Need for supporting Breastfeeding during Emergencies and Risks of Artificial Feeding

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Preamble

Since time immemorial breastfeeding has contributed to infants’ survival and holistic development. To achieve optimal health, development, and survival of infants and young children, and to fulfill their rights to survive and attain the highest attainable standards of health, all infants should be exclusively breastfed for the first 6 months of life, followed by the introduction of appropriate complementary feeding along with continued breastfeeding for 2 years or beyond. Natural disasters and emergencies like earthquakes, floods, typhoons and tsunami pose a real challenge for Governments, aid agencies, NGOs and community. Providing adequate and appropriate nutrition to the affected people including infants and children acquires top priority in such situations. Child survival is a key issue in such a situation and need for adequate strategies to maintain optimal infant and young child feeding (IYCF) is paramount. In emergency situations created by wars, natural disasters, and famines, people are forced to live in crowded, insanitary conditions where access to food and health care is limited and the danger of infection, particularly with diarrhoeal diseases, is great.

The National and International agencies recommend breastfeeding as the best option in a natural disaster situation.

Malnutrition increases dramatically, and kills most rapidly, in emergencies. Most children do not die due to conflicts or natural disasters themselves, but rather to resulting food shortages, lack of safe water, inadequate health care, and poor sanitation and hygiene.

Breast feeding offers fewer health hazards than artificial feeding in war or emergency settings. Breast feeding normally also provides the advantage of immune protection for the infant, psychological well-being of the mother and child, fertility regulation, a hygienic food source, and an economic means of feeding infants.

Although breastfeeding is the safest and often the ONLY reliable choice for young infants, one is likely to overlook the basics like breastfeeding for those who need it the most, in the rapid response that is needed to provide relief during emergencies. Infants and young children are among the most vulnerable victims of natural or human induced emergencies. Interrupted breastfeeding and inappropriate complementary feeding heighten the risk of malnutrition, illness and mortality.

Risks of Artificial Feeding in Emergencies

The risks of artificial feeding were exposed in Botswana in 2005/06 where replacement feeding with infant formula was offered to all HIV-infected mothers as part of a national programme to prevent transmission of HIV from mother to child (PMTCT). Flooding led to contaminated water supplies, a huge rise in diarrhoea and malnutrition in young children. National under five mortality increased by at least 18% over 1 year. Non-breastfed infants were 50 times more likely to need hospital treatment than breastfed infants, and much more likely to die. Use of infant formula 'spilled over' to 15% of HIV-uninfected women, exposing their infants to unnecessary risk.

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Similar results were reported in a study from the Indian state of Pondicherry after the Tsunami in 2004, where the occurrence of diarrhea was three times higher among children who were fed with free breast milk substitutes (BMS) than in those who were not fed with the same.\(^9\)

Emergencies destroy what is ‘normal,’ leaving caregivers struggling to cope and infants vulnerable to disease and death. Children are the most vulnerable in emergencies – child mortality can soar from 2 to 70 times higher than average due to diarrhoea, respiratory illness and malnutrition.\(^{10}\)

Violation of the Code has been recorded in emergencies, often associated with donations of breast milk substitutes (BMS) and infant feeding items. During the earthquake response in Indonesia in 2006, distribution of donated infant formula to children under 2 years of age led to its increased use amongst breastfeeding infants. Diarrhoea prevalence was double amongst those who received donations of infant formula (25%) as compared to those who did not (12%).\(^{11}\)

**Are we prepared to ensure appropriate infant feeding practices during the disaster/emergency?**

In 2008, Indian Civil Society groups BPNI and PHRN (Public Health Resource Network) along with partners conducted an assessment of policy and programmes on breastfeeding and one of the indicators No. 14 was on Infant Feeding during Emergencies. It was found that India is least prepared to meet breastfeeding demands during an emergency situation. India scored 0 out of 10. Though the National Guidelines for Infant and Young Child Feeding stress the need for ensuring optimal breastfeeding during disasters and emergencies, it is not included in any contingency plan. Women are neither counselled nor supported for correct IYCF during disasters.\(^{12}\)

Though some progress have been made internationally to develop guidelines for infant feeding in emergencies. But preparing and disseminating policies only is not adequate. There is a need to translate them into practice. Borrel et al\(^{13}\) identified some underlying reasons behind failure to implementing the policies:

- The weak institutionalization of policies
- The massive quantities of unsolicited donations of infant-feeding products
- The absence of monitoring systems
- Inadequate co-ordination mechanisms
- The high costs of correcting mistakes
- The cumulative effects of poor practice.

Most of the time, the emergency response fails to address psychological support needs of the mother during the disasters. Prevailing conditions of conflict that contribute to a mother’s anxiety and insecurity may interfere with a mother’s “let down” reflex and lactation.\(^7\) The Indian study during the post tsunami period reported that most mothers in the villages studied were under stress and were in the process of frequent shifting between their homes near the sea shore and the temporary relief shelters due to rumours of repeat Tsunami. They did not eat well in anxiety and hence could not breastfeed their babies properly.\(^9\)

**What needs to be done?**

Emergency preparedness is the key to quick, appropriate actions for safe feeding practices. Districts and States need to have capacity to further the skills of existing health workers to be ready to meet such demands during an emergency.

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Those who provide health care and relief assistance during emergencies should undertake the following measures to support breast feeding and to protect the health of mothers. Kelly M identified following actions to achieve appropriate infant feeding during emergencies (2):

1) Work for agreement between outside agencies and local health workers on breast feeding policy and practice, share up-to-date information, and establish mechanisms to ensure actions are implemented in a coordinated manner.

2) Ensure that maternity care practices follow WHO/UNICEF Guidelines.

3) Encourage women who are not breastfeeding to do so, rather than criticizing them.

4) Educate the whole community about the benefits of breast feeding and highlight the importance of family and social support.

5) Offer one-to-one assistance to mothers who are experiencing difficulty breast feeding through use of a network of experienced mothers, or by training breast feeding counselors (women), who are sensitive to the culture, health beliefs, and circumstances of the mothers they assist.

6) Provide assistance with re lactation to mothers with infants who have stopped breast feeding early.

7) Supply adequate basic food rations to every family, targeting supplementary food for pregnant and breast feeding women, and children of weaning age, not young infants.

8) Only provide infant formula to infants who do not have access to breast milk, and make sure their caregivers have the knowledge, skills, and resources to prepare and give feeds hygienically by cup rather than bottle.

Jellife and Jellife (14) suggested that two practical approaches need to be incorporated into field instructions. Firstly, artificial feeding should be restricted to situations where breastfeeding is not possible. Secondly, lactation should be reinforced in the mothers concerned; this means stimulating the prolactin reflex and the "letdown" or "milk ejection" reflex. The latter is a psychosomatic reflex that is impaired by anxiety and enhanced by confidence. Moreover, it is important to maintain or improve maternal nutrition because in very severe food shortages milk production becomes affected and ultimately ceases.

The Indian National Guidelines on Infant and Young Child Feeding (4) says protecting, promoting and supporting breastfeeding in disaster areas with due focus on the following is essential to ensure child survival, nutrition and health:

- Emphasis should be on protecting, promoting and supporting breastfeeding and ensuring timely, safe and appropriate complementary feeding.

- Pregnant and lactating women should receive priority in food distribution and should be provided extra food in addition to general ration.

- Complementary feeding of infants aged six months to two years should receive priority.

- Donated food should be appropriate for the age of the child.

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• Immediate nutritional and care needs of orphans and unaccompanied children should be taken care of.

• Efforts should be made to reduce ill effects of artificial feeding by ensuring adequate and sustainable supplies of breast milk substitutes, proper preparation of artificial feeds, supply of safe drinking water, appropriate sanitation, adequate cooking utensils and fuel.

*The Guidance for Emergency Relief Staff and Programme Managers* \(^{(15)}\) by the IFE core group suggests following practical steps to achieve appropriate infant feeding during the emergencies:

1. Each agency should, at central level, **endorse or develop a policy** that addresses infant and young child feeding in emergencies, stressing the protection, promotion, and support of breastfeeding and adequate, timely complementary feeding.

2. 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.

3. Capacity building and technical support requirements among operational partners should be evaluated and addressed by the coordinating body.

4. To determine the priorities for action and response, **key information** on infant and young child feeding should be obtained during assessments.

5. Specific efforts should be made to protect, promote, and support optimal infant and young child feeding with integrated multi-sectoral interventions.

6. **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 re-lactation.

7. **Integrate** breastfeeding and infant and young child feeding training and support at all levels of health care. The Baby Friendly 10 Steps to Successful Breastfeeding should be an integral part of maternity services in emergencies.

8. 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.

9. To **minimize 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.

**Summary**

Correct IYCF during emergencies and disasters is crucial to keep down mortality and prevent disease. Though the national and international agencies stress the need for ensuring optimal breastfeeding in disasters and emergencies, it is yet to be included in any contingency plan at the national level. Families need counseling and support for correct IYCF practices. During disasters, there is the added danger of promotion of artificial feeding, especially formula feeding, which can threaten exclusive and continued breastfeeding. Thus violations of the IMS Act also need to be monitored closely in such situations. Disaster Management policy and contingency plans for all kinds of emergencies and disasters need to make IYCF support and counselling a central part of the strategy, and training of disaster managers should include this component.

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