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CHAPTER - 5

PROMOTING BREASTFEEDING

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AFGHANISTAN: Children and women wait to be attended to at a therapeutic feeding centre for displaced persons run by the international NGO Medecins Sans Frontieres, on the outskirts of the western city of Herat, capital of the province of the same name. Most of the displaced are from the drought-affected provinces of Badghis and Ghor, north-east of Herat, as well as from conflict areas.

WHY PROMOTE BREASTFEEDING IN EMERGENCIES?

In nearly all contexts, breastfeeding is the most beneficial form of infant feeding for both mother and baby. Infant feeding is an important issue in emergencies because:

- Nutrition is closely linked to an infant's health and survival in the short and long-term.
- A child's early nutrition will affect his/her later growth, health and mental development.
- Infant feeding practice offers the first bonding between mother and baby.

PRINCIPLES OF BREASTFEEDING PROMOTION

An emergency is an ever-evolving situation that creates challenges and opportunities to promote exclusive breastfeeding. The following principles should guide your breastfeeding communication initiative:¹

1. All infants, including those born into populations affected by emergencies should normally be exclusively breastfed for the first six months.
 - The beneficial effects of colostrum in breast milk, particularly in building the infant's immune system, are especially important. Infants should be breastfed on demand from birth, within the first hour after birth.
 - Every effort should be made to identify ways to breastfeed infants whose mothers are absent or incapacitated.
 - Re-lactation should be attempted before the use of infant formula is considered.

2. Every effort should be made to create and sustain an environment that encourages exclusive breastfeeding for the first six months, and continued frequent breastfeeding thereafter up to two years.
3. The quantity, distribution and use of BMS at emergency sites should be strictly controlled, using the following guidelines:
 - Nutritionally adequate infant formula (BMS), fed by cup, should be available to infants who do not have access to breastmilk.
 - Those responsible for feeding BMS should be adequately trained and equipped to ensure its safe preparation and use.
 - Feeding infant formula to the minority of children who cannot be breastfed should in no way interfere with protecting and promoting breastfeeding for the majority who can.
 - The use of infant feeding bottles and artificial teats in emergency settings should be actively discouraged and cup feeding promoted instead, as cups are much more hygienic and easier to keep clean.

Note:

Recognise a mother's right to make and implement decisions regarding infant feeding, and acknowledge the actual and potential role of family members, and the affected community in influencing those decisions.

10 steps to successful breastfeeding: ²

Every facility providing maternity services and care for newborn infants should:

- 1 Have a written breastfeeding policy that is routinely communicated to all health care staff.
- 2 Train all health care staff in skills necessary to implement this policy.
- 3 Inform all pregnant women about the benefits and management of breastfeeding.
- 4 Help mothers initiate breastfeeding within half an hour of birth.
- 5 Show mothers how-to breastfeed, and how-to maintain lactation even if they should be separated from their infants.
- 6 Give new-born infants no other food or drink other than breastmilk, unless medically indicated.
- 7 Practice "rooming-in" to allow mothers and infants to remain together 24 hours a day.
- 8 Encourage breastfeeding on demand.
- 9 Give no artificial teats or pacifiers (dummies or soothers) to breastfeeding infants.
- 10 Foster the establishment of breastfeeding support groups and refer mothers to them upon discharge from the hospital or clinic.

DOING THE GROUNDWORK

Your communication initiative to promote breastfeeding will depend much on which pre-emergency partnerships you have established, for instance with healthcare providers, community groups, community health workers, maternity caregivers, school and youth groups, government agencies and other relevant stakeholders. It will also depend on how much you know about the affected community's pre-existing knowledge, attitudes and practices regarding infant feeding. This, along with rapid assessments, will give the information needed to set SMART behavioural results (**Please see Tool 1 in Part III of the toolkit**) and design effective breastfeeding promotion strategies. Doing the groundwork will ensure that your breastfeeding communication actions, messages and materials are based on an adequate understanding of the key factors that influence a woman's decision to breastfeed.

Focus group discussions

Experiences from past emergencies show that common barriers and disincentives to breastfeeding can include following:

- are mothers believing that they do not have sufficient milk;
- women not breastfeeding prior to the emergency;
- breastfeeding practices changing during the emergency;
- some breastfed infants appearing malnourished;
- unacceptability of wet nursing due to cultural taboos or HIV prevalence;
- separated or orphaned infants;
- and/or bottle feeding is the norm.³

Focus group discussions are useful to examine barriers and disincentives regarding infant feeding in detail, and to educate women and service providers on the importance of exclusive breastfeeding. **See Tool 10 in Part III of the toolkit.**

FOCUS GROUP DISCUSSION IN NAGAPATTINAM

As part of the Indian emergency response to the tsunami, several focus group discussions were organised to probe into women's infant feeding beliefs and practices in Nagapattinam district, located in the State of Tamil Nadu. Besides getting an inside view on why women in this community chose bottle feeding over breastfeeding, the FGDs also provided opportunities to clarify myths and doubts and to counsel women on optimal infant feeding practices and other maternal child health aspects.

Separate focus group discussions were organised with adolescent girls, newly married couples, and antenatal and postnatal mothers in an attempt to gain information across the board. A common finding, however, was the strong influence of traditional beliefs and cultural values on women's attitudes and practices towards infant feeding. Another common finding was the need to increase women's understanding of maternal and child health.

Specific findings from the FGD included:

- Many mothers believed that bottle feeding was a harmless and hygienic practice.
- Several mothers did not recognise the traditional practice of giving infants mercury drops immediately after birth as harmful to the infant. They believed this would avoid skin rash.
- Some mothers regularly gave their infant "rubber nipples" or pacifiers.

Dr. Durairajan Gopinath, UNICEF Health and Nutrition District Coordinator in Nagapattinam, explains that the FGDs brought out the following important lessons:

Lessons Learned

1. Prevent or stop the supply of BMS and bottles as a form of relief to mothers.
2. Encourage the supply and use of properly cleaned stainless steel spoons and cups for artificially fed infants.
3. Gain a thorough understanding of the affected community's cultural beliefs and traditions before launching a breastfeeding promotion initiative.
4. Develop clear and precise messages such as:
 - Only breastmilk from birth until 6 months.
 - Stop bottle feeding (unless an exceptional case).



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AFGHANISTAN: A woman is feeding solid food to her baby.

Pocket chart

A pocket chart can be used to explore or examine the affected women/ community's infant feeding preferences and practices more closely. This exercise can also be used as a means of information exchange – to protect, support and promote breastfeeding – by increasing knowledge and engendering supportive attitudes across all sections of the affected community. **See Tool 6 in Part III of the toolkit**

Setting behavioural results

Once you have identified the incentives and barriers to breastfeeding in emergencies, you can easily develop SMART behavioural results. Some points to consider when setting behavioural results are the cause and severity of the disaster, the affected community's pre-existing infant feeding practices, and social taboos and misconceptions about breastfeeding and wet nursing. **Please see Tool 1 in Part III of the toolkit.**

Common myths about breastfeeding in emergencies

MYTH: Women under stress cannot breastfeed.

TRUTH: Women under stress **CAN** successfully breastfeed.

Milk production is stable; but milk release (let down) can be affected by stress. The treatment for poor milk release and for low production is increased suckling and social support. The most effective support for a breastfeeding woman comes from other breastfeeding women.

MYTH: Malnourished women don't produce enough milk.

TRUTH: Malnourished women **DO** produce enough milk.

It is extremely important to distinguish between true cases of insufficient milk production (very rare) and mistaken perceptions. Milk production remains relatively unaffected in quantity and quality except in extremely malnourished women. Malnourished women and children are best served by feeding the mother and letting her breastfeed the infant. By doing so, you protect the health of both mother and child. Giving supplements to infants decreases suckling and so can reduce milk production.

GETTING THE MESSAGE RIGHT

When developing breastfeeding promotion messages, remember that women, mothers and primary caregivers are often the main audience for behaviour change in an emergency, as humanitarian workers are communicating messages for diarrhoea prevention, measles vaccination, and other hygienic practices to keep children and adults alive and well.

Consider three main factors to getting the message right:

1. It is important to only focus on a few messages that are vital to influencing women to exclusively breastfeed. Use participatory communication methods such as group meetings with primary caregivers, peer educators and one-to-one counselling to discuss these vital infant and child health related messages.
2. You may have to counter some harmful messages and

The treatment for insufficient milk production—real or perceived—is to increase suckling frequency and duration, ensure the mother has sufficient food and liquids, and offer reassurance from other breastfeeding women.

MYTH: Breastmilk substitutes are needed during an emergency.

TRUTH: Usually, breastmilk substitutes are NOT appropriate.

There are appropriate guidelines on the use of breastmilk substitutes and other milk products in emergencies. They include the WHO International Code of Marketing of Breastmilk Substitutes (May 1981), the UNHCR guidelines on the use of milk substitutes (July 1989), and the World Health Assembly resolution 47.5 (May 1994). Under the Code, donors must ensure that any child who receives a breastmilk substitute is guaranteed a full, cost-free supply for at least six months.

Health workers may need training on how-to help women who have difficulty breastfeeding because of incorrect positioning, cracked nipples or engorgement. A mother's fear that she "may not have enough milk" is often a cause of early termination of breastfeeding. This (mis)perception may be intensified by the stress of an emergency situation.

Health workers should encourage optimal breastfeeding behaviours.

advertisements regarding the use of BMS with positive ones that reinforce the benefits of breastfeeding.

3. Different groups of women, families and communities in an emergency are likely to have unique infant feeding beliefs, practices and challenges that we have to understand before launching a communication initiative. Note that the emergency may lead to a breakdown of internal family support systems – partners, mother, mother in law, sisters, aunts – and other people in the family who traditionally influence and support mothers' infant feeding choices.

Keep in mind:

Past emergencies have revealed two main behaviours that keep babies alive and healthy:

1. Women that can breastfeed do so exclusively for the infant's first 6 months.
2. Women that cannot breastfeed have access to an adequate amount of appropriate BMS, can safely prepare it, and cup-feed their infants.

In the initial response of an emergency, the above mentioned are the two most important infant feeding practices that should be promoted.

MYTH: General promotion of breastfeeding is enough.

TRUTH: Breastfeeding women **NEED** assistance; general promotion of breast-feeding is **NOT** enough.

Most health practitioners have little knowledge of breastfeeding and lactation management. Women who are displaced or are in emergency situations are at increased risk of breastfeeding problems. They need help, not just motivational messages. Health workers may need to be trained to give practical help to women who have difficulty breastfeeding because of incorrect positioning, cracked nipples or engorgement.

A mother's fear that she "may not have enough milk" is often a cause of early termination of breastfeeding. This (mis)perception may be intensified by the stress of an emergency situation. Health workers should encourage optimal breastfeeding behaviours, even if they require selective feeding of lactating women.

Policies and services which undermine optimal feeding, such as giving food supplements to infants less than six months and using bottles for Oral Rehydration Salts (ORS) delivery, should be avoided.

What do we need to know?

The following messages cover a range of information on what different audiences (adolescent girls, pregnant/lactating women, mothers, health workers and other service providers) need to know.

Breastfeed exclusively for the first 6 months⁴

- Almost every mother/woman can successfully breastfeed.
- Breastmilk *alone* is the only food and drink an infant needs for the first six months.¹
- Breastfeeding helps protect babies and young children against dangerous illnesses, and creates a special bond between mother and child.
- Stress doesn't necessarily prevent a mother from producing milk.
- Continue breastfeeding babies who have diarrhoea.
- Frequent breastfeeding stimulates milk flow.

Minimise the dangers of artificial breastfeeding

- Bottle-feeding can lead to illness and death.
- Use safe water to prepare BMS.
- Use clean cups to feed BMS; never use bottles.

Create an enabling environment for women who breastfeed

- Help breastfeeding women with food preparation, childcare.
- Ensure that lactating women eat nutritious food and take supplements.
- Establish "safe havens" and support groups for pregnant and lactating women to help reduce stress.
- Provide breastfeeding women with special rations, water and supplements, and provide re-lactation support if needed.

Priorities of alternatives for infant feeding in emergencies

1. Breastfeeding
2. Wet nursing*
3. Breastmilk from Milk Bank
4. Generically packaged infant formula
5. Locally purchased branded formula
6. Stop-gap home made recipes

*The practice of wet nursing may be unacceptable or inappropriate in situations of high HIV prevalence where testing, support and counselling are not available.

Source: UNICEF Technical Notes



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Healthcare workers are key to breastfeeding promotion

- Initiate breastfeeding within 30 minutes of birth to stimulate milk flow.
- Help mothers return to exclusive breastfeeding by increasing frequency of feeds and ensuring “emptying” of breasts.
- Re-stimulate lactation where milk production has been affected by stress.

Prevent solicitation of unnecessary donations of powdered milk and powdered formula, and help prevent unsolicited donations from being delivered to the camp, shelter or affected community

- Breastmilk keeps infants in an emergency alive and well.
- BMS are not affordable to most women in developing countries, and may be hard to obtain once the emergency stabilises.

COMMUNICATION ACTIONS FOR BREASTFEEDING

UNICEF's emergency response is guided by the Core Commitments for Children in Emergencies (CCC) that provide the overarching organisational framework in a humanitarian response (see Chapter 3). The table below outlines the CCC in the areas of Health and Nutrition related to infant feeding. Included are suggested behaviour change communication (BCC) activities that have proven to improve infant feeding in an emergency. Remember to plan your communication and social mobilisation actions with the involvement of the affected community and your partners, and to carefully monitor and evaluate the programme.

TABLE: Extract from UNICEF's CCC in health and nutrition and corresponding BCC and social mobilisation support.

FIRST SIX TO EIGHT WEEKS	SUPPORTIVE BCC AND SOCIAL MOBILISATION ACTIONS
<ol style="list-style-type: none"> 1. Based on rapid assessments, provide child and maternal feeding: support infant and young child feeding and therapeutic and supplementary feeding programmes with the World Food Programme (WFP) and NGO partners. 	<ul style="list-style-type: none"> ▪ Ensure that affected women receive information on the importance of feeding newborns colostrum and exclusive breastfeeding for the first 6 months – i.e. group meetings/ discussions, IEC materials, flip charts that explain benefits of exclusive breastfeeding, audiovisual demonstrations. ▪ Make sure that health workers and other service providers understand the importance of breastfeeding <u>and</u> are able to communicate it to women, by involving government and health

FIRST SIX TO EIGHT WEEKS	SUPPORTIVE BCC AND SOCIAL MOBILISATION ACTIONS
	<p>associations in training and supporting service providers in giving advice and support to women in choosing the appropriate feeding methods.</p> <ul style="list-style-type: none"> ■ Provide health workers, peer educators, and breastfeeding counsellors training and support to increase the breastfeeding ability of lactating women; guarantee that women know how to breastfeed in a way that stimulates milk production, make sure that women who cannot breastfeed know how to safely prepare BMS and cup feed; give accurate information and correct breastfeeding misconceptions; introduce breastfeeding women to each other in the camp; and increase awareness on the benefits of colostrum. ■ Mobilise the community to support breastfeeding women by facilitating mother-to-mother support networks, “safe havens” for pregnant/lactating women, women’s groups, etc. ■ Advocate and mobilise support with the local government, camp management, private sector, and humanitarian agencies to increase knowledge on the dangers of unnecessary, unsolicited and inappropriate BMS in emergencies, and promote compliance to the International Code of Breastmilk Substitutes regarding the prevention of the marketing of BMS among health and aid workers.

FIRST SIX TO EIGHT WEEKS	SUPPORTIVE BCC AND SOCIAL MOBILISATION ACTIONS
<p>2. Introduce nutritional monitoring and surveillance.</p>	<ul style="list-style-type: none"> ▪ Facilitate participatory monitoring and evaluation methods – i.e. monitoring chart, ongoing FGDs – to systematically monitor the nutritional status of children and women.

Communication interventions that span beyond the initial response should build upon those implemented pre-emergency and during the initial response. Besides increasing knowledge and optimal infant feeding know-how, community participation and advocacy efforts are central in protecting, promoting and supporting breastfeeding.

BEYOND THE INITIAL RESPONSE	SUPPORTIVE BCC AND SOCIAL MOBILISATION ACTIONS
<p>3. Support infant and young child feeding, complementary feeding, and when necessary support therapeutic and supplementary feeding programmes with World Food Programme and NGO partners.</p>	<ul style="list-style-type: none"> ▪ Ensure that health workers, community volunteers are trained to provide support to breastfeeding women – i.e. ongoing advice, and encouragement at health centres and homes through motivational talks, flip charts, one-to-one counselling; motivating breastfeeding women by sharing with them how they can produce enough milk and providing assistance, if needed. ▪ Provide supportive supervision (and, if needed, further training) to health workers, peer educators, and breastfeeding counsellors to increase the breastfeeding ability of lactating women; guarantee that women know how to breastfeed in a way that stimulates milk production, make

BEYOND THE INITIAL RESPONSE	SUPPORTIVE BCC AND SOCIAL MOBILISATION ACTIONS
	<p>sure that women who cannot breastfeed know how to safely prepare BMS and cup feed; give accurate information and correct breastfeeding misconceptions; introduce breastfeeding women to each other in the camp; and increase awareness on the benefits of colostrum.</p> <ul style="list-style-type: none"> ▪ Mobilise the community to support breastfeeding women by facilitating mother-to-mother support networks, “safe havens” for pregnant and lactating women, women’s groups, etc.
<p>4. Provide health and nutrition education, including messages on the importance of breastfeeding and safe motherhood practices.</p>	<ul style="list-style-type: none"> ▪ Ensure that the affected mothers, community and service providers know the health and nutrition benefits of colostrum and breastfeeding and other safe motherhood practices; know how to breastfeed and how to safely prepare BMS and cup feed – i.e. through interpersonal communication channels such as individual and/or group counselling, community health education, cooking demonstrations, mother-to-mother support networks, activities in women’s groups/clubs, trials of new feeding practices - depending on the duration of the emergency - and positive deviance approaches.⁶ ▪ Train health workers, peer educators, breastfeeding counsellors, TBAs, midwives and other relevant stakeholders on how

BEYOND THE INITIAL RESPONSE	SUPPORTIVE BCC AND SOCIAL MOBILISATION ACTIONS
	<p>to communicate health and nutrition education messages to mothers in a way that motivates them to feed infants colostrum, exclusively breastfeed, and adopt nutritious habits (including taking vitamin A supplements).</p> <ul style="list-style-type: none"> ▪ Advocate and mobilise support with local authorities, camp management and other relevant stakeholders to provide women a safe place to breastfeed, prevent the solicitation of unnecessary donations powdered milks and formulas, and help prevent unsolicited donations from being received into the camp.

MONITORING MILESTONES

One of the main goals of breastfeeding promotion is to improve infant survival and decrease risks of malnutrition, diarrhoea and other diseases. Your communication initiative has to support this goal.

The following are some key indicators to monitor whether our communication initiative is on track (**Tool 13 in Part III lists possible sources of information to help you measure the indicators**):

- Health workers, peer educators, birth attendants, midwives and other relevant service providers are trained on infant and child feeding practices, and can communicate and motivate affected women to exclusively breastfeed and safely prepare appropriate BMS and cup feed (in exceptional cases).
- Women with newborns know the benefits of colostrum and the importance of/ how-to breastfeed. Women who cannot breastfeed know how to safely prepare appropriate BMS and cup feed. The affected community is mobilised to support breastfeeding women via, mother-to-mother support networks, “safe havens”, trials of new feeding practices, activities in women’s groups, etc.

- Infants less than six months are exclusively breastfed, wet nursed (where acceptable), or in exceptional cases, have access to an adequate amount of an appropriate BMS.
- Local governments, humanitarian agencies, camp management and other service providers know the international guidelines on the marketing of BMS, the appropriate use of BMS in emergencies, and are supplying it to artificially-fed infants without undermining the breastfeeding population at the camp.

PRACTICAL EXPERIENCES

Advocacy helps Maldivian mothers breastfeed after tsunami

During the aftermath of the 26 December tsunami which affected 11 Indian Ocean countries, many private sector companies and individuals flooded camps and affected communities with infant formula. This gesture – perhaps rooted in good will, but doing more harm – was aimed at feeding orphans and babies whose mothers were believed to be too stressed to breastfeed.

The following example from the Maldives demonstrates the effect of quick-and-high level advocacy with the government; the importance of having guidelines on breastfeeding promotion in emergency situations and the need to train health workers in breastfeeding promotion and counselling skills.

In the Maldives, prior to the 26 December Tsunami, breastfeeding practices were generally good and the use of breastmilk substitutes (BMS) was not widely practiced. After the tsunami, many affected mothers felt that they could not properly breastfeed their babies. This was coupled with the sudden widespread availability of BMS, which prompted many to switch to the bottle. What's more, when the tsunami hit, many community health workers were unaware that they should encourage mothers to continue breastfeeding – even in emergencies. Many health workers didn't know how to handle the deliveries of BMS and supported bottle feeding in the initial response.

It was only after UNICEF shared the international infant feeding guidelines with the government – which in turn educated health workers – that they realised the benefits of exclusive breastfeeding in emergencies. Subsequently, health workers started to promote and support breastfeeding to affected mothers via one-to-one talks and counselling. Follow-up reports show that many of the health workers would have an added benefit of interpersonal communication and counselling training to promote breastfeeding beyond the initial response.

The Maldives experience illustrates the positive impact that swift advocacy can have. This is a reminder that messages on the importance of breastfeeding, and the guidelines on the use of BMS should be easily accessible and quickly shared in emergencies. It also highlights that information is necessary but not sufficient on its own to influence positive behavioural change. It was through advocacy, education and health worker training that mothers learned to engage in optimal infant feeding practices. We should remember that health workers are necessary and valuable partners in breastfeeding promotion. Our communication initiatives should include training them with the necessary communication skills to protect, promote and support breastfeeding in emergencies.

Lessons Learned

1. Breastfeeding promotion works best when it is a joint-effort between health workers, camp managers, government officials and other humanitarian workers.
2. Don't assume that health workers have knowledge on best breastfeeding practices in emergencies, or are aware of the international standards on the use of adequate and appropriate breastmilk substitutes.
3. Include health worker training as part of the emergency preparedness and recovery phases of your breastfeeding promotion initiative.
4. Be sure to quickly share knowledge with all relevant sectors of the concerned humanitarian and government organisations in an emergency, to ensure that breastfeeding messages are harmonious and disseminated to the intended audiences.

SPECIAL CONSIDERATIONS: BREASTFEEDING AND HIV



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In South Asia, where HIV prevalence is still considered relatively low, promoting and supporting exclusive breastfeeding is vital to significantly reduce the risk of a newborn's death - which diarrhoeal infections can easily cause - and exclusive breastfeeding can just as easily prevent.

However, where HIV rates are known to be high, it is important that we standardise HIV and infant feeding messages so that women and their partners are not confused on the issue of breastfeeding and the possibility of mother-to-child transmission (PMTCT). Admittedly, communicating these facts to mothers may be difficult; dialogue and pictorial aids will often be needed. In addition, partner and family involvement, if feasible, and depending on the consequences of the emergency, will be crucial. It may be possible to draw a risk analogy that is based on cultural knowledge and traditions. This, however, should be carefully researched.

In an emergency, the following information must be taken into account before an appropriate infant feeding and communication strategy is developed:

- Assessment of the prevalence of HIV in the affected population – using secondary sources (including pre-emergency estimates) and relevant information from health information systems; whether it is a high HIV prevalence country of South Asia (pre-emergency) or not? This is particularly important before we can recommend wet nursing.
- Assessment of the knowledge of HIV status: Were voluntary counselling and testing facilities available pre-emergency? Are there such services available now?
- Are there any relevant policies on infant feeding and HIV, from the host and/or home countries?

RESOURCE BANK

Further reading

1. Almedon, A., *Socio-cultural Consideration for Infant Feeding in Emergencies: A discussion paper*, Health Promotion Sciences Unit, Dept. Public Health & Policy, London School of Hygiene & Tropical Medicine, London, 1994.
2. Brownlee, A., 'Breastfeeding, Weaning and Nutrition: The behavioural issues', *Behavioural Issues in Child Survival Programs, Monograph Number Six*, International Health and Development Associates, Malibu, 1990.
3. Brownlee, A., 'Growth Monitoring and Promotion: The behavioural issues', *Behavioural Issues in Child Survival Programs, Monograph Number Six*, International Health and Development Associates, Malibu, 1990.
4. Carter K., *Feeding in Emergencies for Infants Under Six Months: Practical guidelines*, OXFAM Public Health Team, Oxfam, London, 1996.
5. Geneva Infant Feeding Association, 'Breastfeeding in refugee situations', *Breastfeeding Briefs, No. 21*, GIFA, Geneva, 1995.
6. Ockwell, R., *Assisting in Emergencies: A resource handbook for UNICEF field staff*, UNICEF, 1986.
7. McGrath, M., et al., *Meeting the Nutritional Needs of Infants During Emergencies: Recent experiences and dilemma, report of an international workshop*, Institute of Child Health, SAVE UK, London, 1999.
8. Robertson, A., et al., *How to Breastfeed During an Emergency: A guide for mothers*, WHO, Copenhagen, 1997.
9. Sokol, E., *The Code Handbook: A guide to implementing the international code of marketing and breastmilk substitutes*, International Code Documentation Centre and IBFAN, 1997.
10. United Nations Children's Fund, *Facts for Life*, New York, UNICEF, 2002.
11. *HIV and Infant Feeding Guidelines for Decision Makers*, UNICEF, UNAIDS, WHO and UNFPA, Geneva, 2003.

Web sites

1. Baby Friendly Hospital Initiative
<http://www.babyfriendlyusa.org/eng/01.html>
2. Breastfeeding.com
<http://www.breastfeeding.com>
3. CDC Breastfeeding Page
<http://www.cdc.gov/breastfeeding/index.htm>
4. Department of Nutrition for Health and Development (NHD)
<http://www.who.int/nut>

5. International Baby Food Action Network (IBFAN)
<http://www.ibfan.org/>
6. La Leche League International (LLLl)
<http://www.lalecheleague.org/>
7. The Academy of Breastfeeding Medicine
<http://www.bfmed.org/>
8. The Emergency Nutrition Network
<http://www.enonline.net>
9. The Linkages Project
<http://www.linkagesproject.org>
10. UNICEF
<http://www.unicef.org/nutrition/index.html>
11. Wellstart International
<http://www.wellstart.org/>
12. World Alliance for Breastfeeding Action (WABA)
<http://www.waba.org.my/>

Glossary

Breastmilk Substitutes (BMS) Any food being marketed or otherwise represented as a partial or total replacement of breastmilk, whether or not suitable for that purpose; in practical terms this includes milk or milk powder marketed for children less than 2 years and complementary foods, juices and teas marketed for children less than 6 months.

Colostrum The thick, yellowish milk the mother produces in the first few days after birth. It is very nutritious and helps protect the baby against infections by building the baby's immune system.

Exclusive breastfeeding Only breastfeeding or breastmilk feeding and no other foods or fluids (no water, no juices, no tea, no pre-lacteal feeds), with the exception of drops or syrups consisting of micronutrient supplements or medicines.

Infant An infant is a child under 12 months. For the purpose of breastfeeding promotion, however, where prime concern is for the period of the infant's life when milk feeding is essential, the term infant is used for those below 6 months only. This age coincides with the period for which exclusive breastfeeding is recommended by the World Health Assembly (WHA) in Resolution 47.5, 1994.

International Code of Breast-milk Substitutes The International Code of Marketing and Breast-milk substitutes was adopted by the World Health Assembly (the policy-setting body of WHO) in 1981. The aim of the 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.

Optimal infant and young child feeding Exclusive breastfeeding for the first six months of life, followed by continued breastfeeding with adequate complementary foods for up to two years and beyond.

Re-lactation The re-establishment of breastfeeding after the breastmilk supply has stopped, or is reduced.

Spill-over The feeding behaviour of new mothers who either know that they are HIV-negative or are unaware of their HIV status – they do not breastfeed, or they breastfeed for a short time only, or they mix-feed, because of unfounded fears about HIV or of misinformation or of the ready availability of breast-milk substitutes.

WHA resolutions Since 1981 the World Health Assembly has passed a number of Resolutions all of which have equal status with the Code. The Code and subsequent Resolutions aim to ensure that information on infant feeding is not influenced by commercial considerations, and that marketing practices do not undermine breastfeeding. The Code and Resolutions are therefore important safeguards for health workers, parents and infants, including those in emergency and relief situations.