

From Policy to Practice: Challenges in Infant Feeding in Emergencies During the Balkan Crisis

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The preparation and dissemination of policy statements are necessary but insufficient to prevent the inappropriate use of infant-feeding products in emergencies. The widespread failure of humanitarian agencies operating in the Balkan crisis to act in accordance with international policies and recommendations provides a recent example of the failure to translate infant-feeding policies into practice. This article explores the underlying reasons behind the failures which include: (1) the weak institutionalisation of policies; (2) the massive quantities of unsolicited donations of infant-feeding products; (3) the absence of monitoring systems; (4) inadequate co-ordination mechanisms; (5) the high costs of correcting mistakes; and (6) the cumulative effects of poor practice. Efforts to uphold best practice during the crisis are also documented. Finally, the article identifies actions that could be undertaken in advance of and during future emergencies to enhance the application of infant feeding policies in emergencies.

Keywords: infant feeding, policy, practice, humanitarian response.

Introduction

The benefits of breastfeeding are well documented (Akre, 1989; Michaelson et al., 2000). Until the age of six months, exclusive breastfeeding provides all the nourishment an infant requires for normal growth and development (personal communication, Graeme Clugston, 5 April 2001). Exclusive breastfeeding also

provides considerable protection against infection during the first six months. Breastfeeding practices, however, can be undermined by the indiscriminate provision of breastmilk substitutes. Artificial feeding practices, such as the use of these substitutes, have been shown to be associated with increased infant mortality and increased morbidity — especially gastro-intestinal disease — among infants (Kelly, 1993).

In 1979, in response to a growing awareness of the association between advertising breastmilk substitutes and the declining rate of breastfeeding, WHO and UNICEF convened an international meeting on infant and young child nutrition. One of the recommendations from the meeting was the need for an international code of marketing for infant formula and other products used as breastmilk substitutes. Subsequently, representatives from UN and other institutions, including the food industry, were then involved in a consultative process that culminated in the drafting of the International Code of Marketing of Breastmilk Substitutes. The code was endorsed by the World Health Assembly (WHA) in 1981 in a resolution which stressed that the code is a ‘minimum requirement’ to be enacted in ‘its entirety’ by all countries, that it should be translated into ‘national legislation’, and that compliance with the code should be monitored (WHA 34.22). The aim of the code is:

to contribute to the provision of safe and adequate nutrition for infants, by the protection and promotion of breastfeeding, and by ensuring the proper use of breastmilk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution.

Since 1981, the WHA has passed a number of resolutions, all of which have equal status with the code. The code and resolutions provide important guidance for health workers and safeguards for parents and infants, including those in emergency situations.

In the environmental conditions characteristic of most emergencies, breastfeeding becomes even more important for infant nutrition and health. The crowded and unsanitary conditions typical of many emergency situations contribute to the increased prevalence of diarrhoeal diseases and subsequent malnutrition and mortality (Yip and Sharp, 1993). The resources required for safe artificial feeding, such as water, fuel and adequate quantities of breastmilk substitutes, are usually scarce in emergencies (ENN, 1998). Furthermore, artificially fed infants, who lack access to the unique anti-infective factors in breastmilk, are correspondingly more vulnerable to disease (Kelly, 1993). The impact of humanitarian crises on breastfeeding, the risks associated with artificial feeding in emergencies and the importance for humanitarian agencies and other relevant institutions to ensure that the international code is equally adhered to and applied in emergency situations was highlighted during the Iraqi crisis in 1991 (Kelly, 1993). In recognition of the increased risks for infants associated with artificial feeding in emergency situations, the 1994 Resolution specifically states that

in emergency relief operations, breastfeeding should be protected, promoted and supported. Any donated supplies of breastmilk substitutes (or other products covered by the Code) may be given only under strict conditions (if the infant has to be fed with breastmilk substitute); the supply is continued for as long as the infants concerned need it; and the supply is not used as a sale inducement (WHA 47.50).

During the past decade, a number of different policy documents and guidelines describing the actions necessary to support and promote best practice in infant feeding in emergencies have been prepared and disseminated by international agencies and experts (UNHCR, 1989; UNCHR, 1999; WFP, 2000). These documents have been reviewed and the areas of inconsistency highlighted; gaps in related policies are described elsewhere (Seal et al., this issue). Despite these policy statements, many humanitarian agencies, in fact, fail to comply with these best practice recommendations. More recently, documents providing guidance on how to implement infant-feeding policies have also been prepared (ENN, 1998; Interagency Working Group on Infant Feeding in Emergencies, draft Feb 2001). These documents and others, describe how good practice can be practically supported in emergency situations.

The application of these policies and the role of humanitarian agencies in the acceptance, supply and distribution of infant-feeding products were the subjects of scrutiny during and following the Balkan crisis of 1998–2000. The humanitarian response to the Balkans during this period exemplifies the failure to adhere to best practice. The evidence presented here was gathered by staff of Save the Children (SC-UK) and the Institute of Child Health (ICH) and several of the authors working in the region during the crisis. The examples of mistakes made by agencies selected for inclusion in this paper represent a small proportion of those made by the majority of agencies. We analyse the reasons behind the documented failures and highlight any efforts made to uphold best practice recommendations. Finally, we suggest actions that could be undertaken in advance of and during future emergencies to enhance the application of infant-feeding policy in emergencies in order to ensure that the humanitarian community protects the life and health of young infants. The systematic assessment of infant feeding practices and the specific programme interventions required to support and promote good practice for infant feeding in emergencies are not discussed in this paper.

Background

Kosovo, a province of southern Serbia, at the time of the crisis had an ethnically mixed population, the majority of which was Albanian. The region enjoyed a high degree of autonomy within the former Federal Republic of Yugoslavia (FRY) until 1989, when it was brought under the direct control of Belgrade. A period of increasing unrest in Kosovo followed. International attention in the mid-1990s focused on the escalating conflict, its humanitarian consequences and its potential to spread to other countries (Wiles et al., 2000). Throughout 1998 and early 1999, diplomatic efforts aimed at achieving a peaceful resolution to the crisis intensified (op. cit.). In March 1999, failure to achieve a political solution was followed by the aerial bombing of Serbian targets by the NATO and the deployment of military ground forces. Between 24 March and 10 June 1999, an estimated 444,200 Kosovars had fled to Albania and a further 247,200 to Macedonia (op. cit.). An unprecedented number of agencies and institutions were involved in the humanitarian operations in the Balkans, including UN agencies, donor organisations, NATO and up to 350 non-governmental organisations (NGOs). The amount of international financial resources that were allocated for the Balkan emergency was far greater in comparison with that available for emergencies in other parts of the world (ACC/SCN, 2000: 71).

Traditional infant-feeding practices were relatively poor in Kosovo prior to the onset of the crisis (AAH, 1999), which may have rendered the challenge to promote and support breastfeeding even more difficult. The conditions in the refugee camps in both Macedonia and Albania and for the refugees during the repatriation were not conducive for the safe preparation of artificial breastmilk substitutes. Furthermore, the safe preparation of artificial breastmilk substitutes was extremely difficult for families who returned to homes in Kosovo that had been completely or partially destroyed. Power failures that occurred frequently throughout post-repatriation were also obvious constraints. It is in this context that the failure to implement good practice infant-feeding guidelines and policies is examined.

Awareness and application of policies and good practice guidelines

During the Kosovo crisis, many agencies with infant-feeding policies and good practice guidelines did not apply them. Good practice was more dependent on the presence of individuals with relevant knowledge, interest and experience in infant feeding than on the systematic communication within the respective organisations of a previously endorsed policy. Two examples include (SC-UK and ICH, 1999):

- A representative from an international organisation in Geneva made a clear reference to their own agency policy which prohibited the distribution of feeding bottles. Despite this, a field representative in FYR Macedonia distributed bottles to refugees during the early phase of the crisis.
- An international NGO in FYR Macedonia had an organisational policy prohibiting the use of infant formula within their programmes. However, an exception was made for the donated infant formula distributed in the emergency since it had not been procured directly by the organisation.

The distribution of commodities during humanitarian interventions usually involves multiple stakeholders, such as donors, transport contractors, UN, international NGOs and national NGOs. In the Balkans, management staff of humanitarian organisations incorrectly assumed that partners with specialised expertise farther down the distribution chain would ensure that the items would be distributed and used appropriately. For example, during the early stages of the humanitarian response in Macedonia, a major UN agency, by accepting unsolicited donations of commercial infant food including brand-name infant formula, did not comply with best practice. Despite not being covered by their operational guidelines, these donations and others were distributed to aid organisations on request (SC-UK and ICH, 1999). This action was contrary to the Joint UN Statement on Infant Feeding in the Balkans¹ to which the agency is signatory.

The successful application of good practice guidelines requires a mechanism for raising awareness among relevant implementing partners. Despite facing a number of challenges in Kosovo, humanitarian agencies made significant efforts to raise awareness of good practices. An example of these efforts included the working group established jointly by United Nations High Commissioner for Refugees (UNHCR) and World Health Organization (WHO) to promote awareness of good practice in infant feeding. The working group, which was based in Pristina and jointly chaired by

UNHCR and WHO was well supported and included representatives from UNHCR's eight food-aid partners, as well as World Food Programme (WFP) and the United Nations Children's Fund (UNICEF).

The working group, however, faced a number of challenges. After the initial meeting, the majority of the food-aid partners requested substantial support from one of the UN or NGO agencies with expertise in the area of infant feeding, so their agencies could move ahead in promoting best practice through, for example, staff training and modifying monitoring systems. In reality, the agencies to which requests were made did not have the time or human resource capacity to provide sufficient support for any substantial progress to be made. Furthermore, within the working group, there were diverse opinions and knowledge of infant-feeding issues. While representatives themselves may have been better informed after attending meetings, change depended on their ability to influence attitudes and actions within their own agencies.

Another constraint facing the working group resulted from the exclusion of other important partners in the field. To be effective, the working group needed to include organisations such as national NGOs, Ministry of Health staff, donor representatives and other food aid agencies. Different strategies were required in approaching these different sections of the humanitarian community. For example, for the working group to challenge traditional perceptions of infant feeding among national partners, the need was for a very different approach from that required for donors — where the emphasis would predominantly be on the cost implications of poor practice. To implement a more effective strategy, the working group required more skilled human resources to provide support, wider membership and more timely intervention — namely at a much earlier stage of the emergency.

Co-ordination

The broad co-ordinating roles of the relevant UN agencies in humanitarian emergencies are generally well known: WHO is a technical UN agency while UNCHR, UNICEF and WFP are operational agencies that contract work out to government or NGOs. The unprecedented number of NGOs, donors and bilateral agencies and the quantity of resources directed to the humanitarian response in the Balkans created enormous challenges for co-ordinating agencies. Efforts to prevent or control the distribution of infant-feeding products were, to a large extent, in vain throughout the different stages of the crisis; from the acute phase, to the repatriation phase and finally, to the return of the population to Kosovo.

The acute phase of the emergency

During March and April 1999, prior to the establishment of the WFP food pipeline in Macedonia, the British NATO logistics camp was responsible for receiving, storing and transporting all donated food. However, the distribution of food-aid commodities was co-ordinated by WFP. The difficulties of co-ordination were exacerbated by the fact that NATO military staff members were unaware of standard humanitarian distribution procedures, particularly in the areas of targeting and monitoring.

The lack of effective co-ordination mechanisms during this initial stage in FYR Macedonia contributed to a number of problems. In particular, ultra-high-

temperature (UHT) milk and other infant-feeding items that were distributed as part of the food rations provided by NGOs were not monitored (SC-UK and ICH, 1999). Systems of co-ordination and monitoring of 'complementary food'² distribution, as required under the Memorandum of Understanding (MOU) between UNHCR and WFP (UNHCR/WFP MOU, 1997), were not established until the arrival of a UNHCR nutritionist in June 1999. Subsequently, UNHCR's ability to co-ordinate nutrition-related activities effectively was limited because it did not fund any agencies directly for nutrition programmes. Furthermore, specific operational responsibilities of UNHCR and UNICEF, such as the systematic monitoring of NGO and UN warehouses, required for the support of good practice, were not clearly defined at this initial stage.

The repatriation to Kosovo

The scale and speed of the repatriation was remarkable. As part of the humanitarian response during this stage of the crisis, a major international donor funded the provision of 500,000 food parcels (packaged in plastic buckets) for refugees repatriating from Macedonia to Kosovo. The buckets contained, among other items, UHT milk without health warnings and chocolate-flavoured infant foods.

Once the majority of refugees had left Albania to return to Kosovo, many NGOs transferred their staff, assets and humanitarian commodities from Albania to Kosovo. Despite efforts by UNHCR to prevent milk products that had been received and stored in Albania from being transported into Kosovo, a substantial quantity of milk was nevertheless transported across the border. The control mechanisms in place were inadequate to prevent this.

The returnee population in Kosovo

Despite the fact that the Joint UN Agency Statement on Donations of Breast Milk Substitutes was in effect by October 1999 in Kosovo, effective co-ordination of good practice was also limited during the period following the return of the refugee population there. As a result of ineffective co-ordination, a number of examples of poor practice were observed. One example was the distribution of dried milk powder by an international NGO working in Gjilane municipality. This action was taken in response to requests made by mothers for milk for their children to members of NATO forces. Neither UNHCR nor any other agency was in a position to stop these distributions as the control mechanisms were inadequate. Suggestions were offered by another international NGO, Action Against Hunger (AAH), for appropriate alternative uses such as: mixing milk with flour to make a traditional porridge for young children; preparation as hot milk for use in schools or as a donation to the local hospital for use in cooking. These suggestions were not acted upon. The failure to implement any of the suggestions may have been as a result of the lack of designated authority of the NGO AAH.

Strong sectoral divisions and poor communication between agencies, most notably between the health agencies on the one hand, and the food/non-food agencies on the other, represented another important limiting factor for effective co-ordination. During emergencies, the health and nutrition sectors are generally responsible for infant feeding. Consequently, only health and nutrition agencies tend to be aware of policies

and best practice guidelines such as the International Code of Marketing of Breast-Milk Substitutes. For example, UNHCR (which funded the majority of food distribution partners), took the initial lead in co-ordination and management of infant-feeding products in Kosovo. This occurred after UNHCR technical staff members were made aware of the inappropriate distribution of infant-feeding products during food distribution monitoring activities. On the other hand, health and nutrition agencies, such as WHO and UNICEF in conjunction with Action Against Hunger (AAH), took a leading role in developing a policy statement for Kosovo, specifically the *Joint UN Agency Statement on Donations of Breast-Milk Substitutes* (UN, 1999). These agencies also contributed to the development and integration of appropriate training material into the educational curricula for the Ministry of Health's medical and health staff. The division of responsibilities that occurred between UNHCR, UNICEF and WHO were *ad hoc* and not clearly defined, despite provisions stipulated in the respective Memoranda of Understanding.

The experience in Kosovo demonstrated that the prevention of the practice of accepting and distributing infant-feeding products was as important as the development of policy statements. Agencies responsible for the co-ordination of infant feeding were slow to target the key players responsible for the distribution of infant milk products. Staff of agencies associated with food aid — such as programme managers, logisticians, warehouse managers and storekeepers, unaware of policy violations — frequently accepted quantities of these infant-feeding products. Relevant information, such as the risks associated with the distribution of milk products, rarely reached those who were responsible for resource management and commodity storage. Infant-feeding products, including breastmilk substitutes, were perceived by many staff members of the food and non-food sector as just another type of humanitarian aid, no different from school bags, clothes or household items. These items had been provided after a limited needs assessment, in large quantities, without clear targeting criteria and with very little follow-up. In fact, milk products with a relatively higher market value, were generally well accepted by communities and, therefore, perceived by many aid agencies, as highly suitable commodities for general distribution. During the later stages of the emergency in Kosovo, a poster was distributed to all warehouse managers as a strategy to raise awareness among key players of the risks associated with accepting and distributing infant-feeding products. The poster was prepared by AAH and supported by WHO (see Figure 1).

Unsolicited donations

Unsolicited donations comprised a significant proportion of the aid that arrived during the recent crisis in the Balkans. A NATO representative in Skopje estimated that during the initial weeks of the crisis, NATO in Macedonia received and transported 3,500 metric tonnes of donated humanitarian aid of which an estimated 40 per cent was baby food (SC-UK and ICH, 1999). The NATO countries from which much of the aid was donated, provided planes that worked on a 'load-up-and-go' policy with little documentation of payloads other than their weight. During the second week of April, in addition to 156,000 litres of water, milk and fruit juice, non-food items distributed under WFP co-ordination was estimated to amount to 190 metric tonnes (SC-UK and ICH, 1999).



Attention all procurement agencies

It has come to our attention that products (infant formula, cow's milk products, infant cereals, pots of pureed baby food & baby bottles) aimed at feeding young infants continue to come to Kosovo.

We would like to bring to your attention the following points:

- Nearly all women can breastfeed their babies.
- WHO/UNICEF strongly recommend that **breastmilk alone has everything** the baby needs to grow in the first six months of life.
- Giving infant formula or similar products is counterproductive to breastfeeding which is healthy and safe.
- Even underweight and traumatised mothers can produce adequate quantities of good quality milk.
- **Feeding the mother** would be a more cost effective and safe way of ensuring good nutrition for both mother and child.
- Any **NECESSARY** infant feeding products should be **MEDICALLY TARGET-ED** and supplied in quantities sufficient to feed the recipient infants as long as they need the product. These products should be labelled clearly in the appropriate language.
- Mothers facing difficulties in breastfeeding need medical counselling and a lot of encouragement, not a tin of infant formula.

Imagine yourself living as a mother in Kosovo. The water from the well is not always clean, and the firewood supply is poor. The house is crowded and hygiene is difficult to maintain. Your baby is screaming to be fed.

Q. How do you make up a bottle of powdered milk properly in this situation?

A. You can't — but if you are breastfeeding your baby, you don't need to!

If you receive infant formula from outside donations, please contact Action Against Hunger, UNICEF or WHO.

Figure 1 Poster distributed to agency warehouse managers in Kosovo

Within a few weeks of the exodus of refugees from Kosovo, a large proportion of the unsolicited donations were arriving by road. Convoys of trucks containing humanitarian aid went directly to the refugee camps where items were unloaded and distributed without record. For example, in May 1999 a convoy of 36 trucks, known as the 'Convoy of Hope', arrived in FYR Macedonia from the UK, with donations of clothes, bedding, toys, infant formula and commercial infant baby food, all labelled in English. Therapeutic infant formula, which strictly required a medical prescription and

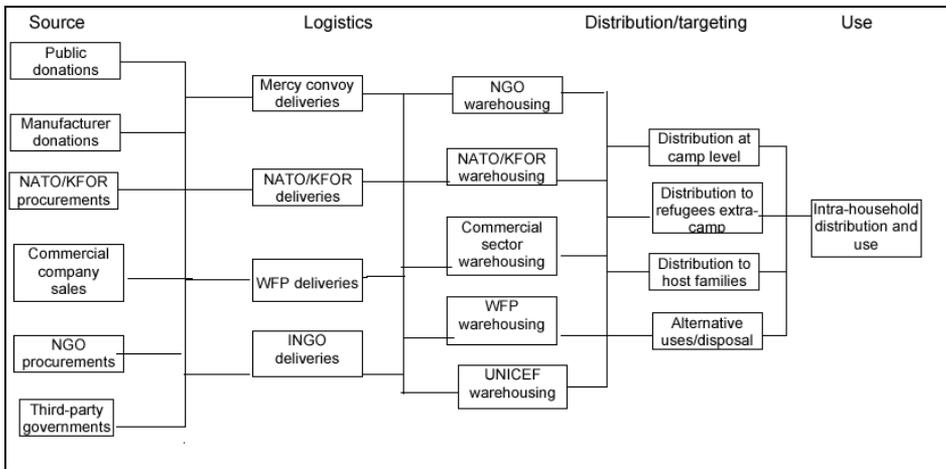


Figure 2 Infant-feeding commodity flows in FYR Macedonia

was suitable only for children with severe fat malabsorption, was included in this donation. International NGOs accepted these donations.

General monitoring mechanisms for humanitarian aid were undoubtedly slow to become established during the Balkan crisis. However, the challenge for humanitarian agencies to establish effective monitoring mechanisms adequate for the complex flow of donated goods including unsolicited donations was huge. In particular, considering the many different sources of infant-feeding commodities and the various logistical systems with the capacity to store and transport them (see Figure 2), a comprehensive monitoring system established at all levels was required. Given the sheer volume of donations, the humanitarian agencies were ill prepared to establish monitoring systems that were effective in preventing the inappropriate distribution of unsolicited infant-feeding commodities.

Resourcing best practice

Resources are required to prevent the inappropriate distribution and use of infant-feeding commodities. Inappropriate products that need to be destroyed, transported elsewhere or re-labelled are actions that are time-consuming and costly. Where the resources are unavailable for such activity, inappropriate distribution and use is likely to occur. Several examples in the Balkan crisis serve to illustrate the potential cost of ensuring best practice standards are maintained.

The cost of destroying inappropriate commodities

An excess quantity of the food parcels, intended for the refugees repatriating from FYR Macedonia to Kosovo (but delivered four months late), were delivered. As a consequence, the remaining stocks stored in WFP's warehouse in Kosovo during the last three months of 1999 contained UHT milk no longer within safe time limits. While NGOs and the UN recognised that it was inappropriate to distribute the remaining food

parcels, no single agency was willing to incur the cost of destroying the UHT milk. The cost, estimated at about \$500,000, was significant. Many local people perceived the potential solutions for the expired milk — use as livestock feed or destruction — as inappropriate. AAH made efforts to remove the expired milk from the food parcels and label the remaining milk with a health warning.

In FYR Macedonia, an estimated 60,000 baby bottles and teats that had initially been accepted into a UN agency warehouse were later transferred, as non-food items, to the UNHCR warehouse. After being stored for several months, the only option was to destroy them. However, it is an accepted procedure that UNHCR consult the respective donor before destroying donated goods of any kind. Efforts to identify the donor failed because the donation was unsolicited and after a further five months of discussion and consultation with a number of partners including the Ministry of Health of the FYR Macedonia, the items still remained in the warehouse. Further constraints that prevented any conclusive action occurring included: the local perception that destroying these items was ‘wasteful and inappropriate’, the cost of destroying them and the lack of suitable alternative uses for the baby bottles.

The cost of re-labelling

From September 1999 onwards, UNHCR funded and co-ordinated four partner NGOs to distribute complementary foods to 50,000 vulnerable families in Kosovo. The complementary food basket included UHT milk and fresh fruit and vegetables. UNHCR and its partners recognised that while the UHT milk was a valuable commodity for vulnerable families, its inappropriate use might potentially affect infant-feeding practices. Consequently, a label with a health message was attached to the milk cartons, explicitly stating the benefits of breastmilk in Albanian and Serbian. The health message also warned that the milk was not an alternative to breastmilk and should not be used to feed infants younger than six months. The cost of producing these labels amounted to an additional \$5,000 per week — not including labour. UNHCR was willing to fund such a strategy in the short term. However, the NGO partners considered that, for the longer term, the costs could not be justified and the labour demands were unrealistic. Strategies such as post-distribution monitoring at the household level and the distribution of relevant health education messages to those families with infants and young children, were considered to be potentially more cost-effective. To our knowledge, the impact of labelling each individual milk carton was not evaluated.

In many humanitarian situations, small quantities of breastmilk substitutes may be required for those infants with specific conditions who have been identified by health professionals as needing these products. According to the 1994 Resolution (WHA 47.50): ‘there should be no free or subsidised breastmilk substitutes or other products covered by the Code in any part of the health care system’. It also urges ‘that supplies of breastmilk substitutes are not used as a sales inducement’, implying that generic rather than commercial products should be used in these limited circumstances.

According to the UNICEF/WFP MOU (1998), UNICEF is responsible for the procurement and distribution of generic breastmilk substitutes in humanitarian emergencies. However, no single agency took responsibility for ensuring the availability of generic breastmilk substitutes in Kosovo. The substantial quantity of commercial infant-feeding products that were already available in Kosovo was a contributing factor. To a large extent, AAH provided a solution by re-labelling locally

procured commercial (brand-name) infant foods. These were donated by other agencies that found themselves with large stocks of infant formula. The process of re-labelling the commercial infant foods was time-consuming and required resources. Furthermore, AAH did not have the capacity to re-label all commercial infant-feeding products that were made available in the humanitarian system.

Undermining traditional practices

The prevalence of infant formula and infant-feeding products during the crisis undermined traditional perceptions of how these products should be used. Furthermore, their widespread availability served as a disincentive for agencies to explore alternative approaches to support optimal infant-feeding practices. These issues are explored in the following examples.

In Kosovo, a number of agencies reported procuring and distributing infant-feeding products in response to the needs of the communities that specifically ranked these items as a priority during assessments. Many agencies, however, did not have the capacity or skills to verify these needs, to target the supplies carefully or to respond in a more appropriate manner. Humanitarian agencies failed to recognise that the perceived needs of communities were likely to have been influenced by the fact that, in both Albania and Macedonia, infant-feeding products including breastmilk substitutes were distributed extensively to the majority of the refugees, and that these actions had possibly altered the expectations of women and health workers. A quote from a midwife in Pristina aptly describes the implications of the widespread availability of infant formula following the humanitarian response in the Balkans: ‘The war has taken the infant formula off the shelves where it was too expensive to buy and put it into the clinics and food distributions where it is distributed for free’ (L. Phelps, personal communication).

There is limited documentation of the impact of the war on traditional infant-feeding practices in Kosovo. Factors such as family separation, pre-existing poor practice and psychological trauma may have exacerbated the problem. Qualitative research through focus group discussions revealed that in Kosovo, the paternal grandmother has an important role in influencing and advising young women on infant-feeding practices (AAH, 1998). Family separation as a result of the war was common, and many older people remained behind in Kosovo while younger members left. Consequently, young mothers, who had previously enjoyed traditional support and advice, may have become more vulnerable to external influences such as the free distribution of infant-feeding products during periods of separation from their extended families. Other poor practices, such as the early introduction of solid foods (by three months) using a biscuit-and-milk mixture served in a bottle, the use of diluted cow’s milk with sugar added and the introduction of tea by three months, became common and were even supported by paediatricians (AAH, July 1999). The availability of infant-feeding products most likely served to reinforce such practices.

Psychological trauma among the Albanian and Serbian populations was well documented (Lopes Cardozo et al., 2000; Salama et al., 2000). Discussions held with community-based health workers revealed that many women believed that the traumatic events that they had experienced during the war — witnessing violence, family separation, loss of homes, relatives being killed — affected their ability to breastfeed. There is sufficient evidence to show that while psychological stress can

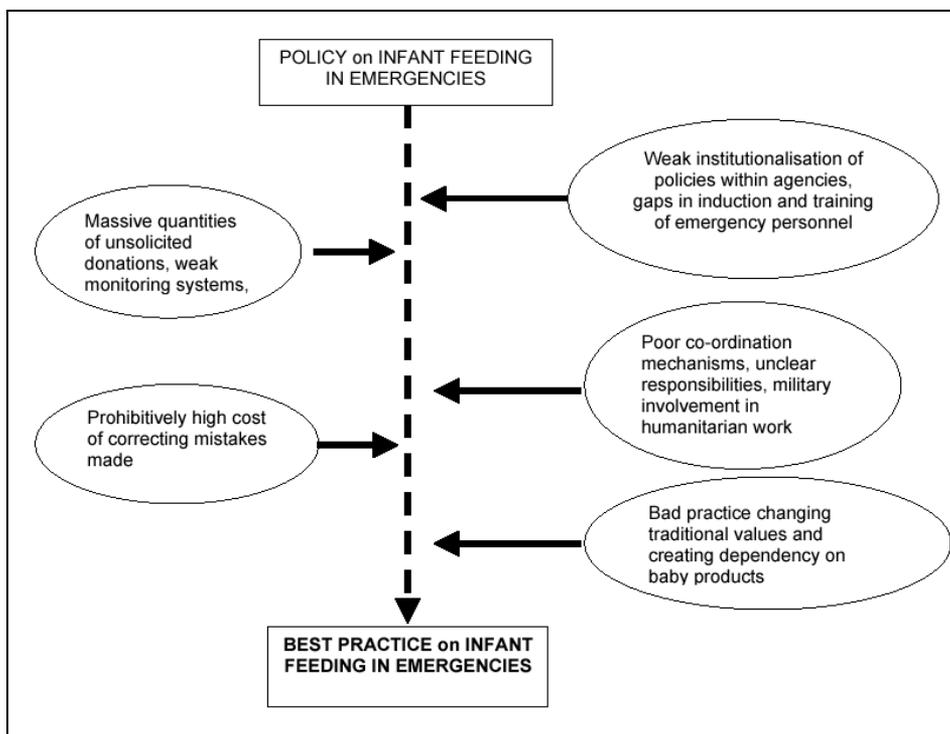


Figure 3 Factors affecting the successful application of policy in infant feeding in emergencies

inhibit the milk 'let-down' (release of milk from the breast), it does not affect the woman's ability to produce milk. The effect of psychological stress on 'let-down' can be overcome if the baby continues suckling (Akre, 1989; Kelly, 1993). However, the belief that the capacity to breastfeed among women in Kosovo was indeed influenced by trauma, was widespread and to some extent, reinforced by senior health workers, who were later given the responsibility of 'targeting' the massive quantities of infant formula when agencies stopped distributing it through the general food ration system.

Conclusions and recommendations

The preparation and dissemination of policy statements are necessary but insufficient to prevent the inappropriate distribution of infant-feeding products in emergencies. The widespread failure of humanitarian agencies operating in the Balkan crisis to act in accordance with international policies and recommendations provides an example of this phenomenon. The contributing factors and the reasons for the failure are described conceptually in Figure 3. The examples that are documented in this paper allow relevant actors to reflect on two important issues; whether or not poor practice could have been avoided and how standards of good practice could have been maintained.

We recommend the following practical measures for institutionalising policy within the humanitarian sector and improving its practical application in future emergencies.

- International agencies should invest in pre-deployment and ongoing training of emergency personnel to ensure that policies are clearly understood. This should not be restricted to health staff but should include logisticians and food aid managers, programme managers and fundraisers.
- Agencies should take responsibility for ensuring that partner agencies are aware of infant-feeding policies and have the capacity to implement them.
- At the onset of the emergency, an appropriate agency must be designated and resourced to co-ordinate infant-feeding practice and implementation of policy. The responsibilities of the co-ordinating agency must be agreed upon and made clear to all agencies. With a policy statement as a guide, the co-ordinating body must have the mandate to take corrective action against poor practice.
- Since multiple partners and sectors such as bilateral donors, UN agencies, international and national NGOs, food aid, health and nutrition agencies, logistical operations and community services, are directly and indirectly involved in infant feeding, a multi-tiered strategy is required. The co-ordinating agency for infant feeding in emergencies should address the multi-faceted nature of infant feeding in order to be effective. This multi-tiered strategy would need to develop new and creative ways, tailored to the needs of each partner, to address issues with these different partners. This would require that lead agencies make a much greater commitment of time, expertise and resources.
- The co-ordinating agency would be required to be involved in, among other activities, advocacy, assessments, capacity building, field observations, identification of corrective mechanisms, operational research, participation in food aid meetings, food distribution monitoring, policy development, preparation and dissemination of relevant education material, technical support, training activities and workshop facilitation.
- Mechanisms for preventing the influx of unsolicited bilateral donations of inappropriate products to emergency-affected population need to be explored and established.
- Systematic and comprehensive monitoring systems, which allow infant-feeding products to be tracked through the distribution system, need to be implemented in the relevant UN agencies. This will promote accountability and allow identification of weak points in the application of policy.
- Viable solutions for dealing with inappropriate products need to be agreed upon, explicitly stated and endorsed by the humanitarian community. Financial resources should be made available to agencies that recognise the importance of implementing good practice and are willing to invest the time and effort to carry out activities such as the re-labelling of branded infant formula tins for the very small number of infants who actually require it. The adoption of these strategies, which would require adaptation to the special circumstances presented by each emergency, could make a major contribution to ensuring not only that best practice is followed, but also — and this is the actual purpose of best practice standards — that infants affected by humanitarian emergencies do not suffer negative nutritional and immunological outcomes as a result of a deterioration in feeding practices.

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Notes

1. This was revised in 1999 and subsequently published as the *Joint UN Agency Statement of Donations of Breast-milk Substitutes*.
2. 'Complementary' in this context refers to foods distributed by UNHCR to refugees given in addition to the WFP food basket. These foods include fresh fruit and vegetables, spices, tea and dried and therapeutic milks.

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