

Review of Policies and Guidelines on Infant Feeding in Emergencies: Common Ground and Gaps

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Recent crises in regions where exclusive breastfeeding is not the norm have highlighted the importance of effective policies and guidelines on infant feeding in emergencies. In 1993, UNICEF compiled a collection of policy and guideline documents relating to the feeding of infants in emergency situations. In June 2000 Save the Children, UK, UNICEF and the Institute of Child Health undertook a review of those documents, updating the list and identifying the common ground that exists among the different policies. The review also analysed the consistency of the policy framework, and highlighted important areas where guidelines are missing or unclear. This article is an attempt to share more widely the main issues arising from this review.

The key conclusions were that, in general, there is consensus on what constitutes best practice in infant feeding, however, the lack of clarity in the respective responsibilities of key UN agencies (in particular UNICEF, UNHCR and WFP) over issues relating to co-ordination of activities which affect infant-feeding interventions constrains the implementation of systems to support best practice. Furthermore, the weak evidence base on effective and appropriate intervention strategies for supporting optimal infant feeding in emergencies means that there is poor understanding of the practical tasks needed to support mothers and minimise infant morbidity and mortality.

We, therefore, have two key recommendations: first that the operational UN agencies, primarily UNICEF, examine the options for improving co-ordination on a range of activities to uphold best practice of infant feeding in emergencies; second, that urgent attention be given to developing and supporting operational research on the promotion of optimal infant-feeding interventions.

Keywords: infant feeding, policy guidelines, co-ordination.

Introduction

During emergencies, inappropriate feeding practice, in particular the inappropriate use of breastmilk substitutes, may contribute to a greatly increased morbidity and mortality rate making infant feeding in emergencies an area of special concern. The resources

needed for safe artificial feeding — including water, fuel and adequate quantities of breastmilk substitutes — are usually scarce in emergencies. Artificial feeding in these circumstances increases the risk of diarrhoeal disease and malnutrition (Emergency Nutrition Network, 1999). The importance of infant feeding has been highlighted during crises in Iraq and the Balkans where breastmilk substitutes are sometimes part of the normal infant-feeding practice (Kelly, 1993; Save the Children and Institute of Child Health, 1999). From the available data it appears likely that in some of these situations the health of infants has been compromised (Yip and Sharp, 1993).

In June 2000, UNICEF, Save the Children UK (SC-UK) and the Institute of Child Health, London (ICH) reviewed the policy and guideline documents concerning infant feeding in emergencies (see Table 1). Documents were obtained from all of the major agencies and organisations that were known to be involved in such work, starting with a collection of policy and guideline documents that had been compiled in 1993 (UNICEF, 1993). The SC-UK/ICH review sought to incorporate new documents that have been published since then.¹

The review aimed to analyse the consistency of the policy framework between key international organisations, identify constraints to effective implementation of policies, highlight problems in interpretation and reveal gaps in knowledge reflected in the policy frameworks where these have been found. This article seeks to highlight the key findings of the earlier review. Analysing the implementation of the various policies and guidelines by agencies operational in emergency contexts is beyond the scope of this paper, although this issue is addressed in the context of the Balkan crisis elsewhere (Borrel et al., this issue).

Background

The International Code of Marketing of Breastmilk Substitutes adopted by the World Health Assembly in 1981 and subsequent World Health Assembly (WHA) Resolutions² form the foundation of much of the recent policy debate concerning infant feeding. The inappropriateness of the distribution of dried skimmed milk as a single commodity in food rations has been recognised in emergency response policies since the mid-1980s and is articulated in the International Red Cross policy in 1985 and the UNHCR policy in 1989. Since then and following analysis of emergency response in Iraq and the Balkans, many more policies have been formulated and increased concern has been given to applying the code in emergency contexts (as highlighted in WHA Resolution 47.5 adopted in 1994) and to practical issues of how to support optimal infant nutrition in emergency contexts (Oxfam, 1996).³

The UN agencies have played an important role in policy formulation. The technical agencies — notably WHO — provide recommendations for national governments as articulated in the World Health Assembly Resolutions. The UN High Commissioner for Refugees (UNHCR), the UN Children's Fund (UNICEF) and the UN World Food Programme (WFP) operate emergency programmes, although in most instances they subcontract their operations to non-governmental organisations (NGOs) or national authorities. These agencies have developed their own operational policies for emergency response (see Table 1). Since the mid-1990s UN agencies and NGOs have made increased efforts towards interagency policy development. The key events during this period were a series of international meetings in which the International Baby Food Action Network played a crucial role.⁴ Most recently, and following

Table 1 Current guidelines and policy documents on infant feeding in emergencies (listed by date of publication)

<i>Organisation</i>	<i>Date</i>	<i>Title</i>
World Health Organisation	1981	'The International Code of Marketing of Breast-milk Substitutes'
International Red Cross	1985	'The Use of Artificial Milks in Relief Actions'
World Health Organisation	1986	'Guidelines Concerning the Main Health and Socio-economic Circumstances in which Infants Have to Be Fed on Breast-Milk Substitutes' (WHO A39/1986/REC/1 Annex 6, Part 2)
UNICEF	1986	'Assisting in Emergencies'
UNHCR	1989	'Policy for Acceptance, Distribution and Use of Milk Products in Refugee Feeding Programmes'
WFP	1990	'Guidelines for the Use of Dried Milk Powder in all WFP-assisted Projects and Operations' (currently under revision)
European Community	1992	'Council Directive of 18 June 1992 on Infant Formulae and Follow-on Formulae for Export to Third Countries' (92/52/EEC)
European Community	1992	'Council Resolution of 18 June 1992 on the Marketing of Breast-milk Substitutes in Third Countries by Community-based Manufacturers' (92/C 172/01)
World Health Organisation	1994	'Infant and Young Child Nutrition' (WHA 47.5)
Médecins Sans Frontières	1995	'Nutrition Guidelines'
Canadian International Development Agency	1995	'Statement on the Use of Milk Products During Emergencies'
Oxfam	1996	'Feeding in Emergencies for Infants Under Six Months: Practical Guidelines'
UNHCR/UNICEF	1996	'Memorandum of Understanding between United Nations High Commissioner for Refugees and United Nations Children's Fund'
WFP/UNHCR	1997	'Memorandum of Understanding on the Joint Working Arrangements for Refugee, Returnee and Internally Displaced Persons Feeding Operations'
UNHCR/WHO	March 1997	'Memorandum of Understanding Between the United Nations High Commissioner for Refugees and The World Health Organisation'
UNHCR/WFP	Dec 1997	'WFP/UNHCR Guidelines for Estimating Food and Nutritional Needs in Emergencies' (currently under review)
UNICEF/WFP	Feb	'UNICEF/WFP Memorandum of

	1998	Understanding in Emergency and Rehabilitation Interventions'
USAID/Bureau for Humanitarian Response/Office of Foreign Disaster Assistance	1998	'Field Operations Guide' Version 3.0
UNHCR/WFP	Feb 1999	'UNHCR/WFP Guidelines for Selective Feeding Programmes in Emergency Situations' (currently under review)
UNICEF/UNHCR/WFP/WHO – Joint Statement	1999	'Policy on Infant Feeding in the Balkan Region'
WHO, UNICEF, UNAIDS	4 Sep 1999	'Statement on Current Status of WHO/UNAIDS/UNICEF Policy Guidelines'
UN Civil Administration Secretariat for Health (Kosovo)	4 Oct 1999	'Joint UN Agency Statement on Donations of Breast-milk Substitutes'
Ad hoc Group on Infant Feeding in Emergencies	1999	'Infant Feeding in Emergencies'
Interagency	1999	Reproductive Health in Refugee Situations: An Interagency Field Manual
Sphere Project	2000	Humanitarian Charter and Minimum Standards in Disaster Response
UNHCR	Un-dated	'Handbook For Emergencies' second edition

publication of research into the humanitarian response in Macedonia (Save the Children and Institute of Child Health, 1999; Borrel et al., this issue), interagency operational guidance has been drafted for endorsement by a wide range of bilateral, UN and non-governmental agencies.⁵

Results of review of policies and guidelines

Common ground

The following section outlines the common ground that exists among the policy documents reviewed. These documents are listed in Table 1.

Breastfeeding: Human breastmilk provides complete nutrition and is the best food for infants up to about six months of age.⁶ Support for breastfeeding is of particular importance in emergencies where hygiene conditions are likely to be poor, there may be a high level of psycho-social stress, and alternative feeding methods unsafe or unavailable. The active support of exclusive breastfeeding is a critical public health intervention and should not be undermined by the inappropriate distribution of breastmilk substitutes (BMS).⁷

Support for breastfeeding and re-lactation are the first-choice interventions to mitigate feeding problems for infants under six months. Psychological stress may affect 'let down' of breastmilk, but this can usually be overcome by regular suckling by the infant and support to the mother. The use of breastmilk substitutes or wet-nursing are alternative feeding options for those infants who cannot be breastfed by their

mothers. The number of babies requiring these alternatives in most situations is likely to be small. Wet nursing is often stated as the preferred option though more recent policies recognise that this may not be acceptable or appropriate in contexts with high levels of HIV prevalence.

Use of breastmilk substitutes: Where a need for BMS is established, modern formula feeds which meet the requirements of the Codex Alimentarius are the best substitutes. Dried skimmed milk (DSM), as a single commodity, should not be distributed as part of a dry take-home ration except for pastoral nomads in the tropics for whom milk is a traditional part of the diet and only then under strictly controlled conditions. This is because of the danger of it being used as a breastmilk substitute and the risk of high levels of microbial contamination when prepared with unclean water or in unsanitary conditions. If used, it should be vitamin-A fortified. DSM can be safely distributed as a dry, take-home ration if premixed with cereal flour. Pre-mixed dry rations are used as part of a general ration or as a supplementary ration for malnourished individuals.

Feeding bottles and teats should never be distributed or used due to risk of bacterial contamination. Where artificial feeding is necessary, it should be performed with a cup and spoon or cup alone (the latter recommendation being preferred in more recent documents). An exception is made for interim feeding under medical supervision of very young motherless babies unable to take a spoon (UNICEF, 1986). However, subsequent documents have not supported this exception.

Complementary feeding: Appropriate complementary infant foods should be made available and introduced from about six months of age. These should comprise energy- and nutrient-dense foods which are easily eaten and digested by infants and young children. Commercial complementary infant foods are not recommended for general use and foods made from locally available foods, items of the general and complementary rations,⁸ or blended cereal foods⁹ such as corn/soy blend are preferred.

Nutritional support for pregnant and lactating women: Supplementary feeding programmes should consider pregnant and lactating women as a vulnerable group due to their higher nutritional requirements. Usually pregnant women in their third trimester and lactating women up to six months post-partum are targeted.

Constraints to implementation

It is clear that there is a high level of agreement between agencies on the key principles of infant feeding in emergency situations. However, a comparison of the available policies and guidelines reveals a number of areas where gaps or overlaps make interpretation and implementation difficult. This section aims to examine critically a number of the areas where further work is required.

Co-ordination of infant-feeding interventions

There needs to be some overall co-ordination. While the role of national governments in the co-ordination of emergency responses is obviously preferred, at the present time no single agency within the UN system is automatically charged with responsibility for the co-ordination of infant-feeding interventions if governments cannot take on this function. Infant-feeding issues cut across food and health agencies making co-ordination issues paramount.

Memoranda of Understanding (MOU) between specific UN agencies that subcontract operational programmes serve as important tools for identifying respective responsibilities in different emergency contexts. These are described in Table 2 below. The WFP/UNHCR MOU has been in place since 1985 and was revised in 1994 and 1997. Other MOUs are more recent and their provisions are not widely known. While MOUs are necessary management tools, their application in practice relies on the institutionalisation of their provisions (see Borrel et al., this issue). The limited conditions under which each apply can contribute to uncertainty over their application. Specific activities on which co-ordination is required are highlighted below.

Responsibility should be assigned for the supply of generically labelled infant formula. It is generally acknowledged that babies who cannot be fed breastmilk will require a regular and sufficient supply of a generically labelled breastmilk substitute (including infant formula). In situations in which the MOU between UNICEF and WFP is operational, the responsibility clearly lies with UNICEF for procurement of generically labelled breastmilk substitutes. This MOU does not apply in all circumstances (see Table 2) and given the sensitivities over handling these products, agencies may not be willing to take responsibility for procurement in other circumstances.

There should be responsibility for monitoring NGO activities. Currently there is no recommended mechanism for the co-ordination and monitoring of NGO activities and a responsible body is not identified. Therefore, in situations in which, for whatever reason, national governments do not assume this responsibility and services are provided without NGOs being subcontracted by UN agencies, there is no specified co-ordination mechanism. While this situation is not peculiar to interventions in the area of infant feeding, the response to infant and child issues during emergencies makes this area of work particularly at risk from interventions driven by public and commercial donations. Such influence is heightened in emergencies in European or middle-income countries, where there tends to be a preponderance of relief organisations with limited knowledge or understanding of international guidelines. The Sphere Humanitarian Charter and Minimum Standards in Disaster Response specifies a number of key indicators that can be used to assess the effectiveness of an intervention, but is not intended to give guidance on the details of implementation.

There should be responsibility for the activities of military humanitarian operations. The co-ordination of humanitarian responses carried out by military forces is not subject to a formal co-ordination mechanism by the UN, which could ensure compliance with international guidelines on infant feeding. While the complex political nature of military intervention makes the establishment of a single successful mechanism unlikely, there does appear to be ground for greater communication and co-operation. Preferably, humanitarian interventions in infant feeding run by the military should be subject to co-ordination by the same lead agency as other implementing organisations.

Responsibility for unsolicited donations should be assigned. The current policy framework does not identify agencies responsible for determining the content and quality of unsolicited donations, which may be channelled through UN, NGO or independent routes. An exception is unsolicited donations of artificial milks received by the International Red Cross (articulated in their 1985 policy) which will be refused or disposed of by the International Red Cross unless conditions comply with the strict distribution criteria. This has meant, in situations such the Kosovo crisis of 1999, that agencies become involved in transport and distribution of commodities, including breastmilk substitutes without assuming responsibility for their targeting or use and

Table 2 The applicability of UN Memoranda of Understanding

<i>Memorandum of Understanding</i>	<i>Scope of application</i>	
	<i>Potential beneficiaries</i>	<i>Qualifications</i>
UNHCR/ UNICEF, 1996	Refugees; returnees; IDPs; local population affected by the presence of other beneficiary groups.	1. Applies in countries where UNICEF has an established office or programme. 2. The roles of the two organisations depend on the beneficiary group.
WFP/UNHCR, 1997 (revised from versions in 1985 and 1994)	Refugees; returnees; and in specific situations internally displaced persons (IDPs).	1. There must be a minimum of 5,000 beneficiaries (although UNHCR will meet the food needs for fewer than 5,000). 2. In developed countries (i.e. countries other than those listed in the OECD/DAC annual report as aid-recipient countries) the provisions of the MOU will only apply if donor resources would not be at the expense of WFP's relief operations in developing countries.
UNHCR/WHO, 1997	Those of concern to UNHCR comprising: refugees; returnees; IDPs; or other people within their own country on whose behalf UNHCR has been authorised to act.	
UNICEF/WFP, 1998	IDPs and local population.	1. Agreement between WFP and UNICEF required. 2. May not apply to refugees.

thereby risk violating the International Code on the Marketing of Breastmilk Substitutes and WHA Resolutions and other policies (Save the Children and Institute of Child Health, 1999; Borrel et al., this issue).

The International Code of Marketing of Breastmilk Substitutes should be applied in emergencies. The seeming inconsistency in the wording of the original code in 1981¹⁰ and the WHA Resolution of 1994 was brought to the fore by events in Kosovo. In this situation the UN Civil Administration in Kosovo released a Joint UN Agency Statement in October 1999 which states that: 'donations must be distributed through the local health house or family practi[ti]oner or, in their absence, through the closest health NGO' (UN Civil Administration Secretariat for Health, Kosovo, 1999). This statement was a contradiction of WHA 47.5 and the Joint Statement by UNICEF/UNHCR/WFP/WHO (1999), issued in April of the same year for the Balkans, which says that 'Free and low-cost supplies of breastmilk substitutes to health care facilities should be banned immediately'.¹¹ The code permits the donation of these

products only to institutions and organisations (outside of the health-care system — although this is not explicitly defined).

The rationale behind this change probably reflects the fact that the refugees had returned home to Kosovo by October 1999, however, the policy was nevertheless technically in contradiction of the World Health Assembly Resolution. Currently, there is no strong evidence base for making a judgement as to which position would result in a better or worse situation regarding inappropriate use of breastmilk substitutes in a post-emergency scenario such as the one found in Kosovo. This example serves to illustrate the difficulties that exist in interpretation and application of some of the provisions of the code and subsequent resolutions during emergency situations (see Borrel et al., this issue).

Ambiguities in technical guidance

UHT milk and commodity guides

Both the UNHCR policy on milk products and the Red Cross policy on the use of artificial milks refer to ‘non-fresh’ milk or milk products. It therefore remains ambiguous whether the policy provisions contained in these documents would also apply to the use of UHT milk.¹² However, the policy of the Red Cross goes on to state that they will not supply or distribute milks packaged in liquid or semi-liquid form, thereby excluding distribution of UHT milk. Specific mention of UHT milk in commodity guides would help clarify if and when there is a role for this product during relief operations and if so, the safeguards that should be employed during its use.

Terminology

The term ‘complementary’ is currently used to describe three different things. These are, first, a class of refugee food described in the UNHCR/WFP MOU (including local fresh foods, spices, tea and dried and therapeutic milk), and second, foods for young children which are given to complement breastmilk. Third, the term ‘complementary ration’ is used in the Sphere guidelines to describe a ration for the general population which provides one or two food commodities to complement existing foods. These various meanings may sometimes lead to confusion in the field. Given the range of meanings in the emergency literature it may be prudent to consistently use the term ‘complementary infant food’¹³ when referring to infant foods in this context.

Gaps in technical knowledge

Re-lactation: While general guidelines for re-lactation are available, these have not been incorporated widely into emergency guidelines. The requirement for infant formula or other breastmilk substitute during re-lactation is not acknowledged in some policies and guidelines for its use in these situations are limited. More work is required to clarify the feasibility of re-lactation support as a population-level intervention in emergencies.

Implementing infant-feeding interventions to meet the needs of all mothers:

When establishing interventions in situations in which there is a high prevalence of artificial feeding, aid workers are faced with many dilemmas on the best way adequately to support mothers feeding infants, such as: how to support safe artificial feeding while not undermining breastfeeding; how to determine and who should decide whether a mother should receive breastmilk substitutes. Guidelines for implementing or managing interventions in such situations which integrate the different needs of all mothers are not currently available. There is a need for the testing of different intervention packages in a range of scenarios and incorporating the knowledge gained into policy- and field-level guidelines.

Interventions in situations of high HIV prevalence: Many of the current policy documents were prepared before the scale of the current HIV pandemic was apparent and the transmission of HIV through breastmilk was established. Policies for emergency contexts and practice guidelines for advising individual mothers need to be developed based on recent research findings and need to complement policies developed to prevent the transmission of HIV in emergency-affected populations.

For all mothers who are known to be HIV negative or whose status is unknown the recommendation to breastfeed has been established for non-emergency contexts (UNICEF/UNAIDS, WHO, 1998) and is likely to apply also to emergency contexts.¹⁴ Whether to promote wet-nursing for infants who cannot be breastfed by their mothers is a difficult programming decision that needs to be faced in the field and requires a careful assessment of available information on the local risk of infant morbidity and death through artificial feeding (which is likely to be elevated in emergency conditions) versus the risk of morbidity and death from contracting HIV via breastmilk. If validated, recent evidence of the protective effects of exclusive breastfeeding (Coutsoudis et al., 2001) may also help determine the best option for an individual child.

It is anticipated that the increasing awareness of the risks of HIV transmission through breastmilk may lead to an increase in the donation of breastmilk substitutes to emergency contexts which until now have not been recipients of these products and perhaps also an increase in the demand for these products by mothers who suspect they may be HIV positive. Policy and practice recommendations need to be developed in advance to avoid uncoordinated and inconsistent responses which may place infant lives at risk.

Nutritional and health assessments of infants: Analysis of the nutrition and health environment for infants is incorporated into various elements of existing recommendations for emergency nutrition assessment. For example, one of the standards for humanitarian response in the Sphere Handbook is: 'Before any programme decisions are made, there is a demonstrated understanding of the basic nutritional situation and conditions which may create risk of malnutrition.' The UNICEF conceptual framework for the causes of malnutrition is recommended to provide a framework for this assessment and includes immediate, underlying and basic causes of malnutrition, morbidity and death. Analysis of these causes as they relate to infants (for example, lack of access to clean water, infants separated from their mothers, etc.) will allow judgements on the needs of infants to be made. The anthropometric assessment of infants is often not performed due to lack of technical guidelines on methodology and validity. More work is required to enable this information to be collected and analysed during surveys. The assessment of diarrhoea prevalence in infants, while quite often performed, is difficult to achieve reliably. Development of new methods to enable this to be performed during routine surveys

would be valuable and assist in the objective measurement of the needs of infants and the impact of interventions.

Therapeutic feeding of malnourished infants

Recent field reports have suggested that acute malnutrition (wasting) in infants may be more common than previously thought (Prudhon, 2000). This may have important implications for the support of breastfeeding and the protection of infant health during acute emergencies. Standard guidelines for feeding centre admission and treatment are often based on the 6–59-month age group and need to be modified and validated for use with the young infant age group.

Concluding remarks

The review of policy documents relating to infant feeding in emergencies has helped identify those areas where policies are consistent. It is important to note that there is consensus and consistency on much of the technical detail of what constitutes good practice. Where the policies and guidelines fall short is in attributing responsibility for specific activities which would allow best practice to be implemented, monitored and maintained. These activities include co-ordination within the UN system for infant feeding. While responsibility for this function most obviously falls with UNICEF, the existing MOUs do not make this explicit, allowing room for alternative scenarios. Other important functions, hitherto overlooked by the policies and guidelines, are the monitoring and control of unsolicited donations of infant feeding items and the co-ordination of NGO and military activities in infant feeding. These functions could all be fulfilled effectively by a designated co-ordinating agency with authority to uphold best practice and existing policies. Given that many agencies are potentially involved in supporting infant-feeding activities (from water, logistics, food, health and transport agencies) the co-ordination function will be challenging and must therefore be adequately resourced to fulfil this specific function, both in terms of financial and human resources, and in terms of receiving the support of donors and operational agencies. We therefore recommend that UNICEF in collaboration with other UN operational agencies notably WFP and UNHCR, negotiate the details of operational co-ordination on infant feeding and the implications for existing systems of response, give attention to estimating the cost implications of a strong co-ordination mechanism and use this information to advocate for necessary resources in future emergencies.

One of the most important gaps in current policies and guidelines is evidence-based, practical recommendations for promoting and supporting breastfeeding and supporting the safe use of substitutes when these are necessary. While some important experience has been gained in the Balkan crisis by national NGOs and international NGOs such as Action Against Hunger, there is relatively little understanding of feasibility of options in different emergency contexts including those with high prevalence of HIV/AIDS. We therefore recommend that urgent attention be given to researching possible intervention strategies in different emergency contexts to ensure that future policy statements are realisable and infant morbidity and mortality can be minimised.

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Notes

1. Given the number of agencies operating in emergency contexts around the world, we may not have included all policy documents in existence.
2. The WHO Constitution gives the WHA the power to adopt conventions, regulations and recommendations. Conventions are the most binding and regulations less so. Recommendations are generally not binding although 'they carry moral or political weight as they constitute the judgement on a health issue of the collective membership of the highest international body in health' (cited in Sokol, 1997). The code was adopted as a recommendation and annexed to WHA Resolution 34.22.
3. More recently, an interagency group has drafted operational guidance for emergency relief staff and policymakers on infant and young child feeding in emergencies. This operational guidance is currently undergoing a process of endorsement by many agencies operating in emergencies.
4. Meeting reports include: IBFAN (1996) *Crucial Aspects of Infant Feeding in Emergency and Relief Situations*; IBFAN, WEMOS and Baby Milk Action (1998) *Report of the International Meeting on Infant Feeding in Emergency Situations, Split Croatia*; Emergency Nutrition Network (1999) *Infant Feeding in Emergencies, Policy Strategy and Practice*.
5. Draft available on www.enonline.net.
6. The World Health Organisation has just confirmed that the international recommendation for populations is that infants should be breastfed exclusively for the first six months of life (180 days) (G. Clugston, personal communication, 5 April 2001).
7. This was first confirmed in 1981 when the World Health Assembly accepted the International Code on the Marketing of Breastmilk Substitutes. The code sets out the responsibilities of national governments, companies, health workers and concerned organisations in ensuring appropriate practice in the marketing of breastmilk substitutes, feeding bottles and teats. The code's objective 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'. A number of resolutions have been passed by the WHA since 1981 (notably WHA 47.5 in 1994) to further clarify and amplify the code, and provide strict conditions which must be met before breastmilk substitutes, bottles and teats can be distributed.
8. 'Complementary' in this context refers to a class of refugee foods distributed by UNHCR which may include local fresh foods, spices, tea and dried and therapeutic milks.
9. Blended foods are a milled, blended and pre-cooked (by extrusion or roasting) mixture of cereals, pulses, oilseeds and other ingredients. Blended foods were originally designed to provide protein supplements for young children. Blended foods are often now fortified with a range of micronutrient and sometimes used to prevent or correct micronutrient deficiencies (WFP, 2001).
10. The code states:
 - 6.6 Donations or low-price sales to institutions or organisations of supplies of infant formula or other products within the scope of this Code, whether for use in the

institutions or for distribution outside them, may be made. Such supplies should only be used or distributed for infants who have to be fed on breastmilk substitutes. If these supplies are distributed for use outside the institutions, this should be done only by the institutions or organisations concerned. Such donations or low-price sales should not be used by manufacturers or distributors as a sales inducement.

6.7 Where donated supplies of infant formula or other products within the scope of this Code are distributed outside an institution, the institution or organisation should take steps to ensure that supplies can be continued as long as the infants concerned need them. Donors, as well as institutions or organisations concerned, should bear in mind this responsibility.

11. The rationale behind the banning of free or low-cost supplies donated to health-care facilities was to prevent their indiscriminate use. If these products have to be purchased by the health-care system, their use will be much more strictly controlled.
12. UHT milk is an ultra high temperature treated liquid milk, has a prolonged shelf life and is usually packaged in cartons.
13. It is acknowledged that the term still used most often in the field is 'weaning food'. However, the use of 'complementary infant food' is recommended because it encourages extended breastfeeding after the first introduction of other foods.
14. Forthcoming interagency operational guidance on infant and young child feeding in emergencies.

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