Mothers gather at a Mother Baby Area for IYCF support, Cox's Bazar, Bangladesh, 2019

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Challenges in protecting non-breastfed infants in the Rohingya response in Bangladesh

By Alice Burrell

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Location: *Bangladesh*

What we know: Non-breastfed infants require timely identification, protection and support in emergencies.

What this article adds: A 2017 SMART survey of refugee camps in Cox's Bazaar revealed low levels of exclusive breastfeeding in infants under six months, with 1.4 – 2.3% never having been breastfed. Save the Children International (SCI) efforts to support non-breastfed infants through wet nursing and relactation (including piloting home-based supplementary suckling support for two infants) as part of a comprehensive package of infant and young child feeding in emergency interventions were challenged by a lack of relevant operational guidance, capacity and practical limitations. For those who chose to or had to adopt artificial feeding as a last resort, a safe, sustained supply of breastmilk substitutes (BMS) in line with international recommendations was not available; SCI and United Nations High Commission for Refugees (UNHCR) proposals to address this were not validated by the Nutrition Sector. SCI reduced risks to affected infants through provision of safer BMS kits, counselling and close follow up. Interim operational guidance on the management of non-breastfed infants has been developed by SCI, UNHCR and UNICEF for the Rohingya response but is not yet endorsed by government; there is still no safe BMS programming for the population. Guidance, tools, capacity, resources and mechanisms for the safe supply of BMS and effective support for wet nursing and re-lactation in emergencies are urgently needed to translate international recommendations into practice to support this vulnerable group.

Background

Recommended infant and young child feeding (IYCF) practices greatly benefit the health of children and their mothers. Breastfeeding could save the lives of an estimated 823,000 children under five years and 20,000 women annually (Victora et al, 2016). In emergencies, disrupted access to healthcare; food; water, sanitation and hygiene (WASH) facilities and a lack of privacy to breastfeed can compromise IYCF practices. Additionally, heightened stress levels, traumatic experiences, disrupted support networks and increased time required for daily tasks can negatively impact mothers' mental health, care and breastfeeding practices. Sub-optimal IYCF practices put young children at risk of acute malnutrition, stunting and micronutrient deficiencies, with the youngest being the most vulnerable. Therefore, protecting, promoting and supporting recommended IYCF practices and minimising associated risks around feeding and care are crucial to child survival, nutrition and development in emergency contexts.

IYCF interventions in both emergency and development settings should align with key policy guidance, such as the Global Strategy for Infant and Young Child Feeding (WHO and UNICEF, 2003); the International Code of Marketing of Breastmilk Substitutes (WHO, 1981) and subsequent relevant World Health Assembly (WHA) Resolutions ("the Code"); and the Operational Guidance on IYCF in

Emergencies (OG-IFE), endorsed by the WHA (IFE Core Group, 2017). These documents provide key guidance and recommendations around the support, promotion and protection of IYCF for all children and their mothers.

Recent emergencies, such as the Syrian crisis (Mboya, 2014) and European migrant crisis (Modigell, Fernandes and Gayford, 2016) have highlighted the needs of non-breastfed infants in emergencies. The World Health Organization (WHO)/UNICEF Global Strategy for Infant and Young Child Feeding emphasises that not being breastfeed for the first six months of life is a risk factor for malnutrition, illness and mortality. In emergencies, non-breastfed infants require timely identification and specialised support. The OG-IFE reaffirms this principle, highlighting mandated United Nations (UN) roles (UNICEF/UNHCR) for the protection and support of non-breastfed infants, including ensuring appropriate supplies of breastmilk substitutes (BMS) and associated support services. At an agency level, this is reflected in UNICEF's Core Commitment to Children in Humanitarian Action (2010)[1] and Standard Operating Procedures (SOPs) on the handling of breastmilk substitutes, developed by both UNHCR (2015) and UNICEF (2018, updated pending 2019).

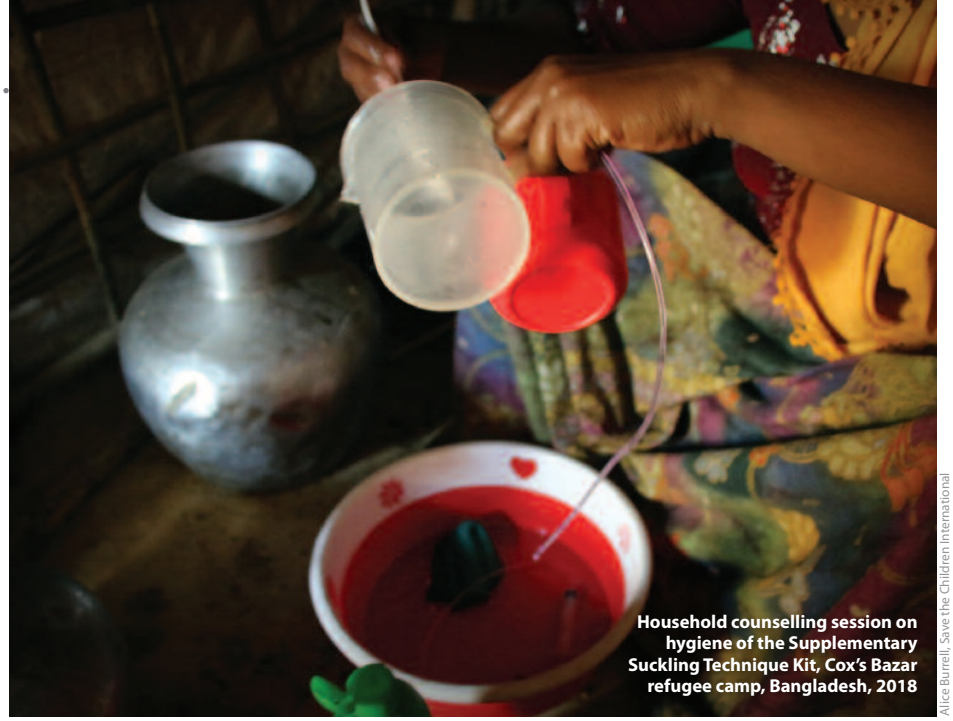
The Rohingya response saw significant challenges and shortfalls in the protection and support of non-breastfed infants, which are critical to examine and address and are shared in this article.

The Rohingya crisis

In August 2017, intense violence in Rakhine State Myanmar led Rohingya people to flee to neighbouring Bangladesh. As of 12 December 2018, 908,000 Rohingya people were residing in makeshift settlements and camps in Cox's Bazar, Bangladesh. Over 700,000 of these had arrived since the 25 August 2017 (IOM, 2018). The population was and remains highly dependent on humanitarian aid and, due to exposure to traumatic events, many remain in need of medical and mental health/psychosocial support. The potential outbreak of contagious diseases given the low health status of the population, severely crowded conditions in the settlements, and poor water and sanitation are serious concerns. The estimated proportion of children under five years and pregnant and lactating women (PLW) is 29% and 10% respectively. As of October 30 2017 there was an estimated total of 8,129 infants less than six months old among those displaced (RRRC-UNHCR, 2017).

Nutrition coordination

The humanitarian response is led and coordinated by the Government of Bangladesh. Following the influx, the Refugee Relief and Repatriation Commissioner (RRRC), under the Ministry of Disaster Management and Relief (MDMR), was mandated to provide operational coordination for all refugees/Forcibly Displaced Myanmar Nationals (FDMNs).[2] For humanitarian agencies, strategic guidance and national-level government engagement is provided by the Strategic Executive Group (SEG) in Dhaka, co-chaired by the Resident Coordinator, International Organisation for Migration (IOM) and UNHCR. At district level, the Senior Coordinator leads the Inter-Sector Coordination Group (ISCG), composed of thematic Sector and Working Group Coordinators representing the humanitarian community.



Household counselling session on hygiene of the Supplementary Suckling Technique Kit, Cox's Bazar refugee camp, Bangladesh, 2018

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The nutrition response in Cox's Bazar is led by the Nutrition Sector, chaired by the Ministry of Health and Family Welfare (MoHFW) in collaboration with UNICEF. The response plan focused on treatment and prevention of acute malnutrition with specific interventions including community-based management of acute malnutrition (CMAM) for children aged 6-59 months and PLW, IYCF in emergencies (IYCF-E)[3] including one-to-one and group counselling and community-based management of at risk mothers and infants under six months old (C-MAMI).[4]

Assessment of need

Results of SMART surveys in October and November 2017 in Kutupalong, Makeshift and Nayapara camps raised serious concerns. Prevalence of global acute malnutrition (GAM) was found to be at crisis levels at 24.3%, 19.3% and 14.3% respectively, with severe acute malnutrition (SAM) prevalence at 7.5%, 3.0% and 1.3% respectively (AAH, 2017). Results also showed worrying IYCF practices with 17.9%, 43.9% and 27.8% of infants under six months old in the respective camps not exclusively breastfed and between 1.4% and 2.3% of children aged 0-23 months across all camps never breastfed (an estimated total of 167 infants). In addition, a very low proportion of children aged 6-23 months were receiving a minimum acceptable diet (MAD) (8.8%, 6.4%, and 15.7% respectively).

Follow up SMART surveys conducted in April and May 2018 indicated a marked improvement in GAM in Makeshift camp from 19.3% to 12.0%, with less improvement in Nayapara camp from 14.3% to 13.6% (AAH, 2018). The survey was not repeated in Kutupalong camp. However, IYCF practices showed no improvement; in Makeshift camp the proportion of non-breastfed infants increased from 1.4% to 3.4% and exclusive breastfeeding reduced from 56.1% to 50.0%. When applied to population numbers, this indicates a significant number of children needing identification, management and support. In addition to those infants never breastfed, there were likely additional infants under six months whose caregivers had stopped breastfeeding prior to six months; these non-breastfed infants are not captured in the survey results.

Save the Children's nutrition response

Save the Children (SCI) nutrition response involved establishing Nutrition Centres with an Outpatient Therapeutic Feeding Programme (OTP) for acutely malnourished children aged 6-59 months and Mother Baby Areas (MBAs) for IYCF-E support; IYCF-E corners in targeted Supplementary Feeding Programmes (TSFPs) and Blanket Supplementary Feeding Programmes (BSFPs); and piloting the C-MAMI tool[5] to cater for infants aged less than six months at nutritional risk in select sites. SCI also responded with interventions in health; education; child protection; WASH; shelter; food security and livelihoods.

IYCF-E response

SCI was a key agency in the IYCF-E response, leading implementation of the IYCF Framework

[1] https://www.unicef.org/publications/files/CCC_042010.pdf

[2] The Government of Bangladesh refers to the Rohingya as "Forcibly Displaced Myanmar Nationals" (FDMN). The UN system refers to this population as "Rohingya refugees" in line with the applicable international framework for protection and solutions, as well as the resulting accountabilities for the countries of origin and asylum in addition to the international community as a whole. These terms refer to the same population.

[3] IYCF focuses on improving practices, whereas IYCF-E focuses on doing no harm, minimising risks and protecting practices, and may require artificial feeding support that is not usually a component of routine IYCF programmes.

[4] C-MAMI is an approach to identify and manage at risk mothers and infants under six months in the community who are nutritionally vulnerable. The C-MAMI Tool can be accessed at https://www.ennonline.net/c-mami

[5] The community based management of at risk mothers and infants under six months (C-MAMI) tool was developed to inform case management of this age group. www.ennonline.net/c-mami

with UNHCR[6] to support multiple sectors to create an infant and young child friendly environment and facilitate optimal IYCF in this emergency.

SCI also led the development of the initial IYCF- E response plan and supported all Nutrition Sector IYCF-E initiatives, including coordination and technical leadership and chairing the IYCF technical working group (TWG) for an assigned period. SCI led a quality-monitoring initiative, providing IYCF-E supervisors to the collective to facilitate supportive supervision, training and other capacity building initiatives. SCI also supported the Nutrition Sector to ensure that all stakeholders considered IYCF-E and prioritised the needs of infants and young children across the response.

SCI established Mother Baby Areas (MBAs) with trained IYCF-E counsellors to provide IYCF-E assessment, counselling and group sessions and a private space to breastfeed. Support for non-breastfed infants was provided on a one-to-one basis, usually at the household level, given the relatively low caseload and sensitivities around the demonstration of the safe preparation of infant formula. MBAs were established within Nutrition Centres, which also housed OTPs and, in some locations, a C-MAMI programme (Kueter et al, 2018). Nutrition centres were located next to SCIs health clinics where possible to facilitate easy referrals and linkages between the various services.

IYCF-E supervisors and counsellors were recruited locally and trained on IYCF-E counselling over two days, including on wet nursing, relactation, cup feeding and risks of formula use (with supervisors given an additional day's training on MBAs and supervision). On-the-job coaching on counselling for BMS use was provided as cases arose, rather than through formal training, due to sensitivities around the topic. IYCF-E counsellors conducted rapid IYCF assessments for all identified caregivers with children under two years old; if a feeding issue was identified they then conducted a full IYCF assessment and developed a counselling care plan. Caregivers of children under two years old were mainly identified through community outreach activities by SCI's counsellors and community mobilisers. Health and nutrition facilities and protection teams also referred caregivers of children under two years old with feeding difficulties to the MBA.

Challenges managing non-breastfed infants

Serious challenges were encountered in the management of non-breastfed infants due to limited guidance on the support of wet nursing and relactation in emergency settings and the lack of agreed and coherent policy and implementation plans on the support of non-breastfed infants less than six months old with artificial feeding when wet nursing and relactation were not feasible.

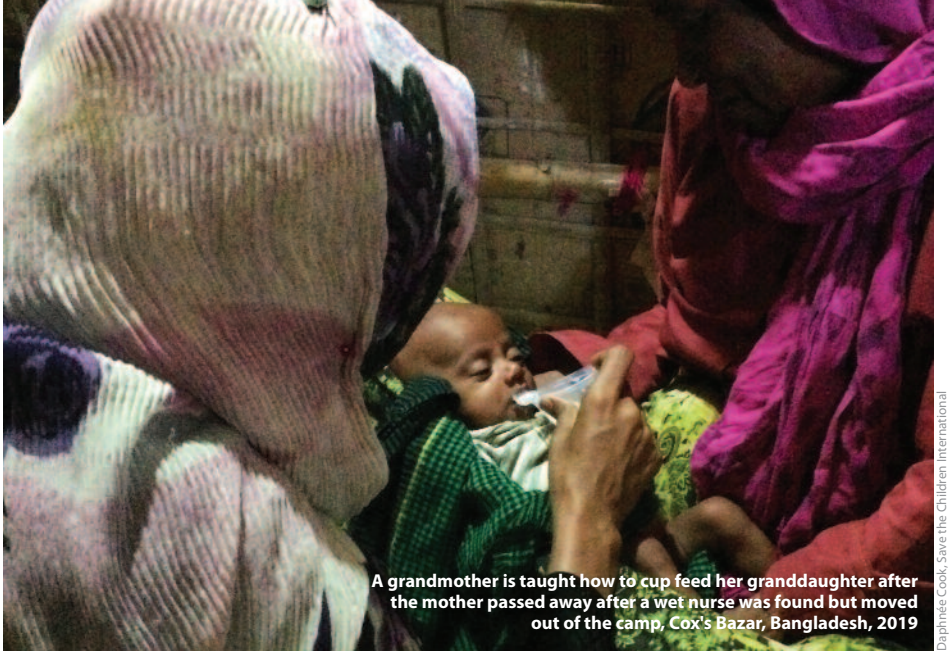
Wet nursing

There is a paucity of documented experiences on the support for wet nursing in emergency situations (Teshome, 2019). Experiences documented by UNHCR in 2008 found wet nursing to be acceptable in the Rohingya population (Sfeir, 2008). Challenges experienced by SCI in the Rohingya response included identifying wet nurses if unavailable among close relatives; relocation of wet nurses; acceptance by the wet nurse's family and expectation of incentives; poor access to nutritious and adequate foods for lactating women; practicality of the arrangements between infant carers and wet nurses to support exclusive breastfeeding; and preference for use of BMS when it was accessible to the family.

Relactation

SCI could not source guidance on the operationalisation of relactation relevant for refugee camps and settlements in Cox's Bazar. Available guidelines focused on relactation during inpatient care (ACF International, 2012), but this was often impossible for caregivers in this context due to high opportunity costs and multiple children to care for. Additionally, SCI did not support inpatient facilities and MBAs were an unsuitable place to conduct the Supplementary Suckling Technique (SST) due to sensitivities around the use of infant formula and risks of discouraging other caregivers from breastfeeding. Lastly, considering the limited geographical scope of SCI's programme and dispersion of identified cases of non-breastfed infants (<1% of infants under six months old assessed by SCI, over 10 operational areas, were not breastfed) it was not operationally viable to create a separate establishment for this purpose within each camp.

Given these considerations, SCI piloted home-based SST support for two infants whose mothers were willing to attempt relactation and where it was considered the most sustainable, safest option. Specific challenges that arose in supporting these two cases were limited guidance on reducing the supplement once breastmilk production began; maintaining caregiver motivation for re-lactation; keeping good hygiene of equipment within poor household hygiene and environment; lack of team capacity to conduct regular household support visits; and lack of household capacity to support SST. It was also difficult to provide home-based support to referred infants residing in camps where SCI was not operational.



A grandmother is taught how to cup feed her granddaughter after the mother passed away after a wet nurse was found but moved out of the camp, Cox's Bazar, Bangladesh, 2019

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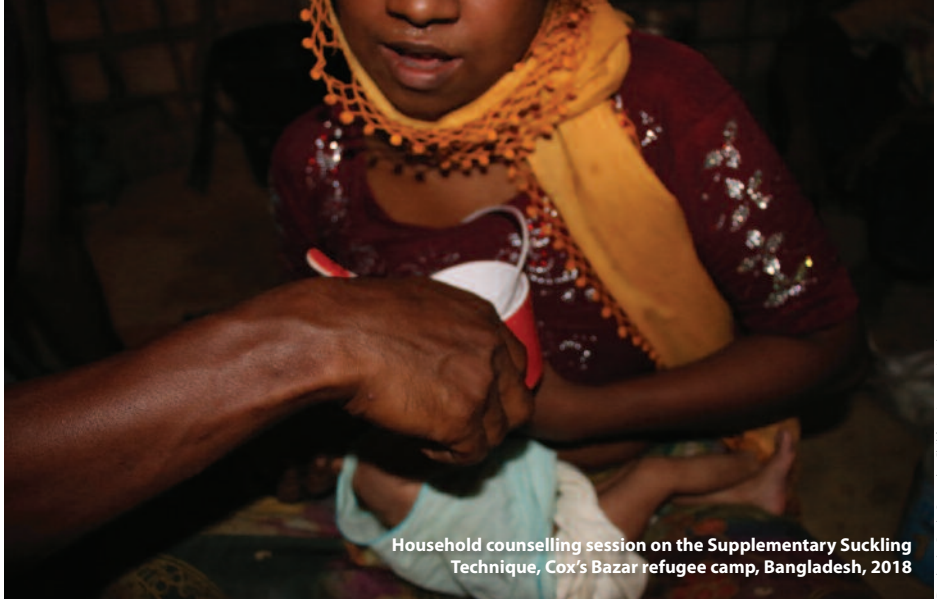
BMS programming

Major challenges were encountered when non-breastfed infants began to be identified and wet nursing and/or relactation was either ineffective, inappropriate or not accepted. Most non-breastfed infants were detected either by the child protection case management team, the UNHCR protection team and medical teams in health facilities, or were among those infants referred by SCI community mobilisers to the C-MAMI site or MBA for assessment. From the start of the response, SCI engaged the Nutrition Sector and partners to seek support to initiate a safe BMS supply programme in full compliance with national laws, regulations and recommendations. An initial joint proposal from SCI and UNHCR to provide the necessary support to families and a supply of BMS and associated materials for the small number of non-breastfed infants identified was never validated through the Nutrition Sector.

In Bangladesh, breastfeeding is strongly supported both through cultural practices and official legislation, such as the Bangladesh Act 2013 and the national IYCF strategy (IPHN, DGHS, MoHFW and GoB, 2007). Current national regulations recognise that a minority of infants may need BMS support, but no guidance and directions are provided on the operationalisation of this support in a humanitarian context. At the same time, the Nutrition Sector's experience and capacity needed strengthening in these areas. There was also a lack of accurate data on the caseload of non-breastfed infants,[7] which made it difficult for agencies responsible to decide if they would financially support the supply of BMS and accompanying materials for safer preparation in the context of the response.

[6] www.unhcr.org/publications/operations/5c0643d74/infant-young-child-feeding-refugee-situations-multi-sectoral-framework.html

[7] There was an effort to collect an estimate of non-breastfed infants through the IYCF TWG, however agencies experienced challenges in collecting this data from the field teams and some data received was inaccurate and required follow up.



Household counselling session on the Supplementary Suckling Technique, Cox's Bazar refugee camp, Bangladesh, 2018

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Given these factors, no supply chain for an appropriate BMS for the response (such as providing cash or vouchers to purchase BMS) was provided or made available to families of non-breastfed infants for whom BMS was indicated. While SCI had the resources, there was no government or UN approval to source infant formula and the necessary UN supply chain was not established. When families chose or needed to use BMS as a last resort, SCI reduced risks by providing a safer BMS kit (thermos flask, preparation utensils, feeding cup, and washing materials); counselling on safe and appropriate type and use of BMS; close follow up with home visits; and information to the family on risks associated with not breastfeeding and using BMS, especially in an emergency context.

Attempts to address barriers – policy and guidance

The situation reveals gaps and barriers from policy and regulatory level down to programme level that prevent a prompt and effective response and continues to compromise the protection of vulnerable infants. Dialogue with partners and authorities prompted the development and proposal of an interim Operational Guidance for the non-breastfed infant for the Rohingya response. This process began in December 2017, led by SCI with the support of other partner agencies, including UNICEF and UNHCR, and entailed several rounds of review. Sections were included on identification, referral, management (including wet-nursing, relactation and BMS provision and support for safe use) and technical capacity building. The guidance was presented to the IYCF-E TWG for endorsement, the Civil Surgeon of Cox's Bazar for approval, and the Nutrition Sector. Reviewers requested more details, data and better clarity of roles and responsibilities. In June 2018, the finalised interim guidance was presented to the national Nutrition Cluster, presided over by the Institute of Public Health within the Ministry of Health. The guidance was neither rejected nor approved and, at time of writing, no further progress has been made. The Government simultaneously developed and finalised national IYCF-E guidelines for Bangladesh, which also remains under review. Both the interim Operational Guidance and national IYCF-E guidance are critical for current and future responses but are, as yet, unavailable.

Conclusions

The experiences documented here highlight a failure to translate global guidance into practice. Concrete guidance and coherent regulations are needed that allow for timely and safe interventions to protect, promote and support recommended and safe IYCF practices for all infants and young children affected by an emergency. However, the current lack of operational guidance for managing the non-breastfed infant in emergencies with wet nursing or relactation means that humanitarian organisations do not have essential tools they need to manage the most vulnerable infants.

While it is important to ensure that all mothers are enabled to breastfeed or that infants can receive breastmilk feeding as a safe alternative, there is sometimes a need for the provision of a BMS, as recognised by international guidance. Agency and country-level protocols, guidance and tools are needed to ensure that skills, capacity and resources are in place at the national level to manage the feeding of these infants as needs arise.

Current systems are inadequate for supporting the operationalisation of BMS programmes. There are no clearly defined mechanisms to access safe BMS and necessary equipment in the humanitarian sector and a pipeline for these products does not exist; hence humanitarian agencies have no standardised and systematic way to manage non-breastfed infants for whom BMS is indicated. International leadership by UN agencies is not always aligned from headquarters to country levels on this issue. Advocacy and sensitisation must therefore continue to ensure that national and regional-level offices have a common understanding and vision of mandated responsibilities for the management of non-breastfed infants among the key humanitarian nutrition response interventions.

Mechanisms for BMS support need to be further developed at national level to ensure timely and responsive availability in an emergency setting when required. Training modules on safe BMS programming should be developed and adapted to different contexts and scenarios, learning from best practices globally. Protocols and guidance for procurement, transportation, logistics, stocking, distribution, targeting and utilisation may be partially available, but need to be updated to reflect learnings and best practices and translated to more user-friendly tools for field practitioners. IYCF-E core indicators are available to assess the need for safe BMS programming, but are rarely used. More advocacy and sensitisation on how to accurately collect and use such data is required.

At time of writing there is still no safe BMS programming in place in Cox's Bazar for the infants who need it.

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References

ACF International (2012) Guidelines for the integrated management of severe acute malnutrition: in- and out-patient treatment.

Action Against Hunger (2017) Emergency Nutrition Assessment: Cox's Bazar, Bangladesh.

Action Against Hunger (2018) Emergency Nutrition Assessment Final Report.

IFE Core Group (2017) Operational guidance on infant feeding in emergencies version 3.0. Available from: www.ennonline.net/operationalguidance-v3-2017

International Organisation for Migration (IOM) (2018) Needs and Population Monitoring (NPM) Site Assessment: Round 9, Cox's Bazaar.

IPHN; DGHS; MoHFW; GoB (2007) National Strategy for infant and young child feeding (IYCF). Institute of Public Health and Nutrition (IPHN).

Kueter, Anne-Marie; Burrell, Alice; Butler, Sarah; Sarwar, Mostofa; Rahaman, Habibur (2018). Piloting the C-MAMI approach in the Rohingya response in Bangladesh. *Field Exchange* issue 51. www.ennonline.net/fex/58/pilotcmamiapproachbangladesh

Mboya, Suzanne (2014) Artificial feeding in emergencies: experiences from the ongoing Syrian crisis. *Field Exchange* issue 48. www.ennonline.net/fex/48/artificialfeeding

Modigell, Isabelle; Fernandes, Christine; Gayford, Megan (2016) Save the Children's IYCF-E Rapid Response in Croatia. *Field Exchange* issue 52, page 106. www.ennonline.net/fex/52/rapidresponseincroatia

Sfeir, Yara (2008). Wet nursing for refugee orphans in Bangladesh. *Field Exchange* issue 25.

Teshome, S. (2019) A review of wet nursing experiences, motivations, facilitators and barriers. Available from: www.ennonline.net/wetnursingreview

UNHCR (2015) Infant and young child feeding practices: standard operating procedures for the handling of breastmilk substitutes (BMS) in refugee situations for children 0-23 months. www.ennonline.net/iycfsopbmsrefugee

UNICEF (2018) UNICEF Standard Operating Procedure on the procurement and use of breastmilk substitutes in humanitarian settings.
UNHCR (2017) RRRC-UNHCR Family Counting Analysis.

Victora, C.G. et al (2016). Breastfeeding in the 21st century: epidemiology, mechanisms and lifelong effect. *The Lancet* 475-490.

WHO & UNICEF (2003). Global Strategy for Infant and Young Child Feeding. Available from: www.who.int/nutrition/topics/global_strategy/en/

WHO (1981) The International Code of Marketing of Breastmilk Substitutes and subsequent WHA resolutions ("The Code").