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Babies First: Ensuring Proper Infant Nutrition During Emergencies

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Babies First: Ensuring Proper Infant Nutrition During Emergencies

By Abigail M. Alonso

Spring 2015

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Acknowledgments

I would like to thank my parents, Jim and Kadee Alonso, for supporting me in following my passions for global health. They have encouraged me to pursue whatever I feel called to do, which has developed into a love for working with and working for people in need. I also would like to thank the SIT Switzerland: Global Health and Development Policy academic directors, Heikki Mattila and Alexandre Lambert, as well as Françoise Flourens for being available and helpful through this process; their connections and advice helped me shape my topic into what it has become. I would like to thank Dr. Lida Lhotska of IBFAN/GIFA for her inspiring lecture that helped me choose a focus on breastfeeding in emergency situations, and as well for being available to interview and provide me with invaluable information about breastfeeding. As well, Dr. Sathya Doraiswamy of UNHCR, Dr. Mary Lung'aho of CARE USA, and Maryanne Stone-Jimenez of WFA provided me with unique insight into my topic, and I appreciate their time and assistance greatly. I'd also like to thank Marie Chantal Messier of Nestlé for taking the time to reach out to me and clarify information while providing me with useful documentations for my research. Lastly, I'd like to thank my host mom, Nanda Magnin, for providing me with more than just a room to stay for the semester; she offered me a warm and welcoming home. I am so grateful for her support and willingness to discuss my topic, proving to be a wonderful soundboard for my ideas.

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Abstract

Background: Breastfeeding is the best source of nutrition for an infant, living in all regions and cultures. Recommendations apply across the board, from developed nations to refugee camps, from women with HIV to those with time constraints regarding feeding. There also exists a complex relationship between corporations that provide BMS and the NGOs working to promote breastfeeding in emergency situations amongst vulnerable populations.

Objective: The objective of this paper is to expose breastfeeding promotion, using the Dadaab camps in Northeastern Kenya as a case study of IYCF programs and support of breastfeeding among low-literacy populations with an emphasis on women with HIV, then broadening the scope and looking at breastfeeding promotion and the role of corporations in development and health.

Method: An interactive research approach is used, first by conducting research through literature and policy review, followed by the collection of primary data from experts in this field.

Results/Findings: This paper finds that breastfeeding can be a lens to look at all aspects of development, providing a specific focus on nutrition. Corporations have an interesting role when it comes to development, and a complex relationship with NGOs.

Conclusion: Solutions are not straightforward and there is no single answer to provide support and aid to pregnant and lactating mothers. Education must be provided in order to empower women and allow them to make decisions about their own health and protection from aggressive marketing of producers of BMS. Breastfeeding, though specific, can be applied across the board to virtually all aspects of society and means of development.

Preface

I have always been interested in maternal and reproductive health. As well, I have a distinct interest in nutrition, from multiple standpoints but specifically regarding nutrition for infants and young children. I believe it is incredibly important to consider infants and young children as a key focus group in need of specific attention regarding nutrition and breastfeeding. One of the most vulnerable populations is the population of refugees and asylum seekers. Everyone's rights must be ensured, especially those who have faced lives dictated by conflict and natural disaster. A stark reality lies in the fact that there exist distinct and explicit challenges in the places where these individuals are seeking refuge. I am interested in exploring specifically infants and young children, as well as pregnant and lactating mothers, who are living in such a fragile state, and how the challenges associated with refugee camps like HIV prevalence impact infant nutrition. These populations also require the support and protection from aggressive marketing of breastmilk supplements, and I am curious as to how various public organizations and agencies interact with the private sector regarding infant formula. This topic allows me to combine my interests while focusing on a specific group within an extremely vulnerable population.

Introduction

Close to 7 million children under five die annually, mainly by preventable causes. Breastfeeding allows all children to thrive and develop; there exists a potential to prevent over 800,000 deaths in children under five because breastfed children have a six times greater chance at survival (UNICEF, 2014). Breastfeeding is a natural practice with more than simply nutritional benefits. It has the ability to save lives of this vulnerable population: infants under six months. Without exclusive breastfeeding, infants are significantly more likely to become infected with disease, die from diarrhea, and limit their full potential for successful development. In my paper, I will explore many challenges that specific populations of infants and mothers with children under six months face: refugee situations and emergencies, HIV transmission and breastfeeding, and the role of corporations in emergencies. Each layer adds more complications for the assurance of a bright, healthy future for the child. I seek to explore the work that organizations and agencies are doing to create policy and guidelines while implementing programs and practices to be applied in emergency situations, specifically for women with HIV.

Literature Review

My paper focuses mainly on themes surrounding the World Health Organization's standards for infant nutrition and breastfeeding. Their guidelines can be found in many documents but are explicitly stated in the *Global Strategy for Infant and Young Child Feeding*, published in 2003 by the WHO and UNICEF. The document states "As a global public health recommendation, infants should be exclusively breastfed for the first six months of life to achieve optimal growth, development, and health. Thereafter, to meet

their evolving nutritional requirements, infants should receive nutritionally adequate and safe complementary foods while breastfeeding continues for up to two years of age or beyond” (WHO, 2014). Every international organization and NGO working towards improving the lives of infants and the standards of care in terms of nutrition abide by this standard.

Dr. Lida Lhotska, one of the experts I interviewed for this paper, provided me with a document that she, along with Rebecca Norton of IBFAN-GIFA and Marie McGrath of the Emergency Nutrition Network, developed in collaboration with other members of the IFE Core Group for the UNHCR. This document, *Guidance on Infant feeding and HIV in the context of refugees and displaced populations* provided me with concrete definitions and current policies that helped me frame my paper. The guidelines cover the risks of HIV transmission and explicate the UN policy regarding infant feeding in this specific context. The current recommendations on infant feeding and HIV are as follows:

When the status of the mother is unknown or she is HIV-negative, she should be supported to exclusively breastfeed for the first six months of her infant’s life, abiding by the WHO standards. When a mother is known to be HIV positive, the most appropriate option should continue, which depends greatly on the context of the situation. Exclusive breastfeeding is recommended for the first six months of life unless replacement feeding is *acceptable, feasible, affordable, sustainable, and safe* (AFASS).

The definitions of AFASS conditions are also explicated in the document, *Guidance on Infant feeding and HIV in the context of refugees and displaced populations*. Acceptable means that the mother perceives no barriers to replacement feeding,

associated with cultural or social differences, fear of stigma, and discrimination. As well, she has the support of her community and family in opting for this method of replacement feeding. Feasible refers to the mother's time, knowledge, skills, and resources available to prepare the replacement food up to twelve times in 24 hours. Affordable acknowledges the ability to pay of the cost of purchasing, producing, preparing, and using the method of replacement feeding. In addition, this refers to the affordability of medical care if a child develops diarrhea, for example, and the cost of that specific care. Sustainable refers to the availability of a continuous, unchanging supply of replacement feeding for up to one year of age or longer. Safe means that replacement foods are hygienically prepared and stored, fed in adequate amounts, and sanitation levels are proper; this means, for example, that there exists access to reliable, safe water to prepare the adequate amount of the replacement food, can be sanitary when preparing and cleaning the utensils used for feeding, and store them in appropriate containers. These standards exist to ensure that the method of replacement feeding will not provide increased risk of other infections and potential causes of death for the infant.

I relied fairly heavily on Nestlé's publications and sources available online in order to formulate the company's perspective on infant feeding and breastfeeding. I was able to find a limited amount of documents and facts published on their corporate website, which helped me understand their viewpoint on breastfeeding, specifically in emergencies. I was not able to conduct a formal interview with someone at the corporation; instead, I corresponded with the Senior Public Affairs Manager at Nestlé, Marie Chantal Messier. She provided me with statements that verified what I found online and in print.

Research Questions

I seek to explore what structural barriers exist for refugees in regards to nutrition, specifically pregnant and lactating mothers and their children. As well, I would like to explore what role HIV plays in refugee camps and what programs exist to reduce mother to child transmission. I would like to expose the work that UNHCR has in specific regions, focusing on refugee camps in Kenya as a case study. In addition to exploring the work that UNHCR does from a policy and standards viewpoint, I hope to understand what programs are in place to educate women, healthcare workers, and others involved in refugee camps about the importance of breastfeeding in accordance with WHO standards. As well, I would like to gain a full understanding of how UNHCR supports other NGOs on the ground in the countries they work in. I seek to explore what alternative feeding practices exist for HIV positive mothers living in refugee camps like the Dadaab camps in Northeastern Kenya, and what the standards are regarding pregnant and lactating women who are HIV positive. I hope to uncover how these most vulnerable populations are ensured protection against companies like Nestlé and unethical marketing strategies that have historically been detrimental to the health of infants. In addition to this, I hope to gain a perspective from Nestle, attempting to understand their viewpoint on their role in emergency situations. I would like to explore what a company like Nestlé is doing to ensure fair and transparent marketing of infant formula.

Research Methodology

I reviewed policy on infant feeding and nutrition, exploring the documents that are already written and published in order to provide standards and guidelines across the board. As well, guidelines exist for infant feeding in emergency situations, in addition to

specific publications by organizations like the World Health Organization, UNICEF, and UNHCR referring to specifically the challenges that exist in terms of infant feeding and mothers with HIV. After reviewing these policies, I explored publications available on Nestlé's website, as well as documents provided by IBFAN/GIFA. I was able to gain understanding of their position in terms of infant feeding and nutrition in emergency situations over time through these perspectives. I reviewed notes and presentations from relevant lectures of this semester, as well as from previous courses I have taken that cover this subject.

After this comprehension of the subject through publications and written sources, I then sought out the perspective of individuals working at various organizations involved with refugee situations, infant feeding, and HIV. By speaking with these experts, I was able to gain a more comprehensive understanding of the subject through conversation and interviews. I spoke with Dr. Sathya Doraiswamy, UNHCR; Dr. Lida Lhotska, IBFAN/GIFA; Dr. Mary S Lung'aho, CARE USA; and Maryanne Stone-Jimenez, WRA. I also was able to have a conversation with Marie Chantal Messier via email, which verified the perspective that I had developed of Nestlé through reading publications available online.

I chose to conduct my research this way because it allowed me to gain an understanding of the subject through literature and reading; once I felt comfortable with the subject, I was able to speak with experts on the matter and ask questions that I could not find through reading online and in publications by various organizations. I believe that in further pursuits of this subject, it would be useful to add an ethnographical element to the paper, involving personal interviews of pregnant and lactating mothers in refugee

situations to provide a personal narrative to the guidelines and policies. However, due to various limitations, this type of research was not possible. Interviewing vulnerable populations would involve a great deal of ethical considerations, ensuring that the rights of the participant were recognized and supported. In terms of ethical considerations of my research without the ethnographical aspect, it was important to alert my interviewees of their rights as a participant. I volunteered access to my final report to each individual; as well, I fully explained that our conversation would be used in my research paper.

Analytical Framework

My paper will refer to a fairly specific population: pregnant and lactating mothers living with HIV in refugee situations, specifically focusing on camps in the Turkana County of Kenya. By choosing such a specific population, I must be careful not to generalize what I find to be true in the Turkana County of Kenya and the camps there to therefore apply to all camps and all pregnant and lactating women across eastern Africa. As well, each individual camp faces its own challenges and its own risk factors. However, I believe that this selective study will allow me to gain an invaluable understanding of the greater problem at hand.

Looking at the population of pregnant and lactating women with HIV allows me to address many challenges that exist in refugee situations; it creates an interaction between women with HIV, infant nutrition, and the importance of breastfeeding; HIV in refugee situations; and the problem of malnutrition amongst mothers and children. It is important to consider these factors because they affect one another and relate to the greater framework of global health. As well, corporations like Nestlé can greatly impact infant nutrition and how aid is provided to those living in refugee camps. By combining

this information and these studies, I am exposing a significant and growing population while exploring both what is being done to help improve their situation and also what work must be done in order to provide sustainable solutions.

Analysis

Breastfeeding Recommendations

The World Health Organization recommends six months of exclusive breastfeeding, and continued breastfeeding with adequate complementary feeding for two years and beyond (WHO, 2003). These guidelines exist for all; from situations of refuge and emergency to the working-class life of a new mother with a demanding profession, the World Health Organization recommends this practice to be applied across the board. Mothers must be educated of the scientific evidence that supports these guidelines, in order to provide their children with the optimal chance of survival. Breastmilk is a living substance, filled with nutrients and enzymes that powdered formula simply cannot provide. Breastmilk is more than simply food; it provides significant health improvements and lessens the likelihood of death from diarrhea, acute respiratory infections, and other diseases. “A non-breastfed child is fourteen times more likely to die in the first six months than an exclusively breastfed child” (UNICEF, 2014a). As well, breastfeeding is the most cost effective method of feeding infants, in addition to limiting the need to visit healthcare facilities in order to treat other infections. Exclusive breastfeeding for the first six months, followed by continued breastfeeding supplemented with adequate complementary feeding for up to two years and beyond, is statistically proven to save lives of infants.

Dr. Lida Lhotska, of the IBFAN/GIFA network, provided me a perspective on the importance of breastfeeding and framed our conversation with the work that she has done to increase the prevalence of breastfeeding through the creation of guidelines and the development of policy. As well, she works to protect mothers from aggressive marketing of alternative infant feeding solutions that are not in line with the World Health Organization's standards. She mentioned that ultimately, with breastfeeding, "the level of skills and knowledge is crucial" in providing adequate care; the element of education is extremely significant in ensuring safe practices (L. Lhotska, personal communication, 30 April 2015). In acute emergency situations, like in Nepal after the earthquake on 25 April 2015, infant nutrition will take a backseat to shelter, safe water, and food security; it becomes a challenge to implement breastfeeding programs and ensure that safe breastfeeding is viewed as a priority in emergencies, to ensure that babies are receiving adequate nutrition and their health is not marginalized or affected greatly by a lack of acknowledgement.

In emergencies and refugee situations, IBFAN/GIFA does not have a huge presence on the ground; instead, they support the machinery that works directly with individuals, providing funds and appeals in support of breastfeeding. As well, they develop standards and guidelines to be applied across the board. What is missing, in these situations, is the support; Dr. Lhotska emphasized the importance not to throw formula at situations in need of nutrition support; donations can be detrimental to the health of infants and the practices regarding infant feeding (L. Lhotska, personal communication, 30 April 2015). IBFAN/GIFA works to regulate donations and scan for unsolicited donations, those that are not attached to a specific organization or a request. Many

societies are trending away from breastfeeding because associations of formula and humanitarian aid exist and are causing individuals to believe that infant formula is a viable solution, even when breastfeeding is possible and recommended.

Risks Associated with Other Feeding Practices

Many risks are associated with other feeding practices. A child does not need any other form of nutrition besides breastmilk before he or she reaches six months of age. Mixed feeding is defined as “breastfeeding combined with feeding other fluids, solid foods, and/or non-human milk, such as infant formula or animal milks” (UNHCR, 2009). Partial breastfeeding is included in this category, where breastfeeding is combined with non-human milk, food-based fluid, or solid food. Mixed feeding is a practice that has become widespread but has detrimental implications on infants. Mixed feeding increases the chances of an infant suffering from severe diarrhea and other infectious diseases. The supply of milk available from the mother lessens due to a lack of sucking at the breast. Mixed feeding also contributes to an increased risk of mother to child transmission of HIV; an infant is more likely to become infected with HIV from his or her mother if mixed feeding is practiced.

Artificial feeding can be culturally and regionally dependent; some regions are more likely to breastfeed while others are more likely to formula feed. Artificial feeding, or feeding with infant formula, is expensive and associated with serious risks of additional illness and death, particularly in regions where levels of infection are high and access to safe water is poor. The proper procedures for preparing infant formula are difficult to adhere to, especially in regions where access to clean water is limited and sanitary standards are low. Bottles cannot always be adequately cleaned. Formula is not

considered an adequate substitute because formula simply replaces some of the nutritional components of breastmilk; this food cannot replace the complex, living, nutritional fluid containing enzymes, fatty acids, and hormones that exist in breastmilk (UNICEF, 2014b). In situations where artificial feeding is prevalent, education is key to ensure that people are receiving the proper information regarding breastfeeding and infant nutrition. In many cases, inadequate medical advice is provided and women are recommended to artificially feed when that may not be the appropriate practice. Education and training must be implemented at all levels of care, from healthcare workers to leaders in mother-to-mother support groups, and beyond.

Refugee Camps and UNHCR

I was able to meet with Dr. Sathya Doraiswamy at the UNHCR; he works specifically in reproductive health, with significant past experience and expertise regarding HIV/AIDS in refugee situations. He provided me with comprehensive knowledge regarding the work that UNHCR does and how the agency is structured. The goals of UNHCR are to provide solutions for those living in refugee situations and for displaced populations. The average life of a refugee is seventeen years, though many camps are only structured to support shorter-term stays. UNHCR works to find a focus of assistance, with an initial emphasis on protection and basic human needs like shelter, food, and water. Next, there is an expanse in assistance, closely linked to initial protection. UNHCR works to support technical capacity in terms of assistance, partnering with other international NGOs to provide support (S. Doraiswamy, personal communication, 23 April 2015).

Dr. Doraiswamy explained the structure of UNHCR, specifically the public health sector within the organization, where he works. There are various advisors for various topics, each with a specific focus like water and sanitation, health information systems, nutrition, and food security to name a few. In the headquarters in Geneva, there is full representation of every topic. There are also regional offices, though they vary in organization and structure from region to region, based on need. For example, in Eastern Africa, the entire system that exists in Geneva is completely replicated. Below the regional level, there are country offices, then the sub-office within the country. The sub-office is responsible for overseeing five to six camps located within a zone. A field office overlooks three to four camps, with a more specific focus. Within each camp, there exists a field unit with individuals working on the ground. National staff typically runs field units; the refugees and the UNHCR employees typically have similar backgrounds and speak the same language; there is a distinct association between individuals working for UNHCR and those in need. Those who work at the field office spend time in the camps, identifying problems, solutions and needs. These varying levels of organization and care are all to ensure that top-down solutions are not applied to every camp across the board; they work to be culturally and regionally specific, as well as provide services that do not overarch and fail to consider specific needs of individuals.

I was curious as to how UNHCR ensures cultural competency when working on programs in camps, and Dr. Doraiswamy provided me with an example of the Ikea Foundation wanting to fund the creation of camps in Ethiopia in 2013. In order to be specific to the needs of the population, UNHCR brought in anthropologists to live amongst locals and gain valuable understanding about programs and features of the

camps that would be useful for the population (S. Doraiswamy, personal communication, 23 April 2015). This methodical and systematic approach to understanding the community's needs was invaluable to creating a safe place for refuge.

UNHCR provides life-saving support to individuals, while pursuing sustainable and durable solutions. Dr. Doraiswamy emphasized that the work that UNCHR does “is geared towards durable solutions” (S. Doraiswamy, personal communication, 23 April 2015). He mentioned the benefits of camps, as the success of these temporary mechanisms is measured from a solutions perspective: how many refugees have been returned, resettled, or integrated into the local community. Sustainable systems left behind create long-term support and solutions in places where camps once existed. Dr. Doraiswamy mentioned Uganda as an example, where UNHCR ran clinics, supporting the government's programs but were completely financed by the agency. The uptake of the clinics was 70 to 30, in favor of national Ugandans. The structure and systems of healthcare are often weakest where there is an influx of refugees. This struggling area of the country suddenly became vibrant, benefitting the country over time because of the temporary mechanisms in place. Significant advantages came out of these camps, providing infrastructure that eventually strengthened the county's healthcare system and left a lasting impact. This lasting impact is, according to Dr. Doraiswamy, one of the most significant aspects of the work done by UNHCR.

Dadaab, Kenya

The largest complex of refugee camps in the world is located in Eastern Africa, in the Turkana County of Kenya. Dadaab, the closest town, is the site of a place of refuge for close to 430,000 individuals (Save the Children, n.d.). The camps were originally

designed to hold up to 90,000 refugees; however, the food crisis in the horn of Africa during 2010 to 2012 exponentially increased the population of individuals and expanded the demands on the camp. The greatest numbers of refugees are fleeing the neighboring country of Somalia. Up until now, Kenya has been extremely supportive towards the refugees, exemplifying the country's strong humanitarian traditions and values of generosity and hospitality, specifically towards asylum seekers and refugees. UNHCR is currently working to secure new land for operations in Kenya. However, recent political events have brought to light the potential of a shutdown of the Dadaab camps in Kenya.

The Islamist al-Shabab group in Somalia has been terrorizing the country, becoming more present and violent in recent months. In April, the group attacked Garissa University, killing 148 people (Steers, 2015). The extremist religious group recruits young boys to conduct many of their violent acts. Somalia is currently a very dangerous place to be and reside, hence why so many currently reside in Dadaab camps in Northeastern Kenya. Because of the attack in April and the association with many in Dadaab with al-Shabab, the vice-president of Kenya has demanded that the United Nations closes Dadaab. The temporary camp has provided its refugees with resources and infrastructure that simply do not exist in Somalia; many have more of a sense of security, residency, and access to education and resources in the camp than they do in Somalia. To repatriate the camp would leave many homeless and without a relatively safe and secure place to live. Repatriation would interfere with schooling, health care, and the avoidance of joining al-Shabab. Time Magazine published an article about the dangers of repatriation, titled *Somali Refugees Fear Being Thrown Out of Kenya*. One man living in the camp, Salat, believes whole-heartedly that if he and his family were to return to

Somalia, he would be forced to join the group; “Shabab is everywhere. They cannot be finished just by closing the camp. If my kids go back there, they will recruit them like they forced me to join” (Steers, 2015). Refugee camps everywhere are complexly political and an immediate solution does not exist to find solutions and permanent residence for those living in camps. Dadaab has unique challenges to overcome that involve religious extremist groups and a complex relationship with the receiving country in recent months. Meanwhile, people are suffering and dying because of difficult living situations and a lack of support; mothers, specifically, need support and programs must be in place to provide them with the adequate education about the nutrition of their infants.

Operations in Dadaab

Each year, the WFP releases a Joint Assessment Mission report (JAM) on their operations in various refugee situations throughout the world. This report covered all aspects of current operations in Kenya, focusing specifically on the Dadaab and Kakuma camps. I focused my research on the segments specifically dictating the programs and work being done surrounding infant and young child feeding practices: both the current work being done and the recommendations for the future were discussed. WFP and UNHCR work together to ensure that these populations are supported and each camp is individualized in its needs. The report states, “the promotion of proper infant and young child feeding practices remains the most proven high-impact strategy on child survival” (WFP, 2014). Action Contre la Faim, an organization that work on the ground to support infant feeding, provides technical support, strengthening the ability to achieve optimal feeding practices and improve the survival rate of infants in the camps. Currently, there

still exists a gap in the translation of knowledge between guidelines and education of officials working on the ground in the camps. The current goals are to focus on behavioral change, to strengthen the likelihood that a mother will breastfeed when properly educated. As well, there will be a focus on increasing MIYCN programs across the board in camps, and full integration of established programs of education and the spread of knowledge at all levels, scaling up in camps where they already exist and establishing where needed. Knowledge on high-impact nutrition interventions will be passed onto all mothers in the community.¹

The Dadaab IYCF team, comprised of CARE, UNHCR, GRZ, IRC, NCKK, and MSF-SWISS, works to improve infant and young child feeding in this particular emergency situation (Stone-Jimenez, Lung'aho, 2009). The objective of the work that this team does is to integrate IYCF into multi-sectoral programs, rather than singling it out as a unique entity.² They provide ongoing training, ensuring that each member of the staff understands his or her responsibilities in supporting appropriate IYCF practices, emergency preparedness, training of facility and community based counselors, mother-to-mother support group leaders and facilitators, and others. The work is focused on community approaches to facilitate behavior change communications; one way they work towards this goal is through the camp-wide, annual celebration of World Breastfeeding Week.

¹ Support for programs is established at a large scale, from agencies like WFP and UNHCR, while implemented by NGOs and local figures to ensure cultural competency and accurate, regionally specific action.

² By incorporating IYCF in all aspects, rather than excluding it as a single program with no relation to other parts of development, it becomes integrated and comprehensive. Programs do not exclude women with young children and infants, rather including and empowering them. This is important in increasing success rate and integration.

To ensure support of lower-literacy populations within the camps, information and programs are implemented through community-based workers and volunteers, building capacity. Support groups empower women, catalyzing change within the camps (Stone-Jimenez, Lung'aho, 2009). Individuals are influenced through group support and education. Facilitators are trained, speak the language, and are trusted and known within the community; this ensures cultural competency and increased success and trust within the groups, an extremely influential factor regarding development and community-based health and support.

I spoke with both Mary Lung'aho and Maryanne Stone-Jimenez, the authors of a report on the work done in the Dadaab camp. Both women provided me with invaluable perspectives of their work on the ground in Kenya. Maryanne Stone-Jimenez discussed much of the process surrounding the training of facilitators, and unique perspectives about breastfeeding in Dadaab. She mentioned the relationship between breastfeeding and menses, how when one breastfeeds menses tends to halt; when one finishes, menses returns. In Dadaab, women would begin breastfeeding after giving birth, then their period would stop. They would believe they were pregnant again, and stop breastfeeding, causing them to get pregnant (M. Stone-Jimenez, personal communication, 6 May 2015). This simple lack of scientific understanding caused a higher birth rate, and when educated in support groups, she mentioned that an “aha” moment would occur for the women. Support groups facilitate shared experiences, providing a supportive environment conducive to questions and conversation. She also mentioned another solution of breastfeeding in refugee camps today: breastfeeding corners or tents. These

spaces allow lactating women to gather and breastfeed in a place that is safe and removed from other factors of the camp.

Dr. Mary Lung'aho, a consultant of CARE, works with mother-to-mother support groups in refugee situations from a systems perspective; she elaborated on the organization of the network and training process. CARE no longer has active operations in Dadaab, but prior to 2010 they were very active (M. Lung'aho, personal communication, 6 May 2015). Overall program managers exist in Dadaab, and then one national Kenyan manager works at each camp. Below the manager are Somali refugee workers at each health post in the camp. This structure creates a referral system, so that if a facilitator runs into a situation where she needs assistance, she could refer the pregnant or lactating woman to someone further up the latter.

Volunteers were trained in a way that was accustomed to the culture and led in their language; mother volunteers were often uneducated themselves, and a daylong classroom method of training would not be productive. Training was broken up into smaller parts and implemented over time. The number of support groups grew organically to over 600 at the time that CARE left; they formed somewhat on their own with support and encouragement of the agency (M. Lung'aho, personal communication, 6 May 2015). In Dadaab, the growth of the program was successful because of proximity of health posts and women living close together; the women live in such a small area that it was easy to meet and discuss. As well, it was not required to participate in a support group. Therefore, there existed an element of choice versus obligation, which was invaluable to the success of the groups.

IYCF has been successful in Dadaab, increasing the rate of compliance to global standards for infant nutrition. Mothers are provided with protection, promotion, and support. It can be difficult to convey IYCF as a high priority, when resources are limited and the immediate needs like shelter and nutrition for all must be met; however, providing IYCF support allows for ongoing improvement and brighter outcomes for infants. As well, mother-to-mother support groups provide more than education and facts about breastfeeding; they also provide a safe environment and empower women to be advocates for themselves, in the most difficult of situations. They provide peer counseling, allowing women to discuss their values, discover others' opinions and assumptions, ask questions, and encourage new ways of thinking about health and the health of infants and young children. Mothers are exposed to global recommendations for breastfeeding in an accessible way, along with this invaluable support network. Improvement regarding compliance to these guidelines continues to show, despite the exponentially increasing size of the populations of the camps.

Breastfeeding and HIV

HIV creates various other health challenges, but proves to be uniquely difficult for pregnant and lactating women. When Dr. Doraiswamy was asked about HIV and breastfeeding, he discussed how this goes back to the basic principle of food security and support, that every individual should receive 2100 kCal per day. However, in a family of five, for example, the calculation becomes fairly complex; UNHCR must calculate the division of resources amongst individuals with different needs. For example, one may be infected with HIV, one may be a child, one may be pregnant; various factors go into the calculation. In areas where food security is high, this first level of blanket feeding is

provided, and supplementary feeding is provided afterwards, with a distinct focus on specific, vulnerable populations: children under two, pregnant women, and persons living with HIV are just a few examples of targeted, supplementary feeding (S. Doraiswamy, personal communication, 23 April 2015). As well, periodic screening for malnutrition of those under five is provided; when severe malnutrition is detected, therapeutic feeding is provided for that child. UNHCR, along with the other organizations, work to provide a complex network of support regarding food security in refugee situations.

Many organizations came together to develop a set of guidelines for ensuring access of Antiretroviral therapy to migrants and crisis-affected persons in Sub-Saharan Africa; the development of these guidelines were funded by the UNHCR, aimed to ensure that people in complex environments with poor adherence rates associated with increased resistance to these drugs can be properly guided in taking ART and reduce the viral load in their bodies. Pregnant and lactating women living in crisis-affected populations are among the most vulnerable and most in need of support for antiretroviral therapy; if viral loads are reduced in the body of a woman with HIV, she is significantly less likely to transmit HIV to her child through childbirth and breastfeeding. By practicing exclusive breastfeeding partnered with an increase in ART for the lactating woman lowers risk of transmission, in addition to lowering the risk of the child dying from infection, diarrhea, pneumonia, and acute respiratory disorders (UNHCR, 2010). Because those living in refugee situations are significantly more likely to have issues regarding adherence and face other daily struggles that impact the transmission of disease, special guidance is necessary. The document dictates clear recommendations for states, clinicians, program

managers, and others involved in the reduction of HIV transmission in refugee camps and amongst displaced populations.

Maryanne Stone-Jimenez also mentioned in our interview that HIV and breastfeeding treatment varies country to country, based on resources, finances, and access. It is the Ministry of Health in countries who decide if AFASS BMS or breastfeeding with ART are the viable solution to breastfeeding with HIV. The government then finances whichever they recommend; if the answer is AFASS BMS, then the government must provide enough infant formula to last for six months and beyond (M. Stone-Jimenez, personal communication, 6 May 2015). If a woman decides to choose the other option, she must finance that herself. This complicates in refugee situations, because they are not funded directly through the government. Therefore, women in refugee camps abide by the standards mentioned in UNHCR documentation.

ART makes breastfeeding dramatically safer for infants; the guidelines emphasize the importance of balancing risks between breastfeeding and the potential transmission of HIV to infants and the risks associated with replacement feeding. Evidence has major implications on women living with HIV and how they will feed their infants, and specifically how health workers should consult mothers. The general recommendations for women with HIV and infants under six months will depend on local conditions; replacement feeding must be *acceptable, feasible, affordable, sustainable, and safe* (AFASS), which can be difficult to supply especially in emergency situations and refugee camps.

AFASS

The guidelines for women living with HIV in refugee camps and emergency situations do not differ from the guidelines for women living in other parts of the world. The UN policy on the decision if a mother will breastfeed or not follows the suggestions explicated by the World Health Organization that were concluded and explicated for the October 2002 WHO Consultation on mother to child transmission of HIV:

“Because both parents have a responsibility for the health and welfare of their children, and because the infant feeding method chosen has health and financial implications for the entire family, mothers and fathers should be encouraged to reach a decision together on this matter. However, it is the mothers who are ultimately in the best position to decide whether to breastfeed, particularly when they alone may know their HIV status and wish to exercise their right to keep that information confidential” (WHO, 2002).

The decision ultimately lies in the hands of the educated mother infected with HIV to choose to whether or not breastfeeding will be the safest option. If replacement feeding is AFASS, the mother is encouraged to pursue it; however, specifically in emergency situations, it is rare to find replacement methods that are AFASS. Wet nursing can be AFASS in the context of HIV, depending on if the practice is considered as an acceptable option depending on the culture. Wet nurses must be tested for HIV before and six to eight weeks after they begin nursing (UNHCR, 2009)³. The safety of the wet nurse must be ensured as well; there exists a possibility of transmission of HIV to the

³ Wet nursing is a practice that may not necessarily be widely accepted, and therefore is only a viable option if it is *acceptable*, a key factor in determining replacement feeding as AFASS.

HIV-negative wet nurse from the infant, if he or she was infected at some point before wet nursing was introduced. This can limit the amount of women willing to wet-nurse and make the solution less feasible. Heat-treatment of breastmilk can also be a viable replacement method in the context of HIV, granted that the proper technology is available. This, however, is not necessarily AFASS, because the element of education and technological knowledge may not be a priority or a possibility in emergencies. Frequently, the benefits of breastmilk that has the potential to transmit HIV outweigh the risks associated with mixed or replacement feeding.

IBFAN/GIFA and Corporations

IBFAN/GIFA works to monitor donations, survey the media, and go to the source, alerting people and sharing with them the international policy that exists regarding breastfeeding. They work to inform NGOs on the policy and recommend what should be done to ensure that unsolicited donations do not make their way into the scope of a solution regarding infant nutrition. It is important for a need to be established before donations enter a region; for example, in refugee camps, an influx of infant formula can cause extremely detrimental results. Dr. Lhotska mentioned the psychological association with donated products; individuals remember the products that are available during emergencies and in times of crisis; products then become associated with aid and have a positive connotation, even if they are not nutritionally adequate.

As well, Dr. Lhotska mentioned situations where emergencies are used as means for opening markets; this can be extremely problematic (L. Lhotska, personal communication, 30 April 2015). In Haiti, for example, the earthquake in 2010 was extremely devastating and destructive to one of the poorest nations in the world. Liters of

expressed milk for babies from women in the United States were donated and brought into the country; this solution, however, is not affordable or feasible. This new, expensive product could not be afforded by the nation; donations of this form of replacement feeding were discouraged due to the lack of an ability to support the practice (Rochman, 2010). Dr. Lhotska also mentioned that government officials in Haiti reported that manufacturers of replacement feeding were contacting them and requesting to open a market of breastmilk substitutes after the emergencies.

Public Health Agencies versus Corporations

There are different viewpoints and motives between those working in the public health and humanitarian sector, and those who work for corporations.⁴ Business plans of corporations are shaped by their roles as figures in the humanitarian aid sector and scene. Often, efforts are good-willed and well intentioned; however, there is a lack of documentation supporting this evidence. Corporations will provide products through student groups and NGOs, through networks that are not necessarily providing publicity of their efforts; this makes it difficult for a network like IBFAN/GIFA to trace the donations back to the corporate source. Emergencies are easily exploited by companies, which can be extremely challenging to ensure proper healthcare services and support for those in need. As well, emergencies and refugee camps can be extremely political and governments and NGOs lack the ability to speak up in order to ensure support. Dr. Lhotska mentioned how there is a lack of support for those who speak up in light of controversy; there exists “an absolutely miserable protection of whistle blowers

⁴ Companies often will present themselves as figures that consider humanitarian aid as a priority; however, behind a façade of aid and humanitarian efforts there exists a financial motive.

throughout the world” (L. Lhotska, personal communication, 30 April 2015). Because of this, people are not willing to speak up and spark change because sometimes, it means restructuring the entire system. Those who work in public institutions who have an oath towards the UN Charter to speak up against corruption and unaligned values are often silent because of this lack of protection.

Dr. Lhotska stressed that a company like Nestle has a certain role in society to produce food, and that this food should be of good quality. It has a responsibility to produce food of good nutritional value because as a corporation of such great scale, they are well informed and must work to avoid contributing to the “epidemic proportion of obesity” that the world faces today (L. Lhotska, personal communication, 30 April 2015). This chain of events and development of non-communicable diseases in societies that are influenced by Nestle and their marketing strategies, especially in emergency, must be eradicated from the beginning.

Nestlé and Breastfeeding

Nestlé as corporation has a complex history surrounding marketing of their products. They have been accused of aggressive marketing of breastmilk substitutes that are not necessarily AFASS in the high-risk countries that they are advertised in, something that is considered to be a crime and extremely detrimental to the life and development of an infant (Lhotska, 2008). As well, during emergencies, large influxes of powdered infant formula arrive at the site of a natural disaster or in a refugee camp, sometimes Nestlé brand or others. In recent years, Nestlé has been working extremely hard to eliminate the association with aggressive marketing and of unsolicited donations, following both WHO Code and FTSE4Good BMS Criteria, of which they are the only

corporation to be considered to comply by the standards. Nestlé is one, well-known example of a company that produces BMS and has a corrupt history regarding the promotion of their products; however, they are not the only offender. This is important to note; I am using Nestlé as an example with a fairly well documented history regarding their successes and failures in terms of BMS. The corporation is by no means the only example of this.

Nestlé is committed to marketing their BMS responsibly, with significant efforts promoting good nutrition in the first 1000 days of life. They publicly report their progress to assure their commitment to safe and responsible marketing (Nestlé, n.d.). They have strengthened training for third-party distributors, assuring their requirements to comply with national legislation, and Nestlé's policy for the implementation of the WHO Code. In a correspondence with Marie Chantal Messier of Nestlé, she clearly stated, "Nestlé promotes and supports breastfeeding as recommended by the WHO. We also have a global public commitment to market our breastmilk substitutes responsibly. Which means that, in line with the World Health Organization (WHO) Guiding Principles for feeding Infant and Young Children during Emergencies, Nestlé does not donate infant formula to individuals or organizations in times of emergencies, unless it receives an official request from the government of the country affected" (M. Messier, personal correspondence, 1 May 2015). Her statements confirmed the information I had read online, published by Nestlé.

Currently, in emergency situations and refugee camps, Nestlé has a limited role. Dr. Doraiswamy had acknowledged that the UNHCR does not have a relationship with the corporation (S. Doraiswamy, personal communication, 23 April 2015). They do still

support governments in need, but only when requested. Occasionally, donations slip through the cracks of regulation; Dr. Lhotska mentioned that in Nepal after the devastating earthquake that destroyed much of the region on 25 April 2015, shipments of donations have included infant formula. IBFAN/GIFA regulates donations but cannot always source the donations back to the companies.

Marie Chantal Messier emphasized that Nestlé strictly follows the recommendation from the WHO and UNICEF that states breastmilk substitutes must be channeled through the national government or designated coordinating agency, which will then provide BMS after evaluation of each specific case (M. Messier, personal communication, 4 May 2015). They follow the published guidelines, codes, and standards in terms of emergencies, careful not to be accused of improper practices. She stated, though, that Nestlé “regularly provides assistance to populations affected by disasters through funds donated to a humanitarian agency or in-kind food products, with the exception of infant formula” (M. Messier, personal communication, 4 May 2015). These socially responsible methods of aid are beneficial, and impact the receiving nation greatly.

Nestlé’s Social Progress and Responsibilities

Nestlé publishes a report every year, elaborating on the work they have accomplished and their perspectives surrounding various social issues and challenges they are working to overcome. For example, Nestlé has conducted a research project titled the “Feeding Infants and Toddlers Study,” that works to analyze and understand nutrition of infants and young children, their dietary patterns, and lifestyle factors. They “aim to provide products, information, and education that supports parents in ensuring

health growth and development of their children” (Nestle, 2014). Mothers put their trust in a carefully constructed formula to replace breastmilk. Nestle must ensure that they are providing a product that can be trusted, and they constantly work to create the safest product they can. The problem is, breastmilk is scientifically proven to be the optimal feeding method for an infant; if it is to be replaced, the corporation must also supply other factors like education of the product and adherence support.

Each commitment of Nestlé’s explicitly states what they are working towards and the means of improvement. One goal, to “market breast-milk substitutes responsibly,” elaborates on the efforts of the corporation to promote good nutrition, particularly in the first 1000 days of life (Nestle, 2014). They are working to support breastfeeding, even in the most challenging of circumstances. “We believe breastmilk is the best food for infants and this is why we promote it. However, there are still numerous barriers to breastfeeding” (Nestle, 2014). When breastfeeding is not possible due to various physical and social barriers, Nestlé is committed to providing the best possible alternative. However, there exist many structural barriers in the use of infant formula, especially in emergency situations when basic means of survival like shelter, food, and clean water aren’t available. In these situations, infant formula cannot be an AFASS form of BMS.

FTSE4Good Index BMS Criteria

Nestlé also is consistently working to remain the only corporation to meet the FTSE4Good Index BMS Criteria, which is the only global responsible investment index with clear criteria on the marketing of BMS. This is a status that they actively promote in their publications. However, controversies exist surrounding the FTSE4Good Index BMS Criteria and its relationship with the WHO Code for breastfeeding. The FTSE has the

criteria published; they explicitly state that the criteria build on the code, but differ from it. It requires companies to adhere and be aligned with the code, but goes a step further and assesses how companies implement various interior factors like senior level accountability across different country operations, internal training systems, and whistle blowing to name a few (FTSE, n.d.). Once a company meets the criteria, and Nestle is currently the only company to meet this, that specific corporation is subject to independent verification assessment in two high-risk countries, determined by FTSE. Assessment is regarded in compliance to the FTSE4Good BMS Criteria, rather than noncompliance to the WHO Code. There is this specific focus on high-risk countries rather than low risk countries. This fact is an issue with development, generally, because focus is often placed on specific regions in need; meanwhile, incredible disparities exist within industrialized regions. FTSE is criticized for choosing specific high-risk countries to focus assessment on, while these policies should be universally applied.

Different Perspectives

There exist conflict and significant mistrust between the private sector and the realm of NGOs who are working to promote optimal health and feeding practices for infants. Corporations and NGOs should work together to promote global nutrition, but motives often are notably different. This does not necessarily mean that the private sector is seeking to devastate infant nutrition globally; instead, their motives are typically framed around opportunities to create profits. Presenting a corporation as socially responsible is often a major part of their business plan. One could always question a company like Nestlé and their motives for promoting social responsibility, but the truth

lies in the fact that if they execute their social responsibility well and are not simply creating a façade, then motives are less important.

Often, healthcare NGOs work towards the improvement of social factors, ensuring safety and healthcare access for various populations globally. Their motives are centralized around human rights, without a monetary focus. This does not hold true across the board, but generally in this realm of infant nutrition and those living in emergency situations, most are focused on solutions for the human rights of these individuals. Nutrition is complex because it inherently involves the private sector and the work of NGOs and governments to all intertwine and work together. There is a level of collaboration that must occur, which can be difficult with various perspectives and goals between each group.

Conclusion

Breastfeeding touches virtually every aspect of life; it can be looked at from a perspective of health, ecology, environment, economics, climate change, social issues, politics, the relationship between corporations and NGOs, the interaction of power between those who have it and those who do not, the personal, intimate interaction between baby and mother, and the framework of education and health care. Dr. Lhotska raised the important point that breastfeeding can be used to enter any sphere and any network of international code, used as a case study, and then elaborated to expose and describe a concept. In this case of refugee camps and pregnant or lactating women with HIV, one of the most vulnerable populations in the world, the scope expands from a single case study of mother-to-mother support groups in Kenya to the relationship of

corporations with NGOs, and rights of individuals to be protected from the motives of big companies. Infant nutrition is a complex issue with complex solutions, specific to each mother and her child. Because solutions are so complex and each mother is unique in her health and situation, it is impossible to apply guidelines across the board in a universal way; therefore, organizations must work to individualize each situation while working towards a general framework of development and rights.

Abbreviations List

AFASS – Acceptable Feasible, Affordable, Sustainable, Safe

BMS- Breast Milk Substitutes

FTSE4Good – The Federal Times Stock Exchange Social Good Index

FTSE – Federal Times Stock Exchange

GIFA – Geneva Infant Feeding Association

IBFAN – The International Baby Food Action Network

IFE Core Group – Infant Feeding in Emergencies Core Group (Consists of UNICEF, UNHCR, WHO, WFP, IBFAN-GIFA, CARE, Tdh, ENN)

IYCF- Infant and Young Child Feeding

NGO – Non-Governmental Organization; specifically in this paper, NGOs are organizations concerned with social issues, not associated with the government, and not associated with the private sector.

STC – Save the Children

UNAIDS – Joint United Nations Programme on HIV/AIDS

UNHCR- The United Nations High Commissioner for Refugees

UNICEF- United Nations International Children’s Emergency Fund

WFP- World Food Program

WHA – World Health Assembly

WHO – World Health Organization

WRA – White Ribbon Alliance

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