BFHI NEWS

The Baby-Friendly Hospital Initiative Newsletter • Sept./Oct. 1999

Heldur Netocny/Lineair

A soldier's wife feeds her baby at a rest stop in Phnom Penh during the conflict in 1990.

Relief strategies must include plans for infant feeding

When Rita Bhatia was in the former Yugoslav Republic of Macedonia recently, she saw 6,000 feeding bottles that had been donated for use during the Kosovo crisis. "I offered to burn them," said Ms. Bhatia, Senior Nutritionist for the Office of the United Nations High Commissioner for Refugees (UNHCR). "But my colleagues worried about offending the donors we depend upon." While the donors are well meaning, Ms. Bhatia and others who are struggling to help those in emergencies see such contributions as counter-productive.

Emergency situations amplify concerns about artificial feeding. In refugee camps and other crisis-affected areas, the health risks associated with bottle feeding and breastmilk substitutes are dramatically increased due to poor hygiene, crowding and limited water and fuel. These conditions contribute to diarrhoea and, at worst, to higher infant mortality rates. Ms. Bhatia noted that both occurred during the Gulf emergency of 1991, when thousands of Iraqi Kurds fled across the mountains. "It was a healthy population, but we saw a liberal use of infant formula and baby bottles," she said. Later, when mortality rates were analysed, there was disproportionate wasting and death among children 0-2 years of age due, Ms. Bhatia contends, to feeding bottles. "We saw the same trends during the Kosovo crisis," she said. "Poor water and sanitation conditions created a high potential for outbreaks of water- and food-borne diseases."

Infant feeding strategies are an essential part of any emergency response, according to Yvonne Grellety, Nutrition Adviser in Emergencies at UNICEF. "Protecting and supporting existing breastfeeding should be part of the basic survival activities of all agencies working on nutrition in emergencies," she said.

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In emergencies, breastfeeding is safest method

The life-threatening conditions endured by refugees, the internally displaced and local populations in crisis — war, flood, drought or disease — are in direct opposition to the nurturing care infants need. To help provide that care, the United Nations and relief agencies agree that breastfeeding in emergency situations, as in better times, is the best feeding practice. Among the estimated 30 million refugees and internally displaced people in the world today, up to 2 million women could be breastfeeding their babies, according to figures from the International Baby Food Action Network (IBFAN).

Unfortunately, many women in crisis situations have not received the support needed to begin or continue breastfeeding. And the influx of infant formula and artificial feeding supplies from some donors has discouraged breastfeeding while adding to babies' risks of contracting diarrhoea and other infections, especially where there is poor hygiene and limited fuel and water.

In this issue of ***BFHI News,*** we explore some of these problems as well as several innovative programmes that are helping women breastfeed even under the most difficult conditions.

Accurate information will help relief agencies counsel mothers

From 1992 to 1995, Dr. Aileen Robertson was responsible for the nutrition work of the World Health Organization in Bosnia and Herzegovina. She is co-author of the manual Infant feeding in Emergencies: A guide for mothers (see Resources, page 8), *produced by the WHO Regional Office for Europe Nutrition Unit.*

What advice would you give to relief agencies when it comes to infant feeding in emergencies?

Humanitarian aid should not jeopardize the individual's right to be self-sufficient. Wherever possible, relief agencies should try to support and counsel mothers to continue breastfeeding or initiate relactation if possible. Aid agencies that are inexperienced or unfamiliar with infant feeding issues have a wealth of resources available from NGOs such as IBFAN and from UN agencies. The WHO Web site is one information source *(see Resources, page 8).*

Q & A

What about cases where infants are orphaned or separated from their mothers?

Formula and replacement feeding methods are often required during such times. Replacement options, depending on the circumstances, include wet nursing, expressed breastmilk from another woman, cow's milk that is diluted and fortified, and infant formulas that are supplied in a generic fashion according to the International Code and subsequent resolutions. Instructions and training manuals are needed to help clarify the different options, as there is still a good deal of confusion among relief workers, who often give mixed messages.

If formula and baby food are required, they should not be distributed indiscriminately but managed in a way that does not threaten infant health. Wherever possible, the media should be enlisted to help publicize the dangers of using formula in emergency situations. UN agencies should issue clear press statements on the importance of breastfeeding and formula's likely damage to health.

What can be done to reduce the risks of using infant formulas?

In emergency situations it is crucial that the health interests of infants, their families and society prevail over the profit interests of businesses that govern the marketing of breastmilk substitutes. Donors should be informed about the need to promote breastfeeding during crises and about the pitfalls of providing formula. Any donor helping NGOs that supply formula should ensure that the NGOs help train health professionals to manage its supply and use.

Ministries of health and other branches of government and civil society groups receiving humanitarian aid also need to be informed. When queried by agencies carrying out needs assessments, for example, government officials themselves often request infant formula as a priority item. This was the case in Bosnia and Herzegovina until the Ministry of Health realized that it wasn't formula that was needed, but support for breastfeeding. Many health professionals, both national and international, need more grounding in scientific facts.

Does distribution of formula have any long-term effects?

Often, those helping refugees and the internally displaced find entire emergency areas inundated with formula, with detrimental impact on the local population. With no policy to control their distribution, artificial feeding supplies sometimes end up in local markets, brought by refugees exchanging them for local food.

The spread of formula can have a dramatic adverse impact on traditional breastfeeding habits in a country. This would be a serious problem in a country where sanitation is poor. The risk for infection increased during Armenia's earthquake in 1988, a situation that was recently repeated in Turkey. Supporting breastfeeding in such circumstances is crucial.

Aileen Robertson

Do women in emergency situations need support for breastfeeding?

Absolutely, and support should ideally come from those with knowledge. In all emergency situations, field workers must understand the importance of breastfeeding and the potential risks of bottle feeding and using breastmilk substitutes. However, left to their own common sense, families will cope as they have done for thousands of years by breastfeeding. It is when well-meaning but uninformed people step in that the damage is most likely to happen.

Does stress in a crisis situation affect a woman's ability to breastfeed?

If stress interfered with breastfeeding, human beings would have become extinct long ago. Given that human beings have survived wars and natural disasters since the beginning of time, we know how robust the physiology of breastfeeding is. Furthermore, it appears that anti-stress hormones are produced during breastfeeding that help calm both the infant and the mother *(see Myths, page 5).* One of the problems is that in societies where bottle feeding has become the norm, mothers are unsure of their ability to breastfeed. Aid workers do not realize that when they distribute commercial milks and bottles, they may undermine a woman's confidence in her ability to nourish her own child. Severe stress or shock may inhibit milk flow temporarily, but putting the baby to the breast will soon stimulate production.

And what about a malnourished mother? Will she be able to sustain her child through breastfeeding?

While ideally a woman should have an extra 500 calories per day while breastfeeding, her body will adjust to lactation by using energy more efficiently. Only very severe lack of food stops lactation. Moreover, women

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Training manual synthesizes years of relief workers' experience in emergencies

Over the past few years, agencies confronting emergencies around the world have been increasingly concerned with the issue of infant feeding and have become more aware of Code violations during emergencies. As a result, agencies and NGOs have been working together to devise policies for promoting breastfeeding and managing formula distribution.

A training manual for relief workers that addresses infant feeding in emergencies is being developed by representatives from WHO, Linkages, IBFAN and UNICEF, along with other agencies and NGOs. The guide will reflect the years of experience and observations of professionals in the field and will address concerns about the inappropriate distribution of breastmilk substitutes in times of crisis.

In 1994, a World Health Assembly (WHA) resolution recommended that during emergencies, member States should continue to support breastfeeding, and promote the use of infant formula only under certain conditions *(see box below)*. UNICEF sent an annotated version of the recommendations out to field workers. That same year, agencies working in Bosnia and Herzegovina combined elements of the Code and its subsequent resolutions, along with the Innocenti Declaration and other documents, in a Joint (UNICEF/UNHCR/WFP/WHO) Statement on infant feeding in former Yugoslavia. The document was recently adapted for the Kosovo crisis under the title Policy on Infant Feeding in the Balkan Region.

Members of IBFAN, several NGOs and UN agencies meeting in Geneva in 1995 issued a document entitled Crucial aspects of infant feeding in emergency and relief situations, which outlines the risks inherent in infant formula and proposes strategies and policies to promote breastfeeding. A series of national meeetings followed, and in October 1998, a follow-up international meeting was held in Split (Croatia). The group began work on the next step — to create a training manual addressing the issue of infant feeding and make it available to all relief agencies.

In September and November of this year, a working group will convene in London to review the manual, with field testing expected to be completed by the end of 1999.

Q&A, continued from previous page

who have lost weight during lactation or were already underweight during pregnancy have the capacity to breastfeed normally. There are no special foods required to produce breastmilk, but a normal variety of safe, healthy food is needed to replace the mother's own nutrient stores. Where there is a shortage of food, nourishment should be provided for the mother so that she may feed her child.

What do mothers in emergency situations need to increase their confidence and help them breastfeed?

More than anything, they need reassurance and help in reinforcing breastfeeding skills, which in turn boost their confidence in themselves and their own ability to breastfeed. Women who have been successful at breastfeeding can provide the support needed to other mothers — sometimes more effectively than the health care services. Therefore, health professionals should try to arrange mother support groups as a mechanism to support women.

Code resolutions protect mothers from exploitation by manufacturers

The International Code of Marketing of Breastmilk Substitutes and subsequent World Health Assembly (WHA) resolutions aim to ensure that the marketing practices of manufacturers do not exploit an emergency situation for commercial gain.

WHA resolution 47.5, adopted in 1994, counsels member States to "Exercise extreme caution when planning, implementing or supporting emergency relief operations by protecting, promoting and supporting breastfeeding for infants, and ensuring that donated supplies of breastmilk substitutes or other products covered by the scope of the International Code be given only if all the following conditions apply:

a) infants have to be fed on breastmilk substitutes ... [*see guidelines in document WHO A39/8 Add. 1, 10 April 1986*];

b) the supply is continued for as long as the infants concerned need it;

c) the supply is not used as a sales inducement."

The UNICEF publication *Assisting in Emergencies: A handbook for field staff*, annex 4, provides an additional recommendation: "When breastmilk substitutes are unavoidable ... ensure that every child who must use breastmilk substitutes has a supply adequate to meet his or her full need, normally until the age of about one year. A full year of supply is 40 kg."

Providing an understanding of the Code and subsequent resolutions is essential for all involved in emergency feeding programmes, according to David Clark, Legal Officer for UNICEF. "There are always the well-intentioned but misinformed people whose first response might be to ship off huge quantities of infant formula," he said. "But agencies must understand the increased risk to infant health when there is an attempt to use artificial feeding."

In addition to lack of fuel and safe water for preparing formula, and limited supplies, problems have arisen in emergency situations, according to Mr. Clark, because "there is evidence of manufacturers sending products that have almost reached the expiration date."

In all cases, Mr. Clark added, "the distribution of breastmilk substitutes must be very carefully controlled."

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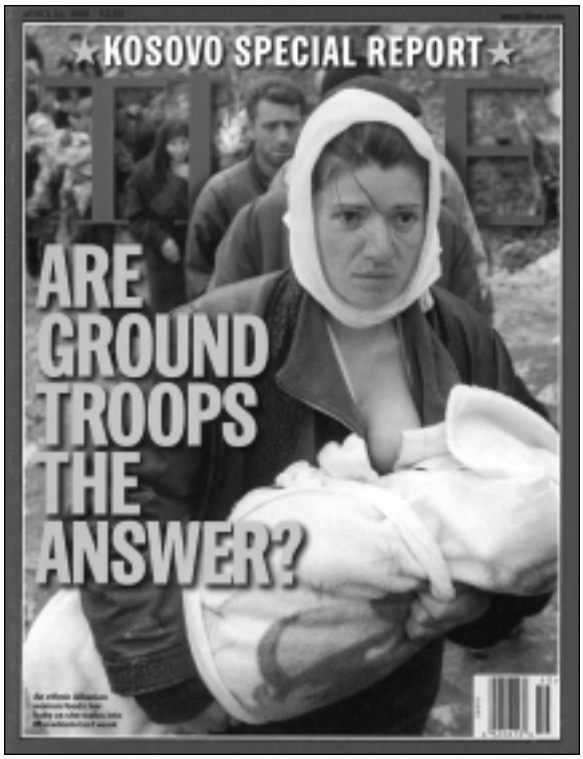
This means that women and their young children must remain together, she explained, and should never be separated for meal programmes or when hospitalized. Furthermore, Ms. Grellety said, "Food and nutrition programmes must give priority to breastfeeding women, ensuring that family rations in emergencies include sufficient food for them."

Moreover, mothers should be encouraged to avoid bottle feeding. "Bottle feeding is bad in normal circumstances, and disastrous in emergencies," said Ms. Grellety. "With the rapid deterioration of hygiene and lack of safe water, it may be impossible to clean the bottles. In such cases, women can turn to cup feeding or, depending on individual circumstances, relactation," she said. *(For more information on cup feeding, see* **BFHI News***, May/June 1999.)* She believes that women who are using feeding bottles — containing their own breastmilk or substitutes — at the outbreak of a crisis should be helped to relactate. Ms. Grellety pointed to a successful example of this in Africa, where women were assisted in re-stimulating lactation in order to feed their severely malnourished infants *(see story, page 6).*

In spite of the risks long associated with their use, breastmilk substitutes do have a place, albeit limited, in some emergency situations, according to Ms. Grellety. "Infants who have no mother and, for one reason or another, cannot be breastfed by another woman or cannot get breastmilk from a milk bank have a clear need for infant formula of some kind," she said. However, to avoid commercial exploitation of crises, UNICEF, WHO and other organizations say that supplies of formula should be limited and always generically labelled. Large supplies of formula delivered to a country during an emergency may end up in local markets, potentially interfering with local breastfeeding practices.

In Kosovo, Ms. Bhatia attributed the fact that infant formula was donated in large quantities to the "misconceptions of donors," who assumed that bottle feeding was the norm in the region. In fact, she said, "Many people live in rural settings where there is a strong tradition of breastfeeding."

Whether an emergency makes media headlines or takes its toll quietly, as in the 'silent emergency' of malnutrition, the survival, growth and development of infants and young children can clearly be enhanced by breastfeeding. Under trying and difficult circumstances, mothers need additional support both to remain confident in their ability to breastfeed and to understand the many benefits of the practice.



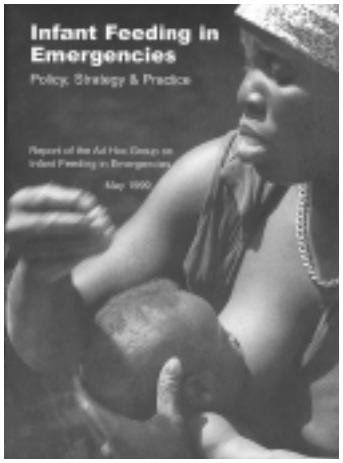
Images presented in the media can influence how relief agencies — and the public — perceive infant feeding. In this cover photograph of the 12 April 1999 issue of Time *magazine, an ethnic Albanian woman breastfeeds her baby as she crosses the border into TFYR Macedonia. (Reprinted with permission.)*

Emergency Nutrition Network shares field experiences

The Emergency Nutrition Network (ENN) was established in 1996 to help agencies share experiences in order to avoid the need to "reinvent the wheel" each time an emergency arose, according to Fiona O'Reilly, ENN Coordinator.

The Network's primary tool is its newsletter, *Field Exchange*, which is published three times a year and includes personal accounts and observations from those in the field, along with summaries of research related to food and nutrition.

The first issue of the newsletter, published in May 1997, looked at the challenges of infant feeding in emergency situations. It included first-hand observations of field workers that were intended to "raise awareness and stimulate debate on some of the issues involved, as well as to highlight the real constraints on the ground," said Ms. O'Reilly.



ENN assisted in publishing this 1999 report.

For example, an article titled 'Experience from Rwanda' described the problems in caring for infants who were separated from their mothers and the need for generically labelled breastmilk substitutes.

ENN also works closely with the Infant Feeding in Emergencies Group, whose report, *Infant Feeding in Emergencies: Policy, Strategy & Practice,* was published in 1999 *(see Resources, page 8).*

Putting together a policy for unaccompanied infants and children

When Sarah Uppard, a Separated Children's Adviser with the emergency and development NGO Save the Children (UK), worked in Rwanda during the rapid repatriation of refugees who had fled to the Congo in 1996, she saw many infants among the thousands of unaccompanied children. "Mothers had been killed, and people had picked up their babies to bring them back into the country. Some of these infants had not eaten anything in some time," she recalled.

The relief workers "were not prepared for this situation," Ms. Uppard said. "At first we had to give babies water to rehydrate them. While wet-nursing was considered the most appropriate alternative, it wasn't practical due to the vast numbers of people moving so quickly. Finally, we had to send people off to buy formula in nearby towns, which we were able to feed to the babies with cups."

Save the Children (UK), which works in 60 countries, and has been involved with infant feeding issues for many years, has been a strong proponent of the International Code of Marketing of Breastmilk Substitutes. The organization provides funds to the NGO Baby Milk Action, the UK affiliate of IBFAN.

According to Lola Gostelow, Livelihood (Food and Nutrition) Adviser, "In recent years, infant feeding in emergencies has emerged as a top priority." Peter Poore, Senior Health Adviser, adds, "Breastfeeding is now promoted in all relief situations."

Experiences like Ms. Uppard's in Rwanda provided a catalyst for inter-agency development of infant feeding guidelines. "It set the ball rolling on providing support for programmes dealing with unaccompanied infants," said Ms. Gostelow. Along with other UK-based organizations, Save the Children formed the Infant Feeding in Emergencies Group to develop policy and strategies. In 1998, the group published *Infant Feeding in Emergencies: Policy, Strategy & Practice* under the auspices of the Emergency Nutrition Network *(see story, page 4).*

"The report outlined a continuum of options for infant feeding during times of crisis," Ms. Gostelow said, "giving the highest priority to breastfeeding and the lowest to traditional animal milk-based breastmilk substitutes. In between are relactation, wet-nursing (safeguarding against risk of HIV), milk banks and so on." If infant formula has to be used, she stressed, it is essential to make its use as safe as possible in emergencies while at the same time promoting breastfeeding through wider public health messages.

The basic thrust of the report, said Ms. Gostelow, "is to force people to confront infant feeding as part of the big picture, to think it through in order to plan for it effectively. It is important for people to make informed decisions on programme responses and to understand the implications of each choice."

Like many organizations examining infant feeding in emergencies, Save the Children (UK) has come a long way since the days of the Rwanda crisis and now makes breastfeeding a nutritional priority. "By the time we got to Kosovo," Ms. Uppard recalled, "we always asked if formula was being given and why."

UNICEF/96-0767/Lemoyne

A woman returning to Rwanda from a refugee camp in eastern Zaire (now the Democratic Republic of Congo) carries her baby on her back and her belongings on her head.

Dispelling myths about breastfeeding in crisis

Dr. Jack Newman, a paediatrician and chair of the Infant Feeding Action Coalition (INFACT) Canada, an IBFAN affiliate, believes strongly that breastmilk is best when conditions are worst. "The importance of breastfeeding is elevated in emergencies. The recent situation in the Balkan region was a perfect example. People were hiding in the hills. If women didn't breastfeed, how else would they feed their babies?" But very often, women are discouraged from breastfeeding by myths and misconceptions that suggest breastmilk is not good enough.

Here, Dr. Newman helps dispel several myths about breastfeeding that can undermine both a mother's confidence and the support she receives when she is fighting to survive an emergency situation with her baby.

Myth: Stress makes milk dry up. While extreme stress or fear may cause milk to momentarily stop flowing, this response, like many other physiological responses to

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'Supplemented suckling' method gets malnourished infants back to the breast

Severely malnourished infants in Liberia were able to regain the strength to breastfeed exclusively after intervention that combined therapeutic feeding with a programme to increase breastmilk production, according to a study conducted by Mary Corbett, a graduate student from the University of Aberdeen (Scotland). The results "exceeded expectations," said Dr. Michael Golden of the Department of Medicine and Therapeutics at the University of Aberdeen, who supervised the programme. The programme has since been repeated with similar success in Burundi and Chad.

According to Dr. Golden, a number of partially breastfed infants under six months of age who were admitted to a therapeutic feeding centre operated by Action contre la faim (Action against Hunger) in 1998 in Monrovia were in dire need of corrective nutrition.

The initial stages of malnutrition are often due to infants receiving foods other than breastmilk, so that adequate production of breastmilk is not stimulated, said Dr. Golden. "Once the infant becomes malnourished, even switching back to exclusive breastfeeding may not work because by that time the baby may be too weak to suckle effectively." Therefore, attempts to reinstate exclusive breastfeeding often fail and relief workers turn to feeding alternatives. However, Dr. Golden said, "If these infants are discharged without the protection of breastmilk, it will be a disaster." But simply giving a therapeutic milk diet by cup or tube, even with the mother's expressed breastmilk added, does not ensure continued breastfeeding, and thereby increases risks to the child's subsequent health.

Twenty-one infants were selected to partake in the study. Initially, they all had a trial of exclusive breastfeeding to see if they could gain weight on breastmilk alone. For those who did not, Dr. Golden and his colleagues then turned to a technique that he calls 'supplemented suckling', which allowed infants to benefit from a nutritional supplement while at the same time partaking of their mothers' milk at the breast, until full breastfeeding could be re-established.

The infants were fed F100, a therapeutic milk product used for nutrition rehabilitation, diluted to 70 kcal/100 ml. The feeding method, which is outlined below, helped infants become reoriented to suckling at the breast, allowed them to regain their strength to do so, and eventually re-established the mothers' milk production.

• The mother put the baby to her breast every three hours, around the clock.

• One hour after the breast-only feed, the infant was put back on the breast, but this time with a fine tube put into the infant's mouth along the nipple. (This made a total of 16 breastfeeds in each 24-hour period, half with the supplementer.)

• The infant was fed diluted F100 through the tube from a cup held by the mother.

• The energy required for suckling depended on the height at which the cup was held, so the mother could adjust the height of the cup as the infant's strength increased.

• As it suckled on the tube and breast together, the infant was stimulating the breast, so increasing amounts of maternal milk were produced and mixed with the supplement at these eight feedings.

• The infant's weight gain was monitored daily.

• The amount of diluted F100 was reduced as the mother's own milk began to flow more amply.

According to Dr. Golden, the infants in the study gained weight at a "phenomenal rate," averaging about 14.7 grams per day per kilo — 44 grams per day for a 3 kilo infant. The supplemented suckling routine was followed on average for 13 days per infant, and in that time a 3 kilo infant would put on another half kilo of weight. "By this time, the infants had regained weight to 85 per cent of the expected weight for their length, and the supplemented suckling was stopped," said Dr. Golden. "The babies were vigorous and were suckling effectively."

Another week of observing the infants breastfeeding exclusively showed that the babies continued to gain weight well; for the 3.5 kg infant, this was about 35 grams a day, or a quarter of a kilo per week. At this point, babies and mothers were discharged.

Although some issues need to be resolved, including proper hygienic care of the fine tube during emergency conditions, the method has since been introduced in all the Action contre la faim therapeutic feeding centres around the world.

According to Dr. Golden, "Supplemented suckling has been found to be a simple and effective technique."

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anxiety, such as accelerated heart rate and sweating, is usually temporary. In addition, Dr. Newman points out, the act of breastfeeding may calm both mother and child. "There is growing evidence that breastfeeding produces hormones — particularly oxytocyn but also prolactin — that actually reduce tension, calm the mother and baby and create a loving bond," Dr. Newman said. "Even being on the move does not prevent women from breastfeeding."

The Emergency Nutrition Network (ENN) warns that a stressful situation might prevent a mother from putting her baby to her breast often enough, and this could affect milk supply. Otherwise, there is no reason why stress need interfere with breastfeeding.

Myth: Malnourished mothers cannot breastfeed. Moderate malnutrition has little or no effect on milk production, and a mother in such a condition will continue to produce milk. "Malnutrition would have to be extreme to prevent a mother from being able to feed her baby," Dr. Newman said. For this reason, he added, "During emergencies, it makes no sense to let the mother go hungry while truckloads of formula are brought in. Food should go to the mothers so they can feed their babies and maintain the strength to care for older children in the family as well."

Myth: Babies with diarrhoea need water or tea. Breastmilk provides all the fluids a baby needs, along with other nutrients. "Breastmilk is 90 per cent water. The baby will know what it needs and will drink if thirsty." However, in cases of severe diarrhoea, oral rehydration therapy, which involves liquids, may be appropriate if admin-

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Mothers and babies benefit from a place of their own: Two success stories

Amid the scramble to provide adequate shelter and care in emergency situations, the outline is emerging of an effective and low-cost intervention: providing a safe place where mothers can rest, eat and receive good advice about breastfeeding and nutrition.

UNICEF/98-0612/Balaguer

A woman breastfeeds her baby at a school serving as a temporary shelter in the city of Choluteca (Honduras) during Hurricane Mitch in 1998.

In the past, mothers may have received some breastfeeding support at health centres, feeding centres or hospitals, but care for their healthy children often got lost in services for those who were severely ill or malnourished. "There is a need for another level of care, specifically for mothers and their infants, separate from the sick children," said Yvonne Grellety, Nutrition Adviser in Emergencies for UNICEF. This involves rest and food, education and support in a safe environment. Mothers who receive such care, she said, "are better able to care for their babies." Two recent country examples attest to this.

Albanian camp provides support

In a refugee camp in Kukes (Albania), Anne Sophie Fournier, Technical Director for Action contre la faim (Action against Hunger), observed how a tent set up for washing babies and staffed by relief workers became an ad hoc meeting place for breastfeeding support. "Women with infants found they could take care of their older children while also consulting with advisers, nurses and midwives about their breastfeeding concerns," she said.

Soon, each of the six camps in Kukes had a space set aside where mothers could breastfeed and bathe their children. This enhanced support for breastfeeding, said Ms. Fournier, raised awareness of the indiscriminate use of infant formula in the camps, and led to its regulation. A relactation programme was started to help mothers who had used donated formula to resume breastfeeding.

Emergency shelters become baby-friendly in Honduras

In Honduras, the principles of BFHI were adapted for use in shelters housing victims of the devastating Hurricane Mitch in October 1998.

During the emergency, said Adriana Hernandez, Assistant Programme Officer for UNICEF Honduras, "neighbouring countries and organizations were donating bottles, infant food and infant formula, which had the potential to undermine the advanced state of breastfeeding promotion in the country."

A three-week project, initiated by the Honduran Health Ministry and supported by UNICEF, offered counselling and support for breastfeeding mothers with children under two years of age. Trained breastfeeding counsellors from nearby health centres were assigned to the temporary shelters. Eighteen shelters housed 2,354 people, including 236 infants under six months of age and 52 pregnant women. The World Food Programme donated food rations and nutritional cookies for lactating mothers to improve their nutritional status. UNICEF donated cups to replace feeding bottles, and storage containers for expressed breastmilk.

The most important component of the project, according to Ms. Hernandez, was the opportunity for interaction with mothers. Mothers, grandmothers and caregivers could meet one-to-one with breastfeeding counsellors and view demonstrations of healthy, hygienic and low-cost food preparation. Health centre personnel saw to the health needs of children under five years of age. Posters and leaflets with breastfeeding recommendations were given to all mothers. Once the crisis ended, participating health centres and volunteers received diplomas from Honduran health authorities to acknowledge the importance of their work.

While the project's success has led to discussions of expanding the concept within Honduras during non-emergency times, it is also a model worth duplicating in crisis areas around the world. With donor assistance, places where mothers can receive care and support can become a regular feature of emergency response programmes.

Myths, continued from previous page

istered correctly. Since water is so often contaminated in emergency situations, the use of other fluids such as tea or glucose water should be avoided.

Myth: Once breastfeeding has stopped, it cannot be resumed. Relactation is often possible, though it might take some time. "It might be hard in emergency situations, but relactation experts can help," said Dr. Newman. If only a week or so has passed since breastfeeding stopped and the mother has a good milk supply, the process will likely be a smooth one for a baby accustomed to taking the breast. "I have even seen babies go back to the breast after four to six months," he said. In South Africa in the early 1980s, Dr. Newman worked at the Umtata Hospital in Umtata, in the Eastern Cape province, where mothers and their babies were helped to restart breastfeeding after they had switched to formula donated by a large manufacturer.

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In 1990, a policy makers' meeting was convened in Florence (Italy) to reinforce a worldwide commitment to breastfeeding as the best possible nutrition for babies. The resulting Innocenti Declaration set specific targets that would guide countries in their efforts to protect, support and promote breastfeeding. The UNICEF/WHO Baby-Friendly Hospital Initiative was established in response.

BFHI News, produced bimonthly by the Division of Communication, UNICEF New York, is committed to reporting on progress towards meeting the targets set forth by the Innocenti Declaration as well as the activities of countries participating in the Baby-Friendly Hospital Initiative.

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Exclusive breastfeeding results in lower transmission of HIV than mixed feeding

A group of infants exclusively breastfed by HIV-positive mothers were 48 per cent less likely to become infected with the virus than a partially breastfed group who had also received other fluids or foods.

The study is reported in the breastfeeding paper for the month of August 1999, 'Influence of infant-feeding patterns on early mother-to-child transmission of HIV-1 in Durban, South Africa: A prospective cohort study', by A. Coutsoudis et al., *The Lancet* 1999; 354: 471-476. The important message is that in the first months of life, exclusive breastfeeding rather than partial breastfeeding seems to be the best option for an HIV-positive mother who chooses to breastfeed, just as it is the best for all infants of HIV-negative and untested mothers. For copies, contact UNICEF field offices or the UNICEF Nutrition Section, 3 UN Plaza, TA-24, New York, NY 10017, USA.

Breastfeeding paper of the month

Resources

The following will provide more information on infant feeding in emergencies:

Crucial Aspects of Infant Feeding in Emergency and Relief Situations, International Baby Food Action Network, available from IBFAN Geneva, tel: 41-22-798-9164; fax: 41-22-798-4443.

Humanitarian Charter and Minimum Standards in Disaster Response: Minimum Standards in Nutrition, The Sphere Project, tel: 41-22-730-4501; fax: 41-22-730-4999; e-mail: <sphere@ifrc.org>.

Infant Feeding in Emergencies: Policy, Strategy & Practice, report of the ad hoc group on Infant Feeding in Emergencies. Available from the Emergency Nutrition Network, tel: 353-1-608-2676; e-mail: <foreilly@tcd.ie>.Web site: <www.tcd.ie/enn/>.

Infant feeding in emergencies: A guide for mothers, a World Health Organization publication. EU/ICP/LVNG 01 02 08. Contact WHO Europe, tel: 45-39-17-1362; fax: 45-39-17-1854.

WHO Web sites, <www.who.dk/cpa/Kosovo/infant.htm> and information on infant feeding in emergencies at: <www.who.dk/tech/hp/hp02.htm>.

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