
Global Health

Nutrition



Supporting Breastfeeding in Emergencies: The Use of Baby-Friendly Tents

The purpose of this document is to provide guidance to World Vision (WV) field staff on how to support infant and young child feeding (IYCF) in emergencies through the implementation of baby-friendly tents (BF tents). This document provides a description of BF tents and provides an overview of their general set-up and operation. This document is not a technical guide on the management of IYCF issues in emergencies. A WV nutrition/health technical advisor should be consulted to support the implementation of BF tents.

BACKGROUND

The World Health Organisation (WHO) and United Nations Children’s Fund (UNICEF) recommend that infants should initiate exclusive breastfeeding within one hour of birth and continue exclusively breastfeeding for the first six months of life. After this time, infants should continue breastfeeding to two years of age or beyond while also receiving age-appropriate, nutritious and hygienic complementary foods.

WHY ARE BABY-FRIENDLY TENTS NEEDED?

Emergency situations can seriously threaten breastfeeding practices and consequently child nutrition, health and survival. Misconceptions of mothers, community members and those involved in the relief effort about the effects of trauma, stress and maternal malnutrition on breastmilk may reduce a mother’s confidence in her ability to breastfeed. Though a woman’s ability to produce breastmilk is not affected by a stressful situation, her body’s capacity to ‘let down’ milk may be impaired by stress. The inability of the mother to ‘let-down’ may interfere with effective suckling and further reduce a mother’s confidence. A lack of privacy in shelters or camp settings may restrict a mother’s ability to comfortably breastfeed and heighten her stress level. As well, post-traumatic stress, illness, sexual violence, and severe depression, all potentially elevated during emergency settings, may cause women to reject their infants or the act of breastfeeding.

Time constraints may also be heightened during emergency settings and undermine breastfeeding. Women with infants who must travel long distances, queue in long lines for food, water and fuel rations and carry rations back to communities may be unable to travel with their infants. This interferes with on-demand and frequent feeding necessary for maintenance of breastmilk supply. These activities also restrict the time mothers can dedicate to appropriate breastfeeding and care of children. Lastly, the unregulated distribution of breast-milk substitutes (BMS)¹, which includes powdered milk provided in food rations, may undermine women’s efforts to breastfeed.

Mothers have the right to specialist support to reinforce and restore their confidence and capacity to breastfeed their child. Given the unique challenges and heightened risks in emergency situations, specific and extra efforts must be taken to ensure that breastfeeding is protected and promoted. Protection and support of non-breastfed infants and young children must also be provided. Baby-friendly spaces, sometimes referred to as tents or corners, are one strategy for addressing many of these challenges. This document briefly summarises what BF tents are and provides an overview of their general set-up and operation.

Common Concerns around IYCF

Many people may have heard that breastfeeding is difficult, especially in emergency situations. Some of these concerns are based on experience and some are deeply held but mistaken beliefs.

Here are some important common concerns and the information to help address them:

“Stress prevents mothers from producing milk.”

Stress does not prevent milk production but it may slow the release of milk from the breasts. This can result in babies being ‘fussy’ when breastfeeding. Mothers and aid workers may think that there is not enough breastmilk. Frequent breastfeeding will help the mother and baby to get over this and ensure the baby receives enough.

“Malnourished mothers cannot breastfeed.”

Malnourished mothers can breastfeed. However they should be provided with extra food and fluids to rebuild their own nutrient stores and be encouraged to breastfeed the infant very frequently. Moderate malnutrition has little or no effect on milk production. Milk production is only likely to be reduced if a woman is severely malnourished; then the woman herself would need immediate feeding and extra food while continuing breastfeeding. “Feed the mother and let her feed the baby” is the key approach.

“The mother thinks she is not producing enough milk to feed her baby.”

A mother produces enough milk to feed her baby if she breastfeeds frequently and for as long as the baby wants at each feed. Her breasts may seem soft and ‘empty’ but they are producing milk.

¹ Breast-Milk Substitutes (BMS) – Any food being marketed or otherwise represented as a partial or total replacement for breastmilk, whether or not it is suitable for that purpose. This includes 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 and teas marketed for infants less than six months. Refer to World Vision International Policy Governing the Procurement and Use of Milk Products in Field Programmes. Revised, 2011.

WHAT ARE BABY-FRIENDLY TENTS?

BF tents, also called baby-friendly corners, are safe, low-stress spaces where mothers can breastfeed, rest, eat and receive skilled counseling and targeted advice about breastfeeding and nutrition. It should be noted the term 'tents' is used for convenience as they may be stand-alone units, spaces within other existing structures, or simply specified areas in the camp setting, where women can come and breastfeed safely and comfortably. In cases where it is culturally necessary the spaces may also provide private areas for individual breastfeeding women. Mothers may attend the tents during the day and return to their homes or shelters at night.

It should be noted that the purpose of BF tents is not restricted solely to breastfeeding. The spaces may also jointly serve to provide information and training on appropriate complementary feeding, infant and newborn care or to provide therapeutic and/or supplementary feeding of malnourished children. BF tents have also been used as a regulated space to provide BMS to orphaned children and those identified as needing artificial feeding. Skilled assessment of the potential to breastfeed and available alternative sources to breastmilk is an important criterion in determining whether artificial feeding is indicated in individual infants (see Artificial Feeding of Infants section below for further guidance on use of BMS in BF tents).

ESTABLISHING BABY-FRIENDLY TENTS

Because the interruption of breastfeeding can lead to the rapid deterioration of an infant's health, adequate and professional support to overcome feeding challenges should be provided in the immediate aftermath of an emergency. **Interventions to protect and promote optimal infant and young child feeding**, including the use of Baby-friendly spaces where appropriate, **should be a standard activity and form part of WV's early emergency response**. The following guidance notes for establishing and operating baby-friendly tents are based on the Infant Feeding in Emergencies (IFE) Core Group modules, the Inter-Agency Standing Committee (IASC) Nutrition Cluster Harmonised Training Package and the UNICEF Emergency Field Handbook (see Resource section). These guidance notes aim to help meet the IYCF Sphere Standards (2011).

Objectives of Baby-Friendly Tents

The overall objective of a BF tent is to prevent morbidity and mortality of infants associated with poor IYCF practices.

Additional objectives include:

- i. To prevent a rise of inappropriate IYCF practices in emergency settings
- ii. To improve infant and young child feeding practices in the affected population
- iii. To provide professional support for breastfeeding women to address breastfeeding problems
- iv. To prevent or reduce the inappropriate use of BMS

Key Considerations for Set-Up and Operation

1. Identify a space where mothers can gather to rest and recuperate. This may be a stand-alone structure (such as a tent) or a space within another site (such as a corner). In planning a 'safe space', investigate whether other sectors have similar initiatives that could be complemented by integrating an infant and young child feeding component. For example, a nutrition component could be added to the protection and psychosocial support offered in child-centred spaces that provide safe, physical spaces for children affected by emergencies.
2. Determine an appropriate size for the space, based on the estimated number of mothers in the area. If the area affected by the emergency situation is large, estimate the total number of sites needed so that women need to walk only a minimum distance to reach a site.
3. Make sure the location of the space is safe and in a quiet area away from excess outside noise and smells, such as those found near markets, garbage dumps and main roads.
4. Based on context and available resources, decide whether the construction of a physical structure, with walls and/or roof for example, is necessary, appropriate and feasible. In areas where it is culturally necessary, individual private spaces, whether as partitioned spaces within a tent or individual small tents, may be needed.

5. Ensure the space is comfortable for breastfeeding. Provide mats or chairs for women who are breastfeeding. If women are sitting on floor mats, then it may be necessary to provide mothers with a pillow or other item so they can rest their backs to make breastfeeding more comfortable. A pillow or rolled-up cloth is also useful to help the mother hold the baby at a comfortable level while breastfeeding.
6. Make sure the mothers have easy access to water and food while at the space. In settings where maternal malnutrition and dehydration are high, supplemental feeding of breastfeeding women at the space may be indicated as an additional integrated service (see page 5'). Ideally latrines and hand washing stations would be easily accessible to the tents or part of the tents themselves.
7. Inform mothers and caregivers that the space is available for them.
8. Arrange for health workers, members of the community or others trained in breastfeeding counselling to support mothers within the space. Given that mothers will likely be accompanied by older children, it may be useful to have toys and other interactive items available for their use. Health workers may be also trained to support women in appropriate interaction and play with children to promote proper development and help children cope with the trauma associated with emergencies.
9. Screen new arrivals to identify and refer any mothers or infants with severe malnutrition and/or feeding problems for immediate assistance.
10. Establish and foster mother-to-mother support, if culturally appropriate.
11. When artificial feeding is occurring at a baby-friendly site, ensure that support for artificial feeding is provided in an area of the tent that is separate and distinct from the area where support for breastfeeding is provided, to reduce the risk of spill-over of BMS to breastfeeding women. If there are a significant number of cases requiring artificial feeding support, WV should consider providing in-kind support to breastfeeding mothers, so as to ensure there is no perceived advantage to artificial feeding. This could include additional food rations or vouchers.
12. Special attention should be given to newly responsible caregivers (of orphaned children, for example), and special arrangements with supervision made for women who might be building up their breastmilk supply using both artificial feeding and breastfeeding during the relactation process.

Breastfeeding counselling involves practical, technical 'know-how' as much as strong communication skills. Listening to mothers, reinforcing their confidence and encouraging them, rather than 'telling' them what to do, is an essential component. A skilled breastfeeding counsellor can provide assistance to breastfeeding women to ensure that the fundamentals of good breastfeeding are in place and to resolve common difficulties. Mothers are greatly helped to breastfeed and care for their infants if someone calm and friendly listens to them, and builds their confidence with reassurance and correct information. Breastfeeding counsellors may be health professionals, community health workers or peer counsellors (such as mothers and grandmothers) who have undertaken relevant training.

BABY-FRIENDLY TENTS IN EMERGENCIES

Bosnia: In Albanian refugee camps in the 1990s, Baby Washing Tents established by Action Against Hunger became ad hoc breastfeeding centres. The tents were staffed with health care workers. Women would come not only to bathe their infants but to breastfeed and to seek advice and assistance with breastfeeding.

Tanzania: In 1998, breastfeeding corners were established near maternal centres in Hutu refugee camps. The tents provided lactation support to all women soon after birth. The spaces, built of poles and plastic sheeting, had straw mats on the ground for sitting, necessary equipment, including cups, basins for bathing, and weighing scales, and specially trained breastfeeding corner assistants who provided support and collaborated closely with community workers and the feeding programme staff to support breastfeeding.

Haiti: After the earthquake in 2010, UNICEF assisted in establishing 107 baby tents which provided services to over 23,000 mothers and their infants. In addition to providing breastfeeding support, women receive information on complementary feeding, hygiene and nutrition. The tents also provided care for almost 3,000 infants who required artificial feeding with breast-milk substitutes.



PROVIDING ADDITIONAL SERVICES THROUGH BABY-FRIENDLY TENTS

In many instances, other services may be offered through the BF tents including nutrition support of breastfeeding women, support for relactation, care and feeding of orphaned children or those for whom artificial feeding is indicated. Below are some general recommendations for these situations – **seek the advice of a WV Nutrition advisor for such situations**. The tents can be used as sites to screen for acute malnutrition. Refer to the World Vision Measuring and Promoting Child Growth Tool – a link is provided in the Resources section of this brief.

Supporting the nutrition of breastfeeding mothers

It is important that lactating women receive an adequate diet – both in terms of the quantity and quality of food. Additional food rations and micronutrient supplements are recommended for pregnant and lactating women in emergency situations (see Resource section below). In addition, fluid intake is a particular concern with populations on the move, in severe drought conditions and during natural disasters that contaminate water. Dehydration may interfere with breastmilk production.

The following actions can be carried out at breastfeeding tents to ensure that breastfeeding women have safe access to sufficient food and water:

1. Support the nutrition and hydration of breastfeeding women by ensuring that drinking water and food rations are available in the baby-friendly space and provide drinking water wherever women must wait in line a long time or in the sun.
2. Ensure that drinking water is freely available to breastfeeding mothers and assist in the provision of an extra litre of water a day in situations where drinking water supplies are severely restricted.
3. BF tents can assist with registration of newborns (in a camp situation) so that the family receives an additional ration that the lactating mother should use.
4. If the BF tent is providing rations for home preparation, ensure the rations provide a sufficient amount to support the household and the lactating women. A lactating woman may require 1,000–1,200 kcal per day in addition to the standard household ration.

Breastfeeding corners or tents are set up in order to provide adequate support to breastfeeding mothers. In emergency settings, women would arrive at camps exhausted, not having eaten properly for many days, as they trek through difficult terrain. Often they are very traumatised and may exhibit a ‘no breast milk’ syndrome... providing them some secluded space where breastfeeding support is provided offers that edge of comfort and usually relactation rates are very high.
UNICEF representative, Kenya

Many lives are saved when conditions are created that protect breastfeeding, especially exclusive breastfeeding, by avoiding interruption due to personal stress or use of breast-milk substitutes, and by providing safe areas for stress reduction and personal assistance to mothers who need it. This means that it is necessary to create a safe haven, or protected area, and to provide support for mothers to ensure that they receive required additional rations for themselves. It is essential to help mothers to continue to provide exclusive breastfeeding for the first six months...and to continue breastfeeding supported by high-quality complementary foods until the child is two years and beyond. Given the stress of emergencies and its potential to temporarily disrupt milk flow, breastfeeding support and counselling is necessary from the earliest days of an emergency.

UNICEF, *Emergency Fieldbook: A Guide for Field Staff*



Supporting Relactation

Women who have breastfed in the past or whose breast milk production has diminished can breastfeed again. It can be easier for a mother to relactate when an infant is less than six months old, but previously breastfed infants as old as 12 months can also begin breastfeeding again. The most important conditions for relactation are the mother's motivation, stimulation of the breasts from frequent suckling of the infant and support for the mother.

1. Identify women who need to or would like to relactate. A seriously ill or severely undernourished woman should get appropriate treatment first; relactation can be started once her condition improves.
2. Designate an area where women can receive assistance in relactation and provide a lower-stress area that will be beneficial to breastfeeding in general (such as a BF tent).
3. Provide a safe and comfortable environment including adequate nutrition and sufficient fluids.
4. Make sure that women have access to skilled assistance and equipment.

See *Infant Feeding in Emergencies, Module 2 for health and nutrition workers in emergency situations for step-by-step guidance on relactation.*

Artificial Feeding of Infants

In certain situations, some infants will require BMS either temporarily or for a long-term period. Special care must be taken in the acquisition, distribution and use of BMS so that breastfeeding practices in the general population are protected, promoted and supported. Regular monitoring must be undertaken to ensure that support for artificial feeding does not undermine breastfeeding.

Conditions for temporary or long-term use of BMS include absent or dead mother, very ill mother, relactating mother, HIV-positive mother who has chosen not to breastfeed, infant rejected by mother, infant artificially fed prior to the emergency and mother unable or unwilling to relactate, and rape victim not wishing to breastfeed.

Assessment of whether a woman qualifies for BMS feeding should be carried out by qualified health and/or nutrition personnel who have training in IYCF. Care should be taken that no stigma is attached to these women choosing to use BMS. Distribution of infant formula to an individual caregiver should always be linked to education, one-to-one demonstrations and practical training about safe preparation, and to follow-up at the distribution site and at home by skilled health workers. Distribution of essential needs to support safe artificial feeding may also be necessary; for example safe water, fuel and cooking equipment. Follow-ups should include regular monitoring of infant weight at the time of distribution (no less than twice a month). It is recommended that support for artificial feeding occur in an area that is distinct from where breastfeeding support is being provided to safeguard against the risk of spill over.

Refer to *World Vision International Policy Governing the Procurement and Use of Milk Products in Field Programmes, 2011* for detailed guidance on use of BMS.

Nutrition Education

It may be appropriate to use the BF tent space to provide nutrition education to address common misconceptions and poor practices that exist regarding infant and young child feeding in a population (see page 2 sidebar for some examples). It is important to identify the key decision-makers and those who have influence regarding infant feeding decisions and include these individuals in education sessions (for example, grandmothers and fathers).

Breastfeeding Counselling in the Context of HIV

Mothers of unknown or negative HIV status should be supported to breastfeed as per general IYCF recommendations for the population. HIV-infected mothers need extra support regarding infant feeding. Normally, this support should be provided through government health systems and by staff specifically trained in HIV counselling. However, in the event that these systems are not functioning in an emergency, there may be a need to support HIV-infected mothers in BF tents. For HIV-infected mothers, combining anti-retroviral (ARV) interventions with breastfeeding can significantly reduce post-natal HIV transmission. Given the heightened risks of artificial feeding in an emergency, breastfeeding offers the greater likelihood of survival for infants born to HIV-infected mothers in an emergency and for survival of HIV-infected infants, including where ARVs are not yet available. Infant feeding counselling for HIV-infected mothers should be done in close collaboration with HIV services. It is essential that staff have knowledge of and are able to refer women to appropriate HIV services if needed. Urgent assistance is needed for infants already established on replacement feeding. **Refer to *World Vision Nutrition Guidelines on Infant Feeding in the Context of HIV, 2011*.**

RESOURCES

General Orientation material on IYCF in Emergencies

IFE Orientation Package, 2010. IFE Core Group. Available at <http://www.enonline.net/ife/orientation>

Technical guidance on IYCF-E

Infant Feeding in Emergencies E-Lessons available at <http://lessons.enonline.net/>

Infant Feeding in Emergencies for Emergency Relief Staff (for orientation, reading, and reference). Module 1 November 2001. Available at <http://www.enonline.net/resources/1>

Infant Feeding in Emergencies for Health and Nutrition Workers in Emergency Situations (for training, practice, and reference). Module 2, v1.1, December 2007. Available at

http://www.who.int/nutrition/publications/emergencies/ife_module2/en/index.html

The Harmonised Training Package (HTP): Resource Material for Training on Nutrition in Emergencies, Module 17: Infant and Young Child Feeding in Emergency Situations. Version 2, 2011, NutritionWorks, ENN, IASC Global Nutrition Cluster. Available at <http://www.enonline.net/resources/888>

UNICEF Emergency Field Handbook: A guide for UNICEF Staff. July 2005. Available at www.unicef.org/lac/emergency_handbook.pdf

Policy Guidance

The Sphere Project (2011). Sphere Handbook 2011. New York: The Sphere Project. Available at <http://www.sphereproject.org/handbook/>

Infant and Young Child Feeding in Emergencies: Operational Guidance for Emergency Relief Staff and Program Managers, v2.1, February 2007 and the Addendum to Operational Guidance on IFE (v2.1, 2007), 2010. IFE Core Group. Available at <http://www.enonline.net/pool/files/ife/ops-guidance-2-1-english-010307-with-addendum.pdf>

World Vision International Policy Governing the Procurement and Use of Milk Products in Field Programmes. Revised, 2011. Available at

<https://www2.wvcentral.org/community/health/Documents/Milk%20Policy%20FINAL%20Jan%202012.pdf>

World Vision International Measuring and Promoting Child Growth Tool. Available at <https://www.wvcentral.org/cop/hnh/nutrition>

Infant Feeding in HIV Context

WV Nutrition Guidelines in the Context of HIV, 2011. Available at <https://www.wvcentral.org/cop/hnh/nutrition>

WHO (2010). Guidelines on HIV and infant feeding 2010. Principles and recommendations for infant feeding in the context of HIV and a summary of evidence. Available at

http://whqlibdoc.who.int/publications/2010/9789241599535_eng.pdf

Micronutrient Supplementation in Emergencies

Preventing and controlling micronutrient deficiencies in populations affected by an emergency: Multiple vitamin and mineral supplementation for pregnant and lactating women, and for children aged 6-59 months. WHO, WFP and UNICEF 2007. Available at http://www.who.int/nutrition/publications/WHO_WFP_UNICEFstatement.pdf