



**ACF-INTERNATIONAL
MANUAL**

BABY FRIENDLY SPACES

Holistic Approach for Pregnant, Lactating Women and their very young children in Emergency



Baby Friendly Spaces

Holistic Approach for Pregnant, Lactating Women and
their very young children in Emergency

December 2013

Scientific and Technical Department

Action contre la Faim-France



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ABBREVIATIONS AND ACRONYMS

ABC	Assisting Behaviour Change
ACF	Action contre la Faim
ADBB	Alarm Distress Baby Scale
AIDS	Acquired Immuno Deficiency Syndrome
BFHI	Baby Friendly Hospital Initiative
BFS	Baby Friendly Space
BMS	Breast milk substitutes
ENN	Emergency Nutrition Network
FBF	Fortified Blended Food
HIV	Human Immuno-deficiency Virus
IASC	Inter Agency Standing Committee
IDP	Internally Displaced Person
IFE	Infant Feeding in Emergencies
IRA	Initial Rapid Assessment
IYCF	Infant and Young Child Feeding
IYCF-E	Infant and Young Child Feeding in Emergencies
IASC	Inter Agency Standing Committee
IBFAN	International Baby Food Action Network
KMC	Kangaroo Mother Care
LBW	Low Birth Weight
MAM	Moderate Acute Malnutrition
MAMI	Management of Acute Malnutrition in Infants
MCH	Mother & Child Health Care Centre
MHPSS	Mental Health and Psycho-Social Support
MUAC	Mid Upper Arm Circumference
ORS	Oral Rehydration Salt
PFA	Psychological First Aid
PIF	Powdered Infant Formula
PMTCT	Prevention of Mother to Child Transmission of HIV-aids
PTSD	Post-Traumatic Stress Disorder
SAM	Severe Acute Malnutrition
RUIF	Ready to Use Infant Formula
RUTF	Ready to Use Therapeutic Food
SFP	Supplementary Feeding Programme
TFC	Therapeutic Feeding Centre
TFP	Therapeutic Feeding Programme
W/H	Weight for Height
WaSH	Water, Sanitation and Hygiene
WHA	World Health Assembly
WHO	World Health Organisation

TABLE OF CONTENT

Statement on copyright	4
Disclaimer	4
Acknowledgements	5
Table of Content	7
Abbreviations and Acronyms	6
Terminology	9
Introduction	13
1. The six Care Practices in emergency contexts	17
1.1. Care for women	18
1.2. Breastfeeding and feeding practices	27
1.3. Psychosocial care	36
1.4. Hygiene practices	44
1.5. Meal preparation and conservation	46
1.6. Home Health Practices	47
2. Baby Friendly Spaces	51
2.1. Objectives and target group	53
2.2. Admission and exit criteria for Baby Friendly Spaces' beneficiaries	56
2.3. Description of the Baby Friendly Space	58
2.4. Evaluation of Baby Friendly Spaces' results and impact	64
2.5. Referral system	66
2.6. Phase out	67
3. Activities	71
3.1. Welcoming beneficiaries and sharing basic information	74
3.2. Intake	76
3.3. Psycho-social support	78
3.4. Psychological support	82
3.5. Group discussion sessions	85
3.6. Relaxation exercises	87
3.7. Baby Massage	89
3.8. Baby bath and activities around hygiene practices	92
3.9. Play sessions	94
3.10. Breastfeeding counselling	96
3.11. Activities around Complementary Feeding	103
3.12. Infant and Young Child Growth Monitoring	104
3.13. Home visits	105
3.14. Community sessions	108
4. Feeding of the non-breastfed infant	109
4.1. Introduction	110
4.2. Alternative solutions to BMS	110
4.3. Inclusion and exclusion criteria for artificial feeding programme	113



4.4. Choice of Breast Milk Substitute	117
4.5. Quantities of BMS	120
4.6. Step by step guide for provision of BMS to infants	124
4.7. To prepare for feeding:	125
4.8. Care practices for non-breastfed infants	129
4.9. Feeding the infant	132
4.10. Low Birth Weight babies	133
5. Technical Information on breastfeeding and child feeding	137
5.1. How does breastfeeding work?	138
5.2. Important information and messages about breastfeeding and feeding practices	144
5.3. Common breastfeeding problems	146
5.4. Common Myths and Misconceptions about breastfeeding	156
5.5. Specific techniques for breastfeeding: expressing breast milk, heat treated breast milk, relactation.	160
5.6. Advice for care of infants and young children in health facilities	169
6. Infant and young child feeding and HIV in emergencies	170
7. Management of unsolicited & unmonitored distributions of BMS	177
7.1. Introduction	178
7.2. The International Code of Marketing of Breast milk Substitutes	179
7.3. Activities to implement the “Operational Guidance on IYCF-E”	181
TABLE OF FIGURES	186
TABLE OF CONTENT	188

TERMINOLOGY

ARTIFICIAL FEEDING

Feeding with breast milk substitute.

BEHAVIOUR CHANGE

Behaviour Change initiatives have the objective to facilitate the attainment of project objectives, through the reinforcement of positive practices, the definition of new or alternative practices, and the promotion of structural changes of the involved psychosocial variables: knowledge, attitudes, behaviors, social practices, that have a structural influence (negative and positive) on many individual, social and community problems of direct humanitarian interest. For more details, see ACF guidelines on Assisting Behavior Change, 2013.

BREAST MILK SUBSTITUTE (BMS)

Any food being marketed or otherwise represented as a partial or total replacement for breast milk, whether or not suitable for that purpose. In practical terms, foods may be considered BMS depending on how they are marketed or represented. These include infant formula, other milk products, therapeutic milk, and bottle-fed complementary foods marketed for children up to two years of age and complementary foods, juices, teas marketed for infants under six months.

CARE PRACTICES

The behaviours and practices of caregivers (mothers, siblings, fathers and child care providers) that provide the food, stimulation and emotional support necessary for children's healthy growth and development. These practices translate food security and health care into a child's well-being. Not only the practices themselves, but also the way they are performed (with affection and with responsiveness to children) are critical to children's survival, growth and development. It is impossible for caregivers to provide this care without sufficient resources, such as time and energy.»¹

COMPLEMENTARY FEEDING (PREVIOUSLY CALLED “WEANING”)

Of the act of providing complementary foods in addition to breast milk or infant formula.

COMPLEMENTARY FOOD

Any food, whether industrially produced or locally-prepared, used as a complement to breast milk or to infant formula when either becomes insufficient to satisfy the nutritional requirements of the

1 - Engle, P.L. et al., (2000), The role of care in nutrition programmes: current research and a research agenda. Proceedings of the Nutrition Society, 59(1): p. 25-35.



infant (from the age of 6 months). Complementary foods marketed for children less than 6 months are breast milk substitutes.

Note: complementary foods should not be confused with supplementary foods which are commodities intended to supplement a general ration and used in emergency feeding programmes for the prevention and re-education of malnutrition and mortality in vulnerable groups.

CONTINUED BREASTFEEDING

The continuation of breastfeeding, in addition to complementary food, after the age of 6 months.

COUNSELLING

Counselling is an approach in which therapists or experts offer advice and support to someone for a specific problem. The term encompasses multiple approaches in the field, from actual treatment by qualified personnel to large-scale projects staffed by unqualified personnel, trained in a few days to “get victims to talk,” especially after natural disasters. ACF implements psychological support operations for populations, the aim of which is therapeutic, using personnel trained over a long period and supervised by expert psychologists; but does not subscribe to the large-scale counselling or debriefing strategy¹, whose limits and risks to both victims and teams have been demonstrated.

EARLY OR TIMELY INITIATION OF BREASTFEEDING

Placing the infant on the breast within the first hour after birth.

EXCLUSIVE BREASTFEEDING

Infant receiving only breastfeeding or breast milk feeding (including expressed milk or from a wet nurse) and no other foods or fluids, no water, no juice, no tea, no pre-lactaeal feeds; with the exception of drops or syrups consisting of micronutrient supplements or medicines.

INFANT FORMULA

A breast milk substitute formulated industrially in accordance with applicable Codex Alimentarius standards (developed by the joint FAO/WHO Food Standards Programme).

- **Generic infant formula:** unbranded infant formula, not available on the open market, thus requiring a separate supply chain.
- **Commercial infant formula:** infant formula manufactured for sale and available for purchase in local markets.

INFANTS

Children less than 12 months of age.

¹ - Cf. IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, 2007.

MENTAL HEALTH

The term “mental health” can refer to different, yet juxtaposed, realities: problems that disrupt the social equilibrium, pathological disorders and mental suffering, ACF uses the WHO’s broad, public health-related concept of mental health: a state of mental well-being, and not just the lack of mental disorder or addictive behaviours (drugs, alcohol, etc.). As such, it applies to all human beings and forms an integral part of their health, determined by social, environmental, biological and psychological factors.

MILK AND MILK PRODUCTS

Includes a wide variety of products, such as dried whole, semi-skimmed or skimmed milk; liquid whole semi-skimmed or skimmed milk; soy milks; evaporated or condensed milk; fermented milk or yoghurt or industrial milk derivatives (e.g. “creamers”).

MIXED FEEDING

Breastfeeding in combination with breastmilk substitutes.

OPTIMAL INFANT AND YOUNG CHILD FEEDING (IYCF)

Exclusive breastfeeding for the first 6 months of life, followed by continued breastfeeding with adequate complementary foods for up to two years and beyond.

PREDOMINANT BREASTFEEDING

Infant less than 6 months old with breast milk as predominant source of nourishment, but who also receives other fluids such as water-based drinks, fruit juice and ritual fluids. It cannot include non-human milk or food-based fluids.

PRELACTEAL FEED

Food or drinks given to a baby before breastfeeding.

PSYCHOSOCIAL

The term describes an individual’s psychological well-being and development (cognitive, affective and emotional) and his or her interaction in a social environment. In the human sciences there are a variety of approaches in which the psychological and social converge. One of these is assistance to people during critical events such as disasters. Psychological support -in its original sense- is a process that aims at helping people recover through a collective approach centred on knowledge of individual needs and of the grieving process. While psychosocial and social aspects are often affected in situations where ACF intervenes - and justify an analysis of the situation’s impact



on both social and family organisation and the individual - the term is often broadly (indeed incorrectly) used in humanitarian contexts for any programme that in any ways aims at improving the well-being of the population.

PSYCHOLOGICAL SUPPORT

Therapeutic method provided by psychologists or psychiatrists for persons with psychological difficulties.

RELACTATION

The re-establishment of breastfeeding after the breast milk supply has stopped or is reduced.

YOUNG CHILDREN

Children aged 12 to 24 months.

INTRODUCTION

The Baby Friendly Spaces is a model of intervention for a holistic program to support pregnant, lactating women and their children in emergency situations.

The Baby Friendly Spaces objectives are:

- Prevent the increase of malnutrition, morbidity and mortality rates
- Help the family to adapt care practices to the emergency and post-emergency context
- Improve the well-being of pregnant women, infants, young children and their mothers/ caregivers, taking into account life experiences, past and present difficulties
- Provide a safe and private space for pregnant, lactating women and their infants
- Help families to facilitate child development and survival
- Prevent or reduce the negative effects of unsolicited and unmonitored distributions of breast milk substitutes
- Provide appropriate and sustainable solutions for infants for whom breastfeeding is not an option

Therefore, the Baby Friendly Space's main objective and line is *to take care of the mother/ caregiver in order to support her/him to take care of the child/infant*.

Baby Friendly Spaces do not only focus on breastfeeding and the child. The goal of the BFS is a holistic psychosocial program that aims at providing comprehensive support to children and their caregivers who are facing emergency situations. Infants and young children belong to the most vulnerable groups. They depend on other people to care for them, they are vulnerable to diseases and malnutrition and what children experience during the early years sets a critical foundation for their entire life course - as research confirmed a strong relation between child survival and child development¹. The child's well-being is the result of different components: health, food and economical resources, as well as the type and quality of the caregiver-child relationship. As the following scheme demonstrates, these components are all linked with each other, and malnutrition or delays / disorders in child development are usually the result of multiple factors. If the living situation becomes unstable, such as in emergency contexts, there is a direct impact on the child's growth and/or development.

1 - WHO (2007). Early Child Development, a Powerful Equalizer, Commission on the social determinants of health.

As shown in this diagram, child care practices appear in the central place among these various components:

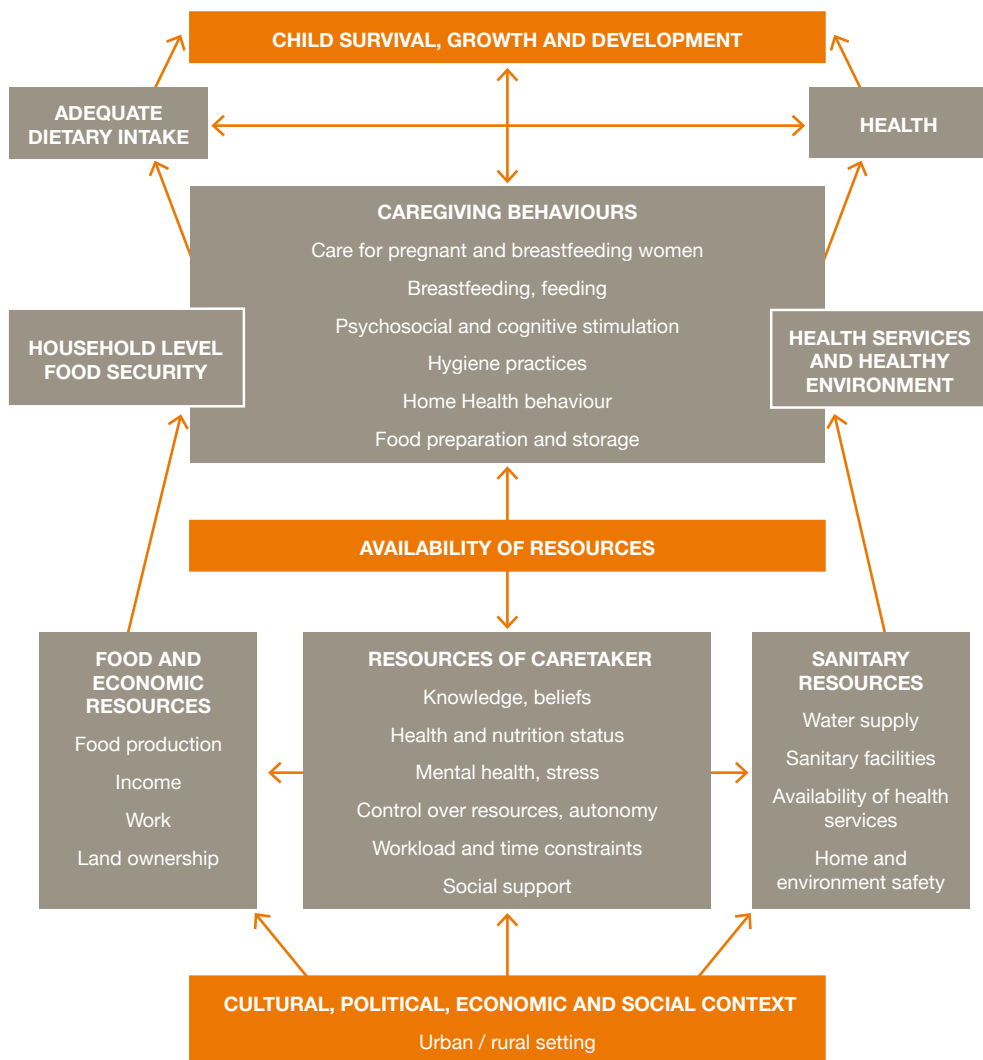


Fig. 1: Extended care model by Engle (1997).

The care initiative: assessment, analysis, and action to improve care for nutrition, UNICEF.

Action contre la Faim relies on the definition of care practices proposed by Engle (1997)¹: *“the behaviors and practices of caregivers (mothers, siblings, fathers and child care providers) that provide the food, stimulation and emotional support necessary for children’s healthy growth and development. These practices translate food security and health care into a child’s well-being. Not only the practices themselves, but also the way they are performed (with affection and with responsiveness to children) are critical to children’s survival, growth and development. It is impossible for caregivers to provide this care without sufficient resources, such as time and energy”*.

Six care practices have been selected in the Initiative Care Manual which was published by UNICEF in 1997: care for women, breastfeeding and feeding practices, psychosocial care, food preparation, hygiene practices and home health practices. Helping caregivers by supporting, developing or maintaining the use of appropriate care practices appear as a fundamental point for the protection of children’s health, nutritional status and development.

The importance of Infant and Young Child Feeding in Emergency has been recognised through the Innocenti Declaration², the WHO Guiding Principles for Feeding Infants and Young Children in Emergencies³ and the IFE Core Group Operational Guidance⁴ and many other documents. As such feeding and breastfeeding are the key issues on which most agencies and organization focus upon.

ACF is of the opinion that guidance for infant and young child feeding should go beyond the feeding aspect, to include all care practices, as their promotion is essential to preventing an increase in morbidity, malnutrition and mortality. Furthermore, care practices are essential to the reinforcement of optimal development, mother/caregiver-child relations and the psychological well-being of children and their caregivers.

Adequate care practices are all the more important when the environment is disrupted, as it allows the optimization of available resources. Humanitarian emergencies, such as natural disasters, wars and conflicts can deteriorate living conditions, putting children further at risk, as not only food security and health are at risk, but all the other care practices as well. The care practices may severely impact the caregivers’ ability to provide essential care practices, both in quantity (time spent for care) and quality (responsiveness, sensitivity continuity of attention and affection and the encouragement of autonomy and exploration). In such contexts, infants and young children might be exposed to a higher risk for malnutrition, morbidity, delayed development and mortality. Those families for whom providing optimal care is an issue should be given psycho-social and psychological support in order to maintain / improve the care provided to their children.

For all the aforementioned reasons, ACF considers priority the implementation of Baby Friendly Spaces in an emergency context.

1 - Engle, P. (1997) « The care initiative: assessment, analysis, and action to improve care for nutrition” - UNICEF.

2 - WHO et al.,(2005) Innocenti Declaration.

3 - Who (2004) Guiding Principles for Feeding Infants and Young Children during Emergencies.

4 - IFE Core Group (2007) Infant and Young Child Feeding, Operational Guidance for Emergency Relief Staff and Programme Managers.



This document aims to explain **WHY** and **HOW** to implement **Baby Friendly Spaces**.

The manual demonstrates why the implementation of BFS is crucial in emergency situations and provides a summary of basic information, practical advice and refers to other documents for further information. It should be used together with the ACF toolkit for BFS which provides key documents on the various topics.

This manual includes seven chapters:

- **The first chapter** is a more theoretical section presenting the six care practices. It includes basic information on each care practice, on the way appropriate child care practices are reinforced / maintained in the BFS setting. The main points to be remembered are listed at the end of each subchapter
- **The second chapter** describes the different steps for the operational implementation of Baby Friendly Spaces
- **The third chapter** focuses on the various activities that can be developed in BFS, with the different implementation steps
- **The fourth chapter** is dedicated to non-breastfed infants. The chapter describes which kind of intervention should be implemented for these children and their caregivers
- **The fifth chapter** is a detailed and technical guidance for breastfeeding and child feeding
- **The sixth chapter** is focused on Infant and Young Child Feeding related to HIV
- **The last chapter** gives information on how to manage unsolicited and unmonitored distribution of Breast Milk Substitute

Throughout the manual, reflections will be presented on how to adapt Baby Friendly Spaces to a wide variety of local situations and cultural context specificities.



I. THE SIX CARE PRACTICES IN EMERGENCY CONTEXTS



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In this chapter, we will provide general information on the six care practices: care for women, breastfeeding and feeding practices, psychosocial care, food preparation and conservation, hygiene practices and home health practices. For each care practice, we will present the specific work done in Baby Friendly Spaces in order to reinforce adequate care practices in emergency contexts. These propositions should always be adapted to the cultural context, the type of emergencies, the existing structures, the needs and resources in the population. Remember that emergencies strongly impact the population but might also provide opportunities for changing or having access to services or information that was not accessible before.

Some examples of actions will also be presented.

1. CARE FOR WOMEN



Care for women is based on the assumption that in most of the contexts, women are in charge of taking care of young children. In this manual, we will use mothers or caregivers as synonymous but consider that the children are taken care of by the families (both parents, co-wives and often extended family) and by the community. In emergencies, determining the caregiver is essential, as well as potential changes in the caregiving due to the context.

Example

After the tsunami in Sri Lanka, the ACF team found a father crying because his wife died in the tsunami and he didn't know how to cook rice for his children. His situation was not unique and many widowers get married very soon after the tsunami to have someone to care for their children. This type of information is crucial in terms of knowledge on the relation between the caregiver and the child and for better understanding the place and the role of the caregiver within the family.

Care for women refers to:

- Care for pregnant and lactating women,
- Reproductive health,
- Physical health and nutritional status,
- Stress and Mental Health,
- Autonomy level within the household, amount of time available for child care and women's workload,
- Access to education and information.

In all projects that aim at improving or maintaining young children's well-being, the question of caring for their mothers and/or their caregivers, is a central point, especially considering the huge impact of the mother's physical and psychological state on her child's health, development and nutritional status.

Research has highlighted the negative effect of maternal depression on how a mother provides care to her young child and in particular in terms of access of health services. The violent nature of emergency situations, where survival is often at stake, greatly affects mothers and pregnant women. In such extreme situations, their capacity to provide suitable care to their children is challenged. As such, caring for the target children's caregivers is one of the most important goals of the Baby Friendly Spaces.

The issue of care for women comprises a large range of factors about the mother's health, social situation and psychological state, which are all interrelated.

Considering the complexity of this problematic, and in order to provide appropriate support to caregivers, it is important to underline that trying to develop a close, supportive and trusting relationship with them appears as a cornerstone.

This is particularly important in the context of emergency situations, where individuals experience traumatic events, uncertainties about their present situation, difficult living conditions, life changes, significant workload, and different priority of needs. An emergency situation affects the people's self-esteem and produces strong feelings of fear, instability and loneliness that cause stress and anxiety, symptoms of depression or psychosomatic manifestations. This very difficult situation keeps these individuals in survival mode preventing them from making future plans and considering prospects that could improve their living conditions.

The difficulty in dealing with this context often pushes individuals (beneficiaries and professionals) to respond to the situation quickly and to propose "immediate answers". Providing a space where it is possible to feel secure and safe, to rest, to take time to share and to be heard is very important.

The project's staff should welcome caregivers with kindness in order to create a pleasant and relaxing atmosphere inside the BFS. They should also express true interest to meet and support the caregivers and their children, to make them feel as comfortable as possible and respect the local culture and traditions.

Based on this supportive relationship and the beneficiaries' positive perception of the Baby Friendly Space, the caregivers will be more willing to share their situation, their present difficulties and their actual needs.



CARE FOR PREGNANT AND LACTATING WOMEN

Pregnant women are given a particular attention in Baby Friendly Spaces as they represent a group who is particularly exposed to risks in emergency contexts (pregnant women's health, nutrition and well-being, foetus' health and survival, baby's health and nutritional status after birth, etc.). It is recommended that BFS staff provide extra attention and closely follow up with women expecting their first child.

Pregnancy comes with many changes (physical changes, changes in the family structure and roles, internal change - psychological and emotional changes, identity status, socio economic implications, etc.). It is a very sensitive period for the mother and the unborn child, with regards to both the physical and psychological / emotional components.

It is worth noting that psychological changes during pregnancy are normal, due to hormone modification and to external factors (such as a woman's previous emotional state or the environment she is living in).

Studies conducted in general context have shown that the occurrence of depression and anxiety in women doubles during pregnancy (and even higher during the year following delivery)¹. Poverty, migration, extreme stress, exposure to violence, emergency, and scarce social support increase risks for specific difficulties. There is a negative effect of maternal stress, depression or other psychological difficulties on the child's health and general well-being, as well as on the mother-child relationship.

Furthermore, the mother-child relationship might be severely compromised. For some reason, certain mothers won't have the psychological resource to take care of their child. For example, women who have previously lost one or more children might have difficulty providing child care because the new pregnancy revives painful emotions linked to the deceased child(ren).

Various actions can be implemented to support pregnant women:

- On the **health aspect of pregnancy**: prenatal care and medical follow-up (through referrals to available medical agencies), support to increase food intake (referral to food distribution programs)
- Information and psycho-education on pregnancy and birth
- Explore with the pregnant woman the possibility to **decrease the workload and have more time to rest** (through family discussion during home visits)
- Discussion on how this pregnancy is different or not from the previous one, birthing plans, etc. due to the new context
- Support the pregnant woman **to prepare for delivery**: plan where to deliver the baby (with referral to medical facilities, if any), home arrangement, family / peer support, possibility to rest after the delivery
- Provide **psychological and emotional support** (talk about her feelings and emotions,

1 - WHO. Maternal Mental Health and Child Health and Development. Accessed on Web. 19 Nov. 2013.

possible concerns about the future, representation of the foetus, physical sensations of the foetus' movements, sharing of possible past experiences of pregnancies / previous loss of children, etc.), with possibility to refer pregnant women to the psychologist for further counselling, if necessary

- Strengthen the capacity to imagine having /being with the baby, help the woman express possible fears/ worries about delivering the child
- **Relaxation exercises and simple stress management techniques**
- **Individual discussions with pregnant women who display specific difficulties** such as fear about the future, uncertainty of her ability as a mother or any other difficulty
- Group discussions and education sessions on the importance of **optimal feeding of women during pregnancy**, develop recipes with affordable food which is available during the emergency and conduct cooking demonstrations
- Group discussions on what **care practices the pregnant mother and the father-to-be can perform**, such as talking to the baby, caressing the belly, thinking positive thoughts, etc.
- Group discussion on breastfeeding just after birth of new baby
- Provide the mother with a baby kit, so the family will have the basic items in order to provide appropriate care to their children ; this is particularly needed in situations where the beneficiaries have lost all of most of their belongings, or are living in extreme poverty. If these items are not included into general non-food item distributions, specific distributions of baby kits can through through the BFS, corner or mobile teams or through health facilities. The content of such kits must be based on specific needs as identified through an assessment, and be in line with items people are used to. Contents of such kits will therefore vary from one country or area to another, but could contain:
 - Baby hygiene material: soap, comb, cotton, diaper (if used in the community) or clothes, baby bath, etc.
 - Protection against the elements: baby blanket, mosquito net, clothes (according to season)

What can be implemented for women after birth and during breastfeeding?

- **Breastfeeding is a key issue** in terms of child survival. This particular topic will be discussed in details in the next section, as well as in chapter 6.
- **Follow-up with the mother and baby after the delivery** (depending of the culture: meet the mother and baby at the BFS or during home visits)
- Group discussions and sharing of information on **optimal care practices for infants**; with the possibility to invite breastfeeding women so as to exchange experiences
- Referral to **postnatal consultation** and vaccination (external medical services - if available)
- Facilitate communication with other family members so as to ensure an understanding that new and lactating mothers require more rest and that household chores are shared.



REPRODUCTIVE HEALTH

In emergency contexts, as the population is struggling to survive and is still experiencing unstable and potentially traumatic situations, it is often difficult to work specifically on the issue of reproductive health.

However, depending on the local situation and the availability of services, this topic can be discussed in the BFS (or during small group discussions in the community setting), and referrals can be proposed to external agencies- if any.

The way to discuss this sensitive topic with the beneficiaries and to propose actions so as to address it depends mostly on **cultural factors**, and also on **the availability of services**.

All the existing organisations providing reproductive health services had been destroyed after the 2010 earthquake in Haiti. A few months after the earthquake, in the post-emergency phase, some NGOs opened programs that offered reproductive health services, and the Baby Friendly Space team was able to refer beneficiaries to these services.

PHYSICAL HEALTH AND NUTRITIONAL STATUS

Women's health and nutritional status are often not optimal even before emergencies. Cultural beliefs might also have an impact on their health conditions and can affect nutritional status during pregnancy and lactation period. The very difficult living conditions in emergency contexts can exacerbate these practices: the impact of trauma or stress, the difficulty of access to water, to sufficient food or to receive health care and treatment, the potential exposure to violence and promiscuity are potentially detrimental to women's health and nutrition. It is interesting to note here that sometimes, individuals are so focused on their daily survival needs that they may have difficulty being aware of their health situation and subsequently to identify their own health needs. Note that in many cultures, psychosocial or psychological difficulties may be expressed through somatic complaints.

In the context of child care practices, this issue covers the access to sufficient food considering the woman's age and condition, as well as the protection against physical aggression and sexual violence. Emergency situations increase the risk for women and children to be exposed to violence and abuse, and the psychological effect of such experiences adds to the overall difficulty they are already facing. Recognizing signs of distress in infants is difficult and staffs need adequate training. There is a need to provide appropriate spaces in BFS to facilitate individual or small group discussions as these are helpful in assessing signs of distress and often ensure women's access to the care they need.

In the Baby Friendly Spaces, various actions can be implemented:

- The team identifies, together with the beneficiaries, their **needs in terms of health and nutrition**, during individual or group discussions.

- Information **and referral to services organizing food distribution**. Note that in emergency situations, food distribution is usually among the first services to be delivered to the affected population, together with medical services.
- **Information and referral to existing health services¹**.
- Information of the health services of the existence of the BFS.
- **Small group discussions to help the women share health issues**, the possible impact of health problems on relationships with their social or family environment, the nature and use of local traditional health practices. These sharing exercises can include discussions on **the impact of their health or nutrition condition on their children, on their child care practices**, and how to improve it.
- **Individual or small group support sessions on exposure to physical bad treatment or abuse, or home-based intervention** (family discussion / family counselling with the psychologist) for caregivers exposed to physical aggression.
- **Specific attention to the issue of exposure to violence during parent-child play activities** or developmental activities organized for children.
- **Intervention at the community level** can be organized (small theatre play / forum, community sessions, information sessions...), in order to raise awareness on the issue of exposure of women to physical aggression and its impact, in order to facilitate the development of protective measures for women in the community.

MENTAL HEALTH AND PSYCHO-SOCIAL SUPPORT

In the context of child care practices, working on mothers' mental health refers to **decreasing stress, strengthening self-confidence, and protection against psycho-affective aggression**.

Baby Friendly Spaces provide a suitable place where caregivers can feel supported and take a rest from the difficulties related to the emergency situation they are facing. In that sense, the whole Baby Friendly Space represents a support facility to improve caregivers' mental health condition.

One important objective of the BFS is to help beneficiaries to improve their coping capacity, their ability to deal with stress and emotions, their feeling of self-confidence and to reinforce the caregiver - child relationships in order to develop emotional stability and well-being.

Following are some examples of actions that can be implemented in BFS:

- **Individual or group activities** aimed at sharing their present and/or past experiences and difficulties, the possibility to share feeling and to be listened to, to reflect and consider possible options to improve or ease the present situation. This contributes to decreasing the caregivers' stress level as well as to improve self-confidence and self-esteem.
- **Simple relaxation techniques** can be done with the beneficiaries in order to help deal with stress and manage emotions more effectively.

1 - In each specific situation, it is important that the staff give clear information on how to access these services (i.e. documents needed, need to be registered, referral voucher, etc).



- **Individual or group psychological support sessions with the psychologist** are available if specific difficulties are identified, such as post-traumatic symptoms, deep psychological or emotional suffering, suicidal thoughts, post-partum depression, etc.
- **Referral to other external services** (medical services, protection services...) can be organized based on the initial assessment done by the psychologist, depending on the availability of such services and the local context.
- **Advocacy** on women's situation in emergency and their exposure to violence should be considered.

The impact of women's mental health on the children is included in all discussions, as well as during rapid assessments and home-visits the impact of children's mental health on the parents should also be analysed and explored.

As an example, we can mention here the Baby Friendly Space program that was developed in Haïti a few days after the January 2010 earthquake, in Port-au-Prince, then in Gonaïves.

Even before the earthquake, the maternal and child health situation was not very good; there were significant levels of chronic malnutrition and micronutrient deficiency. After the earthquake, vulnerable people—particularly very young children and pregnant or lactating women—were increasingly at risk, for emotional, psychological and material reasons. Many families found themselves in difficulty with their infants: they had lost their property and were living in overcrowded conditions under tents. Access to water and hygiene were problematic. Women were often alone; some of them were in a state of shock and were having difficulties to provide adequate care to their children, whose general health was suffering.

In this situation, a certain number of lactating mothers explained that they no longer had any milk after the earthquake because 'the milk had risen into their brains', which explained why they felt sad or why people in the community sometimes considered them as "crazy". In consequence, these mothers stopped breastfeeding, thinking that they indeed could not produce any more milk. These women felt stigmatized because they were "sad," and it was important to explain them that they were actually showing "normal reactions" to an "abnormal" and very stressful situation. Another local belief suggests giving babies a blend of herbs to drink at birth. Since the water was not potable, infants could quickly become malnourished. The team therefore explained to beneficiaries, beyond that belief, the benefits of colostrum and breastfeeding for the child. The staff also offered to support the mothers in the care they were providing their babies. The mothers were gradually able to talk about their worries, their concerns and their beliefs without fear of judgement. They reacted positively to the support and advice provided to them. Many mothers also reacted positively to the relaxation exercises and stress management techniques that were taught to them. Such techniques helped them to develop a feeling of control over their emotions as well as to restore a certain feeling of self-confidence.

AUTONOMY LEVEL WITHIN THE HOUSEHOLD, AMOUNT OF TIME AVAILABLE FOR CHILD CARE AND WOMEN'S WORKLOAD

The practices associated with this topic are a **sufficient decision-making power**, the **access to management of the household income and assets** as well as **sharing of tasks** (domestic chores and economic production).

These three points are explored with the beneficiaries during the various activities at the BFS, in order to assess their situation, the existing constraints on their family and social environment which may affect their availability and capacity to take care of their children.

These are sensitive issues that are related to the local culture, women's position, role and consideration within the society and community. The answers or interventions to be proposed depend heavily on the specificity of the intervention's social and cultural context. Therefore, individual support can be proposed but may often appear insufficient so as to bring global improvements for women's living condition. There is a need here to have a good understanding of the local social and cultural environment.

Depending on the social and cultural context, **community-based interventions** (theatre forum or play) can be developed in order to raise awareness and to discuss possible changes that could bring improvement of women's conditions and work load. Involving community leaders / individuals who have strong influence in decision making within the community is imperative.

Example from Dollo Ado, Hiloweyn Camp: 3 Baby Friendly Spaces have been put in place since July 2011 in the aftermath of the food crisis consecutive to the prolonged drought.

During group discussions, mothers complained about to not have enough time for their babies. Culturally it's mainly the responsibility of the sibling to take care of the youngest ones and to play with them. The mothers complained about the workload that they have in the camp. They had to collect food during the distribution, wood for the fire, water, etc. They raised some challenges like the lack of space in the tents for the children, the lack of support from other family members at home even during pregnancy. The psychosocial workers had organised in the Baby Friendly Spaces, group discussions in order to allow them to express their feeling and to share with the group their strategies and solutions on time organisation and task redistribution within the families. Some activities were focused on finding resources within the community to help them for some tasks: through drawing and sociogram activities¹, mothers can learn how to better organize their time or how to find support from neighbours or other family members, they can also find out how to manage their tasks during the day, in a more optimised manner. In order to facilitate individualized solutions, since working on these issues also requires intervention at the family level, support can be extended on these themes during home visits.

1 - Sociogram is a graphic representation of a person social links. It is a graph drawing the structure of interpersonal relations in a group situation.



ACCESS TO EDUCATION AND INFORMATION

An important component in emergencies is the disruption of social network and existing services. The staff from the BFS should be able to provide to the families information on humanitarian assistance, relevant and current services. Providing information is a very important and reinsuring task for the population. Further needs should be collected and transmitted to the humanitarian coordination to ensure a better response.

In the BFS setting, *all information related to care practices is shared and available during all the proposed activities and should also be offered on an individual basis if necessary.* Adapted visual aid material or leaflets are also available in the BFS to be shown or distributed to the beneficiaries.

The issue of *access to education for girls seldom appears as a priority and might be protective.* If education programs are created, the BFS staff should develop a contact and *referral system* with these structures so as to facilitate access for the beneficiaries.

TO KEEP IN MIND ABOUT CARE FOR WOMEN

Pregnant and lactating women, infants and very young children are considered as priority beneficiaries and should be given particularly close attention and intensive follow-up regarding their overall condition (health, nutrition, psychosocial, etc.).

Breastfeeding is a major protective factor for infants' life: support to lactating women and encouraging breastfeeding represent one of Baby Friendly Spaces' major priorities (see next paragraph and chapter 6).

Exposure to violence, to physical and emotional aggression has a negative effect on the caregivers' overall condition and on their child care practices. The child's well-being and development might be affected by the situation. Although not all professionals are trained psychologists or psychosocial workers, there are actions that can be developed in order to provide support to caregivers (see chapter 3), children and to their relationships, and to reduce / prevent the negative effects of stress and psychological emotional difficulties.

Emergency contexts affect individuals' mental health (including children), with a negative impact on child care practices. The caregivers' mental health condition has a direct effect on the child's overall condition, development and well-being. By offering appropriate support and specific activities, it is possible to help beneficiaries improve their mental health condition and well-being.

The possibility for mothers to care for the children, to take certain decisions and to devote sufficient time to child care is an important factor in care practices. It is important to explore with key actors in the target community possible culturally fair strategies to improve women's autonomy.

Providing appropriate psychosocial support is at the core of Baby Friendly Spaces' concept

2. BREASTFEEDING AND FEEDING PRACTICES

BREASTFEEDING

A detailed description of the breastfeeding physiological mechanisms and process, with the benefits for both the mother and the child and the mother - child relationship, is presented in chapter 6.

Breastfeeding is an unequalled way of providing healthy growth and development to infants and has important implications for the health of mothers. Research proves that suboptimum breastfeeding contributes greatly to child disease¹ and mortality². Therefore, breastfeeding is given particular attention in the interventions implemented in particularly difficult contexts.

Indeed, breastfeeding can be more problematic in emergency situations: for instance, traumatic experiences, high stress levels and emotional difficulties can interfere with breast milk production in some cases. Breastfeeding can also be complicated by the influence of local myths and misconceptions, because of the mother's lack of time, lack of space and privacy³, insufficient support received by the mother or the presence of unsolicited and unmonitored distributions of breast milk substitutes. However, most mothers are actually able to pursue or re-start breastfeeding, even under difficult conditions if appropriate technical and psycho-social support is available, if the caregivers' coping capacity is promoted and developed and if a supportive environment is created. Knowledge on exclusive breastfeeding prevalence and breastfeeding practices before the crisis is essential to determine the changes due to the crisis and the support that should be offered to the families.

In 2006, in Lebanon, many babies and very young children were not breastfed before the crisis. During the conflict, many families were unable to find artificial feeding for their babies. Programs have been adjusted to support women that were breastfeeding before the conflict and to support women that would like to start or restart lactating because of the situation and the lack of artificial feeding. Ultimately artificial milk was also provided for non-lactating women that were not willing to breastfeed according to the international rules for providing artificial feeding in emergencies (see chapter 4).

It is important to keep in mind that feeding or breastfeeding a child is a complex process. Various factors influence the feeding practices and the feeding relationship between a mother and the child (contextual, economic, social, psychological, emotional, physical factors, etc.). Actually, breastfeeding is not necessarily easy nor "naturally established", and many mothers and their newborn babies experience difficulties. Mother's may need help - this is a crucial point, especially in emergency contexts, as breastfeeding is life saving and the best protection for the child's health

1 - Black R. et al., (January 17, 2008) Maternal and child undernutrition 1: global and regional exposures and health consequences, The Lancet, DOI:10.1016/S0140-6736(07)61690-0, , Published online: suboptimum breastfeeding results in 1,4 million deaths and 10% of disease burden in children younger than 5 years.

2 - Save the Children UK, (2009) Hungry for Change.

3 - In some contexts, women are not allowed to breastfeed in public. After a disaster, it might be very complicated for them to find a place for breastfeeding. BFS can be a secure and protective place in those contexts.



and nutritional status. Furthermore, the close bond that is developed between mother and child through breastfeeding has a positive effect on the attachment process and represents an important security aspect for the child too.

BREASTFEEDING, ATTACHMENT AND MOTHER - CHILD RELATIONSHIP

Breastfeeding does not only provide optimal nutrition and immunological protection. It is also an excellent way to reinforce attachment between mother and child; which is beneficial for both. Attachment is a primary need for human beings; it starts developing before birth (even before the baby's conception). After birth, the moments when the mother feeds and provides basic care to her child are very precious as they allow the mother and her child to interact and bond. During the first few weeks, most of these moments occur during feeding. Therefore, feeding is a significant part of the interaction building process between the new-born and his / her environment.

It is interesting to note that physiologically, the hormones released during breastfeeding have a positive effect on the attachment process between mother and child (NOTE REFERENCES).

However, various factors interfere with breastfeeding as well as in the mother - child relationship:

MOTHER

- **Attitude:** a woman who is convinced that breastfeeding is the best for her baby and she is capable of providing it, is more likely to breastfeed successfully.
- **Confidence** in herself and her ability to produce and give enough milk (requires good psychological well-being).
- **Technique:** knowing how to position, attach, and suckle (this includes the importance of showing affection to the baby, looking gently at him / her, caressing him / her).
- **Frequency** of putting the child to the breast, day and night .
- **Support** received by her family, friends and neighbours and/or professionals.

CHILD

- **The specificities of each child:** breastfeeding is not always a simple or “automatic” process for new-borns, and some children have more difficulty suckling than others. It is important to note that each child is different some are more active than others, initiating interaction with caregivers, while others are more passive. Each child is perceived differently by the mother, bringing a tendency to provide care with more or less satisfaction, patience, as the baby may appear as more or less “satisfying” or “gratifying” for her. All these differences impact the mother - child interaction and breastfeeding
- The child's health status:
 - **Low Birth Weight babies** are more fragile; they are more passive and have less energy. Therefore, they tend to be less active and tend not to initiate the interaction with their mother. In reaction to this behaviour, caregivers tend to provide less stimulation

to the child; yet, the child needs more attention and stimulation for his development. Breastfeeding can be more difficult, or take more time for these children, which may affect the mother's feelings, with a tendency to show less attention and to breastfeed the child less. These children are more susceptible to malnutrition, therefore they are considered as priority beneficiaries in the BFS .

- This is also true for children who are already *malnourished* or who suffer from *other illnesses*, which affect their energy level and their way of responding to stimulation provided by caregivers.

CAREGIVER - CHILD RELATIONSHIP

Breastfeeding has a better chance of being successful, if there is a positive and emotional relationship between mother and child: the mother can be encouraged to look at her child and speak to him during feeding, caress him, smile at him. This will make the baby feel comfortable and safe, which will stimulate him to suckle effectively.

It has been observed that breastfeeding mothers have more confidence in themselves and react better to the needs of their children, reducing the risk of neglect and abandonment.

Mothers experiencing insufficient milk flow might stop breastfeeding earlier. Mother milk insufficiency due to physiological factors is less than 5%. Other factors such as the mental health and stress of the mother, difficulties in the mother-child relation might interfere with the production of milk and lead to insufficient milk production.

ENVIRONMENT

Support from the environment is a requirement for lactating mothers, in all aspects: emotional, material, organizational support, social support, etc.

The availability of an **appropriate space for breastfeeding** is very important.

Some important points about breastfeeding to share with the beneficiaries:

- Encouraging the mother to keep the new-born baby on her naked chest just after birth, will stimulate the baby's reflexes and facilitate breastfeeding as well as the mother - child bonding.
- Colostrum (the first milk produced during the first few days after delivery) should be given to the baby, as it contains exactly all the substances that the new-born baby needs for his physical growth.
- Breast milk changes and adapts itself during the feed and during the growth of the child, so it can cover changing needs. The baby should be allowed to suckle as much as they want during each feed.
- Feedings should not be limited in time nor interrupted by the adult (for instance, some babies are slow drinkers, others are fast, some others need to rest now and then, etc.). When the baby has finished suckling, he lets go of the breast himself.



- The more the baby suckles the more milk will be produced.
- Breastfeeding at night helps to keep up a good supply of milk.
- Infants should be exclusively breastfed for at least 6 months. Considering uncertainties about food availability in emergency situations, it is recommended to breastfeed children for as long as possible in addition to complementary food after 6 months.
- Some positions facilitate breastfeeding, while others complicate it. Also, there are signs showing that the child drinks milk effectively (see chapter 5 for details). This is helpful information for lactating mothers.
- The mother's psychological and emotional state affects the milk flow/production (positive feelings maintain milk flow, while negative emotions can lead to temporary slowing/stoppage of milk flow).
- Support, encouragement and confidence building are essential to help the mother produce the oxytocin hormone, which is necessary for milk flow.
- A breastfeeding woman needs nutritional snacks, or a fifth more of her usual diet. It is recommended that she eats food that provides her with energy, proteins, but also sufficient micronutrients, as she passes those on to the baby through the breast milk. Ensuring access to safe water is also important.
- A woman who is not well fed can breastfeed, her body will continue to provide milk for the child. Even moderately malnourished women can produce sufficient breast milk, yet they must be given treatment for their malnutrition.
- In some specific contexts, lactating mothers need adapted spaces allowing enough privacy, where they can breastfeed safely and quietly.

All these recommendations are general, and each culture has its own practices related to breastfeeding.

Some cultural practices delay the moment to breastfeed the new-born baby (with a risk to cause complication to the breastfeeding process, milk production, etc.). Complementary food is given to babies, as breast milk is considered as not sufficient to cover all the child's needs.

Although the local beliefs and practices should always be duly respected, as a relationship of trust develops with the beneficiaries, it is possible to discuss these practices. Information regarding breastfeeding can be shared, with the possibility to explore culturally acceptable adjustments.

COMPLEMENTARY FEEDING

Complementary feeding is the process starting when breast milk alone is no longer sufficient to meet the nutritional requirements of infants, and therefore other foods and liquids are needed, along with breast milk. Complementary feeding should start at 6 months. The name says it all: it aims to complement breastfeeding, not replace it. Therefore, ***the frequency of breastfeeding and the length per feed should remain the same as it continues to make an important contribution to the nutrition of the child.*** However, many women will need support and encouragement to find the energy to continue breastfeeding.

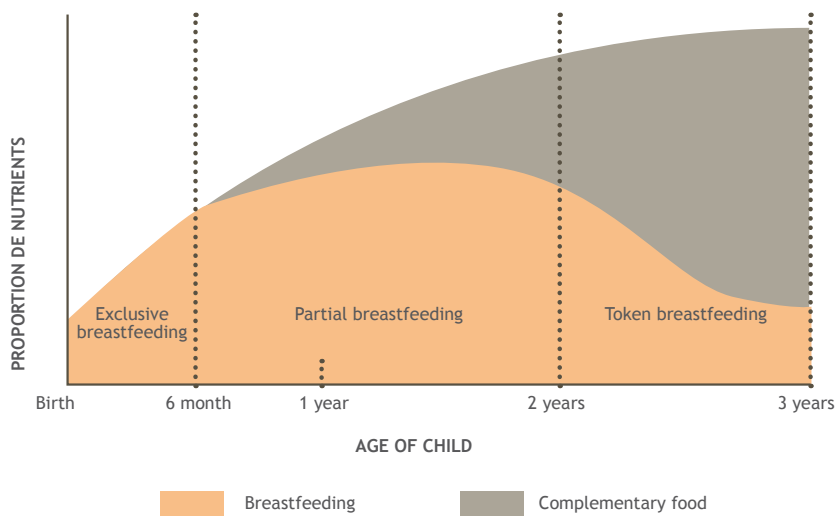


Fig. 2 Proportion of nutrients provided by breast milk and complementary food; IBFAN

There are important guiding principles^{1, 2} on complementary feeding (see a detailed presentation of these principles in chapter 3):

- Practice responsive feeding, applying the principles of psycho-social care (showing attention to all children during meals, taking time to feed the child, encouraging the child to eat without forcing him, etc.).
- Practice proper hygiene and food handling.
- Start complementary feeding at six months of age with small amounts of food and increase the quantity as the child gets older, while maintaining frequent breastfeeding.

1 - Guiding Principles for Complementary Feeding of the Breastfed Child, PAHO/WHO.

2 - Complementary Feeding Counselling, A Training Course; WHO 2004.



- Gradually increase food consistency and variety as the infant gets older, adapting to the infant’s needs and abilities.
- Increase the frequency complementary foods as he/she gets older.
- Feed a variety of foods to ensure that nutrient needs are met.
- Use fortified complementary foods or vitamin-mineral supplements for the infant, as needed. In some populations, breastfeeding mothers may also need vitamin-mineral supplements or fortified products. [Such products may also be beneficial for pregnant women].
- Increase fluid intake during illness, including more frequent breastfeeding, and encourage the child to eat soft, varied, appetizing, favourite foods. After illness, give food more often than usual and encourage the child to eat more.

FOR MORE INFORMATION, SEE:

“Complementary Feeding, Family foods for the Breastfed Child”, WHO 2001
http://www.who.int/nutrition/publications/infantfeeding/WHO_NHD_00.1/en/Index.html

and “Guiding Principles for Complementary Feeding of the Breastfed Child”, PAHO/WHO
http://www.who.int/child_adolescent_health/documents/a85622/en/index.html

and “Complementary Feeding Counselling, a Training Course” WHO 2004
<http://www.who.int/nutrition/publications/infantfeeding/9241546522/en/index.html>

Age	Texture	Frequency	Amount at each meal
From 6 months	600 Soft porridge, well mashed vegetable, meat, fruit	Two times per day plus frequent breastfeeds	2 to 3 tablespoonfuls
7 to 8 months	Mashed foods	Three times per day plus frequent breastfeeds	Increasing gradually to 2/3 of a 250 ml cup at each meal
9 to 11 months	Finely chopped or mashed foods and foods that baby can pick up	Three meals plus one snack between meals plus breastfeeds	3/4 of a 250ml cup/ bowl
12 to 24 months	Family foods, chopped or mashed if necessary	Three meals plus two snackw between meals plus breastfeeds	A full 250 ml cup/bowl

Fig. 3 Summary of texture, frequency and amount of complementary food per age group; WHO, (2004) Complementary Feeding Counselling, a Training Course.

There are a number of risks of starting complementary foods before the age of 6 months:

- The child will consume less breast milk, making it difficult to meet the child's nutritional needs; but also compromising the milk production.
- The thin, watery soups and porridges that are easy for the baby to eat at this age are low in nutrients.
- More exposure to bacteria and viruses through the complementary food, therefore there is a higher risk of illness.
- The baby cannot digest and absorb food other than breast milk well, because his intestinal system is not yet properly developed; therefore there is the risk of allergic reactions and malabsorption of nutrients.

In emergency contexts, there are many benefits of breast feeding until 2 years or beyond, for example:

- Breast milk is safe, free and helps to protect against diseases.
- Breastfeeding reinforces the mother-child bond and is beneficial for the child's development.
- In emergency situations, the quantity and quality of complementary food might be reduced therefore breastfeeding should be increased to cover the baby's nutritional needs.

THE WEANING PROCESS

The child's weaning process refers to the act of stopping breastfeeding to exclusively provide solid food. This is a crucial moment in child development. Because of the close and dependent relationship that breastfeeding supposes, weaning is synonymous of a separation between the mother and the child - the child's autonomy increases and he learns how to survive without been exclusively fed using the mother's milk. If the weaning process is not appropriate and/or abrupt, the child may be exposed to malnutrition or other troubles such as feeling rejected or abandoned. There are various ways to wean a child, depending on cultural factors and beliefs. In many contexts, children are weaned abruptly when the mother gets pregnant again. Some beliefs state that maternal milk is no longer good and may be dangerous for the mother, the foetus or the breastfed child.

As an example, this is the story of Abbakar in Chad, where tradition tells parents to breastfeed girls until seventeen months and boys until eighteen months "so they will be smarter".

They also weaned their child at that age. It is an important date, celebrated with a ceremony that brings all the women of the community together. An Imam came with a wood slate on which he had written a few verses from the Koran. He poured out some water and recited a few prayers. The mother then put coated natron¹ on her breast, took Abbakar in her arms and showed him her breast while telling him: "You see! It is no good, you can no longer suck." The other mothers then spat water on Abbakar's face, before the mother gave him to her own mother living in the neighboring village.

1 - Mineral used in some traditional health care.



During the few days he spent with his grandmother, the child cried and refused to eat. When he returned home, he had diarrhea and was vomiting. The mother was worried and asked her husband for advice. He told her to give the child to her own father so that he could take him to the wazambi, a traditional healer working in the market place. He might be a shoemaker, a merchant, or a blacksmith. After looking in Abbakar's mouth, the wazambi said he was suffering from "uvula" and "false teeth." With the tools he had on hand, he cut off the child's uvula and pulled his canine teeth. But the diarrhea and vomiting continued. His mother tried to give him teas, but the child was no longer able to swallow. He began to lose a lot of weight. Since his stomach was distended, his grandfather took him back to the wazambi, who made burns on his stomach in the shape of a bird's foot around his navel. The mother also went to another healer who said prayers and provided verses from the Koran, also written on a wooden slate board. Despite those repeated treatments and the entreaties of the entourage, Abbakar's state of health continued to deteriorate. With her husband's agreement, the mother finally went to the health centre located 45 minutes away (on donkey back). After weighing and measuring Abbakar, the nurse suggested that the mother send him to the TFC (Therapeutic Feeding Centre) to receive the care he needed. While the mother was telling the story of her son's malnutrition, the mothers present explained to me that their child's experience was relatively similar. Most of the children admitted to the Therapeutic Nutritional Centre had been weaned not long before and they had all received traditional treatments¹."

SUPPORTIVE RESPONSIVE FEEDING AND ADAPTATION OF FAMILY DIET AND MEALS

Aside from the nutritive aspects of meals and the technical process of including solid food into child's diet, it is necessary to provide the child with feeding conditions that are adapted to his capacities and needs. Child feeding practices should be adapted to the child's psychomotor capacities.

For example, in many cultures, family members share food in a common plate. However, when the child is still small, he might not yet have the psychomotor capacity to take a sufficient quantity of food from the plate. Also, young children often need more time to eat. These (normal) psychomotor limitations may result in limited quantities of food eaten, with risks for the child's health and nutritional status.

YOUNG CHILDREN SHOULD BE STIMULATED AND ENCOURAGED DURING MEALS (RESPONSIVE FEEDING).

Meals are important moments of learning for young children. They have to exert effort in order to master the psychomotor skills they need to be able to eat solid food and to eat on their own - this process is not easy and young children need to feel supported by their caregivers. Caregivers should therefore encourage the child and stimulate him appropriately in order to help him through this learning process.

As we mentioned previously, feeding represents more than mere food intake it also plays a

¹ - Full article is published in ACF publication: "Histoire de psy, histoire de soins". English version will be available in 2014.

significant role in the caregiver - child relationship. As he grows and learns how to eat by himself, the child needs to feel that he is not “loosing” his mother’s attention and affection. It is important to provide the young child with emotional reassurance, to spend time with him during meals, etc.

MEALS ORGANIZATION AND FOOD SHARING SHOULD BE ADAPTED TO THE CHILD’S NEEDS.

As much as possible it is recommended that meals are organized at regular times and places, to ensure consistency and regularity.

Distractions should also be limited, so as to help the child to maintain his attention on taking food. The way the various types of food are shared within the family is another important factor for the child’s health and nutrition, as young children need to eat a certain variety of food to cover their nutrient needs.

In some emergency situations (or in specific cultural settings), the most highly nutritive food may be kept for some adults - men, or the family’s bread winners. Young children might then be deprived of a precious source of nutrients, and their health or nutritional status may be challenged. In such situations, specific intervention must be developed (at the family and / or community level) in order to discuss the issue and find acceptable solutions together with the family / community so as to help meet pregnant/lactating women and children’s needs in terms of food intake.

TO KEEP IN MIND ABOUT BREASTFEEDING AND FEEDING:

Breastfeeding / feeding is a complex process, which does not only rely on physiological factors. The establishment of breastfeeding can be difficult for some mothers and infants.

Attachment is a primary need for human beings, it develops before birth. Feeding plays a significant role in the attachment building process between the new-born and his environment.

In the process of supporting the mother, the child and their relationship, it is important to discuss and recognize the specificities of the child, underlying the positive points (his capacities, skills and other gratifying aspects), but also recognizing the aspects that can be more difficult to handle for his caregivers.

If a mother complains of insufficient milk flow, leading to difficulty in breastfeeding, assessment of the mother’s psychological and emotional state is needed.

Lactating mothers who experience insufficient milk flow require specialized support from the BFS staff.

Even moderately malnourished women can produce sufficient breast milk, yet they must be given treatment for their malnutrition. Severely malnourished women should be encouraged to continue breastfeeding while provided with appropriate care as soon as possible.

Low birth weight, sick and malnourished babies are priority beneficiaries of Baby Friendly Spaces.

Children should be breastfed exclusively until the age of 6 months.

Safe and adequate complementary feeding should be started from the age of 6 months, in small but frequent quantities, given to the child with attention and affection, in a responsive way.

The weaning process should be as gradual as possible.

3. PSYCHOSOCIAL CARE



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In the context of childcare practices, psychosocial care refers to the following:

- Respect of the child's development space, and adjustment of caregivers' behaviour and stimulations to the child's development level
- Showing attention and affection to the child
- Providing the child with opportunity to explore, learn and increase his autonomy level

A child's brain develops rapidly during the first five years of life, especially the first three years. It is a time of crucial and rapid development¹.

Child development is divided into different spheres:

- Motor development: development of the body in the physiological and neurological sense
- Language development: communicative and expressive capacities
- Cognitive development: development of intellectual capacities
- Affective and social development: emotional development, development of personality, and social interactions



¹ - This paragraph is based on the ACF Integration Manual on Child Care Practices and Mental Health into Nutrition Programmes, ACF, 2011.

Child development starts at the beginning of pregnancy. During his foetal life, the foetus develops his 5 senses (first, the sense of touch - and proprioception / somesthetic perception¹ -, then the taste, smell, hearing and sight). He is also sensitive to his mother's emotions. It appears that the baby keeps a memory trace of the foetal experiences, and his reactivity after birth reflects what he was able to learn during his intrauterine life (this refers to his sensory perceptions as well as his motor behaviour).

A baby or a young child is not a passive human being but a truly interactive partner, capable of initiating and controlling (in part) his relationship with others (may vary according to development phase). Throughout development, children pass successively from one phase to another once they have mastered the phase they are in. Each child goes through different stages of development, at their own rhythm. A child's environment and loved ones stimulate and encourage, or discourage his development.

The child's brain development is notably based on appropriate nutrition, the stimulation the child receives and experiences. For example, when a child uses one of the senses, it creates neural connections in the child's brain. New experiences repeated many times help make new connections, which shape the way the child thinks, feels, behaves and learns.

Neurological and motor development is progressive: first, head, trunk and then limbs. The infant begins his development by first holding up his head and then by sitting. He slowly begins to master the control of his limbs by cultivating the ability to grab objects through pinching (thumb - index).

Young children learn and develop based on the stimulations they receive, their experiences, and their interactions with the environment (human and material).

As he develops, a child has needs that he expresses in a simple and direct manner. In order to assure a harmonious development, the child has fundamental needs:

- **A need for emotional security:** young children need to experience that their caregivers provide them care, stability, consistency, regularity, and with affection and positive emotions
- **A need for differentiation, identity and self-awareness** that is established as he experiments and evolves
- **A need for exploration and enlargement of his world vision;** this need becomes fulfilled once the conditions of emotional security and self-determination are satisfied

More specifically a child needs:

- Food, clothing, rest and housing
- To develop his body and healthy hygiene habits
- To feel loved
- Health care (psychological and physical care)
- To be respected

1 - This is the perception of body sensations coming from the skin, inner organs...



- To feel integrated into a group
- The satisfaction to create
- To feel that his conduct and efforts are accepted
- To be encouraged
- To be supported in his motivation to learn
- Permanent emotional bonds (support, comfort and structure)
- To learn to think clearly and to resolve problems
- To know how to live harmoniously with others
- To create first friendships
- To develop cooperative behaviors with other children and adults
- To learn and appreciate values, rules and cultural behaviors
- To test his first knowledge

UNICEF¹ has outlined five essential elements for a child's proper development.

1. ***The care and attention*** that a child receives ***particularly during the first 3 years, are crucial and determining for his future.***
2. In order to grow and develop, babies need ***affection, attention and stimulation as well as good nutrition and appropriate health care.***
3. ***Children must be encouraged to play and explore.*** It is in this way that they become enriched and develop socially, emotionally, physically and intellectually.
4. Children ***learn behavior by imitating*** the behavior of those around them.
5. Parents and those who take care of children must be ***capable of noticing the signs signifying a slowdown of growth and development.***

As described before, the environment in which a child grows up, literally sculpts the brain².

Deficiencies in stimulation, and in the quality of the caring relationship experienced by the child in this critical period of life, will stunt their emotional, social, physical and cognitive development.^{3,4}

When a young child experiences severe, frequent, or prolonged adversity (for instance during emergencies), without adult support, the prolonged activation of the stress response can disrupt brain development.⁵

1 - You will find complimentary information regarding child development and other very interesting subjects at Unicef's site: "Facts for Life saves lives!." Facts for Life. Accessed on 19 Nov. 2013.

2 - WHO& UNICEF (2012) Integrating Early Childhood Development (ECD) activities into Nutrition Programmes in Emergencies: Why, What, and How.

3 - Black, M et al., (2008) Policies to reduce under-nutrition include child development. Lancet, 371: 454 - 455.

4 - WHO, Department of child and Adolescent Health and Development (1999) A Critical Link: Interventions for physical growth and psychological development: A Review. Geneva.

5 - National Scientific Council on the Developing Child (2010) Persistent Fear and Anxiety Can Affect Young Children's Learning and Development. Working Paper No. 9.

During emergencies, many caregivers are unavailable or unable to provide psychosocial stimulation to their children due to their own poor physical or mental health. A lack of psychosocial stimulation has adverse consequences for children's development (cognitive, motor, language) and mental health.

In these contexts of crises, programs should be designed with a particular attention on enhancing early childhood development.

WHO advocates combined psychosocial and nutritional programming in food shortage situations in order to address the physical, social, emotional, and intellectual developmental needs of the child and to enhance maternal well-being¹.

The IASC Guidelines on Mental Health and Psychosocial Support in Emergencies also recommend the integration of psychosocial interventions such as Early Child Development into nutritional support².

During emergencies, in order to enhance the good child's development, health and nutritional status some activities on early child stimulation can be implemented, such as:

- Parent-child play sessions,
- baby massage,
- psychomotor stimulation

Providing children with opportunities to experiment free body movements, to explore and discover their environment, is essential to a child's healthy development.

Of course, it is imperative to be aware of the different developmental phases and to adapt stimulations, attitude and expectations to the needs and capacities of the child (see table in Fig. 4: "Child Development 0 to 3 years; Manual for the Integration of Child Care Practices and Mental Health in Nutrition Programmes, ACF, 2011").

The following table outlines these different phases and categorizes them according to the functions that they deal with.

1 - WHO (2001) Mental Health and Psychosocial well-being among children in Severe Food Shortage Situations.

2 - IASC (2007) IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva: Inter-Agency Standing Committee.



	MOTOR SKILLS	LANGUAGE	COGNITIVE ABILITY	SOCIABILITY AND PLAY
DURING PREGNANCY	<ul style="list-style-type: none"> • He can touch his mother's abdominal walls. • He sucks his thumb. • He moves and matches his movements to those of his mother. 	<ul style="list-style-type: none"> • He can hear music and voices, especially his mother's. 	<ul style="list-style-type: none"> • No real intentions but instead, reflexes. 	<ul style="list-style-type: none"> • He feels his mother's emotional state.
0-3 MONTHS	<ul style="list-style-type: none"> • Quasi-null global motility, always lying down. • Can suckle. • Sleeps the majority of the time. • Holds his head around 3 months. 	<ul style="list-style-type: none"> • Cries or makes noise according to the state of discomfort, tension or well-being. • Smiling quickly signifies pleasure or relationship. 	<ul style="list-style-type: none"> • Shies from discomfort and searches out pleasure. • Learns through experience and repetition. 	<ul style="list-style-type: none"> • At first, eye contact moves away quickly but then the baby begins to stare at the human face. • Sees 20 cm clearly. • The infant is dependent on his surroundings for his well-being.
3-9 MONTHS	<ul style="list-style-type: none"> • Can sit up. • Can move about by crawling. • Scooting. • Hand-finger coordination (brings objects to his mouth, manipulates blocks from one hand to the other). 	<ul style="list-style-type: none"> • Uses his body to express needs • Laughs • Gurgles 		<ul style="list-style-type: none"> • Smiling is selective and social. • Pays attention to faces, mimics and voices. • Exchange with mother, develops means of communication such as gurgling and imitating sounds. • Desires contact and mother's presence.
9-18 MONTHS	<ul style="list-style-type: none"> • Remains upright, at first with support (10 months). • Walks independently between 10 and 16 months. • Pinching with thumb and finger. • Slowly manipulates objects within grasp: grabs, brings toward self, looks at them, brings them to the mouth, sucks and bites them. • Can drink by himself. 	<ul style="list-style-type: none"> • Bi-syllabic. • Beginning of the first words. 	<ul style="list-style-type: none"> • Begins to understand the constancy of objects around 10 months. • Begins to take interest in details. • Is capable of imitation. 	<p>Relationship to mother:</p> <ul style="list-style-type: none"> • Is Anxious when separated from her. • Conscious of the pleasure he has when near her, he looks constantly for her presence. He recognizes her and distinguishes her from others. He wants to continue all two-person games. <hr/> <ul style="list-style-type: none"> • Just after 8 or 9 months, a baby can express worry regarding an unknown person. • Can begin to play alone. • Often has a favorite or transitional item (blanket).

	MOTOR SKILLS	LANGUAGE	COGNITIVE ABILITY	SOCIABILITY AND PLAY
18-36 MONTHS	<ul style="list-style-type: none"> • Can go up and down stairs. • Begins to run. • Arm gestures are precise and oriented. • Can stand on one foot to reach an object. • Begins to draw. • Likes to push, pull, fit things together, fill up, put together, and separate. • Can catch a ball and throw it. 	<ul style="list-style-type: none"> • Moves from words to first phrases. • Can say no between 18 months and 2 years. • Has a vocabulary between 100 and 300 words. • Varies the means of communication: drawing, language, and imitation. * Capable of expressing emotion (mistrust, regret, shame, anger, curiosity, joy.) 	<ul style="list-style-type: none"> • Begins to have a mental representation of his surroundings (symbolism). • Capable of abstraction (to refer to an absent object/person). • Begins to take opposition and assert autonomy. • Opposition and imitation serve as means of identification. • Begins to test limits. • Is interested in images. 	<ul style="list-style-type: none"> • Exercises a need for autonomy. • Takes pleasure in doing things by himself. • While asserting his independence, he exercises his need for emotional dependence (won't go to bed at bedtime, needs bedtime rituals in place), begins to show confusion and frustration. • Begins to play with other children, especially one child. • Begins symbolic play. • Can make believe. • His mother remains his consoler in times of emotional and physical pain.

Fig. 4: Child development 0 to 3 years;
Manual for the Integration of Child Care Practices and Mental Health in Nutrition Programmes, ACF, 2011.

The following table provides information on the ways in which a child develops the actions and attitudes to take according to each developmental phase, as well as the elements that could show a developmental problem. It is important to remember that this table offers reference points that can vary from child to child. Each child has its own developmental rhythm. According to culture and context, children develop differently in relation to stimulation and interaction with their entourage and environment.

Slow progress can be 'normal' or symptomatic of malnutrition, poor health care, lack of stimulation or a much more serious problem. It is important to create an institutional network or partner services capable of diagnosing and taking charge of these children.



	What the infant should be able to do	Some suggested important attitudes and gestures	Signs which should be looked out for
1 MONTH	<ul style="list-style-type: none"> • Turn its head towards a hand caressing it's cheek. • Bring its two hands to its mouth. • Turn its head if it hears voices or sounds which are familiar. • Suckle from the breast and touch it with its hands. 	<ul style="list-style-type: none"> • Establish a physical contact and breast feed the baby within an hour of birth. • Support the head of the baby when holding it upright. • Regularly massage and caress the baby. • Always handle the baby gently. • Breastfeed it regularly. • Talk read and sing to the baby as often as possible. 	<ul style="list-style-type: none"> • The baby refuses or has trouble feeding from the breast. • The baby does not move its limbs much. • The baby reacts little or not at all to noises and bright lights. • The baby cries for long periods for no apparent reason. • The baby vomits and has diarrhea.
6 MONTHS	<ul style="list-style-type: none"> • Lift the head and body when it is lying on its front. • Grab for and hold hanging objects. • Hold and shake objects. • Roll onto both its sides. • Sit up with a support. • Explore objects with its hands and mouth. • Start to imitate sounds and facial expressions. • React to its name and to familiar faces. 	<ul style="list-style-type: none"> • Lie the baby down on a flat clean and safe surface so that it can move freely and grab objects. • Prop the baby with a support or hold it up so it can see what is happening around it. • Continue to breast feed the baby as it demands day and night and begin to introduce other foods (two meals a day between 6 and 8 months, 3 to 4 meals a day between 8 and 12 months). • Talk, read and sing to the baby as often as possible. 	<ul style="list-style-type: none"> • Stiffness or difficulty in moving the limbs. • Constant moving of the head (this could be caused by an ear infection which could lead to deafness if not treated). • Little or no reactions to sounds, familiar faces or the breast. • Refusal of the breast or other foods.
12 MONTHS	<ul style="list-style-type: none"> • Sit up without support. • Crawl on all fours and stand by holding on to something. • Make its first steps holding up on its own. • Try to imitate sounds and words and respond to simple questions. • Enjoy playing and clapping its hands. • Repeat sounds and gestures to attract attention. • Pick up objects using thumb and forefinger. • Begin to hold objects like a spoon and a cup and try to eat on its own. 	<ul style="list-style-type: none"> • Show the child objects and name them, talk to and play with the child often. • Use mealtimes to encourage interaction with all members of the family. • If the child develops slowly or has a physical handicap, concentrate on its abilities. Give it more stimulation and interact with it more often. • Do not leave the child in the same position for a number of hours. • Make sure that the environment is as safe as possible to avoid accidents. • Continue to breast feed the child, ensure that the child has enough food and that it eats varied family meals. • Help the child to try to use a spoon and a cup. • Ensure that the child has had all its vaccinations and receives the recommended supplements of oligoelements. 	<ul style="list-style-type: none"> • The child does not make any sound when spoken to. • The child does not look at objects that are moved. • The child is apathetic and does not react when given attention. • The child has no appetite or refuses to eat.

	What the infant should be able to do	Some suggested important attitudes and gestures	Signs which should be looked out for
2 YEARS	<ul style="list-style-type: none"> • Walk climb and run. • Point to objects or images when they are named (e.g. the nose, the eyes). • Pronounce several words in a row (from around 15 months). • Follow simple instructions. • Draw scribbles when given a crayon or a chalk. • Enjoy simple songs and stories. • Imitate the behavior of others. • Start to be able to eat unaided. 	<ul style="list-style-type: none"> • Read, sing to and play with the child. • Teach the child to avoid dangerous objects. • Talk to the child normally and not use baby talk. • Continue to breast feed the child and ensure that the child has enough to eat and that it eats varied family meals. • Encourage the child to eat without forcing it. • Fix simple rules and make reasonable demands. • Praise the child when it succeeds at a task. 	<ul style="list-style-type: none"> • The child does not react when it is given attention. • The child has difficulty balancing when it walks. • Unexplained wounds or change in behavior, (especially if others have looked after the child). • The child has no appetite.

Fig. 5: "Adjusting Actions and Attitude to the Development of the Child";
Manual for the Integration of Child Care Practices and Mental Health in Nutrition Programmes, ACF, 2011.

TO KEEP IN MIND ABOUT PSYCHO-SOCIAL CARE:

Child development starts at the beginning of pregnancy.

To ensure a proper development, *a child needs to receive appropriate stimulation in the different development spheres.*

The *care and attention* that a child receives during his early childhood is crucial and could impact his future.

In order to grow and develop, babies need *affection, attention and stimulation as well as good nutrition and appropriate health care.*

Children need to *play and explore* in order to have a good development. Caregivers should provide them with such opportunities and encourage them to do so.

Adults who provide care and developmental opportunities to young children should be able to *detect signs of growth and development slowdown or trouble.*

BFS staff need to be *properly trained* in order to propose adapted developmental activities for children, and to support caregivers.

4. HYGIENE PRACTICES



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Young children are more vulnerable than any other age group to the ill effects of unsafe water, poor sanitation and lack of hygiene; which cause disease such as diarrhoea, and lead to malnutrition and death.

The simple act of hand washing with soap is estimated to reduce the incidence of diarrhoea by nearly half. It also greatly reduces the risk of respiratory infections such as pneumonia and other diseases, including eye infections, especially trachoma.

In emergency situations, conditions of living can make very difficult to adopt good behaviours on hygiene.

In the Baby Friendly Spaces some activities can support parents sharing simple advices about hygiene with the beneficiaries.

FOR MORE INFORMATION, SEE:

“Facts for Life” Fourth Edition,
UNICEF et al. 2010
<http://factsforlife.org/00/text.html> and *link up with Water, Sanitation and Hygiene specialists*

The following elements should be considered and encouraged by the Baby Friendly Spaces' team:

- Parents and caregivers should wash their hands with soap and water at these critical moments:
 - After cleaning the infant or young child who has defecated
 - After helping the child use the toilet or latrine
 - After going to the latrine or toilet themselves
 - Before touching food and feeding young children
 - After dealing with reflux
- Parents and caregivers need to help children develop the habit of washing their hands with soap before eating and after using the latrine or toilet. Where soap is not available hands can be washed with ash and water.
- Washing the face and hands with soap and water every day helps to prevent eye infections. In some parts of the world, eye infections can lead to trachoma, which can cause blindness.
- Baths, especially for small babies, are best given at the warmer parts of the day, not early morning or late evening.

In the context of Baby Friendly Spaces, general hygiene-related issues are mostly addressed through the coordination with the ACF Water Sanitation and Hygiene (WaSH) teams. In the absence of an ACF WaSH team, it is necessary to work with present NGOs or local partners who are specialized in WaSH in order to guarantee that:

- All faeces (human and animal), including those of babies and young children, should be disposed of safely. Making sure that all family members use a toilet, latrine or potty (for young children) is the best way to dispose of faeces. Where there is no toilet, faeces should be buried.
- All water that people drink and use should come from a safe source or be purified. Containers for carrying and storing water need to be kept clean inside and outside and covered to keep the water clean. Where necessary, home-based water treatment, such as boiling, filtering, adding chlorine or disinfecting with sunlight, should be used to purify the water.
- Safe disposal of all household refuse helps to keep the living environment clean and healthy. This helps prevent illness.
- Hygiene is very important during menstruation. Clean and dry feminine hygiene products should be available to girls and women. A clean, private space should be provided to allow them to clean themselves and wash and dry their cloths. Sanitary napkins need to be disposed of carefully with other refuse or burned.

As the caregivers' attention to a baby's hygiene is also a significant indicator of the caregiver - child relationship, Baby Friendly Spaces' teams have to focus their support and activities on the psychosocial aspects related to hygiene.



For example, proposing activities such as **giving bath to babies in the Baby Friendly Space**, is an interesting way to support the beneficiaries, to assess and work on the caregiver's feelings, emotional state and to reinforce the caregivers - child relationship.

TO KEEP IN MIND ABOUT HYGIENE

Hygiene is an important factor in the risk reduction of exposure to diseases.

It is very important that caregivers carefully wash their hands regularly with soap and water. Special attention should be given to the quality of drinking water used by caregivers and given to children.

Mental health is a factor that affects hygiene practices.

The way caregivers care for the young child's body hygiene, also reflects the quality of the caregivers - child relationship.

Addressing general hygiene issues is done through a close coordination with WaSH teams.

5. MEAL PREPARATION AND CONSERVATION

In the context of child care practices, food preparation refers to:

1. Household food preparation, cooking and processing (time spent in food preparation, combustible saving techniques, etc.)
2. Food storage (in order to avoid bacterial contamination and food loss)
3. Food hygiene (reduced time between food preparation and consumption, appropriate utensils keeping)

The effort and skill involved in these activities affect child nutrition and all these aspects can be affected in emergency context. Even before the crisis, these practices may not have been adequate and the new situation can reduce availability of food and the woman's time for household food preparation and cooking.

Basic input related to meal preparation are shared and discussed with the beneficiaries in the BFS. During group discussions women can share their practices and they can receive advice from the ACF team on how to prepare and store food in a correct way, dealing with the constraints of the emergency context. Specific sessions on workload and how to manage time in order to find enough time for food preparation, can be organized.

Meal preparation issues are addressed through close coordination with the ACF Nutrition and Food Security program team.

TO KEEP IN MIND ABOUT MEAL PREPARATION AND CONSERVATION

Meal preparation and conservation is an important factor in terms of child nutrition and health.

Addressing general issues related to meal preparation/conservation is done through a close coordination with Nutrition and Food Security program teams.



Emergency situations exacerbate all these factors.

Cultural and religious beliefs and attitudes have profound effects on many aspects of care as for instance the role of traditional healers in the community or the attribution of causes for a sickness. Furthermore, many cultural food restrictions may result in increased rates of malnutrition and deficiencies.

HOME MANAGEMENT OF ILLNESSES & UTILIZATION OF HEALTH SERVICES

The care children received at home from their families and in their communities is just as important as the treatment available in health facilities. This is why improving the way children are treated and cared for in the community is recognized as a vital tool in the struggle to protect children from diseases.

The importance of optimal breastfeeding and complementary feeding as well as hygiene in the prevention of diseases and the good health, growth and development of the child have already been described above.

Here is some other advice that can prevent diseases in children, pregnant and lactating women in emergency context:

- encourage that pregnant woman will benefit of ante-natal care if possible and if health structures are functioning.
- Take children to complete a full course of immunization before their first birthday because immunization provides protection against diseases that could cause poor growth, disability and even death. In emergencies this is all the more important since deteriorated and crowded living conditions can lead to a higher exposure to diseases.

Unavoidably children will get sick from time to time. Good practices at that point can prevent the disease from worsening and can prevent serious complications and death:

- Continue to give breast milk to children when they are sick, if they are less hungry, they might have to be put to the breast more often to ensure they drink enough milk.
- For children who are more than 6 months, continue to give breast milk, but also complementary food. If the child is not hungry, give small portions many times a day and ensure they are rich in energy and vitamins.
- For children who are not breastfed, give more safe fluids like clean water. If they have diarrhoea or fever, give a lot of extra fluids.
- Let the children rest, sleep is a good way to overcome diseases; give them special attention love and care (cuddle, sing songs, tell a story, etc.).
- If the child has wounds, clean them out with clean water & soap, put disinfectant or use breast milk¹ to wash out the wound and cover the wound up so no dirt can get inside.

1 - Breast milk has antibacterial properties.

- When children are very sick, take them to the nearest health facility if functioning during the emergency. Waiting too long might deteriorate the health of the child; therefore go as quickly as possible when:
 - The child has fever for more than one day
 - The child has continuous diarrhoea for several days
 - The child refuses to eat
 - The child is too weak to play, talk, walk, sit up...
 - The child has a deep wound or a wound that becomes yellow and smells bad
 - The child has burns
- Follow the health worker's advice:
 - Give drops or pills in the quantities and at the times prescribed; giving more drops or pills than prescribed at the same time could make the child sicker. Give the drops or pills as prescribed until the end of the treatment, do not stop because you think the child is better
 - Return to the health facility for check-up as prescribed by the health worker
 - Return to the health facility if the child does not get better after taking the treatment for some days
 - Return to the health facility if the child is getting worse. If the health worker advises you to go to a specialist care, try to do it as quickly as possible


FOR MORE INFORMATION, SEE:

"Improving Child Health in the Community", WHO

http://www.who.int/child_adolescent_health/documents/fch_cah_02_12/en/index.html

HOME-BASED PROTECTION

- Protect children in malaria-endemic areas by ensuring they sleep under insecticide treated bed nets because:
 - Malaria is spread by mosquitos that bite at night
 - Malaria is a serious disease that causes anaemia, convulsions and death; it is very dangerous for young children and pregnant women
- Respond to a child's needs for care by playing, talking and providing a stimulating environment
- Protect children from injury and accident and provide treatment when necessary:
 - Do not let the child play around material that can hurt him: broken glass, nails, sharp objects
 - Do not leave small children unattended on a table or chair or other surface, as they could fall off and seriously injure themselves
 - Do not leave children unattended with items they can drink or eat that are dangerous, such as cleaning liquids, petrol, rat poison, alcohol, chlorine tablets...

- 
- Do not leave children close to fire as they could seriously burn themselves
 - Do not leave children unattended close to water: water ponds, rivers, as they could fall in and drown; small children can drown in a bucket of water or in their bath!
 - Do not leave children unattended on roads where cars or motorbikes pass

TO KEEP IN MIND ABOUT HOME HEALTH PRACTICES

Emergency situations exacerbate negative factors that can have an impact on good home health practices.

In emergency where condition of life can make difficult to assure a safe environment for the child. BFS staff should support families to guarantee a minimum of safety at home and protection child from accident, illnesses and violence.



II. BABY FRIENDLY SPACES



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During emergency situations, whether man-made or natural disasters, disease and death rates among children under-two years old are generally higher than for any other age group, with the highest risk for infants.

Indeed, the caregivers and children's condition (both in terms of health, nutrition and psychological state), and their relationship are affected by displacement, bereavement (loss of children, husband, parents...) and traumatic experiences, aggravated by changes in the usual environment and resources persons that traditionally support the family, as well as the necessity to find solutions for survival. Stress caused by emergency situations can temporarily interfere with the flow of breast milk of lactating mothers, as was found after the Nargis cyclone in Myanmar in 2008.

In such contexts, the child care practices are affected, with risk for young children's development, health and nutritional status etc.

In every emergency, you will need to rapidly evaluate whether this emergencies has had or risks to have an impact on care practices, including infant and young child feeding.

In most emergencies, a multi-sectorial initial rapid assessment is conducted in the days following the onset. This can be done within the ACF country team, or in an inter-agency team.

This assessment should provide you with the information you need to design, budget and programme your care practices activities, as well as be used to advocate for resources and against inappropriate interventions. In case of a major emergency, initial concepts must be ready preferably within 48 hours, at the latest up to one week.

Some information can be collected through:

- Data from contingency planning (such as percentage of children per age group)
- Other agencies and ministries, possibly through coordination meetings (such as ongoing or planned interventions, gaps in response, etc.)
- Other rapid assessment reports

In the assessments, you can add some extra questions but you must keep interviews and discussions as short as possible because:

- The people you interview are struggling for survival and do not have time to answer to long questionnaires
- Other assessments by other sectors or other NGO's will be ongoing and might target the same groups or households; people might get upset if they keep having assessment teams taking up their time

Therefore coordinate and collaborate to optimize the target population time, but also your means, staff and efforts! Do not ask questions that will be answered by other sectors' assessments; ask only those questions that are absolutely essential.

One can/must also collaborate with other organizations within the same sector:

- Carry out joint assessments
- Carry out assessments with similar methodology and questionnaire in different geographical locations

- Carry out assessments that complete other organizations' assessment (for example, if another organization did an assessment on IYCF only, you can restrict your assessment to mental health and other aspects of care practices)

Based on the findings, child care support can happen through many types of interventions. Interventions have to always be adapted to the local culture, to the needs identified and to the staff's training level. In order to provide appropriate support to children and their caregivers so as to reduce the risk of malnutrition and developmental delays, and to promote or restore adapted child care practice, the Baby Friendly Space concept appears as an adapted and efficient framework.

Considering the high risk for infants and young children in emergency contexts, Baby Friendly Spaces should be implemented, even if the actual malnutrition rate is low.

1. OBJECTIVES AND TARGET GROUP



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The overall objective of Baby Friendly Spaces is to protect infants and young children within their families in an emergency context through optimization of care practices with a holistic approach for pregnant, lactating women and their children.

More concretely, the idea of Baby Friendly Spaces is to create:

- A place, where infants, young children and their caregivers as well as pregnant women are welcome and given support
- A safe place, where sharing of experiences is possible; yet privacy is ensured



- A space where caregivers and their children can get together to spend an enjoyable, positive and gratifying moment together
- A place where sensitization, guidance and support is provided to caregivers of infants and young children, as well as future mothers
- A place for promotion and reinforcing care practices for the child by parents, caregivers, families and communities
- A place to reinforce community links, to meet and exchange thoughts; which can create opportunities to exchange information about subjects such as breastfeeding, hygiene, nutrition, etc.
- A place where mother/caregiver-child bonding can be developed and reinforced; as well as where mothers/caregivers capacity to care for their children despite the difficult living conditions can be reinforced
- A place to prevent and detect acute malnutrition in infants, young children as well as pregnant and lactating women
- A place to identify people in emotional distress; where psycho-social support or psychological care is offered
- A place where care for the infants is provided in security and with good quality (i.e. give a bath, breastfeeding spaces if no privacy in the camps, etc.)
- A context in which optimal care practices are safeguarded and promoted through family support, community awareness

Action contre la Faim has been involved in the creation and implementation of IASC psychosocial guidelines¹. The psychosocial program developed in Baby Friendly Spaces should provide support to the first and second grades of the pyramid of psychosocial interventions. Nevertheless, a close coordination with the special unit is expected and must be developed at the beginning of the program.

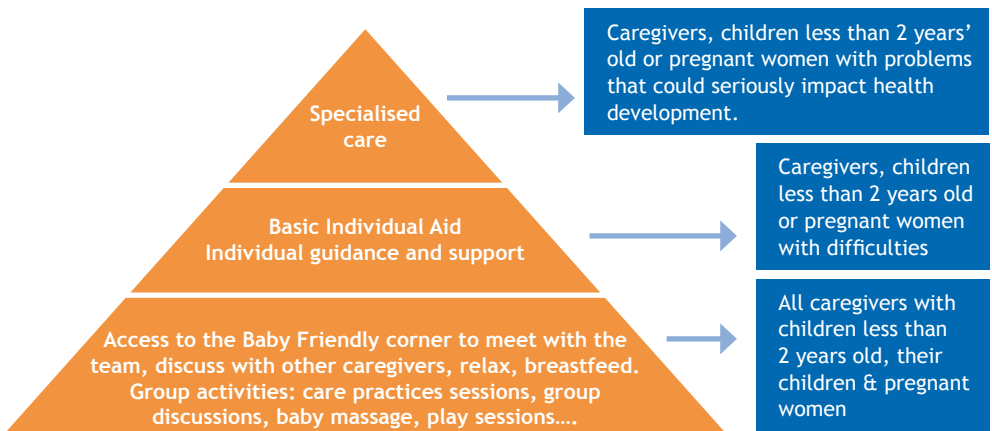


Fig. 6: Pyramid of psychosocial interventions

1 - Inter Agencies Standing Committee (June 2007) Guidelines on mental health and psychosocial support in emergency settings.

The BFS target groups are:

- Direct beneficiaries:
 - All pregnant women
 - All lactating mothers and their child(ren)
 - All children under 2 years of age (breastfed or not) and their caregivers
- Indirect beneficiaries are:
 - The extended family of infants and young children
 - Other community members who are affected by the emergency situation

About care for children older than 2 years:

It can happen that mothers/caregivers come to the Baby Friendly Spaces accompanied by children aged of 2 and more. As these children are not considered direct beneficiaries of this intervention, it is necessary to find solutions in order to permit to mother/caregivers to participate in activities.

1. The team has to check if there are Child Friendly Spaces available in the intervention area.
2. If that is the case, a referral system should be developed with the agency organizing the activities.
3. If not, ACF staff should lobby in order to encourage the creation of such spaces for children older than 2.
4. If there are no possibility to refer these children to external services, basic developmental activities for children aged 2 to 5 should be organized in or just near the Baby Friendly Space. In this situation, the space within Baby Friendly Spaces has to be re-organized so that the other activities (caregiver - child play sessions, breastfeeding, group discussions...) are not disturbed.



2. ADMISSION AND EXIT CRITERIA FOR BABY FRIENDLY SPACES' BENEFICIARIES

The admission criteria are:

1. Pregnancy (depending on each program context, pregnant women can be admitted as soon as they know about their pregnancy, or they may be admitted only after the third month of pregnancy - for example if the number of beneficiaries is very high)
2. Lactating mothers
3. All children aged 0 to 2 years

The exit criteria are:

1. Child is older than 2 years
2. Drop-out
3. Death of beneficiaries (see details below)

When an individual “drops out” it is important for the team to identify why the individual has stopped coming to the Baby Friendly Space over a period of more than two weeks. There is a need to collect information about the beneficiaries (i.e. beneficiaries who moved-out) and a home-visit should be conducted in order to assess the situation. Some questions should be answered: why did the beneficiaries decide to stop participating to the program? Is there any emergency situation that prevents them from coming to the Baby Friendly Space? Is there any misunderstanding about the program that could explain their absence? What is the beneficiaries' present situation? (If the situation is worrying and if the beneficiary refuses to participate to the BFS activities, the team should explore the possibility to refer them to other existing programs).

Of course, the preceding comment does not apply to *pregnant women who give birth*. In many cultural settings, a period of 40 days has to be respected before the mother (and sometimes the baby) can go out of the house. When the team learns that a pregnant woman gave birth, home visit should be organized (if this is culturally appropriate) so as to provide adequate support for the mother, the child, etc. The mother should be encouraged to come to the BFS as soon as she is able to do so.

Deaths of beneficiaries don't necessarily signify discharge from the program. On the contrary, it might be a moment where the caregiver might need more support because of the grief associated with the death of the child/infant, or the new caregiver might need extra support as a result of the death of the usual caregiver. These beneficiaries need extra support and should be welcomed into the program if they are willing to do so. Be aware that it might be difficult for them (especially in case of death of the child) to continue to come to the BFS. In that case, staff might organize home-visits.

In some contexts, the number of beneficiaries may be too high. In that case, before changing the exit criteria, other types of adjustments should be evaluated: opening of new BFS, finding bigger spaces, schedule the planning differently (ie women coming per half day or only once every two

days, etc...). Changing the admission and exit criteria for being able to welcome all beneficiaries should be the last option as the scope of the BFS is to support all pregnant, lactating women and infants.

It is essential to keep in mind that Baby Friendly Spaces have a qualitative goal and a preventive objective. That means that even if the caregivers and infants' situation improves, they are still welcome in the program. Therefore, the beneficiaries' improvement is not an exit criteria (except for psychological support activities - see below).

Note on beneficiaries' status and recording:

In the staff files, each beneficiary is counted and recorded as follows: a caregiver¹ and his baby are counted as two beneficiaries (one caregiver + one child), while a pregnant woman is counted as one beneficiary (one pregnant woman). If a mother has more than one child under the age of two admitted in the BFS, the number of beneficiaries is one mother + number of children.

When a pregnant woman gives birth, she changes status and is now counted as one lactating mother (not as a pregnant woman anymore) + one child (or number of children if more than one).

If a mother is lactating and pregnant at the same time, she is counted as one lactating mother + number of children already admitted. When she will give birth, the new-born will be added as new beneficiary.

In the program's records, each beneficiary is listed with a code number (this code is written on the card given to each beneficiary). Therefore, when a pregnant woman gives birth, she keeps the same number and is only moved from one list to another. An example of record and beneficiary card is presented in the tool kit.

Coverage Area:

It is very useful to know which areas are covered by the BFS and not only the number of admissions and frequency of visits in the BFS. The size area is dependent on your defined target during and after the assessment: it might be a camp, a district, a village or a town. It might be useful when you register the beneficiaries to know where they live for having a better overview of their provenance. For example at the BFS in Port-au-Prince, some beneficiaries had to walk an hour and a half to reach the BFS!

The best method would be to conduct a coverage survey. The minimum is to estimate the number of pregnant women and infants under 2 in the area and to compare them with the number of beneficiaries you have. Number of pregnant and infants might be found through different sources according to the context: medical or administrative sources, other NGO, camp management information. In case, you don't have access to any data, a screening might be done by the out-reach teams to gather information about the number of pregnant women and infants in the area.

1 - In most cases, the caregiver will be the mother. But it might happen that the infant comes with a grandmother, a father (because the mother is dead for example or just delivered). Caregiver should be registered as such. Be careful in case of male caregiver, that it is culturally appropriate (ie women being able to breastfeed when males are present). If it is not the case, specific adaptations should be fine such as specific schedules for the fathers/male caregivers, home-visits, etc.

3. DESCRIPTION OF THE BABY FRIENDLY SPACE



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LOCATION AND PHYSICAL SETTING

The Baby Friendly Space is an area, which can be a tent, a shelter, a room, a corner in health facilities or others available services, etc, located in close proximity to the beneficiaries (for example, inside a refugee or displaced people’s camp, or in the heart of a deprived village or urban poor community). The setting and the modality of intervention will depend on the type of emergency and to the context. If for example, the area affected by the emergency is made up of small villages far between a mobile team can move from village to village and implement activities at community or house level.

Mobile counsellors can exist instead of/or in addition to BFS/corner. According to the modality of intervention, activities should be adapted to the context and the feasibility.

Situation \ Modalities of Intervention	Refugee/IDP camp	Small, wide-spread villages	Pockets of vulnerable families in a large population group	Transit centre refugee/IDP	Urban context or populated villages
Baby Friendly Space	Yes	No	No	Yes	Yes if there is sufficient space
Baby Corner	If facilities in the camp have space and capacity	Yes (ie in health centre)	Possibly	If facilities have space and capacity	Yes
Mobile Counsellor	Yes	Yes	Yes	Yes	Yes

Fig. 7: Type of setting.


This table presents only some indications. It is not exhaustive, nor obligatory.

The Baby Friendly Space's atmosphere needs to be conducive in order to help the beneficiaries feel safe and secure, comfortable and relaxed in order to facilitate sharing opportunities and the development of a trusting relationship with the staff. Therefore, it has to be quiet and private, and as welcoming and "warm" as possible. When different cultural groups are present ensure that individuals (beneficiaries and staffs) are comfortable being together and sharing experiences.

It is a space where caregivers and pregnant women can come with their children to find a quiet and private space to share experiences, receive support and guidance and to breastfeed. It is a space where a team of trained professionals (psychosocial workers, social workers, educators, psychologists) can provide them with care and support through IYCF (counselling, psycho-social support, focus group discussions, parent-child activities, child stimulation). Depending on the context specificities, the activities can be organized in fixed places (same place, all working days of the week), or in different places (BFS moving from one place to another). Additionally, home-visits represent an important aspect of the Baby Friendly Spaces' activities. Activities within the community are part of the program. The structure and needs of an intervention will depend on the type of intervention, but also on the culture and specificities of the country of intervention, as well as the climate.

If the Baby Friendly Space is located in a fixed site, the implementation team should pay attention to the following:

- The Baby Friendly Space should be located in close proximity to the beneficiaries' living place. Make sure the access is easy and possible in all seasons (such as rainy season, cold season).
- The Baby Friendly Space should ideally be located in a quiet and clean place, away from exterior noise, smells, smoke (such as markets, garbage dumps, factories, main roads...). and away from unhygienic areas such as swamps, suck away pit, un-drained area, etc.
- Ensure easy access by car and truck to facilitate delivery and water supply. *Note: if you choose a spot in dry season, check what the conditions might be in rainy season.*
- If the target population is wide spread, there should be a higher number of smaller sites, rather than one big one.
- If possible, they should be situated at a short distance from other related services, such as maternity ward, health centres, MCH, etc. in order to facilitate collaboration and referral.
- The space should as much as possible resemble the usual home environment of the beneficiaries. For example, if the local habit is to sit together on mats during gatherings, then mats should be used in the BFS as well.
- Decorations are important to create a friendly, positive and welcoming atmosphere: colours, children's drawings, etc. It does not have to be expensive! If health education posters are put up, keep them limited and dealing with relevant issues only. Make sure these posters are pleasant to look at and promote positive behaviour.
- Pay attention to a minimum standard of comfort in the Baby Friendly Spaces: make sure, as



much as possible, that the temperature is acceptable. Tents for example, are quick and easy to set up, yet experience has shown that in hot climates, the temperature inside can become very high. Additional sheeting placed above, an electric fan, opening the sides... all that can help to make the temperature reasonable.

- Pay attention to guarantee access to safe water.
- Make sure the size of your Baby Friendly Space is in line with the expected number of beneficiaries.
- The question of security for the Baby Friendly Spaces and the team should be carefully considered.

In order to start activities as soon as possible, a first emergency Baby Friendly Space can be set up, providing time to look for better solutions.

- The Baby Friendly Space should have the following :
 - A waiting area
 - Space for group activities
 - Space for individual discussions
 - Space for psychological support sessions
 - Space to store material
 - If BMS provision cannot happen in a separate location, then a separate space for BMS beneficiaries must be present (see below)
 - Space for older children to play
 - Sufficient privacy to allow breastfeeding, as is acceptable within the culture
 - Sufficient privacy to prevent people passing by from staring and disrupting
 - A presence of sufficient clean drinking water and cups
 - A presence of a place to wash cups or other materials
 - Close proximity to clean toilets or latrines
 - A hand washing area
 - Baby scale, height board, MUAC (if needed)

Having the material for the setup, available in the contingency stock, will help you to move faster!

The material that should be made available will depend on the type of activities you will conduct, but all interventions should have:

- Mats, cushions or other furniture
- Toys, adapted to the age of the beneficiaries
- Toys to let older children play
- Educational tools: demonstration dolls, drawings on flipcharts, booklets, charts, etc.
- Cups
- Soap

- Material for baby hygiene, if this is part of the activities: baby bath, soap, towels, heated water
- Baby oil for massage
- Material for playing music (during caregiver-baby activities, relaxations)

The choice of interventions implemented in the Baby Friendly Space.

THE CHOICE FOR THE TYPE OF INTERVENTION WILL DEPEND ON:

- The context of intervention and the possible setting to adapt to
- The needs identified in the initial rapid assessment
- Presence of health staff and facilities and their expertise
- Expertise and capacity of the ACF team; however if additional capacity is needed to meet the identified needs, it should be requested
- The presence of other YCF-E and/or psycho-social actors within the field
- The presence of national guidelines and coordinated response

It is important to keep in mind that *the population's needs in a post-emergency situation change*. At the start of an emergency, people might still be in a state of shock; life can come to a standstill. Little by little, people will pick up their usual activities again, try to earn a living for their families, rebuild their homes, children will go back to school.

It is essential that care practices activities respond to the actual needs of the beneficiaries, taking into account their availability and, of course, the cultural context and practices. Therefore, the needs will have to be constantly re-evaluated and activities consequently adapted.

Interventions proposed by the Baby Friendly Space are implemented at different levels: individual, family, small groups, community. Some of these *activities can take place outside the Baby Friendly Spaces*, such as:

- Home-visits for the Baby Friendly Spaces' beneficiaries
- Community information sessions (about child care practices for example)
- Community activities (theatre forum for example, on topics related to child care practices)
- Community group interventions (to find solutions for mothers to have enough time - or be allowed- to come to the Baby Friendly Space for example)
- Training for traditional midwives

The Baby Friendly Space offers a wide range of activities adapted to the beneficiaries' needs (based on both the target population's global identified needs and the beneficiaries' individual needs). Then, all beneficiaries do not necessarily have to participate to all the proposed activities, although they are invited to join all of them.

Whether a beneficiary has a specific individual follow-up (one-on-one psychological support for example) or not, the staff should always provide personalized attention to all the Baby Friendly Spaces' beneficiaries.



Note on data collection of Baby Friendly Spaces' activities: when the beneficiaries are admitted in Baby Friendly Spaces, they are offered a "package of activities" that are adapted to the local situation and to their identified needs. Therefore, as we consider that each beneficiary benefits from this global "package", it is useless to record each activity's attendance (i.e. number of beneficiaries present to each activity). Only the number of beneficiaries admitted is relevant.

THE BABY FRIENDLY SPACE'S TEAM

The activities that can take place will depend on the local context and cultural specificities, as well as the skills and competences of the staff recruited. The Baby Friendly Space's team is composed of trained professionals / trained paraprofessionals.

To manage the programme, preference is given to a psychologist profile, with experience in early child development, yet training and follow-up from an infant and young child feeding expert is recommended.

It is difficult to define what background or diploma, psychosocial workers should have, as it varies from country to country or area to area. Most commonly, Baby Friendly Spaces' teams may comprise psychologists, psychosocial workers, animators, lactation consultants, midwives, nurses, community health workers, etc.

Aside from their educational background, other qualities and competences should be taken into consideration, including:

- Having a minimum knowledge on infant and young child care practices, including feeding; and have the capacity and motivation to learn and apply new concepts in a short time frame, with a good capacity to concentrate. Having advanced knowledge on IYCF is a plus
- Possesses good listening and communication skills
- Feeling motivated for this type of work
- Can exercise patience, empathy etc. when required

Adapted training programs need to be designed so as to complete each person's field of expertise. Ensure proper training at the start of the activities¹. It is true that in an emergency the start of activities should be done as soon as possible, but it appears essential for the quality of care to spend some extra days training the staff.

Once activities start, ensure that close guidance and support is available to the staff. This usually means that you will need to start with a limited number of centres, and gradually increase the number.

It is also possible to provide a limited number of activities in the beginning and gradually increase the number of activities as staff gains experience.

¹ - Discuss previous trainings as options for current staff with the Advisor at ACF HQ.

It is important to organise regular workshops and refresher trainings where problems that have been observed can be tackled and where new information can be offered, as well as providing supervision sessions where staff can share their concerns and cases can be discussed in privacy. It is best to provide training and supervision in the local language, to ensure good comprehension by all staff members. Always ensure that the translator has a good understanding of the subject to make sure he/she translates correctly.

In many emergencies, ACF recruits local people from the affected area. While this is beneficial, as they know the situation and the culture, many of these individuals are affected by the emergency as well. They may be displaced, survivors of a natural catastrophe, have lost loved ones and/or have lost their belongings. The psychological well-being of those recruited should not be taken for granted and support should also be provided to them.

It is recommended that beneficiaries are seen by the same staff member, when possible. This means that all staff members should have acquired similar basic competences and training, when possible. According to the context, culture and religion in the country or area, it is important to pay attention to the gender of the staff recruited. In some countries, female staff is recommended when working with women, but it could be necessary to also include men in the team for the work with male caregivers.

4. EVALUATION OF BABY FRIENDLY SPACES' RESULTS AND IMPACT



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In order to assess the Baby Friendly Spaces' impact, a preliminary survey should be conducted in order to evaluate the number of potential beneficiaries in the targeted emergency area. This number will be compared to the actual number of beneficiaries enrolled in the program to obtain the coverage rate.



It is essential to keep in mind that Baby Friendly Spaces aim at working with the highest possible number of beneficiaries, while always ensuring a good quality of the intervention.

Consequently, the idea is not to have a very high number of beneficiaries if they don't come to the Baby Friendly Space regularly enough to get a real benefit from the activities (beneficiaries should visit the Baby Friendly Space at least once a week for the intervention to be meaningful and efficient).

In order to optimise coverage:

- Target areas with highest risk
- Coordinate with other actors providing similar services, and distribute the services geographically
- Provide support to organisations wishing to provide such care through advice and training: invite key staff of those organisations to in-house training sessions, help them with staff training, and let staff follow activities with ACF staff, give advice, etc.
- Let the activities be known by the community: inform and collaborate with community leaders, groups (women' groups or other), other humanitarian actors
- Perform outreach activities and active case finding

The number of tools and indicators should be limited as staff should spend time with beneficiaries and not only fill out documents!

The Baby Friendly Space's **process and activity indicators** can be:

- Types of admission and discharge criteria
- Nb of women (pregnant and lactating) and babies admitted to the program
- Age and sex of the caregivers and infants
- Nb of women (pregnant and lactating) and babies having participated in the BFS
- Frequency of participation in BFS activities
- Nb of beneficiaries (women and children) referred for psychosocial support
- Nb of psychological consultations
- Average of psychological consultations per patient (women and children)

In case of high prevalence before or during the emergency, include indicator on weight and height of the child.

→ **Tools for measuring process and activity indicators of the Baby Friendly Spaces are:**

- ACF Data base
- Attendance sheet
- Initial Rapid Assessment
- Personal file for psychological consultation

All data collected should be protected by password and/or locked in a safe place in order to guarantee the confidentiality of the data.

The Baby Friendly Space's **outcome and impact indicators** can be:

- Mortality rate among children under 6 months¹
- Morbidity rate among children under 6 months
- % of women who reported to have changed from mixed feeding to exclusive breastfeeding
- % of children 0-5/6-11 months suffering from malnutrition
- % of children being exclusively breastfed at 4/5/6 months
- % of women who managed to relactate
- % of women who show an improvement in knowledge on complementary feeding
- % of women and child who improved their relationship
- % of women who improved child care practices
- % of women going to prenatal consultations
- % of pregnant women who after birth, breastfeed exclusively
- % of suffering women who improved psychological status
- % of children who showed withdrawal that improved after appropriate support
- Etc.

→ **Tools for measuring outcome and impact indicators of the Baby Friendly Spaces are:**

- Data base
- The data collected during the home-visit conducted after a pregnant woman beneficiary gave birth, are also very significant of the program's impact (care practices provided to the new-born, breastfeeding, weight at birth...)

For psychological aspects:

- **For children:** result of the **Alarm Distress Baby Scale (ADBB)**. A self-training module is available on demand in HQ; results need to be validated by the authors of ADBB scale
- **For the mother - baby interaction:** **Observation scale** from the Manual for the Integration of Child Care Practices and Mental Health in Nutrition Programmes, ACF, 2011
- **For psychological support activity**, the patients' progress is assessed at the end of the follow-up, based on the combination of:
 - **WHO-five scale**
 - **EPDS scale**
 - Results of the **psychological distress scale** (assessment done by / with the patient)
 - Psychologist's clinical assessment of the patient's progress
 - Drop-out rate (the beneficiary is considered dropped-out if he missed 2 sessions with the psychologist, if he decides to stop coming to the sessions, if he moved-out)
 - The type of phase-out (based on the qualitative results): improved, worsened or unchanged

1 - This data can be collected from local authorities, health centres, international organizations...



5. REFERRAL SYSTEM

Networking with other available services and developing a referral system is an important component in Baby Friendly Spaces, for several reasons.

Baby Friendly Space cannot offer all services in order to respond to all the beneficiaries' needs. Indeed, focusing on the program's specific objectives and logic is a key for success. Consequently in emergency contexts, it is important that a functional referral system is set up. In this way, beneficiaries who need care that cannot be provided within the Baby Friendly Space's scope of intervention can be referred to other programmes.

Networking and partnerships with other agencies also help to work together on assessing the coverage level of the population's needs, on improving coordination so as to increase the services' efficiency, or on supporting the creation of new services.

The following list is an example of important referral possibilities (of course, this depends on each context, on the beneficiaries' particular needs and the availability of services in the area):

- Primary and secondary health care: mobile clinics, health centres, hospitals
- Prenatal consultation and maternity
- Growth monitoring and vaccination
- HIV counselling, testing, treatment and PMTCT
- Targeted feeding programmes: supplementary and therapeutic (in- and out-patient)
- Psychological support: crisis centres and psychiatric wards
- Safe Havens for women, or other facilities for women including protection services
- Care for people with a handicap
- Programmes for abandoned or unaccompanied children, family reunion, etc.
- Women's support groups
- Distributions targeting young children, pregnant and/or lactating women

To conduct efficient referral, the Baby Friendly Space's staff should gather the following information:

- Know the precise activity of each referral place, as well as their admission criteria
- Know the exact location
- Know the opening hours/days for admission
- Know the fees that are requested

Information regarding such facilities will usually be found through the relevant coordination bodies, such as the Health Cluster, Reproductive health sub-cluster, (Child) Protection Cluster, Food Aid and Nutrition Cluster, MHPSS sub-cluster, OCHA coordination... or through agencies managing such programmes and the relevant government bodies.

6. PHASE OUT

The BFS are opened in Emergency Settings. According to the type and the level of the emergency, ACF might be direct implementer (it will be the cases in most of the emergencies as the infrastructures are often destroyed or affected) or intervene with staffs from the government or from national NGO's. In all situations, collaboration and regular information with the government and health services is essential as well as the continuous adaptation to changes of the context and needs. Implementing care practices activities in emergency can have the added value that attention is drawn to the subject and activities continue throughout the post-acute phase and the future development.

The length of the programme can depend on many things, among others:

- The severity of the emergency and the time expected to return to “normal”
- The evolution in the needs identified as cause for set up of the programme
- The (re)-functioning and capacity of existing structures

Some consider the emergency period as a time period, usually 6 months after an event like a natural catastrophe. However in many situations, life has not returned to normal after 6 months: living conditions can still be poor, there can be food insecurity and people are still grieving, etc. Therefore needs and BFS response must be evaluated regularly. This will allow you to adapt the programme to changing needs and to decide when to phase out and close. Participation to the BFS is an indicator that you might use for deciding to continue or stop the program but be aware that participation alone is not sufficient. In many contexts, a decrease in participation to BFS has been observed but after a proper evaluation, this lower frequency was due to a lower quality of the program (too many tools and not enough attention to the beneficiaries, not enough renewal of the topics in group sessions, etc.), a lack of adaptation to the changes of daily life of the population or an inadequate geographical position after relocation of families, etc. In the regular evaluation, it is important to assess which needs are still present, which needs are already covered and if the BFS is the most appropriate response to those needs.

It is also very important to keep in mind that it is common to assist after an emergency to a post-disaster baby boom (see below) and that in such cases, the program should continue for at least one year after the emergency.



“Post-disaster baby boom”

It has been observed that in the aftermath of a major natural disaster, there is an increase of pregnancies among the population. Indeed, ACF teams were able to note this phenomenon in Sri Lanka after the 2004 Tsunami. In the camps where the affected families were accommodated, most parents had lost some family members, including a high number of children. The ACF psychosocial workers who were providing support to these individuals, noted the traumatic effect of the tsunami and these extremely painful losses on the parents, as well as a desperate hope that the new expected baby could “replace” their lost child(ren). In such difficult situations, where traumatic suffering and symptoms, particularly difficult mourning, loss of belongings, uncertainties about future, poverty and unrealistic expectations about the baby accumulate, these new-borns’ overall situation was particularly worrying and at risk. Therefore, Baby Friendly Spaces were recommended and implemented for more than one year.

Phasing out is important so as to not to drop what you have built up. The idea is that there is a smooth departure through:

- Decreasing activities in the programme
- Transfer of activities:
 - Some activities might be able to be integrated into long term ACF programmes that exist and will continue to in the area.
 - Some activities that were conducted in the care practices programme might be transferred to another NGO who can integrate it into their routine programme. Training and capacity building might be necessary and time is needed to allow a smooth transfer.
 - Some activities could be transferred to public health structures or other government structures, in agreement with the concerned ministry and while conducting a thorough capacity assessment and capacity training if needed. Sufficient time must be foreseen to allow proper preparation, hand over and follow up.
 - Some activities can be conducted by community groups, these groups might exist, or you might work together with the community to create new ones. Sufficient time will be necessary to assess the capacity or create new groups, build capacity, work together and finally hand over.
- Admission termination for BMS: all beneficiaries admitted in the BMS programme must be followed-up until they are a minimum of 6 months old, preferably until 12 months. This means that no new admissions can be accepted 6 months before the end of the programme. Still, one must try to identify another programme that helps infants and their caregivers who show up after the admission termination; this way they can be referred; or other alternatives should be discussed. One should not just send away infants in need of help.

In Haiti, ACF has open BFS 4 days after the earthquake. In Port-au-Pince, BFS were full for 2 months. We observe a decrease in frequency in March. After a proper evaluation, it appears that the staff was very much focused by fulfilling files and papers and was not taking care of beneficiaries enough. Limiting the number of documents for monitoring the program, refreshing training and close supervision as well as information in the communities have been done and allow good attendance. In May, nutrition surveys have shown an increase of malnutrition cases. BFS and tents for treatment of SAM have been located in the same area for a better response to this new situation. In 2011, the treatment of SAM has been transferred to national health centres. The BFS have been closed progressively but support to breastfeeding and feeding practices ad child massages have continued in health centers through groups run twice a week.

In Gonaives, the situation was different: it appears that mothers coming in BFS were very young, very isolated and discriminated. Most of them were coming every day and were staying all day long in the tents. A better understanding of their profile and needs has been done and has led to a new setting: development of centers for adolescent mothers and their very young children with vocational training and income generating activities, psychosocial support, health insurance, child stimulation and social and familial reinsertion.

Haiti's programs are examples of adaptation of BFS according to the needs and existing infrastructures.

At all times you must keep the beneficiaries informed of changes and the reason why, as well as communicate and coordinate with the Ministry of Health, inter-agency coordination and other NGO's, especially those with whom collaboration was set up.





III. ACTIVITIES



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In this chapter, activities will be described in detail, yet if the activities are deemed essential, the key element of the BFS is to offer secure and safe space for parents and very young children. It means that the presence and the availability of the staff is the most powerful component of the BFS. Informal discussions with the staff and/or amongst beneficiaries, presence and support from the teams is as important as the activities themselves. It is also one of the most complicated things to teach to the staff. This should be encouraged and explained through regular supervision and through the type of information that is collected in the monitoring of the BFS.

Activities depend on the target population's situation and the specific needs that were identified. Many different activities can be provided in a Baby Friendly Space¹.

It is useful to define a weekly planning of activities. This planning can be flexible and it should be modifiable depending on the evolution of context, caregivers' availability, attendance to the Baby Friendly Space and observed needs.

A structured schedule of activities provides a framework for teams and also for beneficiaries who may have an overview of the proposed activities, they can decide when to participate (this is very important in emergency situations where women dispose of very little time to dedicate to themselves and children), and they know that some activities are repeated during the week. Provide a structure can also be important especially in the first phase of the emergency where everything around is chaotic and difficult to understand.

It is also important for women to understand that the aim of the project may be long-term and that the activities are not repetitive, they evolve over time and needs.

For this reason it is fundamental to:

- Develop individual projects at the time of arrival of the women at the tents, and to propose tailored activities. This allows them to re-enroll in a fixed schedule and to manage their time with their priorities,
- Develop projects over several weeks for example, offer a group of beneficiaries to work on the establishment of a small theater on the difficulties of daily life in the new conditions.

The activities planning can provide a framework and at the same time should remain flexible to changing conditions of the environment and to beneficiaries' needs expressed or observed.

In Haiti, after the earthquake, two different approaches had been implemented for the BFS according to the context.

In urban area: in Port-au-Prince and Gonaïves, BFS have been organized under big tents. A weekly plan had been defined for each BFS respecting women' workload and ability to access the spaces.

1 - ACF has more detailed tools available on demand for expatriates on the field on the different activities and trainings.

In Artibonite region, a rural area, a different organization had been proposed. Villages were widely dispersed and the team could reach each zone just once per week. The team organized activities in spaces given by the community, involving fixed groups of pregnant, lactating mothers and their children. They were involved in a cycle of 4 meetings of half a day each, with a specific program. That fact that mothers were aware about the topics and activities of the following sessions, gave them a structure and a sense of belonging to a program with clear objectives. At the end they expressed the wish to continue with another cycle of sessions. The attendance in these activities was very high.

Time	Monday	Tuesday	Wednesday	Thursday	Friday		
8 to 8.30 am	WELCOME / information time						
9 am	RELAXATION for lactating women	RELAXATION for pregnant/ lactating	RELAXATION for pregnant women	RELAXATION for lactating mother	RELAXATION for pregnant/ lactating		
9.30 am	BABY BATH or MASSAGE	BABY BATH or MASSAGE	BABY BATH / MASSAGE		BABY MASSAGE with fathers		
10 am	FDG / nutrition	STORY TELLING	ART THERAPY	PLAY SESSION for 0 to 11 months	STORY TELLING		
11 am	ART THERAPY	PLAY SESSION for 0 to 11 months	PLAY SESSION 1 to 2 yrs	FGD BF/ Hygiene	PLAY session 0 to 11 months		
12 am	lunch time						
13 pm	PLAY SESSION for children 1 to 2 yrs	PLAY SESSION for children 1 to 2 yrs	Psychologist (counselling, assessment...)	PLAY SESSION for children 1 to 2 yrs	RELAXATION for pregnant	CLOSE	
14 pm	PLAY SESSION for children 0 to 11 months			FDG hygiene	Psychodrama		PLAY SESSION for 1 to 2 yrs
	RELAXATION for pregnant	FDG pregnancy		FDG child development			Preparation of women's day
15 pm	FDG pregnancy	Breast feeding					
16 pm	BABY BATH or MASSAGE	Preparation of women's day					
17 pm	Administrative time/ cleaning						

Fig. 8: Example of weekly activities in a BFS.
(example from Philippines, areas devastated by the tropical storm "Washi" on December 15th, 2011)



The following description of activities is not exhaustive neither compulsory. Activities should be chosen and defined in line with the needs that exist in each situation, the country and ACF strategy, the competences of national and international staff and the budget and logistical capacity available. Additional activities can be added to respond to identified needs.

In this manual, we will present the following activities:

- 1 - Welcoming beneficiaries and sharing basic information
- 2 - Intake and needs evaluation
- 3 - Psychological support
- 4 - Psycho-social support
- 5 - Group sharing / information sessions
- 6 - Relaxation exercises
- 7 - Baby massage
- 8 - Play sessions
- 9 - Breastfeeding counselling
- 10 - Activities around Complementary Feeding
- 11 - Infant growth monitoring
- 12 - Home-visit
- 13 - Community awareness activities

1. WELCOMING BENEFICIARIES AND SHARING BASIC INFORMATION



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The first contacts of the beneficiaries with the Baby Friendly Space and the way they feel welcome by the staff, are crucial. A smile, a warm word of welcome, taking time to introduce oneself... will help make people feel at ease. Welcoming the beneficiaries and behaving in a supportive way with them is an attitude that is actually at the core of the work done in Baby Friendly Spaces (not only during the first encounter).

The beneficiaries' expectations towards the Baby Friendly Space also need to be discussed, especially in emergency situations where people are quite understandably looking for food and essential items for shelter, cooking, and protection (clothes, blankets...) to replace what they have lost. In consequence, some caregivers might be disappointed if the staff does not offer them any material support. This is why it is important that from the very first contact, the staff can explain that they can offer them support, help and advice to help them feel better, to keep the children well-nourished, healthy and happy, as well as referrals to external services for material help (if and when available). Therefore, it is important that staff members know where beneficiaries can turn to for additional aid. They should be able to provide information on or refer to distribution programmes.

It is recommended to work with the team members on how they can deal with these possible demands.

Taking time to talk to them, to listen, giving a follow-up booklet, as well as scheduling a next meeting with the caregivers can already make the beneficiary feel that they are receiving help. It is also important to explain that caregivers do not necessarily have to come for the scheduled activities only: a day long, psychosocial workers are present to welcome them, they are also able to talk to the staff or to other beneficiaries if they need to, and lactating mothers can breastfeed their children quietly in the breastfeeding area at any time (even during lunch breaks).

Of course, one must be aware that in an emergency, people might be grieving for their lost ones. Respect for that grief and for the cultural way of dealing with it is important, so during all activities, group activities or individual discussions, the team should show respect and take into consideration the experiences people have lived through or are continuing to live through.

In order to welcome beneficiaries in an appropriate way, the following is advised:

- Smile
- Welcome people personally and invite them in, offer them to sit down,
- Offer water, or if you have: a juice or snack, tea,
- Introduce yourself and other staff members,
- Explain the purpose of the BFS and present the activities,
- Allow people to ask questions,
- Use a language and words that are understandable for all people,
- If there is a waiting time, organise something to entertain people usefully (group discussion, health education, ...),
- Show respect and empathy,
- Take into consideration people's mental state and show empathy for their difficulty,
- Create a nice environment: not too hot or cold, decorated, provide a place to sit comfortably.

2. INTAKE

For every beneficiary, an intake interview should take place and be duly recorded.

Through an individual discussion with each beneficiary, the goal of the intake is:

- To identify any age-inappropriate or suboptimal feeding practices
- To identify any problems in care practices on quantitative and qualitative level, bonding or psychological difficulty (in children and /or caregivers)
- To offer further psychosocial support to the mother/caregiver, to deal with any problems if identified
- To be able to refer the child or pregnant women to complementary care if the problem identified cannot be dealt with in the Baby Friendly Space or by the staff

There are two types of intake evaluations:

- **A short rapid evaluation:** this evaluation is conducted for all beneficiaries of the Baby Friendly Space, to quickly identify the beneficiaries' "general profile", and to identify the persons presenting serious/complicated difficulty from those who are not. This is especially useful when the Baby Friendly Space is busy and there is no time for an in-depth intake for all beneficiaries. It can be done by most staff. If time allows it, all beneficiaries should have a full evaluation.
- **A full evaluation:** this in-depth evaluation should take place in priority for those beneficiaries with whom specific problems were identified in the rapid evaluation; it can be done for all beneficiaries if time allows it.

The specific difficulties that should draw the staff's attention during the evaluation are:

- **Difficulties with breastfeeding** (real or perceived lack of milk production, babies' capacity/ possibility to correctly suckle, etc.)
- **Difficulties with pregnancy** (very young mother without support for the first pregnancy, high risk pregnancy with previous miscarriages etc, pregnancy as a result of sexual violence, etc.)
- **Psychological vulnerabilities** (mother/ caregivers that express or show depression symptoms, children with withdrawal symptoms, etc.)

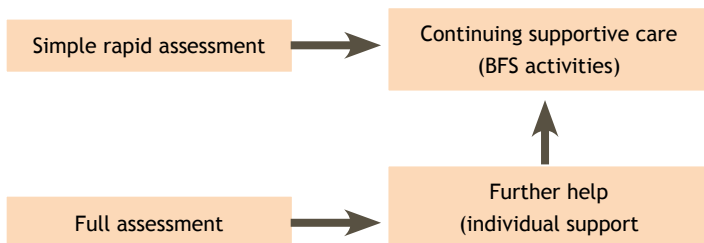


Fig. 9: based on deciding who needs help; IFE Module 2 v1.1; IFE Core Group

All mothers, caregivers and children less than 2 years should receive supportive care in the Baby Friendly Space and they should be invited to participate in group activities.

Mothers/caregivers, children less than 2 years and pregnant women, who present problems that have been identified, that could seriously impact the health and development of the child should receive close guidance and individual support.

During the interview, the interviewer must be respectful, non-judgemental and showing empathy, creating an environment of trust, while listening and observing.

Following is a proposition of intake guideline:

1. Introduce yourself, your role, help the mother/caregiver or pregnant woman to feel at ease
2. Collect practical information: age of the child and the mother/caregiver or pregnant woman, address, means of contact (phone number), etc.
3. Information on the feeding practices: breastfeeding (exclusive, predominant, mixed) or artificial feeding (what type); introduction of complementary food, number of meals per day etc.
4. Information on other care practices: hygiene, play, etc.
5. Information on health problems: does the child or the mother have any health problems; if yes, has he/ she been referred to a health centre, etc.
6. Information on the mother's well-being: how does she feel, how is she coping with taking care of the family in such a context... Does she have any worries or fears?
7. Check nutrition status of the child and the mother/caregiver or pregnant woman: although this is not a nutrition centre, it is important to identify any cases of acute malnutrition so they can be referred to the appropriate centre for treatment. If scales and height boards are available and the staff is sufficiently trained on them, they can be used. If not, it is no problem to identify acute malnutrition through MUAC and oedema screening only, except for children under 6 months.
 - **If the beneficiary is SAM:** refer to the closest TFP, according to admission criteria. If the beneficiary will be admitted in out-patient, inform them they are still welcome to come to the centre as well, and encourage them to do so. If they are admitted in in-patient facility, inform them they are welcome to return as soon as they are discharged or referred to an out-patient facility. Breastfeeding Corners might be developed in TFPs too
 - **If the beneficiary is MAM:** refer to the closest SFP, according to admission criteria. Inform the beneficiary they remain welcome to continue to come to the centre, and encourage them to do so
8. If a need to conduct further interview or to come to an individual psychological support session is suggested, and it cannot take place immediately, define the appropriate day and time for the mother/caregiver or pregnant woman

9. Inform the beneficiary of the activities schedule, and invite them to come.

10. Before the beneficiaries leave the Baby Friendly Space, assure him / her that you are available for them if they need any support or advice and give them the “beneficiary card”.

3. PSYCHO-SOCIAL SUPPORT

Mental health and psychosocial impact of emergencies is reported in the IASC Guidelines on Mental Health and Psychosocial support in Emergency settings:

“Emergencies create a wide range of problems experienced at the individual, family, community and societal levels. At every level, emergencies erode normally protective supports, increase the risks of diverse problems and tend to amplify pre-existing problems of social injustice and inequality.

Mental health and psychosocial problems in emergencies are highly interconnected, yet may be predominantly social or psychological in nature.

Significant problems of a predominantly social and/or psychological nature include:

- *Pre-existing (pre-emergency) social or psychological problems (e.g. extreme poverty; belonging to a group that is discriminated against or marginalised, political oppression, severe mental disorder, alcohol abuse).*
- *Emergency-induced social problems (e.g. family separation, disruption of social networks, destruction of community structures, resources and trust, increased gender-based violence, grief, non-pathological distress; depression and anxiety disorders, including post-traumatic stress disorder (PTSD)).*
- *Humanitarian aid-induced social problems (e.g. undermining of community structures or traditional support mechanisms, anxiety due to a lack of information about food distribution).*
- *Thus, mental health and psychosocial problems in emergencies encompass far more than the experience of PTSD.*



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FOR MORE INFORMATION, SEE:

Guidelines on Mental Health and Psychosocial support in Emergency settings, IASC, 2007

http://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf

Psychological first aid: Guide for field workers, WHO/ War Trauma Foundation/ World Vision, 2010

http://whqlibdoc.who.int/publications/2011/9789241548205_eng.pdf

In emergencies, not everyone has or develops significant psychological problems.

Many people show resilience, that is the ability to cope relatively well in situations of adversity. There are numerous interacting social, psychological and biological factors that influence whether people develop psychological problems or exhibit resilience in the face of adversity.

Depending on the emergency context, particular groups of people are at increased risk of experiencing social and/or psychological problems.”

Pregnant, lactating women and young children are a group who are often strongly impacted by the emergency situation.

Remember that some people in severe pain, distress and / or those who are marginalized or excluded may be unable to make an active approach to ask the Baby Friendly Space’s staff for help. Some people may also be ashamed or afraid of stigma to come on their own to Baby Friendly Spaces. Therefore, depending on each context, it is often relevant to include home visits in order to meet directly with potential beneficiaries and introduce the program, so as to avoid missing the most vulnerable groups.

In the BFS, psychosocial support for mothers, pregnant women and very young children may be proposed by supporting the implementation of recommendations of the psychosocial IASC guidelines.

The goals of psychosocial support should be:

- Strengthening individual and collective resources
- Supporting in adjusting to daily life in new living conditions
- Strengthening and supporting the parent-child relationship and child development

STRENGTHENING INDIVIDUAL AND COLLECTIVE RESOURCES

First, this is done through the way families are welcomed when they come to Baby Friendly Spaces, with teams who are available and responsive, providing opportunities for developing individuals’ skills and resources (adults and children).

The following exercises are examples and can be used with adult beneficiaries (this can be done in groups and/or individually). They can also be used in addition to psychological support so as to enhance the resources of those in distress:

- Identifying "elements / things / actions that are good for me/are beneficial to me, that make me happy, that relax me"
- Using group games: for example, present a whole range of images and people choose the images that correspond to them and then share in groups or do drawing, etc. How can I give myself the opportunity to do those things that do me good or that make me happy? How can I try to do these things I do well every day?



- Working on sociogram based on the beneficiaries' drawing: who are the people present around me? Who are the people on whom I can rely? What for? How do I access or not those resources? Why?
- Group relaxation
- Massage sessions with beneficiaries divided into groups of two persons
- Aside from these exercises, the formal or informal discussions and sharing in Baby Friendly Spaces also represent precious moments to enhance one's resources

SUPPORT TO ADJUST TO NEW LIVING CONDITIONS

This support can be organized in several ways. The goal is to help people to better adapt to the present situation and help them project into the future.

Several methods may be used:

- Creating spaces for sharing, exchange and mutual assistance among the Baby Friendly Space's beneficiaries: what does everyone need, how is possible to fulfil it, what kind of help can the group provide in order to meet these needs, etc. This can be done, for example by designing several large boards with a map of the area with all the places where they can receive assistance or services, etc
- Starting by an exercise of relaxation and visualization: imagine your situation in a year and ask open ended questions about how they see their future
- Working on home organization: how is home organized? Who is living here? How could it be improved?
- Distribution of tasks at home and organization of work

STRENGTHENING AND SUPPORTING THE PARENT-CHILD RELATIONSHIP AND CHILD DEVELOPMENT

In emergency situations, because of the difficult living condition and the caregivers' focus on fulfilling basic survival needs, the time spent with children and the access to developmental activities for them, are very often reduced.

Some examples of activities to strengthen the parent-child relationship are presented here; for more details read the ACF "Manual for the Integration of Child Care Practices and Mental Health in Nutrition Programmes", 2011.

In addition to the activities proposed in the following paragraphs, the team can also:

- Make an inventory with women on what they have at home and on how they make activities with the child (for example using the HOME questionnaire). Include the family as well and see with them how it could be improved.

- Propose play sessions with a few pairs, to strengthen socialization and sharing among parents on the importance of play, to facilitate discussion on what play material could be used in the emergency context, etc.
- Role playing on practical activities of daily life: use a doll to show participants how to bathe a child, role play a feeding situation where the child refuses or accepts to eat, etc. Organize play activities for children and parents, share your observations, discuss with them about what their child learns and how to encourage them. This type of setting also allows caregivers to play, to feel the pleasure of this experience, which is important in order to identify with their child and to ensure their access to play time, material.

4. PSYCHOLOGICAL SUPPORT



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Psychological support service is available in Baby Friendly Spaces, for the beneficiaries who are facing important psychological difficulties. Psychological support is organized in individual or group sessions, depending on the beneficiaries' needs, the culture and the qualifications and training of the staff.

As this activity requires the intervention of *trained psychologists*, the first step consists in assessing the availability of appropriate human resources in the emergency context. If no local psychologists are present or available, it is important to organize the presence of expatriate psychologists on the field, together with local translators. The presence of translators is essential and should not be considered optional in a Baby Friendly Space project.

In any case, the availability of external services offering psychological care should be assessed, in order to explore the possibility to refer the beneficiaries to these services and for coordination purposes (Information can be found in the MHPSS group if existing in the country).



Technically, ACF does not favour a single therapeutic approach¹, but prefers an eclectic approach tailored to the specific issues affecting the population, to the patients and to the programme. The aim is to keep a real flexibility in meeting the beneficiaries' needs, encouraging the creation of tools adapted to the context. The use of culturally sensitive tools is encouraged and favoured when these exist.

Psychological support^{2, 3} can be provided through various activities, such as:

- Individual psychological support sessions
- Psychological support sessions in group (group therapy)
- Psychodrama
- Psychological support sessions based on creative expression
- Psychological support session on strengthening individual/group resources and capacity to deal with new situation

In the BFS set up in the Philippines after the Washi storm in December 2011, there were a high number of beneficiaries in need of psychological support. The psychologist decided to use psychodrama as therapeutic means. Psychodrama is a role play involving the beneficiary to play an unwritten role. In this role, the beneficiary is supposed to express feelings toward individuals. The psychodrama setting should be (and was in this instance) provided to the beneficiaries within a safe and non - threatening atmosphere. When the drama was completed, group members from the audience discussed the situation they had observed, gave feedback, expressed their feelings, and related their own similar experiences. In this way, all group members benefited from the session, either directly or indirectly. The first psychodrama was about the flood. At the conclusion both the main actor and the audience were in tears. It was very difficult to handle for the team. This encouraged the team to create more structured psychodramas allowing for better control.

To set up a psychological support intervention, it is important to:

- Specify the inclusion and exit criteria for psychological support
- Specify the exclusion/referral criteria (i.e. chronic mental illnesses such as psychosis or epilepsy)
- Establish a filing system that ensures the confidentiality of data (locked cabinet etc.)
- Prefer short term support approach. Work on increasing internal and external resources as the priority
- Various methods can be used that can be based on creative expression, relaxation, movements and body sensations, etc.
- Establish a monitoring system: identification of needs, appointments, follow-up, home visits, etc.
- Establish a referral system for psychiatric problems, if services are available

1 - See ACF (2009) Policy on Mental Health and Child Care Practices.

2 - See the documentary "Les blessures de l'ame", directed by Cécile Allegra and Raoul Seigneur, after the earthquake in Haiti 2010.

3 - See ACF, Filorizzo A. (2012) Response to emergency « Sendong », Philippines. Baby Friendly Tent: Care Practices and Psychosocial Support.

There are 3 main steps in the process of identification and inclusion of beneficiaries for psychological support (obviously, these steps should be coherent with the analysis of psychological needs through regular observations of beneficiaries, information from participation in activities or spontaneous demands from the beneficiary):

1. During the rapid assessment, the psychosocial worker includes the five questions of the WHO (five) well-being index (this tool can be used by any staff member)
2. If result at the WHO (five) well-being index shows difficulty, the EPDS scale should be completed with the beneficiary. Note that the score references at EPDS differs from one country to another
3. If result of EPDS reveals that the beneficiary suffers from psycho emotional difficulty, an appointment with the psychologist is proposed so as to assess the relevance of a psychological support follow-up and the beneficiary's openness towards this possibility. The most adapted type of intervention (individual, group) for the person is then defined, as well as the sessions' schedule and rhythm

To identify *infants in need of psychological support the ADBB* (Alarm Distress Baby Scale) should be used in addition to observation of children and caregiver-child relationship.

Following is an example of psychological support conducted in Sri Lanka, where a psychosocial program was developed after the 2004 Tsunami¹:

Lakshmi is a 24 years old woman who lost her 9 month old baby boy during the tsunami. She is now 7 months pregnant. She got pregnant after her baby's death. The psychological support sessions are done with both parents.

The woman seems to suffer from deep sadness. She tells us what happened to her boy in a smooth and monotonous voice: she was giving him food and suddenly she heard an old woman screaming that water was coming and everybody had to run. Her husband took the baby in his arms and they ran together. Unfortunately, the baby got trapped on a fence and the father could not take him from it.

He could only save himself, leaving the baby stuck on the fence. There is hardly any emotion when the mother tells us the story. It looks like for her, her son is still alive; she says she talks to him sometimes. She talks to her baby in her womb too, as if he was the dead baby boy.

On the contrary, the husband refuses to pronounce the word tsunami or to talk about the death of the baby but he is able to listen and stay quiet when his wife narrates the tragic event.

During the following sessions, the couple often complains about physical pains, especially the husband. It is remarkable that he gets more pain (likely to be pregnancy sympathy pain!) than his wife as the baby delivery approaches. He focuses the attention on his physical complaints instead of his wife's (taking a large part of the psychological session's time). This appears as a psychosomatic sign of anxiety, which corresponds to the new child's coming birth.

1 - Written by Joséphine Antoine-Milhomme, Psychological Care Program Capitalisation work, April 2005-February 2006, Batticaloa Sri Lanka, ACF.



The husband's behavior also seems to be a way (certainly unconscious) to avoid taking about the death of the son. The mother speaks of many dreams during the sessions, dreams of the dead boy and the mother in different situations, from frightening visits to more peaceful ones. Lakshmi came to the group sessions for pregnant women. One session was about care practices for babies and a woman bathed a doll. Lakshmi tells us that during the bath of the doll, the other women who knew her baby, said that it would have been impossible for her child to stay as quiet as the doll, as he used to play and moved a lot at bath time. She laughs remembering this characteristic of the child. When the moment of the massage practices came, she remembered how anxious she was regarding her baby walking, and she used to insist on massaging his legs. All these moments shared with the other women gave her an opportunity for grief that she could not get at home. Just like the home-based psychological sessions gives her the necessary time to elaborate her mourning.

At the end of one session, she speaks about her feelings when she was inside the water: she felt as though she was dying, and she was thinking of her baby and the suffering that he felt being trapped on the fence. She wanted to tell and explain to him what was happening, that she wanted to save him but had no possibility to do so.

Lakshmi delivers a beautiful baby boy. The husband calls the psychologist to tell the news, saying that he doesn't know who else to call because all his family died in the tsunami, and the first person he thought of was the psychologist.

The mother was breastfeeding her baby and unfortunately some weeks later, she had stopped when the doctor of the hospital told her she didn't have enough milk. In fact, it appeared that after delivery, she had "baby blues" with tendencies to reject the baby: it was difficult for her to hold the baby in her arms, as she was thinking of the first baby who died.

She said that finally, the baby she expected so much "was not like the first boy" and all the thoughts and images of the dead baby she had during her pregnancy were linked to this dead boy rather to this new born.

The psychologist mentioned that it might have been difficult when the baby died also for her breast milk. She said that it was extremely difficult to see the milk going out of her breast but no baby to give it to ... The new born re-actualised many depressive moments directly linked to the death of the first baby, and also to the consequences such as this milk going out of her breast and the baby absence. This event appears as really traumatic to Lakshmi too, and this was the first time for her that she was able to express it. After the death of the baby, she also suffered from physical pain (breast pain), but she had no one to tell it, nor some medicine to stop the milk. This is not something she could have told her husband, and her mother and grandmother died in the Tsunami, "the only two persons she could tell this".

The possibility of establishing a link between her lack of milk after the delivery, with the deep suffering due to her breast milk over-production without baby to feed, had for consequence that she could restart breastfeeding the new born a few days later. This was as well the result of the clinical follow-up where a "therapeutic alliance" was made with the psychologist through the regular psychological support sessions.

5. GROUP DISCUSSION SESSIONS



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The **objective** of support group and group discussion sessions is:

- To provide social / emotional support, sharing of experiences, good practices and problem solving skills to help the individual to develop his/her own behavioral strategies, and to receive emotional and social support during transitions or difficult periods of life (support group sessions)
- To assess /analyze / share a situation, a problem or a difficulty (group discussion sessions); *note that this is a useful process in crises management*

The goal of group sessions is for participants to express themselves and learn from each other's experience and knowledge, improve their knowledge and get new ideas to try out. The group discussions are not training or education sessions. In fact, the goal is different from health education groups, for example.

A group session is organized to accommodate 6 to 12 participants, in order to have an open discussion facilitated by trained BFS staff. The group size is important as it has to be large enough to generate rich discussion and small enough to allow all participants to express themselves.

The group should be composed of persons who are facing similar issues (for example, breastfeeding mothers or parents of a malnourished child), so as to encourage sharing and to provide a venue for group support.

Group sessions should take place in a quiet and secure setting where the participants can feel comfortable to express themselves freely.

A specific topic is proposed as discussion theme. The theme can be suggested by group facilitator or proposed by participants. First, participants are encouraged to express their opinions. The group facilitator highlights and / summarizes the main ideas, and ask the group to respond. Throughout the process, the facilitator leads the discussion on the main points that appear to be problematic



and need to be discussed by the group (for example, a discussion on some care practices that affect children's health or well-being), and share useful information on that topic. Lastly, different options to improve care practices and to overcome hindering factors are highlighted.

At all times, the facilitator should make sure that the **group session's rules** are respected:

- Confidentiality should be respected
- Criticism and interruptions will not be tolerated
- Allowing each participant to freely express and share his / her ideas and opinions
- Expressing possible disagreement in a respectful way

How to organise a discussion group:

- Bring the participants together and have them sit down in a circle
- The facilitator welcomes everybody to the session
- The facilitator introduces himself/herself and asks each participant to introduce themselves
- The facilitator presents the group session's rules
- The facilitator introduces the session topic (in some cases, it is also possible to ask the participants to suggest topics)
- The facilitator asks a few questions in order to allow the participants to express what they know and think of the topic
- The facilitator may go into more depth with certain questions in order to take the discussion further
- It is essential to allow all the participants to express themselves and to encourage them to share their opinions, beliefs, attitudes, etc. with the other participants (still, if some participants do not want to contribute, their wishes should be respected)
- The facilitator summarises the most important points that were conveyed (he / she may also share some information)
- The main options or directions to use or reinforce appropriate care practices are highlighted
- The facilitator thanks each participant for his / her contributions; he / she may inform the group about next group sessions schedule

Remember that, in order for the session to be effective, the change in behaviour or beliefs must come from the group, and not from the facilitator, who should try to bring about change, not enforce it.

FOR MORE DETAILS, SEE:

ACF Manual: "ABC- Assisting Behavior Change", 2013.

6. RELAXATION EXERCISES

Relaxation exercises are very useful for individuals living in emergency contexts, who have gone through (and are still living) very difficult experiences and who have to deal with high stress.

Relaxation exercises aim at:

- Releasing physical and psycho-emotional tension
- Managing stress more effectively
- Experiencing feelings of well-being, relief in difficult situations
- Realizing one's capacity to reduce tension and to feel more relaxed, with a positive effect on feelings of self-confidence
- Increasing the person's feeling of control over his / her emotions

Based on the positive impact of relaxation, beneficiaries are able to increase their feeling of being able to deal with the present situation, to increase their energy level (in order to take actions so as to improve their condition and the child care practices), to increase / restore self-confidence feelings, and, more globally, to improve their psychological health.

Therefore, relaxation exercises are recommended for all the persons living in an emergency situation. In BFS, relaxation exercises are particularly recommended for:

- Lactating women, just before a feeding, as being relaxed and calm will increase the quality and experience of the feed
- Caregivers before starting a baby massage
- Caregivers who feel they are too tense, who have sleeping problems

Relaxation activity sessions should last 45 minutes to one hour, with varied and detailed exercises, such as:

First part (ideally, beneficiaries stand-up¹):

- Different breathing exercises. For example: 1) breathe in, count until 5 before you release the air, 2), repeat 5 times
- 2 or 3 exercises of dynamic relaxation (these are exercises based on movements, on muscle tension then muscle relaxation)

Second part (beneficiaries sit or lie down):

- Breathing exercises
- Whole body relaxation (example cited above)
- It is possible to include simple visualisation exercises (for example: “imagine a positive colour, observe it, be aware of its benefits for you, imagine that every time you inhale air, you can breathe this colour in your whole body, and feel the positive feelings associated to the colour becoming part of yourself”)
- Prepare to end the relaxation exercise (increase the tone of your voice, ask the beneficiary to take a few more deep breathes, to exhale with more energy, to stretch the whole body out, to open eyes etc.)

¹ - Except for pregnant women.



Third part:

- Ask the beneficiaries how they feel
- Propose to practise a few exercises at home
- Inform the beneficiaries about the next session

For breathing exercises, it is useful to ask the beneficiaries to place one hand on their stomach so as to feel the air movement and to practice abdominal breathing (i.e. breathing by filling one's stomach with air). Abdominal breathing has a physiological effect that helps to reduce stress and that brings feelings of relaxation.

Relaxation exercises have to be simple, with easy breathing and movement exercises. They should be conducted in a quiet area with sufficient privacy. *Remember that it is essential to encourage beneficiaries to practice the exercises at home, in order to reinforce the positive effects of relaxation.*

Example of body relaxation exercise:

- *Let the participants sit or lie down on their back and close their eyes¹*
- *Ask the participants to remain calm and to not talk to each other*

Gently lead the group through the relaxation exercise:

You are now comfortable in your surroundings, close your eyes. Take a deep breath and hold it (...), let the air out gently (...). Relax. Feel the sensation of calm and rest. Concentrate on my voice and do as I suggest..

Take a deep breath and hold it (...), let the air out gently, slowly (...). Feel your body letting go, and you will become more relaxed.

Let yourself go and think only of relaxation (...). Relax your arms, relax both your arms (...).

Think of the relaxation that is settling in your right arm. It feels heavy and relaxed (...).

Now your left arm (...) it feels heavy and relaxed (...). While the arms relax, you might notice that your arms become heavy slowly, slowly; your right arm, your left arm. This heaviness is pleasant and relaxing. Don't fight it; let it come (...) let it increase (...). Your arms are now very heavy and relaxed. Let the relaxation go through your whole body. Now let the tension in your legs go (...) your right leg becomes heavy and relaxed (...) your left leg becomes heavy and relaxed (...). All the muscles in your legs let go and relax (...). The heaviness goes down your legs. It is a nice feeling.

Each time you exhale, tension goes out, every time you inhale, relaxation comes in (...). It is your whole body that now becomes heavy and relaxed (...) heavy and relaxed (...)

Now think of the muscles in your back (...), let them become heavy and relaxed (...).

From the shoulders down, let the muscles relax (...), more and more relaxed (...).

Now feel where your body rests on the ground, your back is heavy (...) very heavy (...) it spreads out and sinks in the ground (...). Let it become heavy (...).

1 - Sometimes it can be preferable to keep the eyes open in order to avoid flash back and intrusive images linked to traumatic events.

With each breath, concentrate on the heaviness. If you still feel a part of your body that is tensed, let the feeling of heaviness invade it. Your arms (...), your legs (...), your calves (...), your back (...), your whole body is heavy and relaxed. Breathe calmly and let yourself feel this sensation of relaxation. (Leave 5 to 7 minutes of silence).

Keep your eyes closed (...). Breathe in deeply, slowly (...), keep your eyes closed (...) stretch out slowly. It is now time to open your eyes and to go back to your activities relaxed. To feel relaxed again, you can do this exercise on your own

- *Ask people to sit up, and let them talk about what they did: was it a good exercise? What was good, what wasn't? Did they like it? Do they want to come another time to do it? Would they like to do it at home? How? Etc.*

**As the emotional relaxation activity session may help the beneficiaries express their emotions, these activities should be handled by a trained psychologist.*

7. BABY MASSAGE

Touch and massage are necessary tools for contact, for relationship building and communication. Hands can soothe, reassure, massage, love, construct, heal and understand.

Above all, a new born baby needs intimate contact with its mother and father, with hands, with skin, smells, voice and breath. It is through these simple activities that a baby will feel loved, respected and reassured. These activities favour and reinforce the parent-child bond. Massage stimulates a baby's physical and psychological development:

- It promotes a baby's physical relaxation by calming the nervous system
- It helps to awake a baby's intellect and senses
- It promotes a more deep and peaceful sleep, thus regulating sleep problems. It reduces stress at bedtime
- It helps digestion and improves eliminatory problems like diarrhoea or constipation. Massage can soothe colic

FOR MORE DETAILS, SEE:

ACF Manual for the Integration of Child Care Practices and Mental Health in Nutrition Programmes, 2011



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- It promotes an understanding, integration and representation of the body image
- It helps to keep a baby flexible and strong
- It promotes joint flexibility and muscular elasticity
- It stimulates the immune system and the efficiency of nutrition

It helps create a strong and special bond between the baby and the person giving the massage. Massage must generate mutual pleasure. In cases where the child is in pain (upset stomach for example) and when the mother is afraid to hurt him, a simple placement of the hands on the child's body can be enough to create an effective and reassuring contact. Little by little, self-confidence and mutual trust will permit a more deep massage. Massage can be done by the mother, father or another caregiver.

- Ensure that the temperature in the space is appropriate, if the space is too hot ensure ventilation, if the space is too cold ensure heating is provided
- Make sure you have a quiet, sufficiently private space; where mothers/caregivers can put the baby down on a clean mat or cushion
- Explain the purpose of the session to the mothers/caregivers, what will happen and how long it will take
- Before starting the massage, conduct a small relaxation exercise with the mothers: breathing, relaxation
- Ask the mothers/caregivers to remove all rings, bracelets, necklaces that hang and disturb the child's attention
- The mother starts scrubbing her hands with oil (natural oil, the one used for cooking: peanut oil, shea oil ,etc.) and iconically asks permission from the child to massage him/her: "do you want a massage today?"
- Do not force the child, if he/she is not comfortable or is cranky, stop the activity and try again at a later time

MESSAGE CAN NOW START

With soft and gentle touches you will work on the head, face, shoulders, arms, chest, stomach and legs. Close your eyes and press your eyelids. The pressure you should use is the same as pressing your eyelids without any discomfort. On the smaller areas of the body use your fingertips. On the larger areas use the palm of your hand.

"Little strokes" mean to touch your baby's skin gently and "massage" is to softly move the muscles under the skin. While you massage your baby look tenderly at him/her.

Doing this you stimulate all the senses of the baby and establish a more intense visual and tactile communication.

Feel free to speak to your baby, do not inhibit yourself.

Try to be flexible by not keeping a rigid routine. If the baby wants to change position let them do so.

Do not force your baby to lay the way you want him/her to, you can go back to these areas later on.

SOME SIMPLE MOVEMENTS FOR INFANT MASSAGE

(Massage from ACF Manual for integration care practices in nutrition programmes)

- **Legs:** rub the interior of each leg from groin to ankle, using the inside of the hand between the thumb (thumb down) and the index finger. This releases tension in the legs and promotes blood circulation toward the feet. Next, lift one leg up without lifting the baby's body and encircle it with both hands, like making a bracelet. Make a gentle 'turning-upturning motion' to relax the depth of the muscle.
- **Feet:** foot massage is beneficial for the entire body because the foot is so loaded with nerve endings. Glide one thumb after another along the sole of the foot, from the heel toward the toes; then massage each toe. Gently rub the heel and then the entire sole with both thumbs. Don't forget the top of the foot and the ankles.

After having massaged both legs thumbs and both feet, massage the baby's bottom with small circular movements.

- **Stomach:** place the hands for a moment on the baby's stomach, and then rub it by bringing one hand after the other toward you. Next glide the hands (held very flat) on each side of the stomach. With the fingertips, rub clockwise in a circular motion. A stomach massage stimulates and helps regulate the digestive system while soothing gas and constipation.
- **Arms:** hold the wrist with one hand and using the other, massage the arm from shoulder to wrist with the palm held toward you. Stabilize the shoulder so the baby doesn't lift up. Like with the legs, make a gentle 'turning - upturning' gesture with both hands together, making sure not to twist the elbow.
- **Hands:** like the feet, massage the fingers and then the underside of the hand and finally the wrist with small circular movements.
- **Face:** glide the fingertips across the forehead from the middle out toward the temples. Then the eyebrows, always moving toward the temples. With the thumbs, slide up each side of the nose and then descend diagonally toward the cheeks. This movement helps to decongest the nose and relax the cheek muscles. Finally, with the tips of the thumbs, spread the upper lips lightly, then the lower lip, like a smile. Relax the jaw by making small circles with the fingertips.
- **Back:** a back massage is often the most relaxing massage for the baby. Settle the infant on his stomach and then place both hands on the upper back. Move each hand back and forth, perpendicularly to the spine, toward the bottom and then back toward the shoulders. Place one hand on the baby's bottom and slide the other across the back from shoulder to bottom. Using the fingertips, cover the entire back with small circles and then with lightly spread fingers, "paint" the baby's back from shoulder to bottom.

Finish the massage with very soft movements so as to relax the baby's muscles. Make sure to choose movements adapted to child age. During massage it is important to talk or sing to the baby. This will help reassure him.



You can find more detailed information about how to caress and massage an infant or a new-born in Laurence Vaivre-Douret's book *de vie du nouveau-né* and starting on page 29 of the ACF Manual for the Integration of Child care Practices and Mental Health within Nutrition Programmes, 2011.

8. BABY BATH AND ACTIVITIES AROUND HYGIENE PRACTICES



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The emergency might have disrupted the way usual hygienic care for children was performed. This can be due to lack of water and soap, lack of material, lack of time of the caregiver... In addition, the deterioration of living conditions, such as crowded camps, might make appropriate hygiene even more important to prevent health problems such as diarrhoea, skin infections and other infections. In many contexts hygiene practices were not appropriate even before the emergency.

ACTIVITIES AROUND HYGIENE PRACTICES CAN BE:

- General hygiene education, specific education on hygiene for small children, food preparation, etc.
- Conduct group discussions on how to adapt hygiene practices to the new context and constraints
- Distribute items necessary for hygiene such as soap, basins, combs (according to what is used locally), mosquito nets, if those items are lacking

- Providing facilities in the BFS for caregivers to give baby baths; especially when facilities within their living environment are insufficient to perform this activity. This could be lack of water, soap or basins to bathe in; but in cold environments it could also be the lack of a warm environment and warm water

Demonstrating a baby bath can be a good starting point to launch such discussions.

BABY'S BATH

(From: ACF Manual for the Integration of Child care Practices and Mental Health within Nutrition Programmes, 2011).

Bathing a child is also an act of love and care between a caregiver and a child, which can help improve the mother/caregiver-child relationship and the child's development.

Because a new-born baby is unable to neither sit by himself nor hold up his head, it is recommended to soap the baby before putting him in the bath. It is better to use bare hands. Also, bare hands provide an opportunity for massage the baby while skin-to-skin contact reinforces the caregiver - child bond. It is also easier to access the baby's many skin folds with bare hands. In general, begin with the baby's neck and armpits. If the baby's arms are folded, spread them gently. Continue on with the stomach and turn the baby onto his side by holding his shoulder in order to gently wash his back. Soap the arms, hands, legs and feet. Finish with the bottom and genitals. Without waiting too long so as not to let the baby get cold, put one hand gently under his neck, another under his bottom and while speaking softly to reassure and encourage him, put him slowly into the water, lower body first. When his bottom is resting on the bottom of the tub, rinse him using the free hand but make sure that one hand is always supporting the neck. Make sure there is no more soap in the skin folds. It is possible to play with the water on the baby's body and to have the infant play with the water.

If he begins to cry, do not force him. It is good to try to reassure him, speak to him, sing to him, but if he really doesn't like the water, take him out of the bath. It will be better the next time.

Take the baby out of the bath in the same way he was put in; this means keeping one hand under his neck and the other under his bottom. Wrap him very quickly in a towel in order to make sure he doesn't get cold. Dry his head first and then thoroughly wipe, without rubbing, the skin folds and other difficult to reach places (fingers and toes) so that his skin will not become irritated.

For the first weeks, the bath will not last more than two or three minutes. Later on, the infant will be more comfortable and you can give him a few toys and allow him to play a little longer (always taking care that the water remains sufficiently warm). Toys must be clean and adapted to water (generally plastic).

It is imperative to stay with the baby at all times during bath time in order to avoid accidents.

It may be necessary to instruct the mothers about the infant bath and show them proper techniques in order that the child's hygiene, comfort and security are insured.

Information sessions can be organized, using dolls to explain a mother's gestures.

IMPORTANT! Avoid sponges as they can breed bacteria. Washing a baby with one's hands or with a large swathe of cotton (which is later disposed of) is more hygienic.

9. PLAY SESSIONS

THE PLAY SESSIONS' OBJECTIVES ARE

- To strengthen the caregiver - child relationship (which is often affected by the emergency situation's effect on their physical and mental state and / or by the child's critical condition)
- To give the child the opportunity to develop all his potential through play and to spend an enjoyable time
- To give caregivers the opportunity to enjoy playing, and to spend an enjoyable, relaxing time with their child
- To present different examples of play activity and simple / available play materials in order to encourage caregivers to provide age-adapted play material to their children and to spend time playing with them
- Support, sharing of ideas and information to caregivers about child care, managing children's behavior... are also part of play sessions' objectives



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As children play throughout their development, all children (even very young babies) are welcome to play sessions with their caregivers.

PLAY MATERIAL OR TOYS

- No play material provided (how to play with the child without toys): play session is based on songs, body movements, rhymes, games such as peek-a-boo, etc.
- Play materials available for the participants: remember that play material and toys must be very simple, available in the beneficiaries' area (for example, a piece of fabric, a piece of paper, a plastic cup, water, sand, cardboard boxes, wooden building blocks, and pots and lids) and of course adapted to the children's age and development level. Note that for babies, "baby boxes" containing adapted and safe material for very young children can be given to the caregivers
- Toy making activities can be part of play sessions too: in this case, remember that the activity's objective is to strengthen the caregiver-child relationship and help caregivers provide the child with adapted play material at home, not to make toys!

ORGANIZING PLAY SESSIONS

For play sessions, the BFS staff should arrange an area that encourages play. It should be comfortable, with mats on the floor, appropriate lighting and play mats for babies. It should also be spacious enough for the participants to sit in a circle and not in a row, which makes it easier to interact and for the children to move around.

In order to ensure more individual attention there should not be too many children in a session (around 5 to 7 children plus caregivers). The duration of the sessions can vary according to the age, the attention span and the interest of the children. In general 20 minutes are enough for the youngest and the weakest, but the sessions can be extended according to the context and the children.

In choosing play material and activities, the facilitator should take into account the children's interests and capabilities. Of course, participation should be spontaneous and free: the right not to play is as important as the right to play.

The play session is organized into several phases:

- Welcome and introduction of facilitator and participants
- If the participants already came to previous play sessions: ask caregivers if they were able to spend more time to play with their child, or provide play material at home, and ask them about their observations, possible difficulties, etc.
- Presentation of the activity (as well as a reminder of the sessions' rules)
- Play activity
- Feedback and sharing time at the end of the session: the caregivers are free to express their feelings about the session, to share observations or express any uncertainties, apprehensions, expectations, etc. The facilitator should also propose to the participants to share their observations about their child's development and their relationship with him/her
- Facilitator's feedback on his / her observation of the play session: for example, the children's particular interest or behavior, or caregivers who played on their own beside their child. This time may allow sharing of information about child development
- Presentation of the next scheduled play sessions

FACILITATORS' ROLE

During the play session, the facilitator should encourage play between mothers and children and help those experiencing difficulties.

During the session they should be able to organize their time between giving individual attention to a child and his / her caregiver, and playing a broader role within the group by guiding the session as a whole.

Whilst the session is taking place they should be able to help caregivers to invite children to play, to let them play, to advise the caregiver on appropriate games and toys for the child, as well as on his / her behavior towards the child.

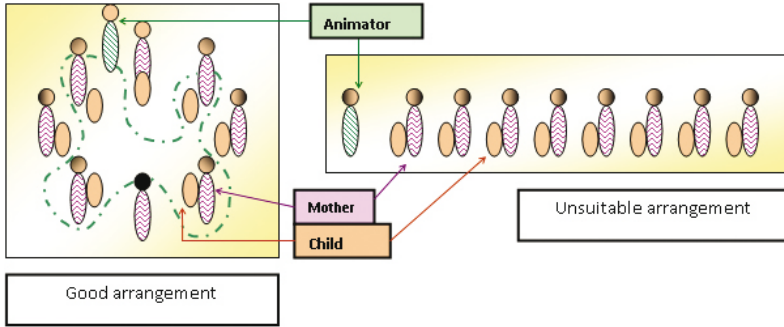


Fig. 10: Arrangement of mothers and children in mother-child play sessions.

ACF Manual for the integration of child care practices and mental health into nutrition programs ed. 2011.

The facilitator should adjust and adapt his attitude and interventions to each group (depending on the age and characteristics of the children) and to each caregiver-child couple.

Remember that it's important to encourage play and not to impose it. This applies to both caregiver and child.

10. BREASTFEEDING COUNSELLING



(Based on *Breastfeeding Counselling, a Training Course*, WHO/UNICEF, 1993)

Individual counselling is indicated if age inappropriate feeding or suboptimal feeding of the child was identified, or if the mother indicates that she is facing problems with breastfeeding.

Breastfeeding is more than an act of feeding. It is a perfect combination of care where close contact, feelings, emotions and satisfying of needs all play a role. If one thing goes wrong, it might influence the other aspects.

For example: a depressed or traumatised mother, might have a reduced milk ejection reflex and start to give BMS to the baby, the baby in return may be affected as he does not receive the warmth and well-being of breastfeeding any more.

A baby who is wrongly positioned or wrongly attached can become frustrated and refuse the breast, which may make the mother feel incompetent.

Maria is a young, proud mother of a 2 month old girl. She survived a cyclone but is living in a tent in a camp because her house and village are destroyed. She breastfeeds, but gives some rice to the baby in addition because her mother said that babies need more than breast milk. Since the cyclone she has been giving more rice, because she is often too tired to breastfeed. She comes to the BFT where she has a discussion with the counsellor Lia. Lia explains her that babies don't really need extra rice, because all they need is in the breast milk. Maria is interested, but is afraid that her breast milk will not be enough. Lia proposes that she does not give rice for 1 day, but gives breast milk every time the baby asks for it and for as long as the baby wants to drink. Maria agrees and comes back the next day. Lia asks if the baby has been hungry after she received all the milk she wanted, and Maria said no. Maria then agrees to continue this for 3 days, then Maria comes back and Lia takes the weight of the baby. She has gained some weight and is in good health. Maria agrees to continue for the next week. If the baby is still in good health and gaining weight, she will be convinced that she is doing the right thing.

Therefore, breastfeeding counselling is a combination of attention and care for all factors involved in breastfeeding, both technical and emotional. *For example: a fearful mother with reduced milk production is advised to keep her baby close as much as possible in skin-to-skin position. Such closeness will bring forth positive emotional feelings for her baby and improve bonding, this will increase her milk production and the baby will feel loved and secure and breastfeed will be easier. Successful breastfeeding makes the mother feel better about herself and gives her confidence in her role as a mother.*

In short: improving mother-child relationships will improve breastfeeding and breastfeeding improves mother-child relationships.

Remember that breastfeeding is a demanding task for any mother. It is even more so in an emergency situation, where mothers experience so much pressure and stress.

Every mother or caregiver has a reason to use their own breastfeeding practices: it can be based on cultural practice, or because they were told to do so by other women or health staff, because the mother fears her breast milk is not enough, because the mother/caregiver thought this was necessary or because the mother is stressed, tired, worried and does not have energy any more. One must also take into account the life experience and the past and present suffering.



Counselling is not telling a mother or caregiver what to do. It is talking with people, listening to them, understanding and acknowledging their problems and coming to an agreement to make a change.

The goal is to achieve a situation where the mother/caregiver understands the problems, understands how she and her child can benefit from changing it, and where the counsellor and mother/caregiver find ways **together** to obtain this change.

First of all, the counsellor needs to understand why the mother/caregiver behaves in a particular way. Then, one can give information to the mother/caregiver as to why this is not optimal. Then the mother/caregiver can be offered help to find solutions to change their practices. The counsellor and mother/caregiver need to find solutions together for change; solutions should not be imposed by the counsellor.

Respect, empathy and patience are the golden rules, and good communication and counselling skills are needed.

Counselling must be done with recognition of the local culture, views and practices. One must always respect the mother/caregivers ideas, views, background, culture and religion.

Acceptance can be improved by putting the mother/caregiver in touch with other people who have had similar problems, yet changed their behaviour with a positive outcome. This might motivate more than all education sessions together!

Caregivers may not talk about their feelings easily, especially if they are shy or in a new or difficult context. Psychosocial workers need to place emphasis on listening, and to make the caregivers feel that they are recognized, making them feel at ease. This will encourage the caregivers to tell you more and be less likely to "shutdown", and say nothing. One must understand the different aspects of the difficulty, and understand why the caregiver has a particular behaviour. It is important to behave respectfully at all times, respect for the person, for their difficulties, for their practices, their culture, their environment, their religion.

Therefore, it is important that BFS staff has enough information about the local beliefs and traditional practices.

In counselling, both verbal and non-verbal communication is used:

- **Non-verbal communication** means showing your attitude through your posture, your expression, everything except speaking. Helpful non-verbal communication makes a mother/caregiver feel that you are interested in her, so it helps them want to talk to you:
 - Sit at the same level as the mother/caregiver (both on a chair, or both on the ground)
 - Turn towards the mother
 - Show interest in the child by tickling, smiling at him, playing a little
 - Be relaxed and unhurried
 - Touch the persons only if appropriate, always ask if it is ok touch the person
 - Nod and smile (if appropriate) when a mother is talking

- **In verbal communication**, you can use open questions and closed questions:
 - **Open questions** usually start with "How? What? When? Where? Why?" For example: "How are you feeding your baby?" They are helpful because to answer them a mother must give you information in full phrases
 - **Closed questions** are usually less helpful. They tell a mother the answer that you expect, and she can answer them with a "Yes" or "No". They usually start with words like "Are you? Did he? Has he? Does she?" For example: "Did you breastfeed your other child(ren)?" If a mother says "Yes" to this question, you still do not have information about exclusive breastfeeding

To start a conversation, open questions are best. To continue a conversation, a more specific open question may be helpful. Sometimes it is helpful to ask a closed question, to make sure about a fact. Use simple language and familiar terms to explain things to mothers. Remember that most people do not understand the technical terms that health workers use.

Recognize and praise what a mother/caregiver and baby are doing right. Health workers are trained to look for problems, and too often only see what we think people are doing wrong, and try to correct them. As counsellors, one must learn to look for and recognize what mothers/caregivers and babies do right. Then it is important to praise or show approval of the good practices. Praising good practices has these benefits:

- It builds caregivers' confidence
- It encourages them to continue those good practices
- It makes it easier for them to accept suggestions later

Do not use words of criticism like: right, wrong, well, badly, good, enough, properly. If you use these words when you ask questions, you may make a mother feel that she is wrong, or that there is something wrong with her baby.

Make general observations of the mother/caregiver and baby. Notice for example: does she look happy? Healthy? Does she have formula or a feeding bottle with her? How does she interact with the child? How is the child? Does he seem to be happy, healthy? What is their interaction like?

Reflect back, which means to repeat back what a mother has said to you, to show that you have heard, and to encourage her to say more. Try to say it in a slightly different way. For example, if a mother says: "My baby was crying too much last night." You could say: "Your baby kept you awake crying all night!" *This way the mother knows you understood her, or she can correct you if you didn't.*

Empathy or empathizing means showing that you understand how a person feels. For example, if a mother says: "My baby wants to feed very often and it makes me feel so tired," you could say: "You are feeling very tired all the time?" This shows that you understand that she feels tired, so you are empathizing. If you respond with a factual question, for example, "How often is he feeding? What else do you give him?" you are not empathizing.

**Be careful not to overuse this technique, as it may become frustrating or even painful for the mother/caregiver to constantly have to hear the words repeated.*



Accept what a mother thinks and feels. Sometimes a mother has a mistaken idea that you do not agree with. If you disagree with her, or criticise, you make her feel that she is wrong. This reduces her confidence. If you agree with her, it is difficult later to suggest something different. It is more helpful to accept what she thinks. Accepting means responding in a neutral way, and not agreeing or disagreeing. Repeating and responses and gestures which show interest are useful ways to show acceptance, as well as being useful listening and learning skills.

Sometimes a mother feels very upset about something that you know is not a serious problem. If you say something like "Don't worry, there is nothing to worry about!" you make her feel that she is wrong to feel the way that she does. This makes her feel that you do not understand, and it reduces her confidence. If you accept that she is upset, it makes her feel that it is alright to feel the way she does, so it does not reduce her confidence. Empathizing is one useful way to show acceptance of how a mother feels.

A mother may have some questions that she wants to ask; or as you talk to her, you may learn that she is worried about something, or not sure about something. Explain simply and clearly what she needs to know, but only if you are sure of the answer.

Give relevant information in parts and not all at once. Relevant information is information which is useful for a mother NOW in her particular situation and in response to her particular problem. When you give information to a mother, remember these points:

- Tell her things that she can do today, not in a few weeks' time
- Try to give only one or two pieces of information at a time, especially if she is tired, and has already received a lot of advice
- Wait until you have built her confidence, by accepting what she says, and praising what she and her baby do right. You do not need to give new information or to correct a mistaken idea immediately
- Give information in a positive way, so that it does not sound critical. This is especially important if you want to correct a mistaken idea

Make one or two suggestions, not commands. Be careful not to tell or command a mother to do something (for example "You must breastfeed exclusively"). Instead, when you counsel a mother, suggest what she could do differently. Then she can decide if she will try it or not. This leaves her feeling in control, and helps her to feel confident. Suggest small changes do not expect significant changes after one counselling session.

What to avoid:

- Do not imply the expected answer in the question; for example: do not say that you are interested in breastfeeding, or ask if a mother is breastfeeding. The mother's behaviour may change. If she is not breastfeeding, she may feel uncomfortable and not feel free to talk about bottle feeding. You should say that you are interested in "infant feeding" or in "how she feeds her baby"
- Be careful that the forms do not become a barrier. The participant who talks to the mother should not take notes while she is talking, or listening

It is important in breastfeeding counselling to have detailed and comprehensive information on the beneficiaries' history. This requires asking relevant questions in a systematic way, using a special form.

Beyond the questions asked to the beneficiaries, the staff's observation of the mother, the child, their interaction is as important as the verbal questions. These observations are an important part of the evaluation and should be noted on the form.

Some guiding principles in asking questions:

- Greet the woman in a kind and friendly way. Introduce yourself, and ask her name and the baby's name. Remember and use them, or address her in whatever way is culturally appropriate.
- Use the mother's name and the baby's name (if appropriate), do not talk about "the baby".
- Ask her to tell you about herself and her baby in her own way. Let her tell you first what she feels is important. You can learn the other things that you need to know later.
- Use your listening skills to encourage her to tell you more.
- Look at the child's growth chart. It may tell you some important facts and save you asking some questions.
- Ask the questions that will tell you the most important facts.
- You will need to ask questions, including some closed questions, but try not to ask too many
- The intake form is a guide to the facts that you may need to learn about. Decide what you need to know most urgently in each session.
- Be careful not to sound critical.
- Ask questions politely. For example: Do not ask: "Why are you bottle feeding?"; it is better to say: "What made you decide to give (name) some bottle feeds?"
- Use your confidence and support skills.
- Accept what the mother says, and praise what she is doing well.
- Try not to repeat questions.
- Try not to ask questions about facts which either the mother or the growth chart has told you already.
- If you do need to repeat a question, first say: "Can I make sure that I have understood clearly?" and then, for example "You said that (name) had both diarrhoea and pneumonia last month?"
- Take time to learn about more difficult, sensitive things. Some things are more difficult to ask about, but they can tell you about a woman's feelings, and whether she really wants to breastfeed.
 - What have people told her about breastfeeding?
 - Does she have to follow any special rules?
 - What does the baby's father say? Her mother? Her mother-in-law?
 - Did she want this pregnancy at this time?
 - Is she happy about having the baby now? About the baby's sex?



Some mothers tell you these things spontaneously. Others tell you when you empathize, and show that you understand how they feel. Others take longer. If a mother does not share information easily, wait, and ask again later, or on another day, perhaps somewhere more private.

The solutions offered will depend on the actual problem and its underlying causes:

- If the underlying problems are stress, worry, trauma, lack of energy: help the mother to relax, listen to her story, help her to build confidence in herself by helping her believe that she can do this.
- If the underlying problems are the related to the influence of family members: invite those members to the Baby Friendly Space or conduct a home visit
- If the underlying problems are due to factors that are beyond the BFS scope, such as disease of the child, serious psychological problems, refer the child and mother/caregiver to the appropriate place where they can receive care for that issue, but continue to support and encourage the mother with regards to IYCF
- If the underlying difficulties are related to lack of knowledge, misconceptions or belief in myths, it is important to assess if this a general issue for other beneficiaries. In this case, interventions in the form of group sessions or community sessions may be implemented

FOR MORE INFORMATION ON PROVIDING SOLUTIONS TO BREASTFEEDING PROBLEMS, SEE:

ACF E-learning CD on Breastfeeding; "Breastfeeding Counselling, a training course", WHO/UNICEF, 1993, http://www.who.int/child_adolescent_health/documents/who_cdr_93_3/en/index.html (this course also contains training on counselling skills) or "IFE Module 2, v 1.1", IFE Core Group, 1997 <http://www.enonline.net/resources/4> or "Infant and Young Child Feeding Counselling - A Community Focused Approach" Care, URC, CHS <http://www.fsnnetwork.org/sites/default/files/cfatrainersguide.pdf>

Make propositions for change, but only small changes at a time. A mother/caregiver is not going to change practices she has believed necessary just because you told her to. Propose to change one small thing, then schedule for the mother/caregiver to come back in a few days to see how it went. During each discussion, another change can be proposed; so that the mother/caregiver can adjust gradually and at the same time see she is doing no harm to her child.

Do's	Don'ts
Know and respect cultural specificities with regards to breastfeeding and child care practices	Criticize or make a mother feel bad about herself
Be welcoming and open	Be critical
Give praise for good practices	Give commands
Make suggestions for improvement	Expect major change in a small period of time
Use simple/easy to understand words	Let data collection forms become a barrier in the discussion
Encourage and motivate	Imply the expected answer in a question
Be patient	Behave superiorly

11. ACTIVITIES AROUND COMPLEMENTARY FEEDING

The complementary feeding period (6 months to 2 years) is well recognised as a particularly vulnerable period for the development of acute malnutrition. Emergencies have an impact on complementary feeding as well, with a potential risk of increase in malnutrition, morbidity and mortality on short and long term. Cultural practices, absence or lack of time of mothers and other caregivers, and reduced presence and/or quality of complementary foods, can be the sources of the increased problems with complementary feeding.

Complementary feeding is in the top three of life-saving interventions for children under 5 years of age; therefore adequate attention to this subject is fundamental.

Please note that not only what food is given to the child is important (quantity and quality), but also how it is given can influence the child's intake. Practicing responsive feeding is recommended (assisting children, being sensitive to their cues, feeding patiently without forcing).

Special attention must therefore be given to the subject of complementary feeding in emergency. This could contain activities such as:

- Group discussions on weaning and complementary feeding: the importance of continued breastfeeding and to avoid abrupt interruption, the key principles to adequate complementary feeding, the importance of increased hygiene in deteriorated living conditions etc.
- Encourage continued breastfeeding, even increasing the frequency of breastfeeding. Mothers who have stopped breastfeeding can be proposed relactation, even for an older child
- Discussion groups and education sessions on responsive feeding
- Follow up of health and well-being of the child: after being breastfed exclusively for 6 months, this is the time where the child will come into contact with more potentially harmful factors through the food and because of increased mobility (crawling, playing, touching things and putting things in the mouth...)
- Development of adequate recipes with sufficient dietary diversity with the food that is available and affordable throughout the emergency; as well as acceptable by the family and feasible to prepare with the means available (be aware of potential lack of utensils, fuel,...)



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- Cooking demonstrations with the above mentioned “new” emergency recipes
- Advocacy for blanket supplementary feeding distributions or complementary feeding voucher distribution if complementary feeding has proven to be threatened due to unavailability of food or due to incapacity of the beneficiaries to purchase adequate food
- Distribution or advocacy for distribution of micro-nutrient supplements if complementary food that is available and/or affordable is lacking in micronutrients
- Distribution or advocacy for distribution of cooking utensils, fuel, soap, etc. if those items are lacking to allow appropriate food preparation

Link up with food security programmes to advocate for set up of programmes enabling cultivation (seeds and tools) or purchase (income generating activities) of quality complementary food.

FOR MORE INFORMATION, SEE:

“Complementary Feeding, Family foods for the Breastfed Child”, WHO 2001

http://www.who.int/nutrition/publications/infantfeeding/WHO_NHD_00.1/en/index.html

“Guiding Principles for Complementary Feeding of the Breastfed Child”, PAHO/WHO

http://www.who.int/child_adolescent_health/documents/a85622/en/index.html

“Complementary Feeding Counselling - A training course” WHO 2004

<http://www.who.int/nutrition/publications/infantfeeding/9241546522/en/index.html>

“Complementary Feeding of Infants and Young Children in Emergencies - Review of current resources” IFE Core Group, ENN, IASC; October 2009

<http://www.ennonline.net/resources/716>

“5 keys to safer food manual” WHO 2006

http://www.who.int/foodsafety/publications/consumer/manual_keys.pdf

12. INFANT AND YOUNG CHILD GROWTH MONITORING

If the usual system for growth monitoring is no longer functional or inexistent, growth monitoring can be considered as an activity. Following the weight gain can be reassuring for mothers who doubt their capacities to breastfeed or fear they have insufficient milk, and it can be a motivation for mothers/caregivers to continue to come to the centre. It is not necessary to take weight on a daily basis, as scales are not always able to detect daily changes in infant’s weight. The weight should then be noted on the child’s “Road to health Chart” as delivered by the Ministry of Health within the country. If those cards are not available, the weight can be noted on his individual chart, but one must advocate with coordination bodies to receive such charts.

Growth monitoring should be combined with group or individual sessions of education, discussion or support sessions.

A note on basic health care.

In most situations, it is not recommended to extend the activities too far away from the initial objective: promoting and improving child care practices and improving parents and infants well-being.

Providing basic health care is therefore not recommended unless absolutely necessary, for example

because there is no primary health care available. If that is the case, one must advocate with the health cluster and/or medical organisations to set this up.

Exceptions to this can be the provision of ORS to mothers/caregivers and children with simple diarrhoea and possibly also zinc; even though they must be referred to the health centre if the diarrhoea becomes chronic or complicated. ORS should not replace breast milk in any case. Breast milk in itself is still the best way to prevent and deal with mild dehydration.

FOR MORE INFORMATION, SEE:

“Integrated Management of Childhood Illnesses”, WHO/UNICEF 2008 for easy-to-use protocols

http://whqlibdoc.who.int/publications/2008/9789241597289_eng.pdf

Remember that breast milk has antibodies, and can be used for:

- Eye infections: the mother can clean the eyes of the child with some breast milk
- Skin infections: the mother can put some breast milk in the clean bathwater when giving the baby a bath
- Small open wounds: the mother can use breast milk to clean them out

Once the “normal” system of growth monitoring is fully functional again in community (health) centres, one must encourage mothers/caregivers to continue the monitoring there.

13. HOME VISITS



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Various situations highlight the need to conduct home-visits in the context of Baby Friendly Spaces. For example, most women do not take care of their children alone, but live with their family where some important decisions on child care practices may not be taken by the mother alone but by the father, the grandmother, or other family members.



For mothers who need to find appropriate support, advice and encouragement from their family, but who are experiencing difficulties with their relatives (communication problems, violence, heavy work schedules, etc.) home-visits are important tools so as to provide support for caregivers.

In other situations, young parents may be alone in caring for baby after most of their relatives died in to a natural disaster or conflict. In some cultures, such situations may be very unusual and the young parents may face significant difficulties to provide adapted care to their child. In this context, aside from other services (such as hired midwives who are available to support the parents at home - somewhat like the role grandmothers or aunts may have in a regular situation), home-visits are important.

Supporting caregivers to implement at home some of the child care practices shown during individual or group sessions in the BFS, strongly increases the Baby Friendly Space's action sustainability as well. It is therefore important to work directly with the family in order to create an environment in which pregnant, lactating women and other caregivers are supported so as to provide optimal care practices.

Home-visits are interesting as it allows the Baby Friendly Space's team to adapt their intervention and provide personalized support to beneficiaries according to their specific needs. The type of intervention must be in line with the needs that are identified as well as with the cultural specificities, and, of course, must be agreed to by the mother/caregiver.

Home visits are conducted by Baby Friendly Spaces' team for different reasons:

- To meet with the beneficiary in his/her home environment to better understand the problems he/she faces and to facilitate the search for appropriate solutions.
- To follow up a family having specific difficulties, and to provide them with additional advice, support, care.
- To meet with family members in order to facilitate behaviour change, discuss a specific issue or to involve family members in child care practices.
- To conduct a home-based session if the beneficiary does not have the time, means or authorisation from family members to come to the Baby Friendly Space.
- To conduct specific sessions (home-based play session for example) to help the caregivers implement play activity for their child in their home environment.
- To cross check whether the family situation is indeed as was said before giving BMS (see below).
- Follow up of pregnant women before and after delivery to support them with specific and adapted interventions.
- Follow up of distressed and depressed women and children that could not reach the BFS.

In some cultures where it is complicated for women to leave their house alone, home visits can be an important part of the programme.

Different steps to conduct a home-visit:

- Set an appropriate date and time for the visit with the beneficiary; sometimes, the home-visit schedule depends on some factors such as the presence of a family member (the husband or the mother-in-law for example).
- When arriving at the beneficiaries' home, wait until they offer you to come inside.
- Introduce yourself (with a brief introduction of the BFS program if necessary) to all family members present.
- Facilitate the discussion with the family (and an activity, if any - caregiver - child play activity for example).
- Make sure that all the family members present are given attention, feel listened to, and are given a chance to participate (According to the problematic it can be better to meet just the woman).
- Before leaving the house, briefly summarize the visit's main discussion points, recommendations; always highlight the positive points.
- Define the next step for the beneficiaries' follow-up (i.e. schedule another visit, invitation to activity in the Baby Friendly Space, etc.).

During home-visits, particular attention should be given to the staff's safety. If there is any question on that point, home-visits should be conducted by two staff members or not conducted at all.

The home-visit duration depends on various factors, such as the visit's objective, the beneficiaries' needs... Generally, home-visits last around 45 minutes. Usually, material is not needed, as the idea is to work based on the beneficiaries' actual situation in their home environment. However, in some cases, bringing leaflets or visual aids can be useful.

The psychosocial worker's attitude should be very open and flexible, with importance place on listening to the beneficiaries and observation.

Considering the difficulty of conducting home-visits, appropriate staff training (including on-going training sessions and supervision) should be organized as soon as the BFS opens.

14. COMMUNITY SESSIONS



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Community awareness sessions, aim at informing the community about the existence of the BFS in order to guarantee a good referral system for pregnant and lactating women with their young children to the centers.

Awareness about BFS should be done among key community persons, such as religious leaders, camp or village leaders, women's groups' leaders, through the organization of specific group sessions. Key messages about BFS and the activities proposed on care practices can be transmitted as well through local media, advertising car or criers, theatre plays, posters, pamphlets, songs.

At the beginning of the program it can be necessary to dedicate more time to this aspect focusing on appropriate way to pass messages in order to let community understand the interest of the activities proposed in the BFS. During the implementation of the entire program, this activity can be done by BFS staff in specific moments of the day, as the morning just after the arrival on the site, before starting the activities or by a team from a different department who is in charge of community mobilization.



IV. FEEDING OF THE NON-BREASTFED INFANT



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1. INTRODUCTION

Despite the many possibilities with breastfeeding, in many emergencies, one will come across some children who do not have the possibility to breastfeed at this moment. These infants and children will be very vulnerable, and special care must be given to them. Alternative solutions must be sought and the use of artificial milk must be as a last resort only.

Providing infants and young children with alternative solutions or artificial milk must be done on an individual basis; after a thorough interview, in which the history of the child is verified, alternative options are explored and decisions are made together with the caregivers, by a qualified staff member.

Provision of BMS should NEVER happen through general distribution or without discussion with a trained IYCF-E counsellor.

2. ALTERNATIVE SOLUTIONS TO BMS



© ACF - Afghanistan

Before switching to artificial feeding, with all the risks it may represent in emergencies one should look at all other possibilities to keep providing breast milk to the child.

RELACTATION

Relactation should be proposed to all mothers who have stopped breastfeeding, but present no medical conditions or receive medication that would contra-indicate starting again. Regarding HIV,

in low HIV prevalence areas, it might be sufficient if the mother is not aware that she is HIV+ or does not present any symptoms that could lead to the suspicion of HIV infection. This should be done according to national guidelines.

Relactation can also be proposed to another woman in the family or community of the child, who is willing to breastfeed, but currently has no milk, such as an aunt or a grandmother.

It should be explained to mothers/caregivers what the negative effects of artificial feeding in this emergency context might be, and how breastfeeding would provide better nutrition, better protection against diseases, how it would be cheaper, etc.

The choice will be taken together with the mother/caregiver and possibly her family.

Ahmed and Mohammed are twin baby boys of 2 months, living in an IDP camp in Darfur. They have recently lost their mother, who died of an illness. Their aunt, Fatima, is breastfeeding her own baby boy of 6 months, and is willing to nurse the twins, but she is worried she does not have enough milk. The aunt and the 3 babies are admitted in the feeding centre, where a milk supplement is given to the twins through a little tube attached to the breast, which the babies obtain by suckling the breast. She also continues to nurse her own baby. The staff gradually reduces the quantity of milk supplement, while monitoring the babies' weight. When the babies no longer need any supplement, Fatima stays some more days to monitor that all 3 babies maintain their weight through breastfeeding only. She can then go home, feeling happy and confident that she can feed the 3 babies. She is admitted in the SFC, where she receives a supplementary ration for herself, and where the weight of the babies is monitored every two weeks.

WET NURSING

Wet nursing is the practice where a breastfeeding woman breastfeeds another child, which is not hers. Usually, it is done in addition to her own child. For children who are not breastfed by their mother, this is the best and safest solution. The wet nurse can be a woman in their family or in close proximity (an aunt, a neighbour, etc.) or can be somebody chosen by the family of the child (in which case clear agreements must be made).

The possibility of this practice depends on the culture: in some places; women will wet nurse another child spontaneously, as this is common practice; in other cultures it is not common practice but accepted; yet in other places it is not culturally accepted to do so. Proposing wet nursing will therefore depend whether it is acceptable or not¹.

It is preferable that the wet nurse is in good health and accepted by the family. In low HIV prevalence areas it might be sufficient that she is not known to be HIV+ and does not present any symptoms that might lead to the suspicion of HIV. In high HIV prevalence areas, it might be necessary to request from the wet nurse that she is tested and that she agrees to protect herself

1 - In the Koran, there is specific mentioning of wet nursing: it states that if a mother cannot breastfeed the baby, the father must find a wet nurse.



from infection throughout the period where she breastfeeds the child. These decisions must be in line with national protocols, and in agreement with the family and wet nurse.

If the wet nurse is worried about not having sufficient milk to breastfeed two children simultaneously, she can be followed closely for some time to stimulate her breast milk production, or can temporarily use a BMS, given by supplementary suckling technique. Close follow up of her and the children she feeds will give her the confidence she needs to successfully continue breastfeeding. She should also receive feeding supplements or micronutrient supplements as other lactating women do.

If the two children she breastfeeds are different ages this is not a problem. Women have even successfully breastfed 2 babies at the same time, even in emergency settings!

If the mother of the child is still alive, she should be encouraged to engage in bonding activities with her baby: bathing, carrying around, singing for him, playing, feeding him with complementary food so that an emotional bond will be created. If the mother is not present, this role can be taken over by the father, grandmother, or other caregiver.

DONATED BREAST MILK

In some situations, a woman cannot be found to wet nurse, but one or more women from the community might be willing to manually express their milk and give it to the child without having to actually breastfeed. This way the baby can still benefit from many advantages of breast milk. The caregivers of the child might find several women, who can each donate some milk.

The health requirements for the donating mother should be the same as mentioned above for wet nurses.

The expressed breast milk should be stored in a clean container with a lid and kept maximum 8 hours in a temperature of around 25°C. It can be kept cooler by putting it in a fridge, on a block of ice, covering it in a wet cloth, placing it in the coolest area of the house.

It must be fed by cup to the child, never by bottle. The child should receive 150 ml/kg/day, spread over 8 to 12 feeds.

If the child passes urine 6 times per day (if solely fed on breast milk), passes stools 2 to 6 times per day and gains 125g/week, while remaining in good health, he has received sufficient milk.

The donating mothers should be supported with extra complementary food packages and encouragement.

In some countries, breast milk banks exist, it is a place where women who have too much milk donate their milk, which is frozen and given to other mothers who need it.

In some emergencies there have been propositions to import donated breast milk from other countries. While in principle this would be a useful alternative to artificial milk, we must keep in mind that:

- Authorisation and regulation by the Ministry of Health is required, stipulating among others the requirements the donated breast milk must fulfil (regarding testing of donors, storage, transport etc.)
- Cold chain is needed to keep the donated frozen breast milk frozen until arrival to the beneficiary


As these requirements are not possible in most emergencies the option of donating milk will not be further discussed in this manual.

3. INCLUSION AND EXCLUSION CRITERIA FOR ARTIFICIAL FEEDING PROGRAMME

One should have a clear idea of which children should be taken into consideration for alternative or artificial feeding at the start of the programme. It would be preferred that all agencies who work within this field use the same criteria, and that they are approved by the Ministry of Health. Coordination is therefore very important. Supervision of the implementation of the set criteria by the field teams is very important to prevent any negative effects on breastfeeding.

INCLUSION CRITERIA

- **Children whose mother is deceased:** this is the most obvious group and will most likely be the biggest group of children who need solutions.
- **Children who are separated from their mother for a long period:** for example, when the mother is missing or lives in another area. In this case, one should help the family to re-unite mother and child; by linking them up with family reunion programmes, by discussing with the family the possibility for the mother to move back to the child or vice versa.
- **Children from HIV-mothers who were not breastfed before the emergency** for whatever reason. At some point the possibility of relactation should be discussed with the mothers.
- **Children from HIV+ mothers who chose not to breastfeed before the emergency** they will need special attention in order to be able to continue with adequate feeding. Relactation cannot be proposed as this would involve a period of mixed feeding, which would increase the risk of HIV transmission.
- **Children from mothers who cannot breastfeed because of maternal medication or disease.** Whereas in most situations, it is possible to continue breastfeeding or feeding by expressed milk, there are some exceptions where use of breast milk is not recommended:
 - *Herpes simplex virus type 1 (HSV-1):* direct contact between lesions on the mother's breasts and the infant's mouth should be avoided until all active lesions have resolved; if lesions do not risk to touch the infant's mouth, breastfeeding can continue, yet mother should pay attention to rigorous hand hygiene

- 
- Sepsis
 - *Maternal medical treatment*: sedating psychotherapeutic drugs, anti-epileptic drugs and opioids, radioactive iodine-131, excessive use of topical iodine or iodophors (e.g., povidone-iodine), especially on open wounds or mucous membranes, cytotoxic chemotherapy

Advocate with doctors to prescribe, where possible medical treatment that is compatible with breastfeeding.

Breast milk production must be maintained during this time, by manually expressing the milk and discarding it; so that breastfeeding can continue when the illness is over or the medical treatment was completed.

If the mother was not able to maintain her breast milk production, relactation must be proposed as soon as possible.

- **Children born as a result from rape of the mother**, whereas it would be recommended that these mothers do breastfeed to provide optimal feeding to the child AND because this would allow a chance to establish an emotional bond between mother and child as well as improving the mothers' well-being; it is recognised that for some mothers it is too difficult. Such an assessment must be made by a mental health professional that should follow the mother and child closely.

AGE OF INCLUSION AND LENGTH OF STAY

The age in which you include children in this programme, will depend on:

- The severity of the emergency
- The presence of adequate complementary food in the households
- The capacity of the programme

Priority must be given to infants aged less than 6 months, as they rely solely on breast milk or breast milk substitutes. If inadequate complementary food is available, it is recommended to also include children 6 to 12 months of age.

A sustainable provision of the BMS must be provided to all children admitted until they are minimum 6 months old, but preferably until the age of 12 months.

This implies that, by starting this activity, ACF must follow all beneficiaries until the age of 6 or 12 months, with an appropriate BMS and care.

If for some unforeseen reason the activity cannot continue, a transfer of all beneficiaries to another programme that will provide similar care must be organised.

EXCLUSION CRITERIA

Should not be considered for this programme:

- **Children born to HIV+ mothers after the emergency**, the BMS programme does not aim to be a PMTCT programme; it provides a solution to children who have no possibility to breastfeed. Children born after the emergency, have the possibility to breastfeed if their mothers are counselled correctly. Additionally it should be noted that the PMTCT program does not comply with the criteria set by WHO for HIV and infant feeding: this programme is not sustainable. Finally, it is important to understand that in many households, hygiene conditions will be insufficient and breastfeeding will then provide a much better chance of survival to the infant
- **Children of mothers who do not breastfeed in order to go out for work**: these mothers should be counselled and search for other alternatives, such as the use of expressed breast milk during the times of separation between mother and child
- **Hospitalized children**, they should continue to receive breast milk either by drinking directly from the breast or by receiving expressed breast milk via cup or nasogastric tube. BMS can only be used to complement breast milk if the latter is insufficient in quantity while helping the mother to produce and express more breast milk
- **Children from mothers with the following medical conditions:**
 - *Breast abscess*: breastfeeding should continue on the unaffected breast; feeding from the affected breast can resume once treatment has started
 - *Hepatitis B*: infants should be given hepatitis B vaccine, within the first 48 hours or as soon as possible thereafter
 - *Hepatitis C*
 - *Mastitis*: if breastfeeding is very painful, milk must be removed by expression to prevent progression of the condition
 - *Tuberculosis*: mother and baby should be managed according to national tuberculosis guidelines
 - *Substance use* : maternal use of nicotine, alcohol, ecstasy, amphetamines, cocaine and related stimulants has been demonstrated to have harmful effects on breastfed babies; alcohol, opioids, benzodiazepines and cannabis can cause sedation in both the mother and the baby. Therefore the mother should be encouraged not to use these substances and should be given opportunities and support to abstain

These health problems may be of concern to the baby; therefore close follow up of the health of mother and child by health professionals is essential!



AVOIDING WRONG ADMISSIONS

Once the programme is known, people will come to request BMS for their children without being in the inclusion criteria. Once they know what those criteria are, they might even come up with false stories to convince you to give the milk. These people don't do this out of mischief but because they think they are doing this for the well-being of the child. Reasons for acting this way are:

- The belief that artificial milk is better than breast milk
- The belief that the mother has insufficient milk to feed the child
- The belief that the mothers' milk is not good

These parents or caregivers must be identified and given correct information about the risks of artificial feeding as opposed to the benefits of breastfeeding and be referred to the Baby Friendly Space, Corner or Mobile Counsellors for further guidance to successfully breastfeed the child.

To reduce the risk of wrong admissions, the following actions can be set up:

- Locate the space where BMS is given in a different location than the BFS/corner or mobile counsellor space. The location should not be in full sight, it should be somehow separated from the rest of the space, yet still easily accessible. If this is not logistically possible, a separate room in the BFS or health facility must be foreseen, or a separate time should be scheduled for the care for these children when there are no breastfeeding mothers
- The provision of BMS should not be advertised as such. All families with children less than 2 years old should be encouraged to go to the BFS, to the corners, mobile counsellors or to the health centre, and qualified staff there should refer those children in need for BMS
- The BMS storage should not be in view of the beneficiaries entering the location. It should be stored in a cupboard, box or in cartons and individual provisions must be taken out per beneficiary. **BMS should NEVER be in view of breastfeeding mothers**
- Conduct thorough intake interviews with the beneficiaries to establish a relation of trust between the counsellor and the beneficiary, as well as to detect inconsistencies in the story (eg. Ask questions such as “who fed the child this morning?” “who bathed the child yesterday?”)
- Conduct a home visit in order to verify if the home situation is consistent with the details given in the interview
- Link up with protection agencies, who might have lists of orphans for each site
- Observe the behaviour of the infant when on a woman's lap. If he turns his head towards the breast, rubs it, wants to take it, this might be an indicator that he is still breastfeeding. If there is suspicion that the child could be breastfed, the risks of artificial feeding as opposed to breastfeeding must be thoroughly explained
- If several people come with exactly the same story, even more so if they come from the same site, this should be considered a warning sign and their stories must be checked thoroughly!

Any action to cross check the actual impossibility of the child to receive breast milk must be done with diplomacy and tact, so as not to lose the confidence of the beneficiary as well as not to put any family who have really lost the mother in distress.

If a family is discovered to have a mother who can breastfeed before, or after admission; they must be handled professionally and with respect. They should not be told off, but explained why it is better for the child to breastfeed. They should be referred to the BFS, corner or mobile counsellors to receive further counselling regarding breastfeeding.

While being careful to avoid wrong admissions or undermining of breastfeeding, care must also be taken to avoid stigma for those mothers or families who do use BMS.

4. CHOICE OF BREAST MILK SUBSTITUTE

If artificial milk is used:

- You must thoroughly explain the procedure to the caregiver and show it to him/her
- You must let the caregiver prepare and give the milk in front of you
- The caregiver should only take the milk home if he/she is capable of understanding and doing all the necessary steps to safely prepare and give the artificial milk
- The caregiver must return on a daily basis at first, in order to follow up closely any problems that might occur
- If no problems occur and the caregiver is fully able to prepare and give the milk safely, he/she can come back every couple of days
- The caregiver must be given the exact quantity of milk needed until the next time he/she is to come to the Baby Friendly Space
- The caregiver must be advised to return to the centre if any problem occurs with the milk or with the health of the child

The choice of the type of BMS will depend on many factors, such as the severity of the emergency, the amount of children in need of BMS, the local habits, the funding available, the logistical means available, etc.

COMPLIANCE WITH THE CODE AND OPERATIONAL GUIDANCE

Whatever choice is made for BMS, the first requirement is that it is in line with the International Code of Marketing of Breast Milk Substitutes, as well as the Operational Guidance on IYCF-E. This means it is:

- Purchased, not donated: any provision of BMS must be purchased directly by ACF or by a coordinating body, who then provides it to ACF. Donations of any kind cannot be used in the programme

- Manufactured and packaged in accordance with the Codex Alimentarius standards
- A shelf life of at least 6 months on receipt of supply, but preferably longer
- Labelled in the local language, preferably a generic (unbranded) label and:
 - State the superiority of breast milk;
 - Indicate that the product should be used only on health workers advice;
 - Contain no pictures or drawing of infants or pictures/drawings idealising the use of infant formula;
 - If labels do not comply with the above criteria, the formula will have to be appropriately relabelled before use.
- Age-appropriate for the group of targeted beneficiaries, follow-up milk, are not necessary.

FOR MORE INFORMATION:
 See an example of a generic label on <http://www.enonline.net/resources/176>

READY TO USE INFANT FORMULA

Ready to Use Infant Formula is a liquid formula, already dissolved and ready to be drunk. It does not need any preparation, not even warming up, and does not need any refrigeration before opening. It comes in small dosage bottles or cans for individual meal use or big cans for institutional use. It must be opened, poured into a cup and then can be drunk immediately by the child.

Bottles or cans that are opened must be drunk within the hour, or else discarded; therefore children must receive one individual dosage (or more, according to their need) per meal.

The fact that little preparation is needed eliminates a number of possible contamination sources, which makes it the preferred choice in emergencies where clean water, cooking stoves and fuel, cooking utensils, cleaning possibilities are usually hard to come by.

However, even if it is less of a risk for contamination than powdered infant formula (PIF), certain risk is still present.

Another downside is that it is more costly, as well as more difficult to transport and store (both for the agency and the family).



Figure 11:
 A generically labelled can of RUIF in Haiti.

POWDERED INFANT FORMULA¹

PIF is infant formula in a powdered form that must be diluted with water before use. PIF is not sterile, as during production, PIF can become contaminated with harmful bacteria, such as *Enterobacter sakazakii* and *Salmonella enterica*, which have been known to lead to illness and death. Also during preparation, unhygienic circumstances, unclean water and tools, can increase the risk of infection considerably. Severe illness and death have been attributed to the use of PIF.

1 - WHO/FAO(2006)Safe preparation, handling and storage of powdered infant formula guidelines.

All health workers, counsellors and users of PIF must therefore be made aware of the potential risks and how to reduce them. Thorough education and follow up of caregivers using PIF to feed infants is recommended.

Preparation must be practiced with the counsellors, either in the centre or during home visits or both.

It is recommended that a kit with all necessary material for preparation is provided to the family, with the instructions that this can only be used for the preparation of PIF:

- A piece of plastic sheeting that can be easily cleaned, to be used as surface for preparation (or top of plastic box lid)
- A cooking pot for sterilising equipment
- A basin for washing equipment
- A small kettle for boiling water
- A spoon
- A measuring scoop
- A cup
- Soap
- Fuel
- Clean water if the family has no access to it themselves
- An airtight box in which all material can fit, for storage

FOR MORE INFORMATION, SEE:

“Safe Preparation, Storage and Handling of Powdered Infant Formula”, WHO/FAO, 2006

http://whqlibdoc.who.int/publications/2007/9789241595414_eng.pdf

as well as the brochure “How to prepare infant formula for cup feeding at home?” WHO/FAO, 2007

http://www.who.int/foodsafety/publications/micro/PIF_Cup_en.pdf

“Guidelines for the use of BMS in emergencies” WHO, 2005

http://www.who.int/hac/crises/international/middle_east/Lebanon_guidelines_for_breast_milk_substitutes.pdf

If conditions to safely store, handle, prepare and give PIF within the household are not present, the infant formula will have to be centrally prepared and caregivers will have to come to the central location for each feed. If this is the case, the location should be in very close proximity to the beneficiaries’ living place to ensure adherence to the programme. The risks are extremely high with wet feeding for infants; strict procedures have to be in place (see Module 2 on IYCF-E)

Caution must be taken as there is a risk in providing a kit to prepare PIF for people who will try to enrol the programme while they can breastfeed. When possible, equally valuable incentives must be given to breastfeeding mothers.

HOME MODIFIED ANIMAL MILK

Home modified animal milk, uses fresh or dried animal milk (usually cow, but fresh milk can also come from buffalo, camel or goat); diluted at home with water, sugar and micronutrients to make them suitable for replacement feeding.

However, there are concerns about its use as the protein and fat content are too low (the latter of which could be countered by adding oil, but the feasibility has not been

FOR MORE INFORMATION, SEE:

“Home Modified Animal Milk for Replacement Feeding, is it feasible and safe?” Discussion Paper Prepared for HIV and Infant Feeding Technical Consultation, WHO, October 2006

http://www.who.int/child_adolescent_health/documents/a91064/en/index.html

and IFE Module 2 v1.1; IFE Core Group, 2007

<http://www.enonline.net/resources/4>



tested in the field). Also there are concerns on their potential health effects, no information on types of micronutrients to be used and no information on the safety of its use.

It is **therefore not recommended** to systematically use this solution in a programme for BMS; it could only be considered as a short term solution if no other; more adequate products are available. It will therefore not be further discussed here.

MILK PRODUCTS THAT ARE UNSUITABLE

- Skimmed or semi-skimmed fresh milk dried skimmed milk have insufficient fat contents and lack of vitamin A and D because they are in the milk's fat and are therefore unsuitable for use for infant feeding.
- Condensed milk may have reduced fat level, insufficient protein and other nutrient; as well as a lot of sugar added, and is therefore not suitable.
- Therapeutic milks such as F75 and F100 are designed for treatment of acute malnutrition; and not suitable as a BMS.
- Animal milk and full cream dried milk in an unmodified state are unsuitable.
- Cereal gruels, water and watery drinks such as juices and teas are nutritionally unsuitable and should never be given to children of less than 6 months of age. For children of more than 6 months old they are not suitable as a BMS.

5. QUANTITIES OF BMS



FOR THE PROGRAMME

The calculation of needs of BMS in an emergency is not a fully developed issue. The needs vary highly from one context to another; and there is not much experience with large scale programmes of use of BMS.

The following guidelines will give you an idea to start with, but you will need to follow the children's needs closely during the programme, and adapt if necessary.

Proceed as following to calculate your estimated number of beneficiaries:

- **Decide on age criteria for inclusion:** < 6 months only or also 6 to 12 months
- **Decide on the duration of the programme,** taking into consideration that all beneficiaries admitted must be followed until minimum 6 months of age, but preferably 12 months of age
- **Collect data on the estimated number of total population that will be covered** by the BMS programme; those are the people that will have access to existing or planned BMS sites
- **Collect data on the estimated number of < 6 months old and 6 to 12 months old** in the targeted population; using percentages from demographic data from surveys or recent assessments

- **Collect data on the estimated proportion of not breastfed infants during pre-emergency;** this can be done using percentages from IYCF surveys. If those are not available, data from rapid assessments can be used
- **Collect data on the estimated number of mixed fed infants pre-emergency**
 - Estimate the number of separated infants and infants who lost their mother during the emergency using data from child protection cluster or rapid assessments
 - Collect data on the new births and maternal mortality pre-emergency 
 - Calculate the estimated number of beneficiaries at the start of the programme:
 - Total target population x % 0-6 and 6-12 months = Nr. of infants in target population
 - (Nr. infants 0-6 months in target population x % artificially fed pre-emergency) + Nr. of separated or orphaned infants 0-6 months due to emergency = Nr. of children 0-6 months in need of BMS at the start of the programme (group A)
 - (Nr. infants 6-12 months in target population x % artificially fed pre-emergency) + Nr. of separated or orphaned infants 6-12 months due to emergency = Nr. of children 6-12 months in need of BMS at the start of the programme (group B)
 - Nr. infants in target population x % mixed fed infants = Nr. of children in need of BMS for 2 months, until relactation can be completed (group C)
- **Calculate the estimated number of new admissions in the following months,** this is the number of children who become orphaned due to maternal mortality in the months following the earthquake: 
 - Nr. of expected new births per month x % maternal mortality = Nr. of new orphans per month (group D)

Proceed as following to calculate your BMS needs:

- Infants < 6 months need between 60 ml (0-1 months) and 150 ml (5-6 months) per feed; 6 to 8 feeds per day or 450 ml (0-1 month) and 900 ml (5-6 months) per day; very rough average is 105 ml per feed or 675 ml per day, if you have more detailed information on division per age group in months (0-1, 1-2, 3-4, 5-6), use more detailed calculations
- Infants 6 - 12 months need approximately 800 ml per day; 200 ml per feed if 4 feeds per day
- Average of milk for all 0-12 months is:

FOR RUIF



RUIF comes in individual dosage bottles. An opened bottle cannot be used for longer than 1 hour; therefore leftovers must be discarded. One must therefore calculate the needs in bottle/feed. The content per bottle may vary per manufacturer; therefore you will need to adapt your calculations accordingly.



An example is given with bottles of 200 ml of RUIF:

Age Group	Nr feeds per day (average)	Quantity per feed (average)	Quantity per bottle (to be adapted)	Quantity per day (to be adapted)	Quantity per month (to be adapted) x 30,5
0-6 months	7	105 ml	200 ml	7	213,5 (y)
6-12 months	4	200 ml	200 ml	4	122 (z)

Supposing the programme will run for one year, with admission stop after 6 months, you may calculate:

- (Nr of children in group A x “y” x 6 months) + (Nr of children in group A x “z” x 6 months)
 - This is an overestimation, as not all children will be admitted if less than 1 month, many will be older and will reach 12 months of age before the end of the 12 months programme duration
- Nr of children in group B x “z” x 6 months
 - This is an overestimation, as not all children will be admitted at 6 months of age, many will be older and will reach 12 months of age before the end of the 12 month programme duration
- Nr of children in group C x “y” x 2 months
- Nr of children in group D:
 - Month 1: (nr children x “y” x 6 months) + (nr children x “z” x 6 months)
 - Month 2: (nr children x “y” x 6 months) + (nr children x “z” x 5 months)
 - Month 3: (nr children x “y” x 6 months) + (nr children x “z” x 4 months)
 - Month 4: (nr children x “y” x 6 months) + (nr children x “z” x 3 months)
 - Month 5: (nr children x “y” x 6 months) + (nr children x “z” x 2 months)
 - Month 6: (nr children x “y” x 6 months) + (nr children x “z” x 1 month)

FOR PIF

PIF comes in tins, that must be diluted at home. The contents of the tin will depend on the manufacturer. You will therefore have to calculate the quantity of milk that can be diluted with one tin for the formula you will have available in your programme.

An example is given based on a 500 g tin, which makes approximately 3,5 liters of milk¹:

Age Group	Quantity per day (average)	Quantity per month (average)	Quantity per tin (to be adapted)	Tins per month (to be adapted)
0-6 months	0,675 l	20 l	3,5 l	5,7 (α)
6-12 months	0,8 l	24,4	3,5 l	7 (β)

¹ - This is not a true value, always follow the manufacturer’s instructions on the tin.

Supposing the programme will run for one year, with admission stopping after 6 months, you may calculate:

- (Nr of children in group A x “a” x 6 months) + (Nr of children in group A x “B” x 6 months)
→ This is an overestimation, as not all children will be admitted if less than 1 month, many will be older and will reach 12 months of age before the end of the 12 months programme duration
- Nr of children in group B x “B” x 6 months
→ This is an overestimation, as not all children will be admitted at 6 months of age, many will be older and will reach 12 months of age before the end of the 12 month programme duration
- Nr of children in group C x “a” x 2 months
- Nr of children in group D :
 - Month 1: (nr children x “a” x 6 months) + (nr children x “B” x 6 months)
 - Month 2: (nr children x “a” x 6 months) + (nr children x “B” x 5 months)
 - Month 3: (nr children x “a” x 6 months) + (nr children x “B” x 4 months)
 - Month 4: (nr children x “a” x 6 months) + (nr children x “B” x 3 months)
 - Month 5: (nr children x “a” x 6 months) + (nr children x “B” x 2 months)
 - Month 6: (nr children x “a” x 6 months) + (nr children x “B” x 1 month)

FOR THE INFANT¹

Infants require 100 kcal/kg/day, whereas prepared infant formula has an energy value of 65-70 kcal/100 ml; therefore an infant needs 150 ml prepared formula/kg/day.

RUIF comes in bottles for use per feed; therefore the quantity of bottles needed must be calculated by nr of bottles/feed and per day; and not total quantity of volume per day (for example: a child needs 40 ml per feed, 8 times per day; therefore 320 ml/day. RUIF bottle contains 60 ml. The child will need 1 bottle per feed; thus 8 bottles or 480 ml; there will be a loss of 20 ml/feed which is unavoidable as once opened, the milk must be used within the hour).

The calculating of tins of PIF must be done on the basis of ml of formula that can be prepared per tin depending on the size of the tin.

1 - Based on IFE Module 2 V1.1; IFE Core Group, December 2008.



6. STEP BY STEP GUIDE FOR PROVISION OF BMS TO INFANTS

Providing BMS to infants in a suitable way is not just about giving the correct infant formula in the correct quantities. There is much more that is involved in order to prevent as much as possible negative side effects that artificial feeding might create.

- 1. Conduct a thorough intake interview:** this is not only to prevent wrong admission but also to get to know the situation of the child and his family, and for them to get to know and trust you so that individually shaped care and solutions can be proposed. Explore all alternative options before going to the provision of BMS.
- 2. Explain the risks and commitments to the caregiver:** explain what the potential risks are with regards to infections and increased risk of diseases as well as for the development of the child are. Explain what commitment is requested from the caregivers to provide optimal care in terms of hygiene, correct use of the BMS and care for the child.
- 3. Educate the caregiver on the procedure to follow for the preparation of the BMS and feeding of the child:** the preparation and feeding must be done in the centre first, under close supervision. Only if the caregiver has proven that he/she has understood everything and is able to repeat it without difficulties can he/she receive BMS to take home. As long as the caregiver is not able to prepare and give the BMS correctly, he/she will have to come to the centre for each feed to prepare it with a counsellor, until it is understood.
- 4. Educate the caregiver on the specific care that must be given to a non-breastfed child,** verify that he/she has understood why, and motivate them to perform this care at home.
- 5. Provide the caregiver with all items necessary for the correct hygienic preparation and feeding of the BMS.**
- 6. Provide the caregiver with small amounts of BMS:** the number of days for which BMS is given will depend on:
 - The distance the caregiver has to travel to get there: people living close by can come more often, for people living far away, bigger quantities can be given;
 - The time the child has been in the programme: at the start of the programme the caregiver might be ill at ease, have more questions and be unsure about correct preparation; therefore it is better for him/her to come more often;
 - The level of understanding of all procedures: as long as the caregiver has not fully understood all procedures he/she will have to come more often;
 - The health/well-being of the child: if some problem has been identified with the child, a close follow up is advised;
 - The risk of misuse of the BMS: if there is a risk of selling or sharing the BMS; providing small quantities at a time can help to prevent this misuse

In camp-like settings, one can ask caregivers to come every day in the beginning, thus providing BMS for one day only and increase gradually to a couple of times per week. It is advised to ask people to come at least once a week, to allow proper follow up of the child. Exceptions could

be made if the distance is too far to travel and asking to come once a week implies the risk that caregivers do not come regularly.

Asking the caregivers to bring back empty bottles or tins before providing new BMS, has 2 advantages:

- It allows for responsible disposal of garbage (look for ways to recycle)
- It allows closer follow up to reduce the risk of selling

7. Conduct close follow up of the health and well-being of the child and caregiver: upon each visit, the health of the child must be checked by interviewing the caregivers, as well as by physical examination. Upon each visit, one must also ask whether there are any problems, whether the caregiver is satisfied with the well-being of the child or has any questions. The caregiver must be given advice, or be referred to a health centre or other facility if a problem occurs. This way problems can be identified and treated early on, preventing deterioration to serious health problems, malnutrition or psycho-social problems.

8. Provide other types of activities: caregivers of non-breastfed children should also benefit from activities such as sessions on care practices, complementary feeding, health of the children; group discussions, animations, etc.

9. Conduct home visits: home visits are useful to see the child and his caregiver in their own environment to create a further confidential relationship, and to meet the rest of the family. It can be an opportunity to observe if hygiene and care, as advised, are respected. It can also be an opportunity to further discuss any problems or questions the caregiver or other members of family might raise.

10. Monitor and evaluate: supervisors must closely monitor activities, and all activities must be noted in the charts, registers and report forms.

7. TO PREPARE FOR FEEDING

READY TO USE INFANT FORMULA

- Measure the quantity the child needs to drink at each meal, and indicate to the caregiver with a marking on the bottle or on the cup, how much milk must be given to the child at each feed. This must be adapted to the growing weight of the child.
- The caregiver must clean the lid or the bottle or top of the can with a clean, wet cloth.
- The caregiver must shake the bottle or can.
- The caregiver must pour the correct quantity in a clean, open cup and give the milk to the child, try during one hour.
- Any leftover milk after one hour can be drunk by the caregiver or by older non-breastfed children in the family, or be thrown away.
- The cup must be cleaned immediately.

The cup must be provided upon admission into the programme, and be used only for the feeding of the child.



POWDERED INFANT FORMULA

Powdered Infant Formula (PIF) represents a high risk of contamination and consequent diseases. Special attention must therefore training, guidance and support given to the caregivers:

- PIF can only be given if the caregiver is able to hygienically prepare it at home; this means:
 - Understanding all the steps of preparation
 - Having all the material needed for hygienic preparation a piece of plastic sheeting that can be easily cleaned, to be used as surface for preparation, a cooking pot for sterilising equipment, a basin for washing equipment, a small kettle for boiling water, a spoon, a measuring scoop, a cup, soap, cleaning cloth or paper napkins, fuel, clean water if the family has no access to it themselves, an airtight box in which all material can fit, for storage). If the material is not available in the house, it must be provided to them.
 - Having shown their ability to correctly prepare;
- If the caregiver is not able to prepare PIF correctly at home, he/she will have to come to the Baby Friendly Space for all meals until he/she can do it at home;
- Close follow up of the child health is necessary.

Proceed as following:

1. Hands should always be washed thoroughly with soap and water before cleaning and sterilizing feeding and preparation equipment: Rub hands with soap and water while counting to 15 slowly. Pour safe water over hands to rinse for while counting to 15 again. Dry using a paper napkin;
2. Cleaning: wash feeding and preparation equipment (e.g. cups and spoons) thoroughly in hot soapy water;
3. After washing the feeding and preparation equipment, rinse thoroughly in safe water;
4. Sterilizing: if using a commercial home sterilizer (e.g. electric or microwave steam sterilizer, or chemical sterilizer), follow manufacturer's instructions. Feeding and preparation equipment can also be sterilized by boiling:
 - fill a large pan with water and completely submerge all washed feeding and preparation equipment, ensuring there are no trapped air bubbles
 - cover the pan with a lid and bring to a rolling boil, making sure the liquid in the pan does not evaporate
 - keep the pan covered until the feeding and preparation equipment is needed
5. Hands should be washed thoroughly with soap and water before removing feeding and preparation equipment from a sterilizer or pan. The use of sterilized kitchen tongs for handling sterilized feeding and preparation equipment is recommended;
6. To prevent recontamination, it is best to remove feeding and preparation equipment just before using it. If equipment is removed from the sterilizer and not used immediately, it should be covered and stored in a clean place;
7. Clean and disinfect a surface on which to prepare the feed;
8. Wash hands with soap and water, and dry using a single-use napkin;

9. Boil a sufficient volume of safe water. If using an automatic kettle, wait until the kettle switches off otherwise make sure that the water comes to a rolling boil. Note: bottled water is not sterile and must be boiled before use. Microwaves should never be used in the preparation of PIF as uneven heating may result in 'hot spots' that can scald the infant's mouth;
10. Taking care to avoid scalds, pour the appropriate amount of boiled water that has been allowed to cool to no less than 70 °C¹, into a cleaned and sterilized feeding cup. To achieve this temperature, the water should be left for no more than 30 minutes after boiling;
11. To the water, add the exact amount of formula as instructed on the label. Adding more or less powder than instructed could make infants ill. Mix thoroughly by stirring with a cleaned and sterilized spoon, taking care to avoid scalds;
12. Immediately after preparation, quickly cool by holding the feeding cup under running tap water, or by placing in a container of cold or iced water. Ensure that the level of the cooling water is below the top of the feeding cup;
13. Dry the outside of the feeding cup or bottle with a clean or disposable cloth;
14. Because very hot water has been used to prepare the feed, it is essential that the feeding temperature is checked before feeding in order to avoid scalding the infant's mouth. If necessary, continue cooling;
15. Discard any feed that has not been consumed within one hour;
16. Clean and sterilise all tools used immediately.

Age group	Number of infants	Number of feeds per day (average)	Quantity of formula needed per feed (average) ml	Quantity of formula needed per day (average) ml	Quantity of formula needed per week (average) ml	Quantity of formula needed per month (average) ml	Quantity per PIF tin (to be adapted) ml
0<6 months *	1	7	104	725	5075	22113	3500

Age	Amount of formula per day	Nr of milk feeds per day*	Quantity of milk per feed	Nr of complementary meals per day	Nr of nutritious snacks per day
6 - 8 months	600 ml	4	150 ml	1 to 2	1 to 2
9 -11 months	600 ml	4	150 ml	2 to 3	1 to 2

Fig. 12²: Quantity of prepared formula per day for infants 0 to 12 months old.

1 - The use of very hot water for the reconstitution of PIF has been questioned because of concerns over the loss of heat-sensitive nutrients; the risk of scalding for infants and the preparer; activation of *Bacillus cereus* or other bacterial spores; and clumping of powder. However, when PIF is prepared with water cooler than 70 °C, it does not reach a high enough temperature to completely inactivate *E. sakazakii* present in the powder. This is a concern for two reasons: a) a small number of cells may cause illness, therefore it is important that cells present in the PIF are destroyed; and b) the potential for surviving cells to multiply in the reconstituted formula. This risk is increased when the reconstituted formula is held for extended periods above refrigeration temperature.

2 - For more details about the calculation, see the "Save the Children. IYCF-E Toolkit - Rapid Start-up for Emergency Nutrition Personnel. Version 1.0, December 2013"



Baby bottles are difficult to clean, and can be an important source of infection. It is therefore recommended to use cup-feeding only:

How to cup feed?*

- Hold the baby sitting upright or semi-upright on your lap, one arm around the baby
- Hold the small cup of milk to the baby's lips



Fig. 13: Cup feeding babies; IFE Module 2 v1.1; IFE Core Group; 2007.

- Tip the cup so that the milk just reaches the baby's lips.
- The cup rests lightly on the baby's lower lip, and the edges of the cup touch the outer part of the baby's upper lip.
- The baby becomes alert, and opens his mouth and eyes. A LBW baby starts to take the milk into his mouth with his tongue, a full term or older baby sucks the milk, spilling some of it. If too much is spilled, hold a clean saucer under the cup to catch the spillage, which can then be poured into the cup again.
- **DO NOT** put the milk into the baby's mouth. Just hold the cup to his lips and let him take it himself. When the baby has had enough, he closes his mouth and will not take any more. He might just take a little break, so try again after some minutes. If he has not taken the calculated amount, he may take more next time, or you may need to feed him more often
- Measure his intake over 24 hours - not just at each feed.
- Clean and sterilise the cup thoroughly after use.

In some places, if bottles are so common that it is not possible to discourage people to use them, explain thoroughly how to keep them clean:

- Bottles and teats must be sterilised before using (being completely covered by water, and boiling to a rolling boil for 5 minutes, then dried in the sun, not with a cloth) the first time.
- Immediately after use, the bottle and teat must be cleaned inside and in all corners with a

1 - WHO/UNICEF(1993) Breastfeeding counselling: A training course.

brush (a long, thin one where the bristles can reach all corners and the bottom of the bottle). It must be done immediately because the milk can leave an invisible film on the inside of the bottle, which is difficult to clean, and a breeding ground for bacteria.

- Bottle and teat must be sterilised after cleaning, and stored away where it cannot be contaminated (or sterilised again just before the next use).

8. CARE PRACTICES FOR NON-BREASTFED INFANTS



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Breastfeeding might be a good opportunity for proximity between the mother and the infant. Non-breastfed children do not share this moment with their mother. In addition, they are more likely to be looked after by different caregivers, some who can be very young themselves. When the mother is present but cannot / will not breastfeed, the failure to breastfeed the child may have an impact on the mother-child relationship. If the child is well cared for and surrounded by attention, it can develop and have a good relationship with his mother.

When the mother is absent for a long period of time or dead, we must consider the psychological impact on the child and on the family or caregivers of the child. This can result in an emotional state and behaviours that have serious consequences on his/her psycho-physical development. The orphaned child or a child whose mother is physically or psychologically absent, can suffer from loss/grief, depending on his age when he lost his mother and according to the substitution by another adequate attachment figure. For the family, it might be difficult to detect and understand the infant behavior (refusal to eat, apathy, depression, etc.), especially if they are also emotionally affected. This can result in the family having an emotional distance and not establishing adequate



care practices. Anorexic behaviour patterns with weight loss and insomnia may aggravate the situation. This might be a very complex situation to manage for the caregiver and/or the family. A specific psychosocial or psychological support is necessary.

It is therefore very important to compensate the lack of proximity due to non breastfeeding with other care practices that make the child feel loved, safe, cared for:

- Always feed the child while he sits on the lap of an adult, an arm around him and feeding him patiently and at his own rhythm,
- Play with the child, talk to the child, sing songs, tell stories,
- Carry the child around on the back, in a sling, in a pouch as much as possible,
- Comfort the child when he is crying by picking him up, carrying him around, singing a song, etc.

Specific attention should be given to the child and the family or caregivers.

For the child:

- Observation of children to detect signs of emotional and behavioral dysfunction,
- Offer psychological support when the baby shows signs of a depression.

For the family:

- Help parents or caregivers to understand the reactions of the child and to implement adequate care practices,
- Help parents develop an emotional bond with the baby, find a substitute of the mother to have a relationship with the child.

Breastfed children still receive a large part of their nutritional needs from breast milk. Non-breastfed children do not have that advantage, making complementary feeding all the more important for them.

These children's' needs are approximately:

- 600 kcal per day at 6-8 months of age
- 700 kcal per day at 9-11 months of age
- 900 kcal per day at 12-23 months of age

Food consistency and variety can be increased gradually as the child gets older, adapting to the infant's requirements and abilities. Infants can eat pureed, mashed and semi-solid foods beginning at six months. By eight months most infants can also eat "finger foods" (snacks that can be eaten by children alone). By 12 months, most children can eat the same types of foods as consumed by the rest of the family (keeping in mind the need for nutrient-dense foods). Avoid foods in a form that may cause choking.

For the average healthy infant, meals should be provided **4-5 times per day**, with additional nutritious snacks (such as pieces of fruit or bread or chapatti with nut paste) **offered 1-2 times** per day, as desired.

The appropriate number of feedings depends on the energy density of the local foods and the usual amounts consumed at each feeding. If energy density or amount of food per meal is low, more frequent meals may be required:

- Meat, poultry, fish or eggs should be eaten daily, or as often as possible, because they are rich sources of many key nutrients such as iron and zinc,
- Milk products are rich sources of calcium and several other nutrients, if adequate amounts of other animal-source foods are consumed regularly, the amount of milk needed is ~200-400 mL/d; otherwise, the amount of milk needed is ~300-500 mL/d. Acceptable milk sources include full-cream animal milk (cow, goat, buffalo, sheep, camel), Ultra High Temperature (UHT) milk, reconstituted evaporated (but not condensed) milk, fermented milk or yogurt, and expressed breast milk,
- If milk and other animal-source foods are not eaten in adequate amounts, both grains and legumes should be consumed daily, if possible within the same meal, to ensure adequate protein quality,
- The daily diet should include Vitamin A-rich foods,
- Provided diets should have adequate fat content. If animal source foods are not consumed regularly, 10-20 g of added fats or oils are needed unless a fat-rich food is given (such as foods or pastes made from groundnuts, other nuts and seeds),
- Avoid giving drinks with low nutrient value, such as tea, coffee and sugary soft drinks. Limit the amount of juice offered, to avoid displacing more nutrient-rich foods,
- As needed, use fortified foods or vitamin-mineral supplements (preferably mixed with or fed with food) that contain iron (8-10 mg/d at 6-12 months, 5-7 mg/d at 12-24 months). If adequate amounts of animal-source foods are not consumed, these fortified foods or supplements should also contain other micronutrients, particularly zinc, calcium and vitamin B12. In countries where vitamin A deficiency is prevalent or where the under-five mortality rate is over 50 per 1000, it is recommended that children 6-24 months old receive a high-dose vitamin A supplement (100,000 IU once for infants 6-12 months old and 200,000 IU bi-annually for young children 12-23 months old),
- Non-breastfed infants and young children need at least 400-600 mL/d of extra fluids (in addition to the 200-700 mL/d of water that is estimated to come from milk and other foods) in a temperate climate, and 800-1200 mL/d in a hot climate. Plain, clean (boiled, if necessary) water should be offered several times per day to ensure that the infant's thirst is satisfied. More fluids should be given in case of diarrhoea, vomiting or fever.

Practice responsive feeding:

- a. Feed infants directly and assist older children when they feed themselves, being sensitive to their hunger and satiety cues
- b. Feed slowly and patiently, and encourage children to eat, but do not force them
- c. If children refuse many foods, experiment with different food combinations, tastes, textures and methods of encouragement



- d. Minimize distractions during meals if the child loses interest easily
- e. Remember that feeding times are periods of learning and love - talk to children during feeding, with eye to eye contact

Special attention must be given to hygiene in storage and preparation of food and utensils.

9. FEEDING THE INFANT

There are different ways of feeding BMS to an infant. The use of nasogastric tube is for institutional use and will not be discussed here. If BMS is given in the relactation phase, it must be given through supplementary suckling, or drip & drop method. See the above paragraphs for more information.

CUP FEEDING

The most common and most suitable way to feed BMS to healthy infants is by cup, for the following reasons:

- Cups with a large opening are easier to clean and therefore represent less risk of infection than bottles,
- Cup feeding demands more adult attention than bottle feeding, which will be beneficial for the child's well-being and development as well as for the caregiver-child bonding,
- If cup feeding is temporary until breastfeeding can be established, there is less risk breastfeeding problems due to nipple confusion; than with bottle feeding,
- Cleaning the cup appropriately is less time and resource consuming than cleaning bottles.

BOTTLE FEEDING

Bottle feeding in emergencies is not recommended for the following reasons:

- Feeding bottles and teats are difficult to clean because of small openings, little niches and considerably increasing the risk of infection.
- Feeding bottles are often given to the child to drink by himself; increasing bonding problems and potentially impeding optimal development due to lack of attention,
- Bottle feeding can increase the risk of breastfeeding problems due to nipple confusion if the child returns to breastfeeding afterwards,
- Cleaning and sterilising bottles and teats correctly is more time and resource consuming.



However, in some cultures or countries, bottle feeding can be so common that it is difficult or impossible to convince people not to use them. In this case, thorough education on the risks (increased risk of infection that can lead to diarrhoea and other diseases) and ways to avoid them must be given to the caregivers of the child.

Bottle feeding exchange could be organised as a last resort.

10. LOW BIRTH WEIGHT BABIES

Infants who have a Low Birth Weight (weight < 2500g) are all the more vulnerable for infections and need more energy to reach their growth. Therefore it is even more important that they receive optimal nutrition and immunological protection that breast milk can provide.

Mothers may need special care and attention to be able to have the knowledge and confidence to care for this child appropriately.

If the child has:

- A medical complication (respiratory infection, gastro-enteritis, fever or other)

OR

- Is too weak to suckle or even to drink from a cup

OR

- Has a weight for height < -3 z-score

OR

- Is more than 6 months of age, yet weighs less than 3 kg,

the child and his mother/caregiver must be referred to a stabilisation unit, where they have specific protocols for babies < 6 months, for specialised care and close follow-up.

If the child does not have medical problems, has a good nutritional status (≥ -3 z-score) and is sufficiently strong to breastfeed or drink from a cup, he can receive counselling.

Even if the child is preterm, it is perfectly safe to give him breast milk; in fact the milk of mothers of preterm babies is adapted to the gestational age of the baby, which cannot be said for infant formula.

Because the children are smaller and weaker, they will have to be put to the breast more often than normal weight babies, as they will not be able to drink large quantities of breast milk in one feed. The child might not ask to be breastfed by himself often enough, so it is up to the mother to put him to the breast regularly (10 times a day or more). Sometimes it might be necessary to remove some of the foremilk by manual expression, so the infant can get to the energy-rich hind milk easier.

If the child cannot suckle the breast, it is still important to give him breast milk, for 2 main reasons:

1. Provide the child with immunological protection and adapted nutrition.
2. Stimulate the breast milk production in the mother, so the child can breastfeed as soon as he's ready.

Show and help the mother to express her breast milk manually and give this by cup to the baby:

FOR MORE INFORMATION, SEE:

WHO's "Guidelines on Optimal Feeding of Low Birth Weight Babies in Low and Middle Income Countries"

http://www.who.int/maternal_child_adolescent/documents/9789241548366.pdf



- Infants who are fully or mostly fed by an alternative oral feeding method should be fed based on infants' hunger cues, except when the infant remains asleep beyond 3 hours since the last feed,
- The 1st day 60ml/kg divided into 12 meals, so 5ml/kg every 2 hours,
- Increase the volume by 20 to 30 ml/kg/day until the baby reaches a total volume of 200 ml/kg/day, divided into 8 to 12 meals per day, with careful monitoring of feed intolerance.

→ Bottle feeding is not recommended as these children are even more vulnerable to the increased infection risk with bottles than normal weight babies.

If the mother cannot express enough breast milk at first, give whatever she can express and complete with heat treated donated breast milk or infant formula. However, keeping the child close as much as possible, preferably skin to skin, looking at him, as well as building the mother's self-confidence should help to express enough breast milk. Avoid the use of infant formula as much as possible, as each feed changes the intestinal flora and increases the risk of infection.

The mother can put the baby to the breast a little before expressing milk and cup feeding as this will make the child familiar with breastfeeding and help to produce, eject and express breast milk.

When the child is ready to suckle more, the mother can put him to the breast more often and longer and complete with expressed milk afterwards until the child is strong enough to suckle from the breast completely. Those children might still need to be breastfed more often during the day.

Monitor the urine output (> 6 light yellow coloured outputs per day) and weight gain (> 125 g/week), as well as the health of the child.

These low weight babies are also very vulnerable for loss of warmth and hypothermia. The best way to prevent or deal with it is through kangaroo care; where the mother, father or another caregiver puts the naked baby onto her/his naked chest and both are covered or wrapped together. The body temperature of the carer will keep the child warm, this can be increased by giving the carer hot drinks but the child will also feel safe and relaxed, which will improve bonding between carer and child AND if it is done with the mother, this will help her to produce more breast milk.

It helps to reduce morbidity and mortality among preterm and LBW infants: it helps the baby to control its temperature and has an effect on the heart and respiratory rates, respiration, oxygenation, oxygen consumption, blood glucose, sleep patterns, behaviour and possibly also on stress. It also has an effect on the mother who often reports to be less stressed and have increased confidence, self-esteem and feeling of fulfilment¹.

1 - WHO (2003) Kangaroo Mother Care, A practical Guide.

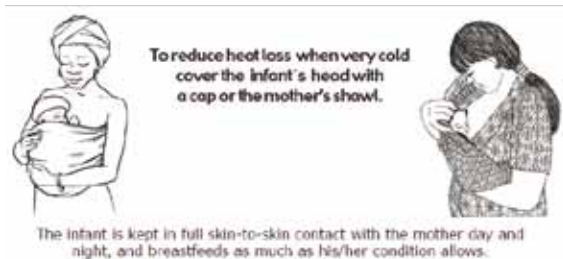


Fig. 14: Kangaroo Care. Management of the child with a serious infection or severe malnutrition, WHO/IMCI/FCH/CAH/00.1.

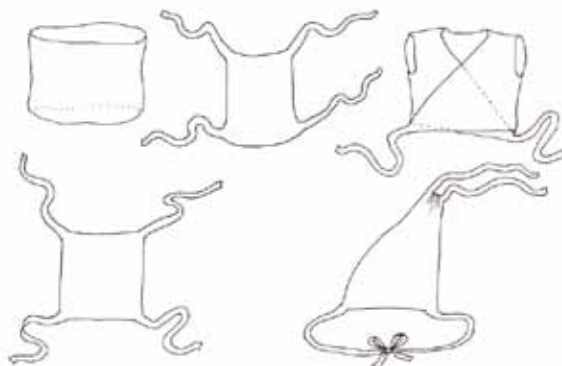


Fig. 15: Carrying pouches for KMC; Kangaroo Mother Care, WHO 2003.



Fig. 16: Positioning the baby for KMC; Kangaroo Mother Care, WHO 2003

To begin with, use a soft piece of fabric, about a meter square, folded diagonally in two and secured with a safe knot or tucked up under the mother's armpit. Later a carrying pouch of mother's choice can replace this cloth. All these options leave the mother with both hands free and allow her to move around easily while carrying the baby skin-to-skin. When baby receives continuous KMC, he does not need any more clothing than an infant in conventional care. If KMC is not continuous, the baby can be placed in a warm bed and covered with a blanket between spells of KMC, depending on the climate.

Place the baby between the mother's breasts in an upright position, chest to chest. Secure him with the binder. The head, turned to one side, is in a slightly extended position. The top of the binder is just under baby's ear. This slightly extended head position keeps the airway open and allows eye-to-eye contact between the mother and the baby.



Avoid both forward flexion and hyperextension of the head. The hips should be flexed and extended in a “frog” position; the arms should also be flexed.

Tie the cloth firmly enough so that when the mother stands up the baby does not slide out. Make sure that the tight part of the cloth is over the baby’s chest. Baby’s abdomen should not be constricted and should be somewhere at the level of the mother’s epigastrium. In this way baby has enough room for abdominal breathing. Mother’s breathing stimulates the baby.

Show the mother how to move the baby in and out of the binder. As the mother gets familiar with this technique, her fear of hurting the baby will disappear:

- Hold the baby with one hand placed behind the neck and on the back,
- Lightly support the lower part of the jaw with the thumb and fingers to prevent the baby’s head from slipping down and blocking the airway when the baby is in an upright position,
- Place the other hand under the baby’s buttocks.

The mother can breastfeed in this position, in fact, it will even be favourable for breast milk production. For twins, the mother can put both, one on each side of her chest, alternating positions, or one baby can be kangarooed by the father or another family member.

Kangaroo care and caring for the LBW infant will require some getting used to by the mother. Explain every step of the process, encourage her, answer her questions and discuss her doubts and fears. It might be beneficial to bring mothers with similar babies together so they can share experiences; especially mothers who have been successfully using the technique with new mothers.

Daily bathing is not needed and is not recommended. If local customs require a daily bath and it cannot be avoided, it should be short and warm (about 37°C) and done at the hottest part of the day, not early morning or later evening. The baby should be thoroughly dried immediately afterwards, wrapped in warm clothes, and put back into the KMC position as soon as possible.

The mother can sleep with the baby in KMC on her back in a semi-reclined position, or even on her side. If the baby is well secured, there is no risk of smothering; in fact there is reduced risk of apnoea. However, the mother should not do this if she or a bed partner has drunk alcohol, smoked or took drugs or sleeping medication (or other medication that can affect her awareness).



Fig. 17: Infant in KMC position; Kangaroo Mother Care, WHO 2003.

FOR MORE INFORMATION, SEE:

“Kangaroo Mother Care, A Practical Guide” WHO, 2003

http://www.who.int/making_pregnancy_safer/documents/9241590351/en/index.html



V. TECHNICAL INFORMATION ON BREASTFEEDING AND CHILD FEEDING

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1. HOW DOES BREASTFEEDING WORK?

The production of breast milk is achieved through the action of hormones and reflexes. This process is prepared during pregnancy. A breast is composed, amongst other things, of milk secreting cells, and milk ducts that lead from the cells to the nipple.

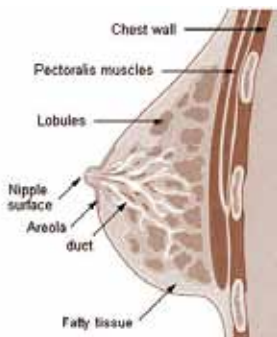


Fig. 18: Anatomy of the breast.

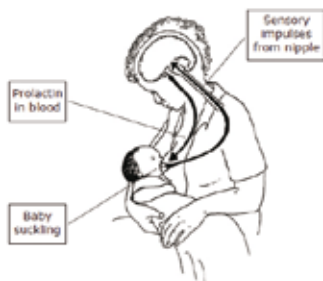


Fig. 19: The Prolactin Reflex, IFE Module 2 v1.1; IFE Core Group.

Every time the baby suckles, he/she stimulates the milk production through the production of a hormone called “prolactin”. In the breast, the prolactin makes the milk secreting cells in the breast glands secrete breast milk. This is the Milk Secreting Reflex or Prolactin Reflex.

The mothers' thoughts, feelings and sensations can affect the oxytocin reflex: good feelings, like thinking loving thoughts of the baby, touching, smelling or looking at the baby help the production of oxytocin.

Bad feelings, like stress, worry, pain, embarrassment, doubt... can hinder the production of oxytocin and interfere with the flow of milk or even temporarily stop the flow of milk (not the production). Helping lactating to deal with stress and improve their psychological emotional state are therefore important issues that can be addressed in the context of baby friendly spaces.

More prolactin is secreted during the night than during the day, so **breastfeeding at night helps to keep up a good supply of milk.**

The more the baby suckles the more milk will be produced! Breastfeeding at night will help to produce more milk!

Another hormone, “oxytocin”, is also produced when the baby suckles. Oxytocin causes the muscle cells to contract and allows the milk to flow.

Support, encouragement and confidence building are essential to help the mother produce oxytocin and thus help the milk flow!

Some techniques are helpful for the mother and the baby. For instance, just after birth, if the child is immediately placed naked on the mother's naked chest, it will facilitate bonding and breastfeeding, because:

- The baby has reflexes to crawl up to the breast.
- The areola has a scent the baby recognizes from the amnion fluid.
- The baby recognizes the heartbeat and voice of the mother.
- It is the ideal position for him to watch his mothers' face.
- It stimulates breast milk production and is beneficial for later successful breastfeeding.
- It keeps the baby warm and prevents hypothermia.

The baby will therefore crawl towards the breast and start sucking the nipple.

KNOWING THE CHARACTERISTICS OF DIFFERENT TYPES OF MILK

There is a difference between different types of milk:

- **Colostrum**, is the milk that is produced in the first few days after delivery. It is yellowish and thick. It is more concentrated with energy, antibodies and white blood cells than the milk that will be produced later. It is very nutritious and contains elements that prepare the baby's intestine to digest and absorb milk. It is also laxative and helps to pass meconium (first blackish stool), which reduces the risk of jaundice. Even though quantities are small, it is exactly what is necessary to cover all the baby's needs.

In some cultures (in Chad for example), traditional beliefs consider the colostrum as a "dirty milk" that may be poisonous and that it should therefore not be given to infants. Also, some traditional practices delay the breastfeeding of the new-born baby (a risk of complications with the breastfeeding process, milk production). Although the local beliefs and practices should always be duly respected, as a trust relationship is developed with the beneficiaries, it is possible to discuss these practices and share information regarding breastfeeding, with the aim of exploring possible and culturally acceptable adjustments to these practices.

It is recommended that the baby is fed colostrum frequently during the day and night, as often as he wants, even more often than he will later when having the mature milk. Drinking often will not only give him the energy and protection he needs, it will also help to stimulate the production of mature milk. After some days, colostrum changes into mature milk.

- **Mature milk** is the milk that is produced after a few days, in larger quantities. It may look thin and watery, but this is normal and enough to cover the baby's needs. Its composition changes during a feed:
 - *Foremilk is produced at the beginning of a feed. It looks bluer and thinner than hind milk. It provides plenty of protein, lactose and other nutrients. It is produced in large quantities, which covers all the babies' needs for fluid intake, even in hot climates*

→ Hindmilk is the milk that comes at the end of the feed. It looks whiter because it contains more fat, and thus much of the energy of a breastfeed. If the baby is taken of the breast too early, it will not get the hind milk and therefore will not be satisfied, will be hungry faster and cry more often

Breast milk adapts itself during the growth of the child, so it can cover its changing needs. The baby should be allowed to drink as long as they want at each feed.

EFFECTIVE PHYSICAL POSITION FOR BREASTFEEDING

In order for the baby to suckle effectively, positioning is important. Good positioning starts with the mother sitting, half sitting (semi-reclined) or lying down in a comfortable position, being relaxed, in a quiet environment. Different holding positions are possible: cradle hold, under the arm or “clutch” hold, or lying down with baby on top or beside her. Lying down with the baby on top has the advantage of full body contact with the baby’s front, which makes him feel secure and triggers his natural reflexes to crawl to the breast and suckle.

Recommended positions depend on the mothers’ own wish (the position she feels comfortable in), the size of her breast and position of her nipples (a mother with long, heavy breasts with downward pointing nipples will have to position her baby differently than a mother with small pointy breasts with nipples pointing straight forward), the baby’s wish (the position in which he breastfeeds best) and sometimes the delivery method (women who gave birth through caesarean section will want to avoid holding the baby against the stomach at first).

Remember that the way a mother breastfeeds her baby is also largely influenced by cultural practices and beliefs. This is an important aspect that needs to be studied by the Baby Friendly Space’s staff in order to adapt the recommendations to mothers and the messages transmitted accordingly.

Different positions might be tried out:



Fig. 20: Different breastfeeding positions for breastfeeding: cradle hold, clutch hold, lying down. Breastfeeding Counselling, a Training Course; WHO/UNICEF 1993.

Whilst the baby's position may vary the following should always be undertaken:

- The baby's belly is turned towards the mother, and his body is in close contact with the mothers, as close as possible. Bring the baby to the mothers body, not the mothers body to the baby.
- Head and mouth of the baby are in front of the breast, facing the nipple; the nipple should be at the level of the baby's nose to allow him to take the breast and attach correctly.
- The ear, shoulder and hip of the baby form more or less a straight line, neck is not twisted or bent.
- The baby's full body is supported, but there is no pressure against the baby's head or neck, pressure can be given to the back to keep the baby close (especially in cradle hold).
- Eye contact between mother and child is beneficial, caressing the child as well.

The mother in figure 21 appears to have the following problems:

- The child's body is not turned towards the mothers, the baby has to twist his head to suckle, which makes it more difficult for him.
- The baby's body is not fully supported, making him feel unsafe, and does not allow him to drink in a relaxed way.
- There is no eye contact between mother and child, which does not encourage the child to drink.

To offer the breast, the mother can place her fingers on the chest wall, so that her first fingers form a support at the base of the breast . DO NOT hold the breast too close to the nipple. If the breast is big, the mother can squeeze the breast (not the nipple) to fit better into the child's mouth.

The mother can slightly tickle the side of the mouth with the nipple.

The baby must open his mouth wide (like a yawn), which will cause his head to twist back a little, to take the full breast in his mouth. If the nipple is positioned around its nose the baby reaches upwards to take the breast which will allow the breast to be well positioned inside his mouth.

The baby must take the breast in its mouth, not just the nipple for appropriate attachment and the nipple must be far back in the mouth of the child. Suckling from the nipple only will not effectively remove the milk from the breast. The baby will not get enough milk and feel hungry and frustrated. In addition, nipple suckling is more painful for the mother and can cause damage to the nipples.

The drawing on the left in figure 16 shows how the nipple and areola stretch out to form a teat in the baby's mouth. The milk ducts are in the baby's mouth and he can press them with its tongue to massage out and drink the milk. On the right hand drawing of figure 16; the milk ducts are outside of the baby's mouth, and he/she cannot press them to get the milk. This baby's suckling will be ineffective. Poor attachment with ineffective suckling will cause painful and damaged nipples, unsatisfied, hungry and frustrated babies, insufficient emptying of the breast with risk of swelling and risk of reduced milk production.

Try drinking from a cup with your head twisted to the side. Now with your head bent backward, then forward. Finally try drinking with your head straight. Which position is most comfortable to drink? It's the same for babies!



Fig.21: Inappropriate positioning for breastfeeding; Breast Breastfeeding Counselling, a Training Course; WHO/ UNICEF 1993.



To evaluate good positioning, the following signs should be present:

- There should be more areola visible above the baby's mouth than below
- The baby's mouth should be wide open
- The lower lip must be turned out (Note: you can't always see this)
- The chin should touch or nearly touch the breast

Do not worry if the baby's nose touches the breast. He can breathe through the side of the nostrils.

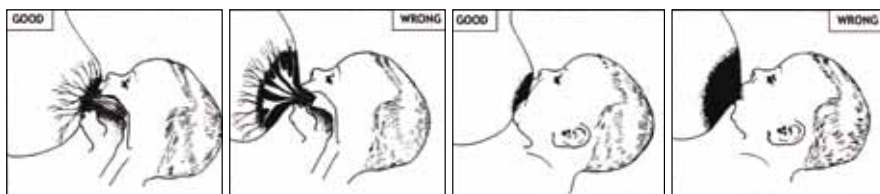


Fig. 22: Good (left) and incorrect (right) attachment; IFE Module 2 v1.1, IFE Core Group.

Signs that the baby is drinking milk effectively are:

- The baby takes slow, deep sucks, sometimes pausing
- You can hear little “gloop” noises
- The baby's cheeks are rounded during the feed, not drawn inwards
- The breast looks “rounded” from the pressure of the baby's face
- The baby releases the breast by himself and looks contented
- The mother does not feel pain

FOR MORE INFORMATION:

Videos of appropriate latching and a demonstration of inappropriate latch on Dr. Newman and Edith Kernerman website:
http://www.nbc.ca/index.php?option=com_content&view=category&layout=blog&id=6&Itemid=13

There is no set time that the feed should last, apart from that it should last as long as the baby is drinking. Some babies are slow drinkers, others are fast. The baby might take a pause now and then, staying latched onto the breast. Do not interpret this as him being finished; he is just taking a little rest. When the baby is finished he will let go of the breast himself. Taking the baby from the breast before he's finished to put him on the other breast, it will prevent him from drinking the hind milk, which comes down slower due to its higher fat content. If you have the impression that the milk flow is slowing down too much, or the baby is just playing around; this might be an indicator to put him on the other breast.

A study conducted showed that for infants who were “incorrectly positioned” at discharge from maternity, only 48% was still breastfeeding at the age of 2 months and 35% at the age of 4 months. This as compared to infants who were correctly positioned at discharge, of whom 98% were breastfeeding at the age of 2 months and 74% at the age of 4 months.

Richard L., Alade MO, 1992, Suckling Technique and its effect on success of breastfeeding; Birth 10(4):185-189.

Not all babies will finish two breasts (2 x foremilk and 2 x hindmilk) in one feed. Therefore, the mother should change sides to start breastfeeding at every feed. Breastfed babies should pass urine 6 to 8 times per 24 hours (except when the child is still drinking colostrum, then it can be only 1 to 2 times a day). The urine should be light coloured and have a mild odour.

The first day(s) after birth, babies have black, sticky stools. Later on breastfed babies have yellowish to yellowish-brown or yellowish-green, paste-like or semi-liquid stools that should not be confused with diarrhoea. Green stools now and then can be normal. The odour should be mild. They pass stools 2 to 5 times per day, but it can be less.

THE MOTHER AND CHILD RELATIONSHIP

As mentioned in the first part of this manual, breastfeeding does not only provide optimal nutrition and immunological protection. It is also an excellent way to create a close relationship and bond between mother and child; which is beneficial for both. Breastfeeding mothers have more confidence in themselves and react better to the needs of their children, which helps to develop a positive and close mother-child relationship.

Factors that can affect successful breastfeeding:

- **Attitude:** a woman who is convinced that breastfeeding is the best for her baby and she is capable of providing it, is more likely to successfully breastfeed
- **Technique** to position, attach, suckle and how to breastfeed children with special needs
- **Confidence** in herself and her ability to produce and give enough milk
- **Frequency** of putting the child to the breast, day and night

This can be achieved by giving her support, by her family, by friends and neighbours and/or by health professionals.

Breastfeeding has a better chance of being successful, if there is a good, positive and emotional relationship between mother and child: the mother can look at her child and speak to him during feeding, caress him, smile at him. This will make the baby feel comfortable and safe, which will stimulate him to suckle effectively.

The availability of an appropriate place where the mother breastfeeds her baby is also important: ideally, this place should be quiet, with an appropriate temperature, ensure sufficient privacy.

A breastfeeding woman needs extra small, nutritional snacks, or a fifth more of her usual diet. It is recommended that she eats food that provides her with energy, proteins, but also sufficient micronutrients; as she passes those on to the baby through the breast milk.

However, this does not mean that a woman cannot breastfeed if she is not well fed; her body will continue to provide good quality milk for the child. Even moderately malnourished women can produce sufficient breast milk, yet they must be given treatment for their malnutrition. Severely malnourished women should be encouraged to continue breastfeeding whilst being provided with appropriate care as soon as possible.

2. IMPORTANT INFORMATION AND MESSAGES ABOUT BREASTFEEDING AND FEEDING PRACTICES



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INITIATE SKIN TO SKIN CONTACT AND BREASTFEEDING, AS SOON AS POSSIBLE, BUT WITHIN THE FIRST HOUR AFTER BIRTH

- Birth is a difficult experience, placing the naked baby on the mothers' naked chest immediately after birth, makes the baby feel safe, he will cry less and be warmer¹. The baby will recognize the mothers' smell, her voice and will look at her face, this will stimulate bonding between mother and child.
- During the first hour after birth, the baby is very much awake, whereas afterwards he will sleep for a long period.
- The baby has reflexes, including a sucking reflex, that allow early initiation.
- Letting the baby suckle improves the production of breast milk and gives the mother more confidence in herself; which will eventually result in less breastfeeding problems and longer continued breastfeeding².
- Suckling the nipple and skin to skin contact improve uterus contractions, facilitating the expulsion of the placenta and reducing blood loss of the mother.
- Colostrum provides all the necessary nutrients; therefore reduces the risk of hypoglycaemia, icterus, improves bowel movements and expulsion of meconium, colonises the bowel which improves the resistance, etc.
- Colostrum provides immunological protection and is rich in vitamin A.

FOR MORE INFORMATION, SEE:

The video on early initiation through breast crawl (UNICEF, WHO, WABA) on <http://www.nhbreastfeedingtaskforce.org/breastcrawl.php>

1 - Moore, E.R. and al. (2007). Early skin-to-skin contact for mothers and their healthy newborn infants. Cochrane Database of Systematic Reviews, Issue 3.

2 - Lbid

EXCLUSIVE BREASTFEEDING FOR 6 MONTHS

- Breastfeeding is normal for human babies.
- It is the **best possible nutrition** for the baby. It is complete and covers all the child's needs for the first 6 months.
- It is totally **free** of charge and available at all times.
- It keeps the infant safe from potential sources of infection that would be present with replacement feeding.
- It **protects children against many infections**; thanks to the mothers' antibodies in the milk¹.
- It is perfect for the digestive system.
- It helps the baby's **development**.
- It promotes **bonding** between mother and child.
- It protects the **mothers' health**, such as reduced risk for ovarian and breast cancer.
- It helps to delay a new pregnancy, as prolactin suppresses ovulation.
- It **helps to protect a baby against HIV transmission** from the mother (as opposed to mixed feeding).
- It helps mothers to relax and gives them a sense of control, empowerment and satisfaction.

BREASTFEEDING DAY AND NIGHT AND ON DEMAND

- Breastfeeding on demand (or on cue) helps to ensure that the baby's physical and emotional needs are covered.
- Letting the baby suckle as long as he likes ensures he can satisfy his needs, helps to ensure that he gets the rich **hind milk** and helps to **maintain a good production** of breast milk.
- The more the baby suckles, the more milk will be produced.
- Breastfeeding at night **helps to keep a good supply of milk** as it stimulates the hormone necessary for the milk secreting reflex (prolactin).

CONTINUED BREASTFEEDING UP TO 2 YEARS OR BEYOND

- Even though the child must start to receive complementary food at 6 months, a **major part of its nutritional needs are still covered by breast milk**.
- It remains perfectly adapted food with a high nutritional value.
- It is still safe, free and helps to protect against diseases; an added value at any time, but even more so in emergencies.
- It is still optimal for mother-child bonding and beneficial for the child's development.
- In emergency, the quantity and quality of complementary food might be reduced; therefore breastfeeding should be increased to cover the baby's nutritional needs.

1 - Dewey KG et al., 1995. Differences in morbidity between breast-fed and formula-fed infants. J Pediatr. 126:696-702.



SAFE AND QUALITATIVE COMPLEMENTARY FEEDING FROM THE AGE OF 6 MONTHS, IN SMALL BUT FREQUENT QUANTITIES, GIVEN TO HIM IN A RESPONSIVE WAY

- Until 6 months all the needs are covered by breast milk, at 6 months the baby **needs additional food** and his **digestive system is now ready** to receive it.
- It is the babies first encounter with food other than breast milk, and as the baby is still vulnerable, therefore **hygiene in storing, preparing and feeding is very important**.
- The baby stomach is still small and can hold only small quantities. Complementary feeding should start with 'tastes', building up to **frequent, small meals**, being careful not to displace breast milk.
- Since the child can only eat small quantities, the **quality must be as high as possible**: a variation of all food groups, with inclusion of vegetables, fruits and later fish or meat on top of the staple food.
- Complementary feeding is new for the baby, to make him get used to it, to make sure he eats what he needs to, individual adult attention during feeding is important.

3. COMMON BREASTFEEDING PROBLEMS

THE BABY CRIES VERY OFTEN, SOON AFTER BEING BREASTFED, THE MOTHER THINKS THE BABY IS HUNGRY:

Possible causes

- The baby is not well positioned or not well attached to the breasts, which does not allow him to suckle a sufficient amount of milk per breastfeed which makes him frustrated and hungry.
- The mother takes the baby off the breast before he has finished; the baby does not get the energy rich hind milk and is hungry faster.
- The baby might have some cramps after eating, or have reflux (some of the baby's food coming back up which can cause some irritation. This is not vomiting) or other discomfort.
- The mother does not breastfeed on demand or not often enough during the day and night.
- The baby is affected by the change in environment, living conditions, stress among his family members and just wants to be held.
- The baby is in a changing phase of development milestone (i.e. growth spurt, teething).
- The baby needs to be changed, he is wet.
- Cluster feeding - it is normal for babies to feed frequently before the longest sleep of their day.
- Many others reasons, etc.

Possible solutions

- Observe positioning and attachment, and correct if necessary. Explain thoroughly to the mother why this is important, encourage her to repeat this at home.
- Ask how many times she breastfeeds per day; and whether this is when the baby asks for it. If not, explain her how she can see that the baby is hungry (looking around, bringing his hand to his mouth, brushing his cheek to his clothes or the breast, sucking his hand, crying), and that she must feed him then. If the baby is not asking for food regularly, she should wake him for feeding more often.
- Observe the length of a breastfeed or discuss with the mother for how long she lets the baby drink at each feed. If you think she might take the baby off too soon, explain to her to let the baby drink as long as he wants. Explain that there are slow drinkers and fast drinkers; but that all babies need the milk of the end of the feed. Explain to start with a different breast at each feed.
- If there is suspicion that the baby has cramps after eating, check the attachment, it is possible that the baby swallows too much air due to bad attachment. Explain to the mother that she, or another family member should keep the baby upright (lying on the person's chest) for some time after the feed.
- Encourage the mother to take the baby in her arms as much as she can, cuddle him, give him kisses, to make him relax, encourage skin to skin contact. If the child is comforted by suckling the breasts, she should let him do this as much as is within her possibilities.
- Discuss with the mother about the child and reassure her on her capacity to find the appropriate solution. Reinforce her positive gestures and observations and encourage her to continue.



Fig. 23: Some ways to help a colic baby; *Breastfeeding, a training course*, WHO/UNICEF, 1993.



THE MOTHER THINKS SHE DOES NOT HAVE ENOUGH MILK

We must be careful, there are 3 main groups of women who will come and say this:

WOMEN WHO KNOW THEY HAVE ENOUGH MILK, BUT THINK ARTIFICIAL MILK IS BETTER OR EASIER; AND WHO COME WITH THIS STORY IN THE HOPE THEY WILL RECEIVE ARTIFICIAL MILK

→ These women must be explained thoroughly about the dangers of artificial milk and why breast milk is so much better. She must be encouraged and motivated to continue to breastfeed and invited to come to the centre/counsellors for further information or counselling.

WOMEN WHO HAVE ENOUGH MILK, BUT HONESTLY THINK THEY DON'T

→ These women have to be supported in identifying the problems and the difficulties they have in breastfeeding. Reassure them on their capacity to produce milk and to breastfeed their babies can be not enough and not useful if they are deeply convinced they can't do it. A specific counselling based on mother beliefs, fears, concerns, etc. should be done.

WOMEN WHO ACTUALLY DO NOT HAVE ENOUGH MILK

Possible causes

- Stress, worry, pain...are temporarily interfering with the milk flow reflex.
- The baby is not suckling enough, because of which the milk production is reduced:
 - The mother does not put the baby to the breast on demand, or takes him off too early
 - The baby has wrong position or wrong attachment, which makes his suckling less effective, and therefore the milk production is insufficiently stimulated
 - Introduction of other food or drinks has made the baby breastfeed less
 - The child is sick or weak and demands the breast less or does not have enough energy to suckle well

If a baby is/has:

- *visibly thin or not gaining weight*
- *not responsive or active*
- *passing urine < 6 times a day AND the baby has breast milk only (this does not count if the baby receives additional liquids)*
- *urine which is dark coloured and strong smelling*
- *not satisfied after he breastfeeds, despite good position and attachment*
- *cries often*
- *has hard, dry or regular green stools*
- *not gaining around 125 g/week*

Or if

- *No milk comes when mother tries to express with correct technique*
- *Breasts did not enlarge during pregnancy*
- *Milk did not 'come in' after delivery*

there is suspicion of insufficient breast milk and action must be taken

Possible solutions

- Help the mother to relax, listen to her story, make her feel at ease, reassure her that she can produce enough milk again, encourage and motivate her.
- Explain that if she puts the baby to the breast as often as possible, and make him suckle as long as he wants, she will produce enough milk again. Encourage her to breastfeed more at night.
- Encourage to keep the baby close to her as much as possible, encourage skin to skin contact, explain her that if she thinks loving thoughts of her baby, this will help to eject more milk.
- Try to identify the problem by observing positioning, attachment and by discussing the feeding practices (length of feed, use of other food...) and explain to the mother why this could cause problems. Suggest solutions accordingly.
- Advise the mother to let the baby drink from both breasts at each feed; but to let him finish one breast before going to the other. Start with a different breast at each feed.
- Advise the mother to express her breast milk manually after each feed, when the baby is finished and satisfied. Taking out more milk will result in a higher milk production. If the mother is worried about losing the milk she expressed, she can keep it for 8 hours at room temperature in a closed container.
- If the baby is less than 6 months old, suggest that the mother reduces the additional feeds or drinks at first, and stops them completely when she feels she is producing more milk.
- Look at the baby's health: is there diarrhoea (more than 3 liquid stools a day), does he have a fever, is he coughing...; if yes, refer him to a health centre for immediate care. If the baby is malnourished; he should be referred to a feeding centre. However, she should still continue breastfeeding. If the baby is too weak, see section... for advice.
- Encourage the mothers' family to let her rest more, ensure that she drinks enough clean water and if possible, has extra food.
- If there is worry for the baby's health due to insufficient breast milk, provide stimulation care with a temporary supplement (see section...).

THE BABY DOES NOT WANT THE BREAST ANY MORE, OR IS RESTLESS AT THE BREAST

Possible causes

- The baby has eaten enough and he doesn't need more breast milk at that specific time.
- The baby is not well positioned or attached and got frustrated because he does not get enough milk.
- The baby's head is being pushed at the back of his head when the mother positions him.
- The use of feeding bottles or teats has made him confused and he is not used to taking the breast anymore (this can happen after one bottle feed).



- The mother is tense and insufficiently relaxed to feed conveniently.
- There has been a change in care: someone else takes care of the baby instead of the mother, and the child is upset by this.
- If it is a new-born baby, it can be due to drugs during delivery or physical pain due to delivery (especially after delivery with forceps or other traumatic delivery).
- Swelling of the breast or engorgement doesn't allow good attachment.
- The baby is in pain due to teething, injury or disease (cold, ear infection...).

Possible solutions

- Observe position and attachment and correct if necessary, try different positions; also try the position in which the mother is semi-reclined and the baby is on top of her.
- Check whether the family has fed the baby with a bottle or has used teats. If so, explain that this might be the cause and encourage the mother not to do so. Encourage her to continue to put the baby to the breast, to make him get used to it again.
- Help the mother to relax, encourage her, motivate her.
- Encourage the mother to take care of the baby herself, to keep him close to her as much as possible, even at night; to talk to him, cuddle him.
- Offer the breast whenever the baby is sleepy or relaxed or after a small cup feed.
- If the baby continues to refuse the breast, show the mother how she can manually express the breast milk, and cup feed it to the baby. She should still try to offer the breast before every cup feed.
- If the breast is too engorged, express some milk before the feed to make the nipple and areola supple to allow a better attachment.

THE MOTHER SAYS SHE CANNOT BREASTFEED HER BABY BECAUSE SHE NEEDS TO GO TO WORK

This is of course a real problem, since many women need to go out to work to provide an income or food, firewood, water etc. for the family. We cannot ask them not to go out to work, as this might be an essential activity for the family. We can help these women to look for the most suitable solutions to maintain optimal infant and young child feeding.

Possible solutions

- See if she can take the baby with her when going out (if culturally accepted), or if she can request her employer that another person takes care of the baby within or in proximity of the workplace; and who can bring the child to her if he's hungry.
- Breastfeed more often at night, in the morning and evening time, when the mother and child are together.
- Teach her how to manually express the breast milk (see further), put it in a closed container

and keep it in the coolest spot in the house. It can be kept in a temperature of around 25°C for 6 to 8 hours, 3 to 4 hours if temperature is up to 29°C. If the temperature is higher, ways to keep it cool are:

- Put it in a fridge if available close by
- Put it on an ice block, if available, in a cooler, or in another container
- Cover it with a wet cloth
- Keep it away from direct sunlight, in a aerated area

The person taking care of the child should be taught how to cup feed the expressed breast milk; bottle feeding is very much discouraged.

If the amount a mother can express at night or in the morning is insufficient, or if there is a worry that the temperature is too high to keep the milk for too long, she can express her milk at work in a clean, closed container, and arrange for it to be picked up and delivered to her house. Expressing her milk during work will also help to keep the breast milk production going.

- If the child is more than 6 months old, the mother can favour breastfeeding as much as possible when she is with the child, and the other caregiver can give the complementary meals to the child when the mother is absent.
- Arrange for someone to pick up expressed milk at the field/place of work and deliver it to the carer of the infant.

THE MOTHER IS INSECURE, FEARS SHE CANNOT BREASTFEED

Possible causes

- The mother is young, first time mother and has never breastfed.
- The mother has lost or been separated from close relatives in the emergency that could otherwise have guided and supported her.
- The mother is stressed, traumatised or in shock.
- The mother has had a previous experience where breastfeeding did not go well, or has lost a child and thinks it might be because of her milk.

Possible solutions

- Listen to the mother's story, let her explain her fears and worries to you.
- Explain to the mother the basic principles of breastfeeding, how it works, how the baby should be positioned, attached, how she can produce enough milk, etc.
- Encourage and motivate the mother; tell her she is doing great and that you will be there to support her.
- Put her in contact with other, more experienced mothers in the centre or in the group, who can help her to gain confidence.



THE BREAST OR NIPPLES ARE PAINFUL, BREASTFEEDING HURTS

Possible Causes

- Painful or cracked nipples are usually due to poor attachment; sometimes due to thrush.
- Engorgement, breasts become too full of milk and tissue fluid and milk cannot flow out easily (not to be confused with normal fullness after the mature milk “comes in”). The breasts look swollen oedematous and shiny and may be a little red.
- Blocked ducts, when the milk is not removed from one part of a breast and forms a hard, tender lump, which may look slightly red; in one place only. The rest of the breast is healthy and the woman is well and has no fever.
- Mastitis, when the milk is not removed effectively, so it stays in the breast. It causes inflammation; which gives the mother fever and pain. The infection can also occur due to an infected sore on the nipple. It can develop into an abscess if not properly treated.

Possible solutions¹

- Observe positioning & attachment and correct if necessary.
- In mastitis, blocked ducts, engorgement; the problem is a stop in milk flow, and the solution is to make the milk flow again; this is best done by continuing breastfeeding, the milk does not make the baby ill, even in case of mastitis; except for known HIV positive women (see later).
- For sore nipples: rub some breast milk on the sore at the end of each feed; it will promote healing; but continue breastfeeding. If the sore is infected, give the mother a vaseline gauze dressing to cover the sore between feeds. If the sore is large and infected, give a systemic antibiotic of a kind that is effective against resistant staphylococci.
- For persistent nipple pain, dry and itchy nipple skin; check the baby’s mouth for white spots (thrush) and his bottom for spotty red rash. Treat the baby’s mouth and bottom with 0,25% solution of gentian violet, and mothers nipples with 0,5%, for 5 days or use Nystatin cream (nipples) and drops (mouth). Encourage the mother to continue breastfeeding.
- For engorged breasts, if the baby cannot attach properly; express some milk by hand to soften the breasts; massage the mothers back while she expresses or feeds to help the milk flow (or let the father do that). Use a warm compress or bathe in warm water and massage the breast before the feed to help the milk flow and use a cold compress after the feed to help to reduce the swelling.
- For a blocked duct, show the mother to gently massage (not too strong) over the lump, towards the nipple while the baby suckles; and show her how to feed in different positions.
- For mastitis, let the baby breastfeed or manually express breast milk and encourage the woman to rest. Give anti-inflammatory analgesics (eg. Ibuprofen) and give an antibiotic effective against resistant staphylococci if there is extensive inflammation and the mother is severely ill, there is a purulent infected nipple sore or if milk removal does not give improvement in 24 hours.

¹ - Based on IFE Module 2, v1.1; IFE Core Group, December 2007.

- If there is an infection of the nipple or areola, bath the breast in salt water (one teaspoon in a cup of lukewarm water) or disinfect with chlorhexidine (never with iodine) and continue breastfeeding. Do not rub breast milk on the nipple for protection, as bacteria will feed on the milk.
- HIV positive women with mastitis, cracked or sore nipples should continue to breastfeed from the non-infected breast and regularly express and discard the milk from the infected breast. If the milk from one breast is not enough to cover the child's needs, the expressed milk should be heat treated (see later) before giving it to the baby. Once the breast has recovered, normal breastfeeding may resume.
- If there is a breast abscess: refer the mother for medical treatment, but encourage her to continue breastfeeding.

FOR MORE INFORMATION ON MASTITIS SEE:

"Mastitis, Causes and Management"; WHO 2000
http://www.who.int/child_adolescent_health/documents/fch_cah_00_13/en/index.html

THE MOTHER BELIEVES HER MILK IS BAD

Possible causes

- Traditional beliefs in curses, acts, activities or actions that can make the milk go bad.
- Emergency beliefs in curses, acts, activities or actions that can make the milk go bad (e.g. tension or grief is passed on to the baby).
- A certain food the mother ate, changed the taste of the milk a little.
- The yellowish colour of the colostrum is believed to be "abnormal".

Possible solutions

- Understand the beliefs and superstitions people believe in, respect them.
- Understand why the mother believes her milk is bad.
- NEVER ridicule women for their beliefs.
- Check whether there are some counter-acts that can make the milk become good again (work together with traditional healers or other knowledgeable people on the subject), such as prayers, offers, ceremonies.
- If it is just a worry, not a real superstition or common belief; reassure the mother that her milk cannot go bad.
- Check what food the mother ate that might have altered the taste; advise her not to eat it or only in small quantities to make the child get used to the taste.

THE MOTHER HAS FLAT OR INVERTED NIPPLES

Small or inverted nipples are less of a problem than people think. Remember that the baby should breastfeed not nipple feed! Raising the subject with unaware mothers might create a self-fulfilling



prophecy, where mothers will then believe they have a problem, whereas otherwise they would breastfeed more relaxed.

It is true that some babies could have some problems attaching correctly, if they do not have the nipple as guidance, but other babies won't have a problem with that.

Therefore, first identify whether the nipple is truly inverted; which few are:

- The nipple does not become stiff when stimulated and does not come out.
- When pressure is put on the areola, they invert inside the breast instead of outside.

Please note that inverted nipples sometimes become soft during pregnancy and come out by the end of the pregnancy.

Possible solutions

- Put the baby to the breast as soon as possible after delivery and give special attention to help with attaching the baby
- Loosen the nipple if the baby does not attach well despite efforts:
 - Place both thumbs on either side of the base of the nipple
 - Press firmly in the breast
 - Move the thumbs towards the outside
 - Make the same movements from a different angle
 - Repeat this 5 times per day
- Use suction to pull out the nipple before the feed, if the above has been unsuccessful:
 - Take a 10 ml syringe
 - Cut the tip off
 - Insert the plunger from the cut end
 - Place the syringe on the areola and gently pull

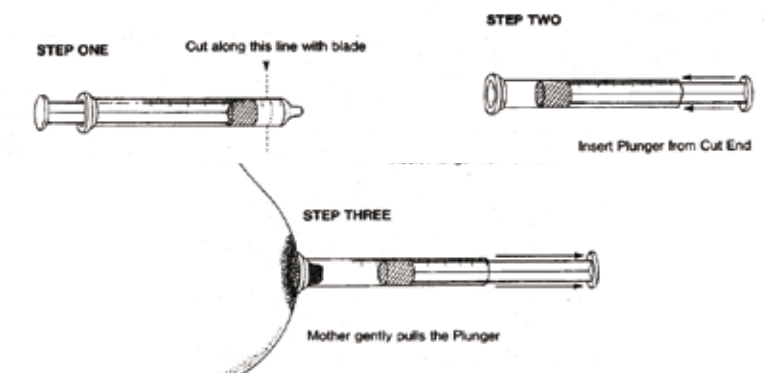


Fig. 24: Using a syringe on an inverted nipple, *Breastfeeding a Counselling Course; WHO/UNICEF 1993.*

THE MOTHER IS DEPRESSED, HAS POST-TRAUMATIC STRESS DISORDER, OR ANOTHER PSYCHOLOGICAL OR PSYCHIATRIC DISORDER

Possible causes

- Traumatic experience (violence, sexual violence, threat to life, etc.)
- Loss of loved ones
- Postpartum depression
- etc.

Possible solutions

- Encourage women to decide on treatment options, the best for them and their babies; involve the mother in the full decision making process
- Provide psychological support as needed
- Encourage family support
- Continue breastfeeding, with support, as breastfeeding can provide an emotional benefit and help the mother through her depression
- Assist the mother as much as possible to produce and eject enough milk, as this may be influenced by the depression or other disorder :
 - Encourage skin to skin contact
 - Encourage feeding at night and on demand
 - Give advice and encouragement for positioning and attachment
 - Build the mothers confidence

If medication is needed, advocate for treatment that is compatible with breastfeeding.

4. COMMON MYTHS AND MISCONCEPTIONS ABOUT BREASTFEEDING



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A MOTHER THAT IS NOT WELL FED OR A MALNOURISHED MOTHER CANNOT BREASTFEED

NO! Even though it is better if the mother is well fed, with food that provides her and her baby with all the necessary nutrients; not being well fed and even malnutrition are not reasons to stop breastfeeding. The mother will continue to produce breast milk. The milk of a severely malnourished mother will contain lower amounts of fat and micronutrients, but her milk still protects the baby from infections. Therefore continuing breastfeeding is essential. The best solution is to prevent or treat malnutrition in the mother, and provide her with guidance and support to continue breastfeeding, rather than switching to breast milk substitutes.

TRAUMA, SHOCK AND STRESS MAKES MOTHERS MILK DRY UP

NO! It is true that the production of oxytocin hormone (see earlier) can be temporarily affected by stress, trauma, worry or pain in some women; but that hormone regulates the milk secreting reflex, not the milk producing reflex. The mother still produces milk. To make the milk flow again, she needs help to relax, to build her confidence that she can breastfeed and advice to put the baby to the breast as often as possible, as long as possible. If the mother is suffering from psychological problems, action must be taken to provide appropriate care for her as well.

A MOTHER CANNOT BREASTFEED TWINS SUCCESSFULLY

NO! A mother can successfully breastfeed two or even three babies. She might need help to position the babies, and even more to build her confidence. She must make all babies suckle on demand and as long as they wish and she will be able to produce enough milk! Monitoring the weight of the babies might help the mother to be reassured that she provides enough food.

WHEN A MOTHER IS PREGNANT WITH A NEW BABY, SHE MUST STOP BREASTFEEDING THE PREVIOUS ONE

NO! Breastfeeding during pregnancy does not represent any harm for the foetus, nor for the child on the breast. It is true that the milk returns to a colostrum state at around 3 to 4 months of pregnancy so there will be less milk and the taste will be saltier. The baby might not like the new taste, but the mother can try to make him get used to the taste. It is true that the colostrum state milk might not cover the infant's needs as the mature milk would, therefore additional quality complementary food might be necessary, but breastfeeding can continue. It is best if the mother can eat good quality food as well and take regular rests.

If there is pain or bleeding from the uterus or a history of preterm deliveries; and the older child can cover its nutritional needs with complementary food it might be necessary to stop breastfeeding; advice should be sought from a midwife or doctor.

IT IS NOT POSSIBLE TO BREASTFEED TWO BABIES FROM A DIFFERENT AGE

NO! It is absolutely possible to breastfeed two babies from a different age, two siblings (an older and a younger one) or your own child and a child who cannot be breastfed by his own mother.

Change breasts per feed for each baby, do not limit one baby to one breast. The mother should be encouraged to drink enough and eat extra food, but even when that is not possible; she can still breastfeed both children.

IF A MOTHER'S BREAST ARE SOFT, IT MEANS THERE IS NO MILK IN THEM, AND SHE CANNOT BREASTFEED

NO! Most mothers' breast soften after a while, but this is not an indication of reduced breast milk production or milk storage. The mother must be reassured and encouraged to continue breastfeeding.

SICK CHILDREN SHOULD NOT BE BREASTFEEDING

NO! Sick children need breast milk even more!!! The high nutritional value will provide them with the energy to fight their disease. Through breastfeeding, the mother's body will recognize the infection and produce specific antibodies that she will give to the baby through the breast milk. The close contact through breastfeeding will make the child feel loved and secure, which will help him to overcome the pain and unpleasantness of his disease. When there is loss of fluid due to diarrhoea, vomiting, fever or other, the child should breastfeed more often to replace the losses.



MOTHERS WHO ARE SICK AND RECEIVE MEDICATION SHOULD NOT BREASTFEED

NO! In most cases, mothers can continue to breastfeed. There are only a limited number of maternal diseases or drugs that indicate the cessation of breastfeeding. This action should only be temporarily until the mother has recovered, and action should be taken to ensure the breast milk production.

GIVING SMALL AMOUNTS OF BREAST MILK PER FEED HELPS YOU TO “SAVE” MILK TO COVER THE REST OF THE DAY

NO! In fact, this will have the reverse effect! If the baby suckles less, the mother's body will produce less milk. If a mother wants to have more milk, she must let the baby suckle as long as he wants and as often as he wants. In addition, taking the baby off the breast in the middle of a feed, will prevent him from drinking the energy rich hind milk. This means he will not get enough energy out of his feed, will be hungry sooner and will cry more often.

IF YOU DON'T HAVE ENOUGH BREAST MILK, YOU MUST GIVE ADDITIONAL DRINKS OR FOOD, EVEN IF THE BABY IS LESS THAN 6 MONTHS OLD

NO! Giving drinks or foods will actually have an adverse effect: the baby will drink less from the breast, which will cause a reduction in milk production. If the mother has a reduced production of breast milk, it is reversible. Encouraging the baby suckle more often and longer will increase her milk production, until she has enough to cover all the needs of the baby. If there is a risk for the nutrition status of the child, a feeding complement can be given by qualified staff through supplementary suckling technique (see later).

IF YOU STOP BREASTFEEDING, YOU CAN NEVER START AGAIN

NO! Any women, having given birth or not, can breastfeed a baby. Stimulating the prolactine or milk producing hormone and the oxytocine or milk secreting hormone, by letting the baby suckle the breast will result in breast milk production. This is called relactation. The shorter the period between the last breastfeed and the relactation, the faster it will go; but it is possible at any time for any woman. Confidence building and encouragement by qualified staff are important to help the mother succeed.

IF YOU DID NOT BREASTFEED OVER SOME DAYS, THE MILK WILL GO SOUR, AND YOU CANNOT GIVE IT TO THE BABY

NO! Breast milk cannot go sour or bad. You can give it to the baby at any time.

LETTING THE BABY SUCKLE FOR TOO LONG CAUSES SORE NIPPLES

NO! The length of a breastfeed does not cause any pain or cracks in the nipples. It is a bad position and/or a bad attachment that causes the soreness.

COLOSTRUM COMES IN SMALL QUANTITIES ONLY, IT IS NOT ENOUGH FOR THE BABY, SO HE NEEDS ADDITIONAL FOOD

NO! It is true that colostrum comes in smaller quantities than mature milk, but it is energy dense, making it sufficient to cover the babies' needs. The baby's stomach at birth is very small and cannot contain a lot of milk at a time. Drinking small quantities of colostrum as much as possible during the day is exactly what he needs.

IT IS NECESSARY TO CLEAN THE BREASTS AND NIPPLES WITH WATER AND SOAP OR DISINFECTANT BEFORE EVERY FEED:

NO! Frequent washing, especially with products removes the natural oil from the nipple and areola, makes the skin dry and consequently easily damaged or fissured. The mother should maintain normal body hygiene, but not wash the breasts before each feed. She should wash her hands before each feed.

WOMEN WITH SMALL BREASTS OR SMALL NIPPLES CANNOT BREASTFEED:

NO! The size and shape of the breast or the nipple does not influence the milk production or the ability to breastfeed. The gland tissue responsible for the milk production lies behind the breast, as such, it is not in relation to the size of the breast. Remember also that the baby breastfeeds and does not nipple feed, therefore the size & shape of the nipple should not matter. It is true that some babies have difficulties taking the breast in the mouth without a protruding nipple, if this is the case, one can help the mother to extract her nipple before feeding. On the other hand, if the nipple is very large, the baby must learn to open the mouth very wide to grasp the breast and not only the nipple.

A DEHYDRATED MOTHER CANNOT BREASTFEED

NO! Even if it is true that the amount of breast milk produced by a dehydrated mother is reduced, it is essential that she continues breastfeeding. Severe and moderate dehydration can be corrected rapidly by using oral rehydration salts or intravenous fluids, or water. The health of the infant should be checked; if the baby passes urine less than 6 times per day, he should receive some ORS by cup feeding in addition to breast milk, until his mothers' dehydration is dealt with.

CHILD CARE PRACTICES AND DEVELOPMENT ARE NOT A PRIORITY IN EMERGENCIES

NO! It is true that water & sanitation, food, shelter and access to medical care are essential needs in emergencies. However they are not the only ones. Child care practices in emergency can be easily compromised due to living conditions, food insecurity, stress, lack of availability of caregivers, etc. This can lead to life threatening diseases and inadequate development. Inadequate development can have consequences for the child's health, motor, intellectual and other capacities later on in life. Focusing on child care practices does not only prevent diseases and mortality on the short term, but also prevents longer term negative effects.



5. SPECIFIC TECHNIQUES FOR BREASTFEEDING: EXPRESSING BREAST MILK, HEAT TREATED BREAST MILK, RELACTATION.

EXPRESSING BREAST MILK

Expressing breast milk¹ is recommended only if necessary. The preferred method to feed a child is from the breast as this will stimulate the milk flow, empty the breast more efficiently and stimulate breast milk production.

However, in some circumstances, it might be necessary to express breast milk:

- To feed a baby who is too weak to suckle,
- To cover the child's needs during an unavoidable separation between mother and child,
- To empty the breast if there is engorgement, mastitis or similar problem,
- To keep the milk production going if the mother cannot breastfeed for a short period (for example if she is taking medication that is not compatible with breastfeeding),
- To empty the breasts after the child has drunk to satisfaction to increase the milk production,
- To donate milk to a child who cannot breastfeed from its own mother.

Expressing breast milk can be done manually, through a hand pump or "hot bottle"-method or with an electrical pump. Since breast pumps and bottle are difficult to clean and thus represent an additional risk of infection; the preferred method in emergencies is manually. This is the most hygienic way, and with some guidance can be as effective as using a pump.

It is important to give sufficient guidance to the women, to make sure they understand and feel comfortable with the technique and to build their confidence. One should therefore:

1. Explain the procedure and its benefits thoroughly
2. Show the mother how to do it and help her the first couple of times, until she feels confident doing it
3. Be patient, encourage and motivate the mother
4. Ask her to come back for follow up to see how she is doing and/or perform home visits
5. Link the mother up with other women who are successfully manually expressing their breast milk

HOW TO PROCEED NEXT

Prepare the mother and the breast:

- Install the mother in a comfortable position in a private area.
- Wash your hands and ask the mother to wash hers.
- Explain the procedure thoroughly.

¹ - For more details, see Annex 3 on "Infant Feeding in Emergency, Module 2, version 1.0, 2004"

- Help the mother to relax by doing some relaxation exercises.
- Let the mother drink a warm drink, like herbal tea (not coffee).
- Apply a warm compress on the breasts.
- Ask the mother how to massage the breast, making round movements over the breasts.
- Ask the mother to knead, stroke or roll the nipples gently, so it does not hurt.
- Massage the mothers back or ask the father or a friend to do so.

PREPARE THE CUP

- Choose a cup with an big opening (which is easy to clean), preferably with a screw lid (so it can be closed properly for storage); preferably glass.
- Wash it properly with water and soap.
- Pour boiling water into the cup to kill all germs, leave it for a few minutes and throw it away when the mother is ready.

EXPRESS THE MILK

- Put her thumb on her breast ABOVE the nipple and areola, and her first and second finger.
- On the breast BELOW the nipple and areola, opposite the thumb; around 2,5 - 4 cm behind the nipple. The fingers should be where the upper and lower lip of the baby are usually positioned. She supports the breast with her other fingers.
- Press her thumb and first two fingers slightly inwards towards the chest wall, not spreading the fingers and not squeezing too hard on the breast.
- Roll the thumb and two first fingers forward, gently pressing the milk ducts; towards the nipple.
- Continue to press and release, press and release, with the same rhythm as with which the baby drinks.
- This should not hurt, if it hurts, the technique is wrong.
- At first no milk may come, but after pressing a few times, milk starts to drip out. It may flow in streams once the oxytocin reflex is active.
- Press the areola in the same way from the SIDES, to make sure that milk is expressed from all segments of the breast.
- Avoid rubbing or sliding her fingers along the skin. The movement of the fingers should be more like rolling.
- Avoid squeezing the nipple itself. Pressing or pulling the nipple cannot express the milk. It is the same as the baby sucking only the nipple.
- Express one breast for at least 3 - 5 minutes until the flow slows; then express the other side; and then repeat both sides. She can use either hand for either breast, and change when they tire.
- Explain that to express breast milk adequately takes 20 - 30 minutes, especially in the first few days when only a little milk is produced. It is important not to try to express in a shorter time.



- Explain she should express as often as the baby feeds, around 8 times per day or more. Later on, when larger quantities of milk are produced, the frequency may be less.

ENCOURAGE AND MOTIVATE THE MOTHER

- Explain that it is normal if little or no milk comes at first, she should persist and milk will come.
- The first time she tries it might not work very well, but if she does it regularly, she will get used to the technique and she will be able to express more milk with less efforts.
- It is normal that colostrum can only be expressed in small quantities; this is still enough for the baby, as long as he can eat it regularly.
- The quantities of mature milk should not be compared to quantities of formula milk, you will need less breast milk per feed as the quality of breast milk is superior.

GIVE ADVICE TO IMPROVE THE MILK FLOW DURING MANUAL EXPRESSION

- Keep the baby close in skin to skin contact.
- If the baby is not present, take some of his used clothes and smell them or think loving thoughts of your baby.
- If the woman has plenty of milk, she can express from one breast while the child is suckling the other (if it is feasible with positioning), or immediately after the child drank.
- Express at night.
- Help the milk flow by pressing the breast, to help to empty the milk ducts.

STORE THE MILK APPROPRIATELY

- Make sure the container is closed well.
- If different containers are kept together, make sure the one that was expressed first, is used first.
- Put it in the coolest place in the house:
 - A fridge OR
 - A coolbox with an ice block OR
 - On an ice block OR
 - Covered in a wet cloth; away from the sun

Expressed breast milk in a clean, closed container is protected against bacterial infection due to its particular contents. It actually has less bacteria after some time at room temperature or in the fridge than just after expressing.

The time you can keep expressed breast milk as shown below is based on the recommendations of the Academy for Breastfeeding Medicine; however other sources indicate different storage times. Colostrum can be kept up to 12 hours at room temperature up to 32°C. Storing in the freezer is also possible for a long period (if the freezer works correctly and continuously), but it can affect the immunological value of breast milk.

Room temperature 25-30° C	3-4 hours	Cover with a wet towel
Room temperature up to 25° C	6 - 8 hours	Cover with a wet towel
Cooler with ice 4° C	24 hours	Keep ice in contact with container, limit opening cooler
Fridge 4° C	5 days	Store milk in the back of the main body

Fig. 25: Storage duration of fresh breast milk.

It might be necessary to give appropriate containers to mothers for whom it is recommended to use expressed breast milk

Explain how to use the milk to feed the child:

- Take the oldest container first
- Take the quantity the child will drink
- The milk may have separated into a milk layer and a cream layer. This is normal. Swirl it gently to redistribute the cream before giving it to baby
- There is no need to heat the milk, one can let it come to room temperature if one wishes; never boil the milk or put the container in boiling water! Do not use a microwave
- Use the container as a cup, or put the quantity of milk the child needs in a clean cup (washed with clean water & soap and boiling water poured into it; then throw the water away)
- Cup feed the baby, do not bottle feed (see later)
- Immediately clean the container and the cup with clean water & soap and let it dry in the sun

HEAT TREATED BREAST MILK

WHO¹ positioned the approach of heat treated expressed breast milk as an 'interim' strategy to assist mothers over specific periods of time rather than for the full duration of breastfeeding.

Mothers known to be HIV-infected may consider expressing and heat-treating breast milk as an interim feeding strategy:

- in special circumstances such as when the infant is born with low birth weight or is otherwise ill in the neonatal period and unable to breastfeed; or
- When the mother is unwell and temporarily unable to breastfeed or has a temporary breast health problem such as mastitis; or
- To assist mothers to stop breastfeeding; or
- If antiretroviral drugs are temporarily not available.

1 - WHO, UNICEF, UNFPA, UNAIDS, (2010) Guidelines on HIV and Infant Feeding.

Advantages and disadvantages of expressing and heat-treating breast milk

Advantages

- HIV is killed by heating the milk.
- Breast milk is the perfect food for babies, and most nutrients remain in breast milk after heating.
- Breast milk is always available, and you do not have to buy it.
- Other responsible family members can help feed the baby.

Disadvantages

- Although heated breast milk does not contain HIV, it may not be as effective as unheated breast milk in protecting the baby from other diseases. However, it is still better than formula.
- Expressing and heating breast milk takes time and must be done frequently. It can be hard to do for a long time.

Disadvantages

- The baby will need to drink from a cup. Babies can learn how to do this even when they are very young, but it may take time to learn.
- The breast milk needs to be stored in a cool place and used within an hour of heating because it could spoil.
- You will need clean water and soap to wash the baby's cup and the container used to store the breast milk.
- You will need fuel to heat the breast milk.
- People may wonder why you are expressing your milk, which could cause them to suspect that you have HIV.

Fig. 26: Advantages and disadvantages of heat treated breast milk; HIV & Infant Feeding Counselling tools reference guide, WHO, 2005.

If this is the woman's chosen option - after having discussed all the options and assessed her situation - discuss with her ways of overcoming possible obstacles:

- How will she find the time to express and heat-treat her breast milk several times each day and night?
- How will she get reliable supplies of water, soap and fuel?
- How will she store the breast milk?
- How will she cope with peer pressure to breastfeed?

Thoroughly train the mother and other caregivers on the heat treatment , using manually expressed milk:

- Before heat-treating milk, gather the following things:
 - Clean containers with wide necks and covers, enough to store the milk
 - A small pot to heat the milk, such as an enamel cup
 - A large container of cool water
 - Fuel to heat the water
 - Soap and clean water to wash the equipment
- Follow these steps to heat-treat and store milk:
 - Wash all of the pots, cups and containers with soap and water.
 - Heat your milk to the boiling point and then place the small pot in a container of cool water so that it cools more quickly. If that is not possible, let the milk stand until it cools.
- But remember, only boil enough expressed milk for one feed. Store it in a clean, covered container in a cool place and use it within 1 hour.

RELACTATION

Relactation means re-establishing breastfeeding, where there is no or not enough milk production. This can be with:


- A mother who stopped breastfeeding and wishes to start again,
- A breastfeeding mother with insufficient milk production, and the use of a BMS in temporarily indicated ,
- A wet-nurse for a child who cannot be breastfed by its mother: a grandmother, an aunt or any other women from the community willing to take on this task; it does not have to be a women who gave birth or gave birth recently, yet the chances of success are greater when less time has passed since the last lactation period.

Please note that many of the tips given here can be used as well to stimulate breast milk production without the use of BMS.

To succeed, 3 basic conditions must be present:

- Motivation of both the woman and the staff





helping her; if the woman is insufficiently motivated, she will need more support and encouragement to become so.

- Stimulation of the breasts, preferably done by an infant suckling; in order to release prolactin and therefore start or increase milk production.
- Support must be given by counsellors by helping out, encouraging the woman and building her confidence. The woman will also need support from her family to succeed.

First of all, the woman and her family should be informed of:

- The benefits of breastfeeding as opposed to the risks of artificial feeding.
- The process of relactation; what will be expected, how it will be done, how long it may take, etc.
- The effort and motivation it will take from the woman and her family.

Experience has proven that women are more motivated to relactate if they have seen other women doing it. Therefore, if possible bring these women into contact with other women who have relactated successfully in the past; for peer to peer education, encouragement and motivation

The decision should be taken in agreement with the woman, her family and the counsellor.

If the child is still breastfeeding, it can work within some days. If the woman has fully stopped, or has not been breastfeeding this child it might take 1 to 2 weeks to start producing milk and up to one month to produce enough to breastfeed exclusively. If there is less time between the last breastfeed and the relactation, it will go faster. The woman must not despair if it doesn't succeed at first, but be encouraged to persevere.

Factors that will help succeed relactation:

- Close contact, if possible skin to skin, between the woman and the child as much as possible, she should sleep with him, hold him, cuddle him, use kangaroo care (see later)...
- Rest and relaxation for the woman, request the family to relief her from some tasks, if possible,
- Adequate nutrition and lots of clean water for the woman, but if that is not available, relactation can still be successful,
- Suckling the breast as often as possible, as long as possible,
- Avoid oestrogen containing contraceptives and thiazide diuretics,
- Avoid smoking just before the feed or smoking altogether.

→ *These factors help to succeed, however it does not mean one cannot succeed if they are not present!*

When artificial milk supplements must be given (see paragraphs below), this must be done so while stimulating production as much as possible. Techniques to do so are the supplementary suckling technique and the drop and drip method.

- **Supplementary Suckling Technique**

- Cut the tip of a nasogastric tube, gauze 5 or 8 and tape it next to the nipple of the woman, so the tube opening is next to the nipple opening.
- Put the other end of the tube in a cup with the milk supplement, and hold the cup at breast level at first, slightly higher if the child is not suckling well, lower if it does.
- Put the baby to the breast and let him suckle (remember positioning and attachment): by suckling the breast, the child will receive the milk from the cup. However, the fact that he suckles the breast will stimulate prolactin and oxytocin production in the mother, and will help to produce and let flow the breast milk.



Fig. 27: supplementary Suckling Technique.

If the milk flow is too strong, lower the cup, make a knot in the tube or put a paperclip on it. Slowing down the milk flow makes the child suckle longer, and therefore there will be more stimulation and prolactin should be produced quicker.

The mother will need help and support to do this, especially the first couple of times.

Cup and tube must be washed and sterilised after each feed. If the woman does not have the tools or skills to do this at home; this practice should be done in the centre only. The mother can come during the day and practice other ways of stimulation at night or if there is an in-patient facility, she can be admitted for some days.

- **Drop and Drip method**

- Put the baby to the breast (positioning & attachment!).
- Drip milk from a cup or container slowly, drip by drip on the breast, the baby can suckle the breast and the milk drops.

The woman will need help with this technique.

If the child is well attached and suckling, the milk does not flow so easily into its mouth. It is therefore a good technique to get the child interested in suckling the breast; less if the child is already suckling well.


It is possible to perform this technique at home.



Fig.28: drop & drip technique, IFE Module 2 v1.1; IFE Core Group.

- **Stimulation and cup feeding**

- Put the infant to the breast frequently, as often as he is willing, every one to two hours is possible, 8-12 times a day; including at night.
- Let the infant suckle on both breasts, for as long as possible until the child refuses to continue even if there is no milk yet.
- Ensure that the child is well positioned and well attached, so his suckling is effective stimulation.

- 
- Cup feed the child only after having put him to the breast; never use a bottle as this might cause nipple confusion; and will cause more difficulties to put the child to the breast.

Full stimulation of breasts is usually all that is needed; the use of drugs to increase low breast milk production is rarely necessary. It is not sure how lactogogues (drugs that increase breast milk production) help when breastfeeding has stopped completely. However, there is risk of dependency, risk of reducing support and stimulation if used and may have some side effects.

The amount of supplement to give, if the mother has little or no breast milk production; depends on the body weight of the child:

- 150 ml/kg body weight/day,
- divided into 6-12 feeds per day, depending on the child's age and condition (small or weak children need to be fed more often; with smaller amounts)
- artificial milk (infant formula, home modified animal milk or other; see later) or expressed breast milk

When the breast milk production starts:

- Reduce the supplement with 50ml; spread over the day (eg. Reduce 5 meals with 10ml per meal).
- Continue with this amount of milk for some days and observe the child.
- If the child seems satisfied after each meal, shows no signs of hunger and/or gains weight of more than 125 g/week; reduce the supplement by the same amount.
- Keep reducing the supplement until it can be stopped completely. Follow the mother/caregiver and child closely once supplements are stopped to ensure the child remains in good health.
- If the child shows signs of hunger, does not seem satisfied after a meal and/or gains less than 125 g/week; increase the supplement to what it was before the reduction, and try to stimulate the breasts more.

Explain thoroughly to the mother or caregiver what quantities she has to give at home and the importance of hygiene (see below).

FOR MORE INFORMATION SEE:

“Breastfeeding Counselling, a training course”, WHO/UNICEF, 1993,

http://www.who.int/child_adolescent_health/documents/who_cdr_93_3/en/index.html or “IFE Module 2, v 1.1”, IFE Core Group, 1997

<http://www.enonline.net/resources/4>

and “Relactation Review” WHO, 1998

http://www.who.int/child_adolescent_health/documents/who_chs_cah_98_14/en/ for more information on relactation

6. ADVICE FOR CARE OF INFANTS AND YOUNG CHILDREN IN HEALTH FACILITIES

Infants of less than 6 months old can be admitted in health facilities for acute malnutrition or for health problems. The following advice can be useful in these cases in order to optimize the treatment and the recovering of the child.

- Sick infants will demand less feeding or feed for shorter period during a feed, because of lack of energy and lack of appetite. Yet they need the breast milk to fight the disease (both energy and immunological protection). Mothers should be encouraged to put the baby to the breast more often, even if the child is not asking for it.
- If infants are admitted who are too weak to suckle; mothers can be taught how manually express her breast milk, which can then be given by cup, syringe or feeding tube. If the child is temporarily not receiving food, the mother should still be encouraged to manually express her milk, so she can maintain her breast milk production and continue to feed the child breast milk when feeding is possible again.
- If mothers of infants are admitted, infants should be allowed to remain with them so that breastfeeding can continue; mother and child should be separated from other infectious patients. If the child cannot remain with the mother, she should be allowed to express her milk manually, so that a family member can pick it up and cup feed it at home to the child. If the mother is too weak to express her milk herself; health staff should help her do it or teach a family member to do it.
- Kits of toys should be available in the health structures in order to support the health staff and the mother to stimulate the child. In most of emergency context, Early Child Development kits are available (Unicef ECD Kit).



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- Mothers who are injured or received surgery, must be helped to find positions in which they can adequately breastfeed their baby.
- Doctors and nurses should prescribe as much as possible medication that is compatible with breastfeeding, or do not risk to present any danger.
- If medical treatment that is not compatible with breastfeeding is essential or the medical condition of the mother justifies temporary avoidance of breastfeeding (such as a herpes infection, for example), the infant can be temporarily put on a BMS; yet the mother must be helped to continue to express her milk manually and discard it, in order to keep breast milk production up. This way she can continue breastfeeding again as soon as is indicated.
- Mothers of breastfed infants and young children who are receiving treatment for severe acute malnutrition, should be encouraged to put the baby on the breast and let him suckle for as long as possible, in between or before therapeutic milk or RUTF feeds.
- Infants of less than 6 months old admitted for acute malnutrition should be fed by supplementary suckling technique ONLY, in order to stimulate or maintain breast milk production. Therapeutic milk should be reduced when breast milk production increases and the child is strong enough to suckle.

FOR MORE INFORMATION SEE:

“Acceptable Medical Reasons for use of BMS” WHO 2009

http://www.who.int/child_adolescent_health/documents/WHO_FCH_CAH_09.01/en/index.html and “Breastfeeding

and “maternal medication” WHO/UNICEF 2002

http://www.who.int/child_adolescent_health/documents/55732/en/index.html

for more detailed information and maternal drugs and medical conditions in relation to breastfeeding.

FOR MORE INFORMATION SEE:

“Management of Severe Acute Malnutrition”, ACF or Management of Acute Malnutrition in Infants, ENN, CIHD, ACF, UNICEF/IASC Nutrition Cluster, 2010
<http://www.enonline.net/research/mami>



VI. INFANT AND YOUNG CHILD FEEDING AND HIV IN EMERGENCIES

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HIV and infant and young child feeding is a much debated subject. New research and experiences fine-tune and adapt guidelines and recommendations continuously. The following text is based on the WHO 2010 guidelines¹; but it is recommended to follow any new developments and adapt guidelines, training and activities accordingly. Please also check national guidelines on HIV in the country you are working in.

The prevention of mother to child transmission of HIV through breastfeeding must be balanced with the nutritional requirements of the child, as well as with the protection against other causes of morbidity and mortality. All HIV infected mothers should receive clear, complete and easy to understand information on the different IYCF feeding options that would be recommended in her particular situation and make an informed choice herself. Whatever choice she makes, she should be supported in it.

Figures 29 and 30 show the risk of transmission of HIV from mother to child during pregnancy, labour, birth and breastfeeding, with or without preventive action (preventive action being single dose of nevirapine and exclusive breastfeeding for the first 6 months). The majority of children are not infected. From those who are infected, the majority are infected during pregnancy, labour and birth. The risk of infection can be significantly reduced with preventive ARV treatment.



Fig. 29: Risk of HIV transmission mother to child without preventive action, based on prevailing evidence June 09 Integration of IYCF Support into CMAM IFE Core Group, ENN, IASC, October 2009; Adapted from De Cock KM et al. Prevention of mother-to child HIV transmission in resource-poor countries: translating research into policy and practice. *Journal of the American Medical Association*, 2000, 283(9): 1175- 1182.

Fig. 30: Risk of HIV transmission mother to child with ARV, based on prevailing evidence June 09 Integration of IYCF Support into CMAM IFE Core Group, ENN, IASC, October 2009; Adapted from Coovadia et al (2007). Mother-to child HIV transmission of HIV-1 infection during exclusive breastfeeding in the first six months of life: an intervention cohort study. *Lancet* 2007; 369: 1107-16.

1 - WHO, UNICEF, UNFPA, UNAIDS (2010). Guidelines on HIV and Infant Feeding.

The current recommendations are:¹

- Ensure that mothers receive the care they need with lifelong ART or ARV prophylaxis
- Mothers known to be HIV-infected (and whose infants are HIV uninfected or of unknown HIV status) should **exclusively breastfeed their infants for the first 6 months of life**, introducing appropriate complementary foods thereafter, and continue breastfeeding for the first 12 months of life. Breastfeeding should then **only stop once a nutritionally adequate and safe diet** without breast milk can be provided.
- Mixed feeding, including water, increases the risk of transmission² as well as the risk of morbidity and mortality
- Nutritionally adequate, means sufficient in quality and quantity
- Mothers known to be HIV-infected who decide to stop breastfeeding at any time should stop gradually within one month. Mothers or infants who have been receiving ARV prophylaxis should continue prophylaxis for one week after breastfeeding is fully stopped. Stopping breastfeeding abruptly is not advisable
- When mothers known to be HIV-infected decide to stop breastfeeding at any time, infants should be provided with safe and adequate replacement feeds to enable normal growth and development:

Mothers known to be HIV-infected should only give infant formula milk as a replacement feed to their HIV-uninfected infants or infants who are of unknown HIV status, when specific conditions are met:

- **safe water** and sanitation are assured at the household level and in the community; and
- the mother, or other caregiver can reliably provide sufficient infant formula milk to support normal growth and development of the infant; and
- the mother or caregiver can prepare it cleanly and frequently enough so that it is safe and carries a low risk of diarrhoea and malnutrition; and
- the mother or caregiver can, in the first six months, exclusively give infant formula milk; and
- the family is supportive of this practice; and
- the mother or caregiver can access health care that offers comprehensive child health services.

Mothers known to be HIV-infected may consider expressing and heat-treating breast milk as an interim feeding strategy:

- in special circumstances such as when the infant is born with low birth weight or is otherwise ill in the neonatal period and unable to breastfeed; or
- when the mother is unwell and temporarily unable to breastfeed or has a temporary breast health problem such as mastitis; or
- to assist mothers to stop breastfeeding; or
- if antiretroviral drugs are temporarily not available.

1 - WHO, UNICEF, UNFPA, UNAIDS (2010). Guidelines on HIV and Infant Feeding.

2 - WHO, HIV and Infant Feeding Technical Consultation Held on behalf of the Inter-agency Task Team (IATT) (2006, October 25-27). Consensus statement on Prevention of HIV Infections in Pregnant Women, Mothers and their Infants, Geneva.



If infants and young children are known to be HIV-infected, mothers are strongly encouraged to exclusively breastfeed for the first six months of life and continue breastfeeding as per the recommendations for the general population, that is, up to two years or beyond.

Evidence demonstrates that heat treatment of expressed breast milk from HIV-infected mothers, if correctly done, inactivates HIV¹. Furthermore, the methods of heat treatment do not appear to significantly alter the nutritional or not completely destroy the immunological composition of breast milk. Breast milk treated in this way should be nutritionally adequate to support normal growth and development. For these reasons, heat treatment of expressed breast milk from mothers known to be HIV-infected could be considered as a potential approach to safely providing breast milk to their exposed infants. However, its acceptability and sustainability at scale as an infant feeding strategy to improve HIV-free survival has not been proven. It is not recommended to use this approach for all HIV-infected mothers who wish to breastfeed. More data is needed from a range of settings to understand what is required from health systems to effectively support mothers in this approach, and evidence is also needed to demonstrate that mothers can sustain adhering to the method over prolonged periods of time.

The WHO positioned this approach as an 'interim' strategy to assist mothers over specific periods of time rather than for the full duration of breastfeeding.

In emergencies, the following can happen:

- Programmes providing ART or ARV drugs and other medical care can be disrupted.
- Provision of replacement feeding; through donation or through purchase by the family; can be disrupted.
- Hygiene and sanitation conditions can have seriously deteriorated.
- Utensils, fuel and other items necessary for the adequate and safe preparation of replacement feeding can be lost.
- Adequate and safe nutritional complementary food might be insufficiently available.
- Time of the mother or caregiver and support available through family and community can be seriously reduced.
- PMTCT programmes in countries with a high risk of emergencies (natural catastrophe, war & violence, displacement, drought...) must take this into consideration when counselling mothers in normal times!

What consequences does this have for IYCF-E interventions?

- Children born to HIV+ mothers who were using replacement feeding before the emergency and whose provision is disrupted, must be provided with a BMS, as well as advice, support and encouragement. Special attention must be given to education on hygiene during storage, handling, preparation and giving of the BMS in the deteriorated living conditions (see chapter on non-breastfed infants for further information).

1 - WHO, (2009) Rapid advice: infant feeding in the context of HIV.

- Children born to HIV+ mothers who were breastfeeding before the emergency must be counselled, encouraged, supported and motivated to continue breastfeeding according to the above mentioned recommendations, as switching to mixed feeding increases the risk of HIV transmission.
- Children born to HIV+ mothers after the start of the emergency must be advised on the different feeding options in emergency. Exclusive breastfeeding for the first 6 months and continued breastfeeding after are strongly recommended as they will represent the best chance of survival for the infant in emergency.
- Actions must be undertaken to provide nutritionally adequate and safe complementary food for infants and young children. HIV+ mothers must be encouraged to continue breastfeeding infants and young children over 6 months old as long as complementary feeding is suboptimal.
- Action must be undertaken to advocate for the provision of ART or ARV as necessary for HIV+ mothers as quickly as possible.

Special attention must be given to the way care practices staff deals with HIV+ mothers to avoid any stigma.

All the above mentioned guidelines are only a selection of information and a summary. Further background reading, as well as counselling training, is essential if IYCF-E activities take place in an area with high HIV prevalence!





VI. MANAGEMENT OF UNSOLICITED & UNMONITORED DISTRIBUTIONS OF BMS





1. INTRODUCTION

Breast milk substitutes in emergencies have the potential to be even more dangerous than in normal situations due to lack of hygiene in storage, preparation & administering, lack of utensils and lack of longer term availability of age & language appropriate products. But most importantly it is the loss of immunological protection, optimal nutritional value and emotional well-being at a time where there is a higher risk of infection, reduced availability of quality complementary food and a higher risk of emotional problems. There is proof that unsolicited and unmonitored distributions of BMS leads to an increase in morbidity and mortality¹.

Despite the presence of international policies, extensive awareness raising and training of key staff, unsolicited, unmonitored and untargeted distribution of BMS, bottles and teats in emergencies continues.

Unsolicited means that the distribution has taken place without there being an indication of need for this distribution, untargeted that it is given to all children and there is no individual follow-up of the child to whom the BMS or other items are given. These types of distributions leads to breastfeeding mothers switching fully or partially to a BMS; whereas otherwise they would continue breastfeeding; which in turn can lead to an increase in morbidity and mortality due to dilution with unsafe water, insufficient hygiene in preparation and because of the loss of immunological factors found in breast milk. The use of BMS can lead to a reduction or a halt in breast milk production; which then makes this family dependant on a product they sometimes cannot afford or is not available. Incorrect dilutions and insufficient feeds, due to lack of training of the family in the preparation, incomprehension of the label because of illiteracy or foreign language on the label, or the goal to “make the tin last as long as possible”; as well as age-inappropriate formulas lead to inappropriate feeding of the child, and ultimately to malnutrition.

Experience has also shown that distributions of milk products destined for older children or for adults (such as “coffee milk”) are often used for infants and young children as a breast milk substitute as well when they are inappropriate for them.

Bottles and teats in emergencies are difficult to clean and sterilise and represent an additional hygiene risk. On top of that they can cause “nipple confusion” with the children, risking to compromise successful breastfeeding even more.

Still such distributions happen because:

- There is media attention given to infant and young child feeding problems, without providing the correct information as to what the appropriate response should be.
- There is a common misconception that children in emergencies need milk products, bottles and teats.

¹ - Adhisivam, B. and al. (2006, August 17). Feeding of Infants and Young Children in Tsunami Affected Villages in Pondicherry. Indian Paediatrics, 43.

- There are calls for donations for BMS & bottles by insufficiently aware government bodies, NGO's, charities, health care facilities.
- They are done by people with good intentions, but who are insufficiently aware of appropriate responses.
- They may be done as a marketing strategy by manufacturers.

2. THE INTERNATIONAL CODE OF MARKETING OF BREAST MILK SUBSTITUTES

The Code is a set of recommendations to regulate the marketing of breast-milk substitutes, feeding bottles and teats, formulated in response to the realization that poor infant feeding practices were negatively affecting the growth, health and development of children, and were a major cause of mortality in infants and young children. The 34th session of the World Health Assembly (WHA) adopted the International Code of Marketing of Breast-milk Substitutes in 1981 as a minimum requirement to protect and promote appropriate infant and young child feeding and in subsequent years has been further clarified and updated with further resolutions.

The Code aims 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 breast-milk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution"* (Article 1). The Code advocates that babies be breastfed and if they are not, for whatever reason, that they be fed safely on the best available nutritional alternative.

FOR MORE INFORMATION SEE:

"International Code for Marketing of Breast milk Substitutes" WHO, 1981
<http://www.who.int/nutrition/publications/infantfeeding/9241541601/en/>
 and "Frequently Asked Questions" WHO 2008
http://www.who.int/child_adolescent_health/documents/924159-0292/en/index.html

The Code applies to the marketing and related practices of the following products: breast-milk substitutes, including infant formula; other milk products, foods and beverages, including bottle-fed complementary foods; feeding bottles, and teats. It also applies to their quality and availability, and to information concerning their use.

The Code is an important part of creating an overall environment that enables mothers to make the best possible feeding choice, based on impartial information and free of commercial influences, and to be fully supported in doing so.

The main points of the Code are¹:

- No advertising of breast milk substitutes to the public
- No free samples to mothers
- No promotions in shops
- No gifts to mothers

1 - WHO (2008). International Code for Marketing of BMS - Frequently Asked Questions.



- No free or low cost supplies in health facilities
- No promotion in health care facilities
- No gifts or personal samples to health workers; health workers should not pass samples on to mothers
- No pictures of infants, or other words or pictures idealising artificial feeding, on labels
- Information on artificial feeding should explain benefits & superiority of breastfeeding, & costs & dangers of artificial feeding
- Information to health workers should be restricted to scientific and factual information

So, the Code does not restrict the availability of BMS, feeding bottles or teats, only how they are marketed. It does not prohibit the use of BMS during emergencies, only the way in which they are procured and distributed.

The IFE Core Group¹ created the “Infant and Young Child Feeding in Emergencies Operational Guidance for Emergency Relief Staff and Programme Managers”; which assists with the practical application of key guidance documents on IYCF, including the international Code, and provides concise, practical (but not technical) guidance on how to ensure appropriate infant and young child feeding in emergencies. It has been endorsed by the World Health Assembly.

FOR MORE INFORMATION SEE:

For more information: read the full “Infant and Young Child Feeding in Emergencies Operational Guidance for Emergency Relief Staff and Programme Managers” IFE Core Group, V2.1; February 2007
<http://www.ennonline.net/resources/6>

Regarding BMS, the Ops Guidance on IYCF-E emphasizes the following:

- **In emergencies, donations of BMS are not needed and may put infants' lives at risk.** This information should be provided to potential donors (including governments and the military) and the media, both in the emergency preparedness phase and especially during the early phase of an emergency response.
- **Soliciting or accepting unsolicited donations of BMS should be avoided.** Instead, interventions to support artificial feeding should prepare a budget for the purchase of BMS supplies along with other essential needs to support artificial feeding, such as fuel, cooking equipment, safe water and sanitation, staff training, and skilled personnel.
- **Any donations of BMS, milk products, bottles and teats that have not been prevented should be collected by a designated agency,** preferably from points of entry to the emergency area, under the guidance of the co-ordinating body. These should be stored until UNICEF or the designated nutrition co-ordinating agency, together with the government if functional, develops a plan for their safe use or their eventual destruction.
- **Infant formula should only be targeted to infants requiring it,** as determined from assessment by a qualified health or nutrition worker trained in breastfeeding and infant feeding issues. Assessment should always explore the potential for wet nursing or donated expressed breast milk.
- **Labels of procured infant formula should be in an appropriate language and should adhere to**

1 - An inter-agency collaboration concerned with the development of training materials and related policy guidance on infant and young child feeding in emergencies.

the specific labelling requirements of the International Code.

- **BMS, milk products, bottles and teats should never be part of a general or blanket distribution.** Dried milk products should be distributed only when pre-mixed with a milled staple food and should not be distributed as a single commodity. Dried milk powder may only be supplied as a single commodity to prepare therapeutic milk (using a vitamin mineral premix such as therapeutic CMV) for on-site therapeutic feeding.
- **Provision of single tins (samples) of BMS to mothers should not occur, unless that tin is part of an assured continuous supply of formula.**
- There should be no promotion of BMS at the point of distribution, including displays of products, or items with milk company logos and BMS supplies should not be used as a sales inducement.

3. ACTIVITIES TO IMPLEMENT THE “OPERATIONAL GUIDANCE ON IYCF-E”

PREVENTION OF INAPPROPRIATE BMS, BOTTLES AND TEATS DONATIONS

Prevention is better than cure; therefore preventing unsolicited and unmonitored distributions or their negative impact is better than having to deal with the consequences after the fact.

Actions should be taken in agreement with or by coordination bodies, but ACF teams should play an active role within these bodies.

1. ADVOCATE FOR A JOINT STATEMENT ON SUPPORT FOR APPROPRIATE IYCF-E PRACTICES

A joint statement, raising awareness on the importance of breastfeeding and the negative effects of inappropriate actions, such as unsolicited, untargeted and unmonitored distributions of BMS and other milk products; should be designed specifically for the emergency; preferably in collaboration with the Ministry of Health, and signed by relevant actors (WHO, UNICEF, WFP, NGO's). This will help to raise awareness among other actors in the emergency. If it originates from the country's Ministry of Health, it will send a much stronger message, and will help to reinforce its contents. Distribute this statement to as many agencies as possible.

FOR MORE INFORMATION SEE:

read the full “Infant and Young Child Feeding in Emergencies Operational Guidance for Emergency Relief Staff and Programme Managers” IFE Core Group, V2.1; February 2007
<http://www.ennonline.net/resources/6>

2. LINK UP WITH OTHER COORDINATION BODIES FOR ADEQUATE ACTIONS:

- **Logistics Cluster:** the logistics cluster helps various agencies with shipment and importation of their goods in emergencies. If the logistics cluster collaborates with the nutrition cluster, one can come to an agreement where shipments that include BMS, bottles or teats are not dealt with, unless cleared by the nutrition cluster. This way, shipments containing those items can be blocked, returned or dealt with to use the contents in a responsible way before or as soon as they enter the country. Ensure they have copies of document to explain their actions to concerned agencies.



- **Food Aid Cluster:** sensitizing the cluster coordinator and its members of the food aid cluster can prevent BMS, bottles or teats being part of general food distributions.
- **Health Cluster:** through the health cluster you can reach many agencies working in primary and secondary health care; where inappropriately targeted distributions of BMS and bottles happen. You can work together to offer awareness raising sessions or trainings to health staff on the benefits of breastfeeding and all the possible solutions. You can also raise awareness on the existence of the IYCF-E programmes, where people can get expert advice or refer infants and young children. Provide them with all necessary documentation, as well as with a list of referral sites and contacts.
- **Child Protection Cluster:** the child protection cluster deals, among others, with orphans, abandoned or separated children and residential care facilities, and will be in contact with agencies wanting to provide aid and care to this group of children; which often includes BMS and bottles as well. A collaboration between nutrition and child protection will be necessary to provide appropriate responses, to orphaned children within families as well as children in orphanages (see higher).
- **Reproductive health subcluster:** through this group one can reach organisations and settings that deal with prenatal and delivery activities and ensure that breastfeeding is supported and inappropriate use of BMS does not occur.
- **Religious leaders, charities, etc.:** smaller charities, religious groups etc. are often active in emergencies, yet might not be aware of the cluster coordination, or do not have the human resources to participate. They are often not aware of the risks of BMS, bottles and teats distributions. Awareness raising among these groups, can be very important in preventing unsolicited & unmonitored distributions.

Experience has shown that due to a high turnover in cluster coordination staff as well as NGO and humanitarian actor staff in emergencies, it is important to repeat awareness raising and distribution of key documents on a regular basis.

3. USE THE MEDIA TO SEND APPROPRIATE MESSAGES

- Contact national or international media to raise interest on the subject, so they can include it in articles or radio or TV programmes; as well as to prevent media from disseminating inappropriate messages that could lead to unsolicited donations of BMS.
- If inappropriate media messages are detected in national or international media (newspapers, magazines, TV, radio...); advocate for a reply to that media by the coordination body to waylay or change their initial message as quickly as possible.

4. Raise awareness through government bodies

If the Joint Statement or other relevant statements are endorsed by or originate from the Ministry of

FOR MORE INFORMATION SEE:

“IFE Media Flyer” IFE Core Group

<http://www.ennonline.net/resources/126>

and “Media messages save infant lives in emergencies – Information for Communication Specialists in Humanitarian Organisations” IFE Core Group/UNICEF

http://www.ennonline.net/pool/files/lessons/Screen_32_Media%20responsibility%20on%20IFE.pdf

Health, they can be used to raise awareness through government bodies who can participate in the prevention of inappropriate BMS, bottles and teats donations, such as:

- Regional, provincial or district Health offices, who coordinate and supervise nutritional and health activities
- NGO regulating bodies, such as offices where NGO's need to register activities, on a national and regional level
- Bodies that deal with importation regulations

MONITORING AND REPORTING OF CODE & OPERATIONAL GUIDANCE ON IYCF-E VIOLATIONS

Unfortunately, despite preventive measures, most emergencies will see distributions that are in violation with the Code and Operational Guidance on IYCF-E. Every IYCF-E actor, including ACF, has its responsibility in monitoring (if not actively, then passively) and reporting any violations. All ACF teams, including from other departments should be aware of the issue, so that all of them can report violations if they come across them.

FOR MORE INFORMATION ON:

on IBFAN code violations report form: visit http://www.ibfan.org/code_watch_form.html

The way violations should be handled should be discussed in the coordination meetings.

If ACF encounters an agency that has activities in violation with the Code and Operational Guidance, what can be done is:

- Give the violating agency a copy of the Joint Statement and the Operational Guidance and explain to them the risks of what they are doing.
- Report the violating agency with as many details as possible (name + contact of the agency; type of violation + location, date, time; details on the product used etc.) to the coordination body or the Ministry of Health, who should then take further steps. In addition, the violation can be reported to IBFAN, who compiles code violations.

If ACF comes across BMS, bottles or teats within a community or family that were donated:

- Unobtrusively collect information from that family or from community leaders :
 - Who donated the products (name agency, contact if possible, more details if available)
 - When was it donated and how (part of a general distribution, or more targeted; in the community or in a health centre, etc.)
 - What are the details of the products: any label violations (language, pictures), age appropriate, expiry date, etc.
- Inform the family or community of the dangers of using this product, of the benefits of not replacing breast milk, and invite families with infants and young children to the care practices project or conduct home visits to limit the risks of those violations as much as possible. Remember, it is the agency who donated who is in violation with the Code; not the family who received it. They should therefore be approached with respect and not be made feeling guilty.



- Report this information to the coordination body, and discuss what action will be taken by who

A report format should be made available to all team members in the field (*see toolkit for an example*).

Raising awareness through the media helps: during the Haiti 2010 emergency, ACF was alerted by a journalist, who had been briefed on IYCF-E; and who had received a press release by an organisation intending to send tons of powdered milk. ACF transferred the information to the Nutrition Cluster, who then contacted the organisation.

MANAGEMENT OF INTERCEPTED BMS

BMS that are intercepted and stored by the coordination body should be used in a responsible way to avoid destruction. Not only would this be more ethical, most agencies also agree more rapidly to hand over BMS if they know it will be used and not destroyed.

This will usually be handled by the coordinating body; but in absence, any agency might be assigned to do so. In addition, ACF as a member of the Nutrition Cluster and the IFE Core Group, should actively participate into finding solutions and putting them into practice.

The most obvious and practical solution is to premix centrally with fortified blended food (FBF), such as corn soy blend, wheat soy blend or other; for example for use in targeted supplementary feeding programmes or blanket supplementary feeding. This is an action endorsed by UNHCR¹ and WFP². Adding whey or skimmed milk powder to FBF improves the protein quality, allowing a reduction in total amount of protein, which could have potential metabolic advantages. Milk proteins will improve flavour, which is important for acceptability in vulnerable groups³. Ready to use infant formula can also be used for this purpose.

However, one must take into consideration the following aspects:

- Premixing milk and cereal flour must happen in a central premixing site, away from the distribution site. Milk and flour should never be distributed separately to the beneficiary to be mixed at home.
- Premixing milk and cereal flour together with oil reduces the expiry date of the ration to one week after mixing. Therefore, rations premixed with oil can only be premixed with milk powder if weekly rations are distributed and the premix is done the day before distribution. For rations premixed with oil for biweekly distributions, or weekly rations premixed more than one day before distribution; milk powder cannot be used.
- There is insufficient information on how moisture affects the expiry date of a premixed ration with milk. It is therefore recommended to ensure watertight storage of the ration by beneficiaries in rainy season or other situations where moisture can be an issue.

1 - UNHCR (2006). UNHCR Policy related to the acceptance, distribution and use of milk products in refugee settings.

2 - WFP, "Food Aid in Emergencies" Annex 6C use of Milk Products.

3 - Hoppe, C. and al. (2008). The Use of Whey or Skimmed Milk Powder in Fortified Blended Foods for Vulnerable Groups - A literature Review. The Journal of Nutrition, 138, 145S-161S.

- The beneficiaries must be made aware of the milk content of the ration, which will alter the flavour of the ration they are used to; although in most cases, children will like the flavour better. However, beneficiaries must be made aware that the ration is still for children more than 6 months only. The milk content does not make it suitable for children < 6 months.

There are no standard recommendations as to the amount of powdered milk that should be mixed into the ration. Reports of experience are talking about 10-15% to 30% of the full ration being composed by powdered milk.

Providing milk for on the spot consumption; for example in schools or child friendly spaces; to children of more than 2 years of age; raises some questions and practical problems:

- Distributing milk, even if controlled and specifically targeted so as not to endanger breastfeeding practices, might give a wrong message that milk distributions are OK.
- Providing sufficient supervision so that the milk is hygienically prepared, targeted to children more than 2 years only, consumed on the spot; and therefore is not endangering breastfeeding practices; can prove difficult to organise and will need sufficient presence of trained staff which might prove to be expensive.

Other options are:

- To use the milk powder in preparation of biscuits and cakes for distribution, yet again, the preparation must be done centrally under strict control to avoid misuse and ensure hygiene.
- To use the milk powder for animal feeds: this must be handled with care as such actions can raise ethical questions, as well as create problems with the population and with media.
- To destroy the milk, this must be done if the milk is expired or expiry date is too close; or if no other solution for the use of the milk is found. Again, this must be handled with care; as the local population may not understand why milk is being destroyed. Be careful to comply with all necessary procedures, such as: having approval from donors, having approval from Ministry of Health and proceed according to Ministry of Health guidelines for destruction.

TABLE OF FIGURES

- Figure 1** *Conceptual framework of nutritional status and child development.*
- Figure 2** *Proportion of nutrients provided by breast milk and complementary food; IBFAN.*
- Figure 3** *Summary of texture, frequency and amount of complementary food per age group; Complementary Feeding Counselling, a Training Course; WHO 2004.*
- Figure 4** *Child Development 0 to 3 years; Manual for the Integration of Child Care Practices and Mental Health in Nutrition Programmes, ACF, 2011.*
- Figure 5** *Adjusting Actions and Attitude to the Development of the Child”; Manual for the Integration of Child Care Practices and Mental Health in Nutrition Programmes, ACF, 2011.*
- Figure 6** *Pyramid of psychosocial interventions.*
- Figure 7** *“ Type of setting”.*
- Figure 8** *Example of weekly activities in a BFS (example from Philippines, areas devastated by the tropical storm “Washi” on December 15th, 2011).*
- Figure 9** *Deciding who needs help; IFE Module 2v1.1; IFE Core Group.*
- Figure 10** *Arrangement of mothers and children in mother-child play sessions -ACF Manual for the integration of child care practices and mental health into nutrition programs ed. 2011.*
- Figure 11** *A generically labelled can of RUIF in Haiti.*
- Figure 12** *Quantity of prepared formula per day for infants 0 to 12 months old.*
- Figure 13** *Cupfeeding babies; IFE Module 2 v1.1; IFE Core Group; 2007.*
- Figure 14** *Kangaroo Care; Management of the child with a serious infection or severe malnutrition, WHO/IMCI/FCH/CAH/00.1.*
- Figure 15** *Carrying pouches for KMC; Kangaroo Mother Care, WHO 2003.*
- Figure 16** *Positioning the baby for KMC; Kangaroo Mother Care, WHO 2003.*
- Figure 17** *Positioning the baby for KMC; Kangaroo Mother Care, WHO 2003.*
- Figure 18** *Anatomy of the breast.*
- Figure 19** *The Prolactin Reflex, IFE Module 2 v1.1; IFE Core Group.*

Figure 20 Different breastfeeding positions for breastfeeding: cradle hold, clutch hold, lying down. *Breastfeeding Counselling, a Training Course; WHO/UNICEF 1993.*

Figure 21 Inappropriate positioning for breastfeeding; *Breast Breastfeeding Counselling, a Training Course; WHO/UNICEF 1993.*

Figure 22 Good (left) and incorrect (right) attachment; *IFE Module 2 v1.1, IFE Core Group.*

Figure 23 Some ways to help a colic baby; *Breastfeeding, a training course, WHO/UNICEF, 1993.*

Figure 24 Using a syringe on an inverted nipple, *Breastfeeding a Counselling Course; WHO/UNICEF 1993.*

Figure 25 Storage duration of fresh breast milk.

Figure 26 Advantages and disadvantages of heat treated breast milk; *HIV & Infant Feeding Counselling tools reference guide, WHO, 2005.*

Figure 27 Supplementary Suckling Technique.

Figure 28 Drop & Drip Technique, *IFE Module 2 v1.1; IFE Core Group.*

Figure 29 Risk of HIV transmission mother to child without preventive action, based on prevailing evidence June 09 *Integration of IYCF Support into CMAM IFE Core Group, ENN, IASC, October 2009; Adapted from De Cock KM et al. Prevention of mother-to child HIV transmission in resource-poor countries: translating research into policy and practice. Journal of the American Medical Association, 2000, 283(9): 1175-1182.*

Figure 30 Risk of HIV transmission mother to child with ARV, based on prevailing evidence June 09 *Integration of IYCF Support into CMAM IFE Core Group, ENN, IASC, October 2009; Adapted from Coovadia et al (2007). Mother-to child HIV transmission of HIV-1 infection during exclusive breastfeeding in the first six months of life: an intervention cohort study. Lancet 2007; 369: 1107-16.*



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