeding behaviors, which may require the selective feeding of lactating women and trauma counseling for women who may believe they "don't have enough milk". Policies and services which undermine optimal feeding such as giving food supplements to infants <6 months and using bottles for Oral Rehydration Solution, should be avoided. Successful breastfeeding will contribute to the restoration or enhancement of woman's self-esteem, critical to her ability to care for herself and her family.

Human milk substitutes (infant formula and/or milk) are *NOT* always needed

Providing infants and young children caught in an emergency situation with substitutes for human milk is extremely risky. It should be undertaken only after careful consideration and full awareness of the problems that may result. Human milk substitutes must be:

- *limited to the special circumstances of the emergency;*
- *guaranteed for the lifetime of emergency;*
- *accompanied by additional health care, water, fuel, and diarrhea treatment;*
- *include plans for the re-establishment of optimal feeding from the outset of the emergency.*

These guidelines should be disseminated and followed by all agencies working in emergency situations.

Optimal Feeding Practices in Emergencies:

- Initiation of breastfeeding within one hour of birth
- Effective infant positioning (latch-on)
- Frequent, on-demand feeding until 6 months of age
- Exclusive, breastfeeding until 6 months of age
- Continuation of breastfeeding after beginning the addition of appropriate weaning foods at 6 months of age
- Sustained breastfeeding well into the second year of life or beyond
- Increased breastfeeding frequency and continued feeding during illness.
- Increased breastfeeding frequency after illness for catch up growth.

Originally prepared by Wellstart International's Expanded Promotion of Breastfeeding Program (1996); revised and updated, 2005.
For further assistance, consultation and/or training please contact Wellstart International at info@wellstart.org

Emergency situations are usually initially confusing and chaotic. Determining who needs what is an essential early step. For protecting and supporting breastfeeding, the first step is to identify infants who are or should be breastfed and further noting any infants who are temporarily or permanently without their mother. Ultimately three groups can be established: one needing only breastfeeding support, a second requiring more intensive re-lactation help and a third in which substitute feeding is deemed necessary and will need to be very carefully managed and monitored. The triage diagram below may be helpful. It is from: *Infant Feeding in Emergencies: Policy, Strategy & Practice. Report of the Ad Hoc Group on Feeding in Emergencies: May 1999* and has been made available by the Emergency Nutrition Network on their website: http://www.ennoline.net/ife/index.html

Feeding Infants Under Six Months in Emergencies: a Triage Approach to Decision-Making